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SENIOR VICE PRESIDENT
NUCLEAR

October 18, 1985
BECO Ltr. #85-190

Mr. Richard W. Starostecki, Director
Division of Reactor Projects
U.S. Nuclear Regulatory Commission
Region I - 631 Park Avenue
King of Prussia, PA 19406

License No. DPR-35
Docket No. 50-293

Subject: Response to Violations as Contained in
NRC Inspection Report #85-21

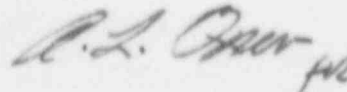
Dear Mr. Starostecki:

This letter is in response to the violations identified during a special NRC Inspection conducted by Dr. M. McBride of your office on July 16-30, 1985 at Pilgrim Nuclear Power Station and communicated to Boston Edison Company in enclosures to the subject letter.

Our response is therefore enclosed as an attachment to this letter.

Should you have any further questions concerning these issues, please do not hesitate to contact me.

Respectfully submitted,



William D. Harrington

Attachments

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ATTACHMENT

Violation "A"

Technical Specification Limiting Condition for Operations 3.7.C.1 requires, in part, that whenever the reactor is critical, secondary containment integrity be maintained. Section 1.N of the Technical Specifications defines secondary containment integrity and requires as one of its conditions that all automatic ventilation system isolation dampers must be operable or secured in the closed position.

Contrary to the above, for approximately 19 hours between 3:00 p.m., July 15, 1985 and 10:00 a.m., July 16, 1985, secondary containment integrity was not maintained while the reactor was critical in that automatic ventilation system isolation damper AO-N-90 in the exhaust ventilation duct from the refueling floor was identified as open and inoperable at 3:00 p.m. on July 15, 1985, and the damper was not secured in the closed position until 10:00 a.m. on July 16, 1985.

Response

Cause of not performing the Tech. Spec. compensatory actions for approximately 19 hours was due to utility Maintenance personnel error. The error occurred when personnel failed to report the event according to Procedure 1.3.24 (Failure and Malfunction Report) which would have alerted the Watch Engineer that appropriate Tech. Spec. action was needed. The cause of the damper not fully closing was, as reported on the Maintenance Request, due to slippage in the drive gears.

Immediate corrective action to correct the condition was to close the redundant damper and to align the drive gears on Damper AON-90.

Corrective action to preclude recurrence was to counsel involved personnel in the requirements of Procedure 1.3.24 (Failure and Malfunction Report), especially the need to issue a F&MR as well as the Maintenance Request in future failures. This need will be re-emphasized in additional training which is explained in further detail in our response to Violation "C" of this letter.

Full compliance was achieved on July 17, 1985, the date by which Maintenance management had been instructed on the importance of promptly initiating F&MR's.

Violation "B"

Technical Specification (T.S.) Surveillance Requirement 4.5.F.1 specifies that when one diesel generator is inoperable, the remaining diesel generator, and all low pressure core cooling and containment cooling systems shall be tested immediately and daily thereafter.

Contrary to the above, on July 23, 1985, Diesel Generator A was found to be inoperable because the water and sediment content in the diesel fuel tank T-126A was in excess of the limits in Table 1 of ASTM D975-77, required core cooling subsystems, and containment cooling subsystems were not tested until July 26, 1985.

Response

Cause of the event was an inadequate procedure and the fact that Chemistry personnel were not fully aware of the requirements of the F&MR procedure. Procedure 7.1.36 ("Diesel Generators' Fuel Oil Sampling and Quality Analyses") was inadequate in that it (1) did not state that the Watch Engineer must be notified if the fuel oil test results are not within specifications and (2) did not clearly require Chemistry personnel to file a Failure and Malfunction report if those specifications are not met.

Immediate corrective action included counseling of the Chemistry personnel involved regarding the need to issue F&MR's and temporarily increasing the storage tank sampling frequency from monthly to weekly (for 4 weeks).

Weekly test results since pumping water from the "A" storage tank on 7/26/85 have been satisfactory. Day tank test results found no water/sediment. Visual inspection of the area of the tank did not identify any obvious point of entry for the water/sediment.

Corrective action to preclude recurrence is that, on 9/18/85, Procedure 7.1.36 was revised to require (1) immediate Watch Engineer notification and (2) filing of a F&MR by Chemistry personnel if the test results for the emergency diesel fuel oil do not meet Technical Specification acceptance criteria.

Full compliance was achieved on 9/18/85, the date upon which the subject procedural controls were put in place.

Violation "C"

Technical Specification 6.8.A requires, in part, that written procedures be established, implemented and maintained that meet or exceed the requirements and recommendations of Section 5.1 and 5.3 of ANSI N18.7-1972 and Appendix "A" of NRC Regulatory Guide 1.33.

Station Procedure 1.3.24, Failure and Malfunction Reports, Revision 11, dated February 6, 1985, written as required by T.S. 6.8.A states that (1) a Failure and Malfunction Report (F&MR) shall be initiated whenever malfunctions identified during surveillance testing of safety related components could prevent the components from fulfilling their intended functions and (2) the objective of the F&MR is to ensure an adequate initial review of events with potential safety significance.

Contrary to the above,

1. At 3:00 p.m. on July 15, 1985, secondary containment ventilation damper AO-N-90 was identified as malfunctioning (would not fully close) during a routine damper surveillance inspection, and an F&MR was not initiated.
2. On July 23, 1985, water and sediment in excess of limits was discovered in the T-126A diesel generator fuel oil storage tank during a monthly surveillance test, and a F&MR was not initiated.

Response

Cause of this violation is an apparent lack of understanding in the failure and malfunction process of problem identification and reporting as exhibited by certain sectors of our staff at Pilgrim Station.

Therefore, as corrective action to correct the condition and to preclude recurrence, a Station-wide re-instruction on the importance of the Failure and Malfunction Report is currently being implemented. The program will cover the following subjects:

- ° Why a F&MR is required to be initiated
- ° Who is responsible for writing a F&MR
- ° How the form is filled out
- ° When a F&MR is required

It is anticipated that the appropriate groups will have received this training by 1/2/86.

We will have reached full compliance on 1/2/86, the date on which the subject training is expected to be completed.

NRC Concern

The NRC concern that, Licensed Operators rely solely upon the F&MR for notification of abnormal conditions, is not shared by this Company. Boston Edison believes an adequate level of aggressiveness is exhibited by Licensed Operators in pursuing resolution of potential problems. However, as we have stated earlier in this response, we believe that a major contributor to this type of problem is a lack of understanding of the reportability process as exhibited by personnel other than in the Operations Group. The training program outlined in our response to Violation "C" will increase plant workers sensitivity and reaction to situations involving potential problems. Another important tool which operators frequently use to identify abnormal conditions is communication with personnel of other disciplines. The training mentioned earlier in this response will improve the frequency and the quality of that inter-disciplinary communication.

Notwithstanding the above, the lessons learned from the above incidents and the subsequent dialogue and training dispensed to various groups, including the licensed operators, has and will result in an increased level of employee sensitivity to abnormal conditions and the reportability concerns which follow.