

SYNOPSIS OF SHOREHAM ALLEGATIONS (RI-85-A-0048)

by

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April 8, 1985

Note: These allegations were apparently provided by unspecified Shoreham I&C technicians, whom the allegor refers to as, "rent-a-techs", over the past three years.

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1. Design error which allowed a motor operated valve (unspecified) on the turbine deck to continue to cycle, after being powered, which was signed off and approved (incorrectly) prior to later checkout and testing.
2. Instrumentation is routinely "tapped" in the presence of QC personnel who don't realize that it invalidates the calibration. The tapping defeats what's known as the "hysteresis effect". Sign off of "fudged data" is then noted on "required documentation". An example is the calibration of Weston indicators, found throughout the plant, which would otherwise fail their calibration if not tapped.
3. Bailey 24 VDC current supplies do not adequately power instrument loads, such as Rosemont transmitters, and cause voltage drops and, therefore, inaccurate calibrations. Some instruments had to be "turned off" in order to do the (calibration) "sign off".
4. Uncorrected design error, brought to the attention of Technical Support, for an "over-ranged" switch (presumably two switches, PS-124 and 125), used for an interlock in the reheat steam system ("1N11") to the low pressure turbine on Turbine Building Elevation 37'. A pressure head correction factor had not been considered in the initial calibration, such that the switch(es) is(are) "made" all the time.
5. "Reactor Cooling Water" system flow indicator (unspecified) does not meet required specifications.
6. Generic design problems (unspecified) in radiation waste feed line expansion joints.
7. High Pressure Coolant Injection (HPCI) system (1E41) sensing line installation causes "traps", creating false indication to a switch (presumably PS-121L) associated with HPCI pump suction pressure which would keep the pump "off". Review of this problem had been requested (presumably by I&C technician who is the alleged source) of the "Technical Department"; however, the foreman (unspecified) told this technician that "management didn't want to hear about things like this now."
8. Generic problem identified by the I&C Group, which had solutions recommended and would be serious if left uncorrected. In the Moisture Separator Reheater drains (N35) system, a "widespread" problem exists with 12 relays (possibly referred to as the '86' relay). These relays are also used on the diesel generators, and some have already experienced failures because of this (unspecified) problem. Possibly related to this N35 system problem is a valve tagged LCV-01N.
9. Regarding the qualification and training of instrumentation technicians: (a) they have not had annual eye tests; (b) required reading has not been "mandated"; (c) orientation classes have not been "made current"; (d) non-certified personnel have run tests and signed off work; and (e) some have been employed on the basis of resumes that didn't "match their security clearance papers".

10. Instrumentation data cards have not been made "historically correct" or, in some (unspecified) cases, have never been filled out. Most importantly, technicians have made changes to instrument calibrations without either reason or authorization.
11. A generic problem that "many workers had corrected at least a half dozen instances of fudged data" (no specified instances).
12. QC has been in violation of "code" (unspecified) by sign off of paperwork without "onsite review" (presumably witness or inspection) of (instrumentation) systems
13. Instrumentation supervisors do not have nuclear experience, and they've asked workers to shortcut procedures, especially on surveillances (no specifics provided).
14. Unqualified Startup technicians, presumably from the Maintenance technician staff, allowed design errors (unspecified) to go undiscovered. These errors should have been detected at the time of system walkdowns (prior to turnover, presumably, to Startup), but went unnoticed by Startup and are now incapable of being identified by inexperienced maintenance technicians. Allegation Number 4 (head pressure correction problem) is an example of this kind of error.
15. Radwaste (G11) system laundry tank nos. 20A and B level alarms incorrectly set. Original calibration data for level transmitter found to be incorrect, since the "zero had been suppressed 10½ inches", and the tanks would overflow before reaching full. Data sheets had specified the alarm point as 8'6"; however, an operator's indicator had read out as 900 gallons at one time. (This may have been corrected already).