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GEORGE C. CREEL
VICE PRESIDENT
NUCLEAR ENERGY
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August 23, 1991

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
Issues Regarding Activities at Calvert Cliffs Nuclear Power Plant

REFERENCE: (a) Letter from Mr. C. W. Hehl (NRC) to Mr. G. C. Creel (BG&E), dated August 8, 1991

Gentlemen:

In response to information provided verbally on or about February 6, 1991 by Mr. Curtis Cowgill of your staff and subsequently documented in Reference (a), an investigation into those concerns has been performed by the Quality Audits Unit in our Nuclear Quality Assurance Department. The issues concerned: (a) the possible improper entry of individuals into a High Radiation Area, (b) improper entry of containment without proper sampling of the air lock atmosphere, and (3) the inadequate control of personnel who experienced radiogas contamination. All three alleged occurrences took place from February 1, 1991 through February 5, 1991.

Our review revealed some disparities between what was communicated verbally to our staff in February and what was written in Reference (a). We have alerted Ms. Daniele Oudinot of your staff and our Senior Resident Inspector that an additional 30 days will be required to address these disparities. We are forwarding the results of our previous investigation into these issues in Attachment (1).

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

Very truly yours,

GCC/REF/ref/bjd

Attachment

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cc: D. A. Brune, Esquire
J. E. Silberg, Esquire
R. A. Capra, NRC
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ATTACHMENT (1)

DETAILS

ISSUE 1

Verbally communicated: Personnel were allowed access to Unit 1 containment without appropriate instruments.

On February 5, 1991, two individuals entered Unit 1 containment while a High Radiation Area sign remained posted at the air lock. The plant was shutdown in MODE 4 and by Calvert Cliffs procedure, such an entry normally would require a Radiation Safety Technician (RST) escort and dose rate meter.

The containment air lock posting had not been properly revised from a High Radiation Area access point following an earlier survey which was conducted on February 2. Following this survey, the air lock's posting should have been revised.

At no time were persons allowed access to actual Hign Radiation Areas without following appropriate procedure. The investigation into this case revealed it occurred through incomplete communications, lack of questioning attitude, and failure to comply with procedure. Due to unrelated matters, the RST who failed to both comply with the procedure and exhibit a questioning attitude is no longer employed at Calvert Cliffs Nuclear Power Plant.

Communications improvements between RadCon Supervision and RSTs were instituted, and these events were briefed at unit meetings to ensure all personnel would benefit from lessons learned.

ISSUE 2

Verbally communicated: Unit 1 containment doors were open to the atmosphere without appropriate samples.

On February 4, 1991, a Unit 1 containment entry was made via the Emergency Air Lock (EAL) for which no EAL atmosphere sample was taken. Unit 1 was shutdown in MODE 4 with a containment vacuum of .36 psig. At the time of the entry, Radiological Controls and Plant Chemistry supervision felt that a sample was not required.

The governing procedure for this entry was Special Work Permit (SWP) 91-011 which did not stipulate that Plant Chemistry be consulted prior to entry. Such a requirement would have resulted in the evaluation of the necessity for issuing a Release Permit before the fact.

Plant Chemistry conducted a study which showed the amount of potential activity which could have been released was not safety significant. The SWP has since been revised to correct this deficiency.

ATTACHMENT (1)

DETAILS

ISSUE 3

Verbally communicated: People who alarmed the half body counters, then alarmed portal monitors at Security - when asked if they worked in Unit 1, were allowed to leave.

On February 4, 1991, two persons alarmed a Personnel Contamination Monitor at the 69-foot level of Auxiliary Building and again at the South Processing Facility, but were released by Security. The concern was that this was due to inadequate controls. In fact, the personnel involved were correctly handled per procedure.

Short-lived radiogas was the suspected source of contamination and the personnel were escorted out of the protected area to dosimetry for the purpose of conducting whole body counts. Once the contamination was verified by dosimetry to be radiogas, the appropriate level of management was consulted and the personnel were allowed to return home.

A concern was also verbally communicated to us as to the timeliness and adequacy of the subsequent corrective measures. Quality Audits determined that our response to these problems was appropriate. There was however, a lack of expediency in identifying the problems to supervision on the part of technicians and contractors. Our concerns regarding this was communicated to them at unit meetings.

A copy of the investigation of these issues is retained in our files and is available for inspection. Further investigation into newly raised issues is being pursued.

Your written details in Reference (a) included issues involving the detection of contamination on personnel entering the plant, and also of personnel passing between containments without frisking. We will investigate these issues and respond in 30 days.