U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-255/84-28(DRP)

Docket No. 50-255 License No. DPR-20

Licensee: Consumers Power Company
212 West Michigan Avenue
Jackson, MI 49201

Facility Name: Palisades Nuclear Generating Plant

Inspection At: Palisades Site, Covert, MI

Inspection Conducted: June 7 - November 28, 1984

Inspectors: B. L. Jorgensen

J. Madeda
Physical Security Specialist 1/2/85 Date

Approved By: G. C. Wright, Chief
Reactor Projects Section 2A 1/2/85 Date

Inspection Summary

Inspection on June 7 through November 28, 1984 (Report No. 50-255/84-28(DRP))

Areas Inspected: Unannounced, special inspection to review the facts surrounding several allegations received by the NRC via written correspondence of June 7, June 21, June 22, July 2 and August 17, 1984, from one individual.
Results: None of the nine allegations were substantiated.

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DETAILS

1. Persons Contacted

   Wm. R. Reed, Personnel Director
   W. Hodge, Property Protection Supervisor

2. Purpose of Inspection

   On June 7, 1984 Region III received a letter from a non-licensed employee of the Consumers Power Company (CPCo), who had been working at the Palisades Nuclear Power Plant. The letter contained a number of concerns as generally listed below:

   a. Dissatisfaction with the licensed operator training program.

   b. Dissatisfaction with treatment he has received from CPCo management and Personnel Office regarding the psychological screening program.

   c. The individual stated he had heard that an auxiliary operator was not performing his rounds and was falsifying data sheets.

   d. Concerns about CPCo's hiring practices.

   Region III attempted to contact the individual during the week of June 11, 1984, but was unsuccessful. On June 19, 1984 Region III sent a letter to the individual requesting that he contact G. C. Wright. A meeting was arranged for July 31, 1984 between the individual and Messrs. G. C. Wright and B. L. Jorgensen.

   Prior to the meeting, Region III received letters on June 21 and June 22, 1984 from the individual; the first amplified Item a. above, the second was a copy of a letter the individual had sent to CPCo's Quality Assurance Department.

   On July 31, 1984 Messrs. G. C. Wright and B. L. Jorgensen met with the individual to discuss the items raised in his June 7, 21, and 22, 1984 letters. During the meeting the individual discussed and amplified on the items as follows:

   a. Dissatisfaction with licensed operator training program.

      (1) The course was weighted towards Senior Reactor Operators.

      (2) The course required study time outside normal working hours.

b. Dissatisfaction with the treatment he has received from CPCo management and Personnel Department regarding the psychological screening program. The individual provided no new information on this subject other than a copy of his "Behaviordyne" test (psychological profile).

c. An auxiliary operator failed to perform rounds and may have falsified data sheets.

   (1) The individual alleged of this activity was named.

   (2) Dates of alleged activity were provided.

   (3) The problem was with the switchyard breaker air compressor cumulative hour meters.

d. The individual was concerned with CPCo's hiring practices, and discussed in detail a former employee's training/job performance and physical capabilities.

The NRC has received two additional letters from the individual, dated July 2 and August 17, 1984. The first letter discussed the results of a grievance meeting between the individual and CPCo management. The second letter addressed specific examples of alleged misapplication of the CPCo psychological screening program. The second letter also included a new allegation dealing with plant operations. The specifics of these letters are listed below.

(1) A named auxiliary operator knowingly allowed "a large vacuum leak on the secondary side to go unreported to 'pay the company back' for a 30 day disciplinary layoff."

(2) A named individual was accused of throwing food on two occasions.

(3) A named individual was convicted of drunken driving and the company did not reassess the individual under its psychological screening program.

(4) A named individual failed the written portion of the "Behaviordyne" psychological test and was allowed to retake the exam. It was alleged that the re-examination was not allowed.

(5) A named individual was sent home after reporting to work intoxicated.

(6) A named individual was allowed to "sleep it off" after reporting to work intoxicated. The named individual no longer works at the site.

In response to the letters and the meeting Region III initiated an investigation into the specific areas of concern raised by the individual. The following are the results and conclusions of that investigation.

1. Allegation: A named auxiliary operator (AO) was not performing switchyard rounds and was falsifying data on the "Breaker sheets" to cover up during the time period May through December 1982. Specifically, the air compressor running times (cumulative hours) recorded by the named AO, when compared to data recorded by others, would show the cumulative hour meter to be running backwards.

   Investigation: The investigation took place on August 2, 3 and 8, 1984. It was determined that the records in question no longer exist. The licensee's document control procedures do not require microfilming or other retention of the breaker sheets. The data sheets are reviewed and maintained in the files for only the current calendar year.

   On the presumption that the alleged activity might still have been ongoing, the switchyard breaker sheets, associated with the named individual for calendar year 1984, were reviewed up to August 1984. Although instances were noted where the data showed that the compressors had not run, no instances were identified where the cumulative hours meters appeared to be running backwards.

   <u>Safety significance of missed breaker sheet rounds</u>: failure of an operator to perform his shift readings of breaker compressor run hours would have <u>minimal</u> safety significance. First, breaker operating air pressure is a monitored and alarmed parameter. This means rapid air leakage without appropriate compressor response (i.e., a threat to breaker operability) would be identified independent of operator monitoring of run time on the compressor. Second, the purpose of the reading is to observe long-term trends (high run hours indicating excessive air leakage). The absence of one shift's readings (or their "fabrication") would not alter the long-term trend. Third, the breakers themselves (and their functions) are not plant nuclear-safety significant. Most accident scenarios assume loss of offsite power, which means the plant becomes independent of <u>whatever</u> happens in the switchyard. Switchyard design is such that if a breaker should fail to open when required, the same isolation function will be accomplished by the opening of adjacent breakers. This minimizes the potential for switchyard

faults propagating into plant electrical systems, and is only a <u>backup</u> to in-plant protection associated with safety-related electrical systems which provide the same function - i.e. protection from damage due to faulting conditions.

Conclusion: Based upon the unavailability of the 1982 records the allegation cannot be substantiated and a review of the 1984 records, on the assumption that the alleged activity was still ongoing, revealed no cumulative hour meters anomalies.

2. Allegation: A named auxiliary operator (AO) knowingly allowed a secondary system vacuum leak to go unreported to pay the company back for a 30 day disciplinary layoff.

Investigation: The investigation determined that the named AO had received a three day disciplinary layoff after an altercation with the alleger. Starting at the end point of the layoff, one instance was identified wherein the alleger and the named AO worked a shift, on September 24, 1982, during which plant vacuum problems developed.

On September 24, 1982, the shift supervisor's log book indicates that at 0310 hours the turbine intercept and moisture separator/reheater stop valves were tested and that the unit started losing vacuum. The unit started reducing power and efforts were made to locate the source of the vacuum "leak". The log indicates that at 0625 vacuum was holding steady. At 0900 the power reduction was stopped and vacuum was improving, and the 0915 entry stated: "Vacuum still improving. The only thing we found was the shell drain on 2B heater slightly open. Got about two turns on the valve."

As far as the inspectors were able to determine, the licensee did not establish positively why the 2B heater shell drain was "slightly" open. It was noted that heater drain valves are not rigorously controlled (not present on checksheets, no independent verification required) as safety-related valves are. Therefore, any errors in valve lineup would not be picked up by a second individual. It is further noted that the vacuum problem did not exist prior to testing of the turbine valves, which can cause pressure and level changes in the moisture separators which may have been responsible for/contributed to the vacuum problem.

The following general observations can be made regarding secondary plant vacuum monitoring.

a) The plant <u>does</u> <u>not</u> rely on auxiliary operators to report vacuum leaks; vacuum is monitored, recorded and alarmed on the main control room.

b) Auxiliary operators and others may be called on to search for known leaks.

c) Condenser vacuum leaks have little safety significance other than the potential for a turbine/reactor trip.

Conclusion: There is no direct evidence that an individual intentionally mispositioned the valve which was found "slightly" open. As stated previously, the licensee does not reply on personnel to report vacuum leaks; vacuum is monitored, recorded and alarmed in the control room. Therefore, the allegation that an individual allowed a secondary system vacuum leak to go unreported is not substantiated.

3. Allegation: A named auxiliary operator was alleged to exhibit aberrant behavior (throwing food).

Investigation: The licensee's site Security Director was contacted on September 21, 1984. He was asked about his knowledge of the described food throwing events (throwing food on the table in the security building and throwing a "wet burrito" at a fellow employee). He indicated that both incidents had occurred. The Security Director also indicated the incidents had been thoroughly reviewed by the licensee's management and that their review did not support the conclusion that the individual in question exhibited aberrant behavior.

In the first event, a bowl of chile was turned over on the X-ray conveyor belt by the named individual. The licensee concluded from interviews with the personnel present at the incident that the event was accidental. The second event (June 1982) involved the named individual throwing a "wet burrito" over the head of a fellow employee. The licensee's investigation determined that the individual had lost his temper (disagreed with the other employee), but the situation did not indicate aberrant behavior. The individual received a three day suspension. No additional findings concerning aberrant behavior were noted concerning this individual.

Conclusion: Given that the first event was accidental and the second event resulted from a disagreement between two individuals, with one losing his temper, we do not find the allegation of aberrant behavior to be substantiated.

4. Allegation: A control room operator was alleged to have been convicted of drunken driving, but the licensee did not re-evaluate the individual under the psychological screening program.

   Investigation: According to corporate and site security representatives, the company requires a reassessment of an individual if it has knowledge of the individual's conviction of a crime or if the individual's trustworthiness is in doubt. In the opinion of the corporate security representative, a drunk driving conviction on its own is not considered to be an action that would have required a reassessment of the individual. The licensee also stated that company policy does not require an employee to notify the company when they are convicted of a crime nor does it require that the alleger should have reported it to the licensee. The licensee's review (records and employee knowledge) showed that they were unaware if the named individual had been convicted of drunk driving. The inspectors found no indication of the individual exhibiting drunken behavior while on duty. Based on the information provided by the inspectors, the licensee will pursue the possible conviction and, if substantiated, a reassessment of the individual will be conducted.

   Conclusion: As the company's reassessment program is based on their knowledge of a conviction and in this case they were unaware of the alleged conviction, the allegation that they took no action cannot be substantiated. At present, the licensee has taken action and is reviewing the matter.

5. Allegation: A named employee failed the written portion of the psychological screening program and was allowed to retake the test, which is not allowed.

   Investigation: Contact with the site security director indicates that it is allowable to retake the written portion of the screening program. Further, if an individual fails the written test, an interview with a person trained to practice psychiatry must be conducted. Based on the NRC's concern and request, the licensee reviewed the file on the named employee and determined that the written test was successfully completed on the <u>first</u> attempt.

Conclusion: As the documentation indicates the individual passed the written portion of the screening program on the first attempt, the allegation is not substantiated.

6. Allegation: Inadequate licensed operator training program.

Investigation: The individual's problems with the training program were threefold: the course required study on one's own time (i.e., time not compensated by salary); a course student population consisting of fifteen senior reactor operators and four reactor operator candidates placed too much pressure on the reactor operator candidates; the course appeared, to the individual, to be slanted towards the senior license candidates, thus requiring additional uncompensated study time.

The area of licensed operator training has been inspected in seven of the last nine years, with only one minor item of noncompliance having been identified in 1983. Inspections typically focus on such areas as operator candidate background qualifications and experience, course content, written and operating proficiency tests administered to license candidates, licensee training facilities, etc. Inspections do not address areas such as course size, student performance standards relative to course syllabus, or other areas which are within the licensee's authority to structure as it deems necessary or desirable. The overall training program has been found to be consistent with the U.S. NRC Rules and Regulations.

Conclusion: As the allegation focused more on the issue of uncompensated study time and other matters more germane to the student-licensee area of jurisdiction and not on the adequacy of the operator training program *per se* (which has been found to be generally acceptable to date), the allegation of program inadequacy is not substantiated.

7. Allegation: Alleged inadequacies in company's hiring practices (only one person's hiring was questioned).

Investigation: The named individual the alleger was referring to no longer works for the company. The concerns dealt with the individual's failure to pass an exam, subsequent retraining, and the person's physical ability to perform the job. The alleger also mentioned two specific items: one pertaining to an injury sustained by the named individual, the other pertaining to the spent fuel pool overfill event of

November 24, 1983[1] (with the inference that both events were the personal fault of the named individual).

Minimum NRC Requirements: Stated in Licensee Administrative Procedure 4.00 "Operations Organization and Responsibilities", Para. 4.11.2 - "A Qualified Auxiliary Operator shall have a high school diploma or equivalent, at least one year of power plant experience and should possess a high degree of manual dexterity, mature judgment and be capable of progressing to higher levels of responsibility, including eventual NRC licensing." Except for the diploma and experience requirements, these qualifications categories are somewhat subjective. Note these are not hiring requirements, but qualification requirements for those hired into the position without prior experience. Nothing about the individual's employment appears contrary to the requirements.

A review of the individual's training records and performance appraisals indicates that after some initial problems the individual's performance was satisfactory. The record also suggests that the licensee monitored the individual's progress carefully and was deliberate in choosing the work assigned to the individual.

A review of the available records pertaining to the two specific events mentioned indicate that the injury was not attributable to carelessness nor was the overfill event ascribed to any personnel failing.

Conclusion: The U.S. NRC reviewed the position requirements and qualifications of the individual and found no discrepancies. A review of the cited events indicates no wrongdoing or lack of judgment on the part of the individual. Based on the negative results of the reviews, the allegation is not substantiated.

8. Allegation: The licensee violated the intent of its own Administrative Procedures by using the psychological screening provisions of the security plan (part of the Administrative Procedures) as the basis for a personnel action, when the basis should have been a union-management problem.

Investigation: The licensee imposed an administrative action (suspension) on the individual, citing as the basis for the action the provisions of the Security Plan,

[1] Refer to Inspection Report 255/83-29.

specifically the results of the psychological screening provisions. The licensee is required under U.S. NRC regulations to have a security plan and to abide by the agency approved plan. The plan's implementation is inspected by the U.S. NRC on a periodic basis and has been found to be acceptable. The licensee's actions, based on the results of their psychological screening program, are consistent with the implementation of the Plan and, hence, are not in violation of the licensee's Administrative Procedures. Whether the licensee should have based its actions on other administrative provisions lies within the jurisdiction of the labor relations arena and is outside the regulatory authority of this agency.

Conclusion: The U.S. NRC has found the licensee's implementation of its Security Plan to be acceptable. The licensee did not appear to violate its own Administrative Procedures in taking the action it did. The allegation, therefore, is not substantiated.

9. Allegation: Named individuals reported to work intoxicated and were either sent home or allowed to "sleep it off".

   Investigation: The licensee's policy on alcohol/substance abuse mandates discharge for the first offense involving possession or intoxication on the job. An individual who reports to work "under the influence" (but does not commence on the job activities) shall be "disciplined" - which could include discharge. Either of these occurrences would be reflected in the personnel files.

   The specific individual's personnel files were reviewed; in neither case was there any evidence that the alleged events occurred.

   Conclusion: As the licensee's company policy mandates discharge or other disciplinary actions concerning the alleged incident and that the actions be reflected in the individual's files, the lack of any such documentation results in the allegation being unsubstantiated.