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February 25, 1993

U. S. Nuclear Regulatory Commission
Washington, DC 20555

ATTENTION: Document Control Desk

SUBJECT: Calvert Cliffs Nuclear Power Plant
Unit Nos. 1 & 2; Docket Nos. 50-317 & 50-318
Reply to Notice of Violation, Inspection Report No. 92-25

REFERENCE: (a) Letter from Mr. T. T. Martin (NRC) to Mr. R. E. Denton (BG&E),
dated January 21, 1993, Inspection at Calvert Cliffs Units 1 and 2,
NRC Combined Inspection Report Nos. 50-317/92-25 and
50-318/92-25

Gentlemen:

Attachment (1) is provided as our response to Reference (a).

Should you have any further questions regarding this matter, we will be pleased to discuss them with you.

Very truly yours,

RED/JV/bjd

Attachment

cc: D. A. Brune, Esquire
J. E. Silberg, Esquire
R. A. Capra, NRC
D. G. McDonald, Jr., NRC
T. T. Martin, NRC
P. R. Wilson, NRC
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ATTACHMENT (1)

REPLY TO NOTICE OF VIOLATION INSPECTION REPORT NO. 92-25

Notice of Violation 50-317/92-25 and 50-318/92-25 identifies two instances where personnel entered High Radiation Areas (HRA) without a radiation monitoring device which continuously indicates the radiation dose rate in the area (dose rate meter), contrary to Technical Specification 6.12.1. On August 13, 1992, a contractor Containment Coordinator and three other individuals entered a posted HRA (Event A), and on September 17, 1992, a Senior Reactor Operator (SRO) entered a locked HRA (Event B) without a dose rate meter.

I. DESCRIPTION AND CAUSE OF EVENT.

- A. On August 13, 1992, a contractor Containment Coordinator and another contractor had the task of a containment walkdown prior to containment closure. Two contractor Decontamination Technicians (Decon Techs) were to assist the Containment Coordinator by picking up and disposing of any trash during the walkdown. The two Decon Techs signed into the Containment under Special Work Permit (SWP) 92-1002A, "routine decontamination, waste and laundry collection in controlled areas." The other two contractors signed in under SWP 92-1017A, "mechanical minor maintenance in general areas of containment as approved by the Radiological Control Shift Supervisor." Both SWPs were for performing work in the Containment. The primary difference between the two SWPs was the allowable dose rate limit. SWP 92-1002A had an area dose rate limit of 300 mr/hr and allowed work in HRAs with an RST escort and a dose rate meter. SWP 92-1017A had a limit of 100 mr/hr and did not allow entry into HRAs.

Prior to entering containment, the Containment Coordinator talked to the SWP Coordinator (SWPC). The SWPC advised the Containment Coordinator that there were no Radiation Safety Technicians (RST) available to support him. For entry by other than certain operators into a HRA, an RST was required by procedure to accompany workers and carry a dose rate meter. The SWPC gave the Containment Coordinator general access to the containment, without permission to enter HRAs, for his walkdown.

At the containment access hatch, the Containment Coordinator met a RST who advised the Containment Coordinator that there was no RST in the containment. The Containment Coordinator acknowledged the RST and went into the containment with the other contractor and the Decon Techs. After walking down the 69 foot level of the containment, the Containment Coordinator and one of the Decon Techs went to the ladder leading down to the 12 Reactor Coolant Pump (RCP) bay. A posting at the top of the ladder designated the area starting at the top of the ladder a HRA. The Containment Coordinator began descending down the ladder when the Decon Tech questioned him about the HRA posting. The Containment Coordinator advised the Decon Tech that he had talked to Radiation Control and it was okay to enter the HRA. Both men descended the ladder, followed by the other Decon Tech and the other contractor. After the walkdown, all four exited the HRA and the containment.

When at the SWPC desk, the Containment Coordinator advised the SWPC that there was still some scaffolding in the 12 RCP bay. The SWPC concluded that the only way the Containment Coordinator could have seen the scaffolding was if he had been in 12 RCP bay. He asked the Containment Coordinator if he had been in the 12 RCP bay. The Containment Coordinator said he had. It was then determined that

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the Containment Coordinator and the three other people entered the HRA without an RST or a dose rate meter.

The cause of this event is that the Containment Coordinator apparently consciously decided not to heed the verbal, written and posted instructions and requirements regarding entry into HRAs. He apparently felt he had adequate knowledge of the area and the radiological consequences were perceived as being small.

- B. On September 17, 1992, a Senior Reactor Operator (SRO) acting as the Shift Supervisor Assistant (SSA) went to verify Unit 1 valve 1-CVC-254 was locked shut. At first he mistakenly went to Unit 2 valve 2-CVC-254, which is in a passageway in the Auxiliary Building and not in a HRA. After checking the valve label and realizing his mistake, he proceeded to the Unit 1 valve.

The Unit 1 valve is about 25 feet away from the Unit 2 valve. The Unit 1 valve is located inside the Volume Control Tank (VCT) room, which is a posted locked HRA. Locked HRAs contain areas where radiation dose rates are 1000 mr/hr or more. The SSA found the door locked, as required, and unlocked it with the locked HRA key he had. Certain Operations personnel, such as the SSA, routinely carried such a key and were qualified to enter HRAs, including locked HRAs, without an RST, as long as they had a dose rate meter. He entered the room to verify 1-CVC-254 was locked shut. After going about 20 feet, he realized the flashing strobe light he had passed indicated that he was in a HRA. Realizing he had entered the HRA without a dose rate meter, he immediately left the room without having verified 1-CVC-254 locked shut. Upon exiting the VCT room, the SSA met a RST who asked him if he had a dose rate meter. The SSA replied he did not. The RST and SSA went to the Radiation Control - Operations Supervisor's office and reported the event.

The cause of the event was a lapse in concentration on the part of the SSA.

II. CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED.

- A. The path in the HRA along which the personnel travelled was surveyed. The personnel were not in any areas where the radiation was greater than 30 mr/hr. Controlled area access was removed for the Containment Coordinator and the two Decon Techs. The other contractor left the site before action could be taken, but his employer was notified of the event. Key site personnel and the NRC were notified of the event. Calvert Cliffs conducted an investigation into the event. The Containment Coordinator was counseled before leaving at the end of his contract, and his radiologically controlled area access was permanently removed after he had left the site. The Decon Techs received disciplinary action. The event was discussed with site personnel at a safety break.
- B. The VCT room was surveyed after the event. The SSA was not in any areas where the radiation was greater than 10 mr/hr. Key site personnel and the NRC were notified of the event. Calvert Cliffs conducted an investigation. The SSA received disciplinary action. The General Supervisor - Nuclear Plant Operations discussed radiological safety philosophy with each Operations crew. The SWP and radiological control briefings were improved to ensure operators were adequately briefed on

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radiation areas during their shift. Control of all the keys for locked HRAs was given to Radiation Safety in order to enhance operator knowledge of radiation areas by conducting briefings during issuance of the keys. The training program has been upgraded to provide more radiation worker training to Operators. A Plant General Manager memo was sent to all site supervisors and a site wide safety break was held to alert personnel about the two incidents. Another Plant General Manager memo was sent to all site supervisors addressing the need to comply with requirements, the potential for changing radiation levels in HRAs, and the potential personal health hazards and disciplinary actions for not complying with HRA requirements. This memo was discussed at site-wide tailgate meetings.

III. CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATIONS.

Management will re-emphasize the importance of radiation safety, including providing plant personnel with descriptions of disciplinary actions taken in selected events where expectations are not met. Additional emphasis will be placed on the potential personal health hazard, the potential for changing radiation levels in HRAs and the potential for disciplinary action.

IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED.

Full compliance was achieved August 13, 1992 for Event A and September 17, 1992 for Event B, when the personnel involved in the respective events left the HRAs and action was taken to verify they had not exceeded any radiation dose limits.