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SERIAL: BSEP 96-0423
10 CFR 2.201

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D. C. 20555

BRUNSWICK STEAM ELECTRIC PLANT, UNITS 1 AND 2
DOCKET NOS. 50-325 AND 50-324/LICENSE NOS. DPR-71 AND DPR-62
REPLY TO NOTICE OF VIOLATION

Gentlemen:

On October 11, 1996, the Nuclear Regulatory Commission (NRC) issued a Notice of Violation for the Brunswick Steam Electric Plant, Units 1 and 2. The basis for the violation is provided in NRC Inspection Report 50-325/96-13 and 50-324/96-13.

Carolina Power & Light Company admits the violations occurred as described in NRC Inspection Report 50-325/96-13 and 50-324/96-13. Enclosure 1 provides Carolina Power & Light Company's response to the violations in accordance with the provisions of 10 CFR 2.201.

Carolina Power & Light Company finds the inspection does not contain information of a proprietary nature. Please refer any questions regarding this submittal to Mr. M. A. Turkal at (910) 457-3066.

Sincerely,

W. Levis
Director - Site Operations

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Enclosures

1. Reply to Notice of Violations
2. List of Commitments

cc: Mr. S. D. Ebnetter, Regional Administrator, Region II
Mr. D. C. Trimble, Jr., NRR Project Manager - Brunswick Units 1 and 2
Mr. C. A. Patterson, Brunswick NRC Senior Resident Inspector
The Honorable H. Wells, Chairman - North Carolina Utilities Commission

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ENCLOSURE 1

BRUNSWICK STEAM ELECTRIC PLANT, UNITS 1 and 2
NRC DOCKET NOS. 50-325 & 50-324
OPERATING LICENSE NOS. DPR-71 & DPR-62
REPLY TO NOTICE OF VIOLATIONS

VIOLATIONS:

During an NRC inspection conducted from August 4 through September 14, 1996, five violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violations are listed below:

- A. Technical Specification (TS) 6.8.1 requires that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, November 1972. Regulatory Guide 1.33, Appendix A requires specific procedures for equipment control.

Administrative Instruction 0AI-58, Equipment Clearance Procedure, implements the requirements of TS 6.8.1. 0AI-58, Section 5.4 requires a temporary tag lift request to be completed to allow a tag to be lifted to perform testing.

Contrary to the above, on August 21, 1996, while performing Periodic Test OPT-20.8.2, 1-CAC-AT-4410 Leak Test, a Reactor Operator positioned a Containment Atmospheric Control sample select switch which was under clearance without the 0AI-58 required temporary tag lift.

This is a Severity Level IV violation (Supplement I). This is applicable to both Units.

- B. Technical Specification 6.8.1 requires that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide 1.33, November 1972. Paragraph A. of Appendix A to Regulatory Guide 1.33 states that the licensee have administrative procedures concerning authorities and responsibilities for safe operation and shutdown.

TM-4.21, Revision 1, dated October 30, 1995, LSRO to Refueling Training Program, paragraph 4.1.3.d, states, in part, that "each candidate will satisfactorily complete an Limited Senior Reactor Operator (LSRO) Qual Card (TM-4.02.08) prior to the LSRO Audit Examination."

Contrary to the above, on September 10, 1996, the NRC identified that the licensee failed to follow TM-4.21 in that one LSRO candidate failed to complete the LSRO training program prior to taking the LSRO audit examination.

This is a Severity Level IV violation (Supplement I). This is applicable to both Units.

- C. 10 CFR 70.24 (a)(2), Criticality Accident Requirements, requires that criticality monitors shall have a preset alarm point of not less than 5 millirem (mR) per hour.

Contrary to the above, the Unit 2 new fuel vault criticality monitor was set a 3mR/hr. This condition has existed since discovery in 1994 until the monitor was reset on August 21, 1996.

This is a Severity Level IV violation (Supplement I). This is applicable to Unit 2 only.

- D. Technical Specification 6.8.1 requires that procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A, Paragraph G, "Procedures for Control of Radioactivity" of Regulatory Guide 1.33, dated November 1972.

Contrary to the above, on July 8, 1996, the licensee failed to implement procedure(s) and work controls necessary to effectively control radioactivity commensurate with the hazards of the specified work evolution being performed on the Unit 1 refueling floor and in the equipment pool.

This is a Severity Level IV violation (Supplement I). This is applicable to both Units.

- E. 10 CFR 20.1501(a) requires each licensee shall make or cause to be made, surveys that are reasonable under the circumstances to evaluate concentrations or quantities of radioactive material and the potential radiological hazards that could be present.

Contrary to the above, on July 8, 1996, during performance of work in the Unit 1 equipment pool, the licensee failed to perform adequate surveys to evaluate the potential radiological hazards that could be present from unknown concentrations or quantities of airborne radioactivity.

This is a Severity Level IV violation (Supplement I). This is applicable to both Units.

RESPONSE TO VIOLATION A:

Admission or Denial of Violation:

Carolina Power & Light admits this violation.

Reason for Violation:

The Reactor Operator stated that he operated the Containment Atmospheric Control sample select switch due to the erroneous assumption that the requirements of the clearance tag attached to the switch were appropriate for performance of the surveillance. This was based on his knowledge that a temporary tag lift had been completed to allow performance of the surveillance. The operator knew that operation of a component under clearance is not allowed by plant procedures. Operation of components under clearance is addressed in Licensed Operator Requalification training and in annual plant employee training for site employees. A review of the site corrective action program database indicates that this is an isolated event.

Corrective Actions Which Have Been Taken and Results Achieved:

The Reactor Operator was removed from watch-standing duties pending further investigation of the event.

A stand-down was conducted by each Operations group to discuss the event.

Management has taken appropriate disciplinary action with the operator involved with the clearance error.

Corrective Steps Which Will Be Taken to Avoid Further Violations:

No further action is necessary to prevent further violation.

Date When Full Compliance Will Be Achieved:

Carolina Power and Light believes that it is in full compliance with the requirements of Technical Specification 6.8.1.

RESPONSE TO VIOLATION B:

Admission or Denial of Violation:

Carolina Power & Light admits this violation.

Reason for Violation:

The one LSRO did not complete all of the required LSRO training program prior to taking the LSRO examination due to inadequate supervisory oversight. The Supervisor-Operator Initial Training did not track student progress closely but relied on the instructor-candidate's knowledge and expertise.

Corrective Actions Which Have Been Taken and Results Achieved:

Training records of those individuals enrolled in initial license classes from October through December of 1995 was performed to verify completion of the required on the job training hours.

A stand-down with operator training personnel was conducted by operator training supervision to reinforce expectations for compliance with operator training program requirements.

The Manager-Training conducted a section meeting with the operator training organization to explain concerns and reinforce expectations for compliance with operator training program requirements.

Specific procedural guidance has been established on the preparation and review of NRC license applications. This guidance establishes the responsibilities for the collection and review of course completion data to ensure program requirements have been satisfied prior to license application submittal.

Corrective Steps Which Will Be Taken to Avoid Further Violations:

No further action is necessary to prevent further violation.

Date When Full Compliance Will Be Achieved:

Carolina Power and Light believes that it is in full compliance with the requirements of Technical Specification 6.8.1.

RESPONSE TO VIOLATION C:

Admission or Denial of Violation:

Carolina Power & Light admits this violation.

Reason for Violation:

Inattention to detail and improper verification of reference and technical information during revision of the fuel vault criticality monitor setpoint calibration procedure resulted in establishing the Unit 2 fuel vault criticality monitor upscale setpoint at a value less than that required by 10 CFR 70.24.

Corrective Actions Which Have Been Taken and Results Achieved:

On August 9, 1996, the fuel vault criticality monitor calibration procedure was placed on administrative hold until the procedure could be revised to reflect the proper setpoint values.

On August 20, 1996, the fuel vault criticality monitor calibration procedure was revised to reflect the proper fuel vault criticality monitor setpoint values.

On August 21, 1996, the Unit 2 fuel vault criticality monitor was recalibrated and the monitor's upscale setpoint established at 6mR/hr.

Maintenance personnel involved with the fuel vault criticality monitor calibration procedure revision have been counseled on the significance of this event.

Corrective Steps Which Will Be Taken to Avoid Further Violations:

A sample of Maintenance procedures revised to incorporate engineering change data will be reviewed by December 18, 1996 to verify proper data incorporation.

Date When Full Compliance Will Be Achieved:

Carolina Power and Light believes that it is in full compliance with the requirements of 10 CFR 70.24 (a)(2).

RESPONSE TO VIOLATION D:

Admission or Denial of Violation:

Carolina Power & Light admits this violation.

Reason for Violation:

The failure to effectively control radioactivity during implementation of the Unit 1 equipment pool work activity is attributed to the following:

When difficulty was encountered installing a ladder in the equipment pool, Maintenance workers and the Health Physics (HP) Technician failed to meet expectations to stop work and notify supervisory personnel of the problem. Work proceeded with an inadequate understanding of the radiological conditions in the equipment pool.

Inadequate and ineffective supervisory oversight of the work station by the Maintenance and Environmental & Radiation Control (E&RC) organizations.

Corrective Actions Which Have Been Taken and Results Achieved:

Contaminated personnel and affected site areas were decontaminated and monitored following the event.

The involved Maintenance and E&RC personnel were counseled on the human performance errors that contributed to the spread of contamination during this event. Issues addressed during the counseling included pre-job briefings, communications, turnovers, work coverage, personnel decontamination, and the value of maintaining a questioning attitude.

Stand-downs with Maintenance and E&RC organizations were conducted to discuss the importance of radiation work permits, conduct of pre-job briefings, proper communications and turnovers, radiological work coverage, and the value of maintaining a questioning attitude. In addition, the expectation for notification of supervisory personnel was also reinforced during these stand-downs.

The Plant General Manager conducted a stand-down with Maintenance and HP supervisory personnel to discuss the importance of communication and effective problem resolution, responsibility for stopping radiological work when expectations are not being satisfied, and ownership of radiological work.

Increased supervisory oversight was provided for refuel floor activities during the preparations for and the conduct of the Unit 1 B111R1 refuel outage.

Corrective Steps Which Will Be Taken to Avoid Further Violations:

The lessons learned from this event will be included in the Radiation Protection Technician Continuing Training program and the training conducted by April 30, 1997.

Date When Full Compliance Will Be Achieved:

Carolina Power and Light believes that it is in full compliance with the requirements of Technical Specification 6.8.1.

RESPONSE TO VIOLATION E:

Admission or Denial of Violation:

Carolina Power & Light admits this violation.

Reason for Violation:

Investigation into the cause of the failure to perform adequate radiological surveys during the event determined that the same human performance errors that contributed to the failure to implement work controls resulted in inadequate surveys. Consequently, the reason for this violation is provided in the response to Violation D.

Corrective Actions Which Have Been Taken and Results Achieved:

The corrective actions are provided in the response to Violation D.

Corrective Steps Which Will Be Taken to Avoid Further Violations:

Additional corrective actions are provided in the response to Violation D.

Date When Full Compliance Will Be Achieved:

Carolina Power and Light believes that it is in full compliance with the requirements of 10 CFR 20.1501(a).

Enclosure 2
List of Regulatory Commitments

The following table identifies those actions committed to by Carolina Power & Light Company in this document. Any other actions discussed in the submittal represent intended or planned actions by Carolina Power & Light Company. They are described to the NRC for the NRC's information and are not regulatory commitments. Please notify the Manager-Regulatory Affairs at the Brunswick Nuclear Plant of any questions regarding this document or any associated regulatory commitments.

Commitment	Committed date or outage
1. A sample of Maintenance procedures revised to incorporate engineering change data will be reviewed to verify proper data incorporation.	12/18/96
2. The lessons learned from the event involving the Unit 1 equipment pool work activity will be included in the Radiation Protection Technician Continuing Training program and the training conducted.	4/30/97