U.S. NUCLEAR REGULATORY COMMISSION REGION I

Conference Report No. 50-322/86-03

Docket No. 50-322

License No. NPF-36

Priority

Category

Licensee: Long Island Lighting Company P. O. Box 618 Shoreham Nuclear Power Station Wading River, New York 11792

Facility Name: Shoreham Nuclear Power Station

Meeting At: U.S. NRC Region I, King of Prussia, Pennsylvania

Inspection Conducted: March 20, 1986

Prepared By:

Clay Warren, Resident Inspector

date

Approved by:

Jack Strosnider, Chief, Project Section 18

date

Meeting Summary:

An Enforcement Conference was held at NRC Region I on March 20, 1986 to discuss the findings of Special Inspection Report 50-322/86-03. This report presented the findings on an inspection conducted in the radiochemistry area between January 27 - February 14, 1986 which raised serious questions regarding the exercising of sufficient management and quality controls in the radiochemistry area.

The meeting was attended by NRC and LILCO management personnel (Attachment I is a list of participants) and lasted approximately two and one half hours.

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DETAILS

1. Purpose

The enforcement conference was held at NRC Region I's request to discuss the apparent lack of management awareness to numerous indications of a programmatic breakdown in the radiochemistry area as identified in Special Inspection Report 50-322/86-03. Specific areas to be addressed were: lack of attention and prompt corrective actions to licensee Quality Assurance Audit Report No. 85-05, lack of senior management involvement in plant radiochemistry/activities, and lack of training department coordination.

2. Presentation

The licensee concurred with the findings in Special Inspection Report 50-322/86-03 based on the results of their own investigations. During the course of the licensee's presentation all the major concerns raised by the inspection report were discussed. The licensee presented the findings of their investigation including the cause of the specific breakdowns and discussed corrective actions detailed for each major concern.

Corrective actions taken or planned by the licensee include the following. A contractor has been hired by LILCO to perform a third party audit of the Radiological Controls Department and eventually all of the onsite organization. A reorganization and restaffing of the radiochemistry area is being planned. A complete investigation and recertification, where necessary, of the training and qualification records has been initiated. In addition, more aggressive management control systems are being initiated. These include attendance by division level managers at all exits of LILCO and third party QA audits and NRC inspections, response to audit findings within 30 days or on a schedule approved by the plant manager, monthly personnel resource reports to monitor personnel utilization, and required periodic inspections of plant activities by Division Managers and Section Heads.

The lack of management attention to prompt corrective action in response to QA Audit Report 85-05 was attributed to deficiencies in the distribution of audit reports. The licensee stated that audit reports were distributed in the past to first line managers to allow the first line managers to take corrective action. In the case of QA Audit Report 85-05, senior level managers were not aware of its content until January 17, 1986. The licensee has instituted procedural changes to ensure that all Division Managers are aware of audit report findings and corrective actions in a timely manner.

The licensee indicated that the failure of their QA hotline to be a useful tool in detecting the problems outlined in Special Inspection Report 50-322/86-03 is twofold, 1) the program is relatively new to Shoreham and 2) has not be presented to employees adequately. Licensee Senior Level Management has instituted a program to present the hotline personally to all plant personnel and stated that as the level of staff awareness has increased so has use of the hotline.

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249STROSNIDER4/1/86 - 0006.0.0 04/02/86 The licensee also indicated that a lack of involvement from the Training Department increases the burden on first line supervisors unnecessarily and is removing this burden by making it part of the Training Department's responsibility to update qualification status for all personnel on a regular basis.

3. Concluding Statements

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The licensee concluded that a breakdown of radiochemistry section middle level management was responsible for the findings in Special Inspection Report 50-322/86-03. The licensee believes that the corrective actions they have taken will prevent this type of breakdown in the future. The licensee indicated that the results of their own investigation shows that this breakdown was isolated to the radiochemistry section and that similar problems do not exist throughout the staff.

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