



Consumers
Power

**POWERING
MICHIGAN'S PROGRESS**

Big Rock Point Nuclear Plant, 10269 US-31 North, Charlevoix, MI 49720

Patrick M Donnelly
Plant Manager

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Nuclear Regulatory Commission
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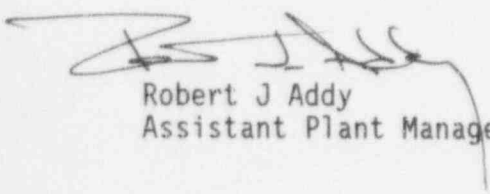
DOCKET 50-155 - LICENSE DPR-6 - BIG ROCK POINT PLANT - REPLY TO A NOTICE OF VIOLATION - NRC INSPECTION REPORT 96010.

During a routine NRC inspection conducted from October 19, 1996, through November 29, 1996, a violation of NRC requirements was identified and forwarded by letter dated January 29, 1997.

The violations concern an operability test of the No. 2 Emergency Condenser loop outlet valve that was not performed within 1 hour in accordance with procedure; a cold weather checklist did not include appropriate acceptance criteria for determining whether work requests containing modifications or repairs required to prevent freezing of plant safety related components had been accomplished; the Reactor Depressurization System Input Channel C surveillance was not performed within the specified interval and allowable extension period; two contracted workers unnecessarily spread contamination on themselves and previously uncontaminated portions of the plant; and a fire barrier was rendered non-functional by the same workers.

Consumers Power Company agrees with the violations as stated.

Pursuant to the direction provided in the report, find attached a Reply to the Notice of Violation. The proposed corrective actions are intended to address the concerns identified by the violation, and to prevent recurrence of the violations.


Robert J Addy
Assistant Plant Manager

CC: Administrator, Region III, USNRC
NRC Resident Inspector - Big Rock Point

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ATTACHMENT

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A CMS ENERGY COMPANY

ATTACHMENT

CONSUMERS POWER COMPANY
BIG ROCK POINT PLANT
DOCKET 50-155

REPLY TO A NOTICE OF VIOLATION

INSPECTION REPORT 96010

SUBMITTED FEBRUARY 26, 1997

VIOLATION 96010

During an NRC inspection conducted from October 19, 1996, through November 29, 1996, five examples of violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the examples are listed below:

1. Technical specification (TS) 6.8.1 requires that written procedures be established, implemented, and maintained for all structures, systems, components, and safety actions defined in the Big Rock Point Quality List. These procedures shall meet or exceed the requirements of ANSI N18.7, as endorsed by CPC-2A, "Quality Program Description for Operational Nuclear Power Plants."

CPC-2A, Section 5.2 states, in part, that system operating procedures (SOPs) are used to control activities affecting the quality of safety related structures, systems, and components.

SOP 6, Volume 3, "Emergency Condenser System," Revision 154, Step 2.2.b states, "If one loop of the emergency condenser becomes inoperable, an operability test of the outlet valve on the other loop must be successfully completed within 1 hour."

Contrary to the above, on November 8, 1996, operators closed the emergency condenser (EC) No. 1 loop inlet valve (MO-7062), making the No. 1 EC loop inoperable, but an operability test of the No. 2 EC loop outlet valve was not performed within 1 hour.

This is a Severity Level IV violation (Supplement I).

2. 10 CFR 50, Appendix B, Criterion V, "INSTRUCTIONS, PROCEDURES, AND DRAWINGS," requires, in part, that instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been accomplished.

Contrary to the above, procedure O-VAS-1, "Cold/Warm Weather Checklists," revision 18, did not include appropriate acceptance criteria for determining whether work requests containing modifications or repairs required to prevent freezing of plant safety related components had been accomplished.

This is a Severity Level IV violation (Supplement I).

3. Technical Specification 11.4.1.5, "Surveillance Requirements," requires, in part, that the Reactor Depressurization System Input Channels A through D shall be instrument trip tested monthly (when the unit is Operating).

Technical Specification 1.1.4 requires, in part, that surveillances shall be performed within the specified surveillance interval with a maximum allowable extension not to exceed 25 percent of the specified interval.

Contrary to the above, from March 11 through May 11, 1994, with the unit operating, the Reactor Depressurization System Input Channel C surveillance was not performed within the specified interval and allowable extension period.

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This is a Severity Level IV violation (Supplement I).

4. *Technical Specification 6.11, "Radiation Protection Program," requires, in part, that procedures for personnel radiation protection shall be adhered to for all operations involving personnel radiation exposure.*

Administrative Procedure 5.5, "Radiation Work Permit," Revision 12, requires, in part, that workers not unnecessarily contact contaminated surfaces with their body, tools or equipment, and not disturb such surfaces to spread contamination.

Contrary to the above, on August 5, 1996, two workers unnecessarily spread contamination on themselves and previously uncontaminated portions of the plant.

This is a Severity Level IV violation (Supplement I).

5. *Technical Specification 12.3.7.12, requires, in part, that with one or more of the fire barriers non-functional, a fire watch patrol shall be established within 1 hour and the affected areas shall be inspected at least once per hour.*

Contrary to the above, on August 5, 1996, a fire barrier was rendered non-functional, but a fire watch patrol was not established within 1 hour and the affected area was not inspected at least once per hour.

This is a Severity Level IV violation (Supplement I).

Consumers Power Company's response is provided by the following.

Violation 96010-1

On November 8, 1996, operators closed the emergency condenser (EC) No. 1 loop inlet valve (MO-7062), making the No. 1 EC loop inoperable, but an operability test of the No. 2 EC loop outlet valve was not performed within 1 hour.

Consumers Power Company agrees with the violation as stated.

I. Reason for the violation

A root cause determination concluded that there was a failure to identify a safety-related component as inoperable.

Once the adjustment of the packing had failed to stop the leak, a decision was made to leave MO-7062 in the closed position. Work was planned, and the intention was to return MO-7062 to its normal operating position. The basis for determining MO-7062 operable in the closed position was a stroke test and a 1980 facility change. The facility change was performed to provide automatic loop operation, if required, even though an inlet valve may be closed. Automatic opening of the closed inlet valve was provided from its associated outlet valve circuitry. This nonsafety-related feature improved the reliability of the emergency condenser by returning the redundant loop to service. The operability determination stated that "the loop (that MO-7062 is in) is available automatically unless there is a loss of AC concurrently". The loop was not declared inoperable.

- The operability determination justification concerning the availability of the emergency condenser was incorrect with regard to the loss of AC power (AC power is required to open MO-7062).
- The automatic opening of MO-7062 via the opening of its associated outlet valve, MO-7063, on high pressure due to the 1980 facility change is a true statement providing AC power is available to open MO-7062.

II. The corrective steps that have been taken and the results achieved.

On November 7, 1996 at 1200, loop number one of the emergency condenser was determined to be inoperable, but available with MO-7062 closed. Later it was determined that in this configuration, loop number one could not perform all its intended safety functions, therefore MO-7062 was reopened and loop number one was declared operable on November 8, 1996 at 1041.

During a forced outage that began December 7, 1996, MO-7062 was repacked. On December 10, 1996 at 2320, MO-7062 was declared operable for startup.

III. The corrective steps that will be taken to avoid recurrence.

- A. Revise Administrative Procedure 1.3, Corrective Action; or develop a checklist referring the Shift Supervisor to the following prior to making operability decisions:
 - a. Standard Operating Procedures, Plant requirement section.
 - b. Technical Specifications
 - c. Volume 17, The Q List.

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- d. Updated Final Hazards Summary Report.
- B. Develop criteria that requires only Safety-Related Systems, Subsystems, Trains, Components, or devices will be addressed as being operable. Nonsafety-related equipment will use other terms to describe their condition.

THESE ACTIONS WILL BE COMPLETE BY MAY 1, 1997.

- C. Conduct training for Shift Supervisors and On-Call managers on Generic Letter 91-18, Information to Licensee's Regarding Two NRC Inspection Manual Sections on Resolution of Degraded and Nonconforming Conditions and on Operability. Also conduct training on the use of Volume 17, and the Updated Final Hazards Summary Report in the determination of all system, subsystem, and component operability requirements.

THIS ACTION WILL BE COMPLETE OCTOBER 1, 1997

IV. The date when the facility will be in full compliance.

The facility is currently in full compliance.

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Violation 96010-2

Procedure O-VAS-1, "Cold/Warm Weather Checklists," revision 18, did not include appropriate acceptance criteria for determining whether work requests containing modifications or repairs required to prevent freezing of plant safety related components had been accomplished.

Consumers Power Company agrees with the violation as stated.

I. Reason for the violation.

During the performance of O-VAS-1, the operators are instructed to place the Waste Hold Tank (WHT) overflow vent line heat tapes in service by checking that the supply breaker is closed and that the local indicating light is illuminated. The operator closed the breaker, however the indicating light did not illuminate. He verified that the tapes were producing heat, noted the problem with the indicating light in the procedure, and submitted a work request to repair the indicating light.

Note: The WHT overflow vent line is not safety-related. The radwaste system performs no action associated with the prevention or mitigation of design basis accidents. The chances of an unmonitored release through this vent are remote.

O-VAS-1 was signed off by the shift supervisor with the knowledge that the WHT overflow vent line heat tapes were operating, that a work request had been submitted to repair the indicating light, and that the system is not essential for the safe shutdown of the reactor. The procedure did not require that the work request be completed in order to sign off the procedure.

II. The corrective steps that have been taken and the results achieved.

O-VAS-1 was rechecked to ensure that no other outstanding work had been identified and signed off without being completed. All work had been completed.

III. The corrective steps that will be taken to avoid recurrence.

- A. O-VAS-1 will be enhanced to ensure that any work requests initiated from the procedure are complete prior to closing out the procedure.

THIS ACTION WILL BE COMPLETE MAY 1, 1997

- B. Administrative Procedure 4.3.3, Planning and Scheduling will be enhanced to consider the effect of maintenance on cold weather measures.

THIS ACTION WILL BE COMPLETE SEPTEMBER 1, 1997.

IV. The date when the facility will be in full compliance.

The facility is currently in full compliance.

Violation 96010-3

From March 11 through May 11, 1994, with the unit operating, the Reactor Depressurization System Input Channel C surveillance was not performed within the specified interval and allowable extension period.

Consumers Power Company agrees with the violation as stated.

I. Reason for the Violation

During the previous three year review of surveillance T30-59, RDS Channel Tests at Power, it is apparent that the resident knowledge of the Big Rock Point staff was being relied upon as a final barrier to ensure that the RDS surveillance requirements were up to date. Exceeding surveillance requirements is most probable during forced outages, or outages of limited duration (i.e., 4 to 14 days) when T30-59 comes due; and the surveillance scheduled for one of the trains of RDS is not performed due to the condition of the plant (cold shutdown). The surveillance control mechanism for plant startup addresses postponed surveillances during shutdown; however this specific surveillance was not included in the startup procedure used for this purpose. The root cause was determined to be a less than adequate procedure. The information provided in the procedure controlling plant startups did not provide adequate guidance for surveillance procedures not performed during shutdown conditions.

II. The corrective steps that have been taken and the results achieved.

1. An immediate corrective action consisted of issuing a revision to the facility's start-up procedure, O-TGS-1; MASTER CHECKLIST. This change enhances O-TGS-1, providing clear instructions concerning RDS surveillance.
2. The periodic activities board identifies surveillance tests that are not performed when the plant is shutdown by using "green dots". The following "greendotted" procedures were reviewed with the Operation's Supervisor to ensure surveillance compliance and coverage by O-TGS-1:

T7-03 CRD Coupling Integrity (Required by Technical Specifications - addressed in O-TGS-1, Part B; Steps 30 and 46).

T7-12 Pipe Tunnel Leakage Inspections (not required by Technical Specifications)

T7-30 Plant Water Inventory (not required by Technical Specifications)

T30-01 Reactor Protection System (Required by Technical Specifications - addressed in O-TGS-1, Part B; Step 44)

T30-43 Steam Drum Relief Valve Monitor Checkout (Required by Technical Specifications - addressed in O-TGS-1, Part B; Step 2).

T90-07 RDS Isolation Valve Test (Required by Technical Specifications - addressed in O-TGS-1, Part B; Step 42).

T30-59 L2 Module Test; Electric and Diesel fire Pumps RDS Cabinet Test (A,B,C,D). (Required by Technical Specifications - revised O-TGS-1, Part B; Step 42 to address).

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III. The corrective steps that will be taken to avoid recurrence.

Corrective action with regard to this issue is complete.

IV. The date when the facility will be in full compliance.

The facility is currently in full compliance.

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Violation 96010-4

On August 5, 1996, two workers unnecessarily spread contamination on themselves and previously uncontaminated portions of the plant.

Consumers Power Company agrees with the violation as stated.

I. Reason for the Violation

The contract employees did not follow plant requirements pertaining to Radiation Work Permits, and radiological status sheets. In addition, the contractor oversight provided by the Big Rock Point plant staff was less than adequate.

II. The corrective steps that have been taken and the results achieved.

As an interim action, the Health Physics manager assigned a radiation safety technician to the access control area during the day shift just to control access to the radiologically controlled area. The contract employees were also discharged and not allowed to return to the site.

Management expectations with regard to radiation work permits, radiation monitoring, and radiological conditions were discussed with the radiation protection technicians. The Health Physics manager also committed to maintain health physics presence in access control when contractors are working onsite, during the normal dayshift, to question and assist contractors as necessary on radiological aspects of their work activities.

III. The corrective steps that will be taken to avoid recurrence.

Training will be developed for managers to use for conducting continuing training with the plant's contract coordinators. The training is expected to include lessons learned, procedure changes to Administrative procedures, and the role of the contract coordinator.

THIS ACTION WILL BE COMPLETE BY APRIL 1, 1997

IV. The date when the facility will be in full compliance.

The facility is currently in full compliance

Violation 96010-5

On August 5, 1996, a fire barrier was rendered non-functional, but a fire watch patrol was not established within 1 hour and the affected area was not inspected at least once per hour.

Consumers Power Company agrees with the violation as stated.

I. Reason for the Violation

The contract employees did not adhere to plant requirements pertaining to fire barriers. In addition, contractor oversight by the Big Rock Point staff was less than adequate.

Another contributing factor may have been that the size and configuration of the door way opening is not easily recognizable as a fire barrier. There is no visible door and the opening is five times the size of a regular door.

II. The corrective steps that have been taken and the results achieved.

When the contract coordinator recognized that the fire barrier had been breached by the air hose, he immediately removed the hose and restored the fire barrier. The contract employees were also discharged and not allowed to return to the site.

The roll-up fire door frame has been painted red, and the following warning was stenciled on both sides of the frame at eye-level: "Fire Door. Notify the SS Prior to Blocking by Running Hoses/Cables through Doorway".

III. The corrective steps that will be taken to avoid recurrence.

Corrective action with regard to this issue is complete.

IV. The date when the facility will be in full compliance.

The facility is currently in full compliance.