

I. General

Steps have been taken to correct specific weaknesses in the areas of plant operations, radiation protection, and quality assurance as identified in the non-compliances referred below. Licensee corrective actions have been reviewed and onsite inspection performed where necessary. An enforcement conference was held with senior licensee management to discuss specific problems and corrective actions. Programmatic improvements were made by the acquisition of additional staffing, a major corporate office reorganization, and a comprehensive review of Quality Assurance program standards.

II. Specific

A. Contention

"The Surry facility displayed evidence of weaknesses in the areas of plant operations, radiation protection, and quality assurance."

The basis, NRC actions and licensee corrective actions for this contention are discussed in contentions B-F below.

B. Contention

"Weaknesses in the operations areas were characterized by repetitive instances of failure to follow procedures, improper system lineups or tagging errors, and unapproved use of temporary hoses or jumpers.

1. Basis

Examples of inadequate procedures or a failure to follow procedures include the repetitive findings of recirculation pump screens improperly placed or with excessive trash near the screens, electrical cable trays uncovered, or covered by trash, prints or wood, Unit 2 main steam line flow instruments isolated and inoperable during plant operation, and failure to correct roof leaks leading to the shorting and inoperability of a Low Head Safety Injection pump during operation of Unit 2. Other examples include ventilation system filters and charcoal beds not adequately inspected or replaced when excessive differential pressures or known damage occurs, and failure to follow procedures in answering annunciator alarms. Failure

References

LERs 280/79-13,30,
31,38; 80-6,8,9,16,
17,20; 281/80-1

IE Rpt. 50-280/79-45,
79-50, 79-52, 79-67,
80-1, 80-7, 80-10, 80-19

IE Rpt. 50-281/79-42,
79-47, 79-80, 79-86,
80-3, 80-10, 80-11,
80-19

to follow maintenance and operations procedures resulted in numerous licensee event reports during 1980. Improper system lineups or tagging errors include improper identification tags on valve components resulting in inadvertent isolation of the boric acid tanks on several occasions. Improper valve lineups or tagging errors resulted in numerous LERs during 1980.

Temporary hoses and jumpers have been installed incorrectly and without proper authorization and approval. One improper hose installation on the sump system inadvertently diverted several hundred gallons of contaminated containment sump water to the basement of the Safeguards Building.

2. NRC Actions

These and related topics were discussed with senior licensee management at a meeting on October 8, 1980. Items of noncompliance were issued as noted in the reference given in the Basis, above. In addition, inspection activities have increased in the problem areas.

3. Licensee Corrective Actions

The licensee took appropriate corrective action on the items of noncompliance referenced above. An extensive program of retraining personnel on the requirements and consequences of procedural noncompliance was also established. There has been an increase in the number of reprimands and management involvement in cases of personnel errors. Internal licensee instructions and memos have been issued in an effort to heighten awareness of proper plant operations. The number of tagging errors and use of temporary hoses and jumpers has decreased.

IE Rpt. 50-280/80-28
IE Rpt. 50-281/81-2

C. Contention

"The licensee experienced difficulty in responding to unplanned maintenance problems, failed to take corrective actions in response to several recurring problems, and did not adequately test equipment following maintenance on several occasions."

1. Basis

The licensee's onsite engineering, maintenance and testing staff were minimal, and experienced difficulty in responding to unplanned maintenance problems. Periodic testing was not properly performed or evaluated, and engineering solutions to recurring problems were delayed due to the workload of the staff. Routine maintenance was delayed because of priority maintenance on failed equipment. In December 1979 and January 1980, some 50 health physics requests for engineering studies were submitted to the engineering staff. These requests were to determine the feasibility of adding shielding to certain components and piping, for radiation exposure reduction, without overstressing the components or piping. As of January 1981, none of the requests had been reviewed by the engineering staff due to higher priority items.

The licensee's failure to take corrective action in response to several recurring problems is exemplified by the continued problem with procedural noncompliance and design problems in the heat tracing and service water systems.

2. NRC Action

These and related topics were discussed with senior licensee management at a meeting on October 8, 1980. Items of noncompliance were issued as noted in the references given in the Basis, above. In addition, inspection activities have increased in the problem areas.

3. Licensee Corrective Action

The licensee took appropriate corrective action on the items of noncompliance referenced above. Additional staffing was acquired allowing greater response to unplanned maintenance with less impact on other tasks. A corporate office reorganization has occurred in an effort to provide thorough

Reference

IE Rpt. 50-280/79-63,
79-67, 80-10
IE Rpt. 50-281/80-11
LER 280/80-09

licensee letter of 8/1/80

evaluation and corrective action of recurring problems.

D. Contention

"Weaknesses in the radiation protection area were indicated by numerous radiation protection items of noncompliance and escalated enforcement action concerning inadequate radiological surveillance on a radioactive waste shipment."

1. Basis

On April 14, 1980, the licensee shipped a radioactive waste shipment to Barnwell, SC which violated NRC and Department of Transportation (DOT) regulations. Radiation levels on the external surface of the vehicle were higher than allowed resulting in two items of noncompliance (exceeding DOT limits and failure to perform an adequate survey).

Other inspection findings included eight items of noncompliance related to a failure to follow Technical Specifications, radiation protection procedures, and 10 CFR 20 (Standards for Protection Against Radiation).

2. NRC Action

A special inspection was conducted on April 25, 1980 regarding the radioactive waste shipment. On April 30, 1980, an enforcement conference was held to discuss NRC concerns over the shipment. On May 28, 1980, the licensee was issued a Civil Penalty relating to the waste shipment. The licensee's June 20, 1980 response to the May 28, 1980 escalated enforcement action was reviewed, and the licensee's actions to correct the problems were found acceptable. These and related topics were discussed with senior licensee management at a meeting on October 8, 1980.

Notices of Violations were issued for the remaining items of noncompliance.

Reference

IE Rpt 50-280/80-16

IE Rpt. 50-281/80-17

IE Rpt. 50-280/79-24,
79-32, 79-64, 79-70

IE Rpt. 50-281/79-42,
79-50, -79-80, 79-84

IE Rpt. 50-280/80-16, and
50-281/80-17

NRC letter of 5/28/80
Licensee letter of
6/20/80

IE Rpt. 50-280/79-24,
79-32, 79-64, 79-70

IE Rpt. 50-281/79-42,
79-50, 79-80, 79-84

3. Licensee Corrective Action

The licensee has taken specific corrective actions in response to the identified items of noncompliance.

IE Rpt. 50-280/80-11
IE Rpt. 50-281/80-9, 80-12

E. Contention

"Quality assurance weaknesses were characterized by instances of longstanding and uncorrected design problems in plant systems, instances, where the licensee used unqualified parts in safety-related maintenance, and several procedures that were not properly revised following technical specification revisions."

1. Basis

Instances of longstanding and uncorrected design problems in plant systems included numerous problems with the heat tracing and service water systems. Heat tracing problems included repeated replacement of heat tape, low circuit current, excessive system heat and failure to replace insulation after piping repairs were completed. Service water problems included valve degradation and low discharge pressure.

An unqualified gasket was used during pressurized valve repairs.

Examples of procedures which were not properly revised following technical specification changes include one resulting in a violation of the minimum level requirements in the Radwaste Storage Tank and the Chemical Addition Tank, and one involving a technical specification violation of containment pressure and temperature limits.

2. NRC Action

These and related topics were discussed with senior licensee management on October 8, 1980. Notices of violation were issued as documented in the above references.

3. Licensee Corrective Action

The licensee has taken specific corrective actions in response to identified items of noncompliance and to the problems associated with the heat tracing

References

LERs 280/79-33, 79-35,
79-37, 79-39, 80-18,
80-23, 80-27, 80-32,
80-50, 80-69;
281/80-18, 80-28, 80-29

IE Rpt. 50-280/80-1 and
281/80-3

IE Rpt. 50-280/80-20,
80-34
IE Rpt. 50-281/80-21,
80-37

NRC letter of 5/23/80
license letter of 8/1/80
IE Rpt. 50-280/80-19,
80-43

and service water systems. The licensee has committed to a comprehensive review of their Quality Assurance program to meet more current NRC and industry standards.

IE Rpt. 50-281/80-19

F. Contention

"... there was one instance where escalated enforcement action was taken to assure corrective action by the license."

The basis, NRC actions, and licensee corrective actions for this contention are discussed in contention D, above.