

June 11, 2001

EA-01-131

Mr. Oliver D. Kingsley, President
Exelon Nuclear
Exelon Generation Company, LLC
1400 Opus Place, Suite 500
Downers Grove, IL 60515

SUBJECT: NRC OFFICE OF INVESTIGATIONS REPORT NO. 3-2000-051
(BRAIDWOOD NUCLEAR GENERATING STATION)

Dear Mr. Kingsley:

This letter refers to an investigation by the NRC Region III Office of Investigations (OI) completed on April 25, 2001. A summary of the OI report is enclosed. The Office of Investigations conducted an investigation into an incident at the Braidwood Station described in condition report CR A2000-03990, where a contractor boilermaker employed by GNV Venture exited the protected area after alarming at least two separate gatehouse portal monitors. Contamination was subsequently found on the boilermaker's boot. The OI investigation concluded that the boilermaker had deliberately violated radiation protection procedures.

As a result of the OI investigation, an apparent deliberate violation of NRC requirements was identified and is being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, May 1, 2000. The Enforcement Policy can be found on the NRC's website at www.nrc.gov/OE. Braidwood Technical Specification 5.4.1.a provides that written procedures "shall be established, implemented, and maintained" covering certain activities delineated in Regulatory Guide 1.33, Revision 2, Appendix A, dated February 1978. Among the activities described in Section 7.E.7 of that Guide requiring written procedures are procedures for personnel monitoring. Braidwood Station Radiation Protection Procedure No. BwRP 5822-3, Revision 1, "Operation and Calibration of the Eberline PM-7 Portal Monitors," requires in Section 3.c(3)(c) that if the monitor alarms, then step back out and perform a second frisk after the monitor resets itself and notify the radiation protection department if the monitor alarms again. The boilermaker apparently deliberately violated the procedure when he twice alarmed two separate portal monitors at the gatehouse and did not contact the radiation protection department.

The NRC is concerned that the apparent failure to follow the portal monitor procedure occurred previously at the Braidwood Station. A Severity Level III violation was issued on May 18, 2000, for a similar violation that occurred in April 1999. The recurrence of a similar violation indicates a potential lack of sensitivity on the part of individuals to the importance of following the portal monitor procedure. The portal monitors are intended to be the last radiological survey of personnel before leaving the facility. The failure to follow the monitoring procedure has the potential to release radioactive material into the public domain.

The NRC recognizes that Exelon Nuclear identified the violation and entered it into the Braidwood Station corrective action program. The NRC has assessed the extent of the corrective actions taken by Braidwood Station in this matter. The corrective actions included: (1) decontaminating the individual; (2) surveying the involved areas for contamination (none found); (3) conducting an investigation; (4) locking the individual out of the radiologically protected area for the duration of the outage; (5) tailgating the event to the GNV contractors and discussing expectations with the contractors; (6) tailgating the event at outage meetings for communication to all station departments; and (7) working with both Eberline and MGP Corporation for the manufacture of turnstiles to be installed at the gatehouse portal monitors to prevent site egress upon monitor alarms. If the description of the corrective actions described above are not accurate, please provide a written statement that accurately reflects your position within 30 days of the date of this letter.

Based on our review of the corrective actions taken, we believe that we have sufficient information to make an enforcement decision without conducting a predecisional enforcement conference. Since you identified the violation and took appropriate corrective actions as described above, a civil penalty would not be warranted in accordance with Section VI.C.2 of the Enforcement Policy. However, before the NRC makes an enforcement decision, we are providing you an opportunity to either: (1) respond to the apparent violation, or (2) request a predecisional enforcement conference. If a conference is held, it will be transcribed and closed to public observation because the actions of an individual will be discussed. Please contact Wayne Slawinski at 630-829-9820 within seven days of the date of this letter to notify the NRC of your intended response and if the description of the corrective actions described above are inaccurate.

If you choose to provide a written response to the apparent violation, your response should be submitted within 30 days of the date of this letter and be clearly marked as a "Response to An Apparent Violation." Your response should be submitted under oath or affirmation and may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If a response is not received within the time specified or an extension of time has not been granted by the NRC, the NRC will proceed with its enforcement decision.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if you choose to provide one) will be made available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public

Electronic Reading Room). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

Sincerely,

/RA/

John A. Grobe, Director
Division of Reactor Safety

Docket Nos. 50-456; 50-457
License Nos. NPF-72; NPF-77

Enclosure: OI Report Summary

cc w/encl: J. Skolds, Chief Operating Officer
W. Bohlke, Senior Vice President, Nuclear Services
C. Crane, Senior Vice President - Mid-West Regional
Operating Group
J. Cotton, Senior Vice President - Operations Support
J. Benjamin, Vice President - Licensing and Regulatory Affairs
H. Stanley, Operations Vice President
R. Krich, Director - Licensing
R. Helfrich, Senior Counsel, Nuclear
DCD - Licensing
J. von Suskil, Site Vice President
K. Schwartz, Plant Manager
A. Ferko, Regulatory Assurance Manager
M. Aguilar, Assistant Attorney General
Illinois Department of Nuclear Safety
State Liaison Officer
Chairman, Illinois Commerce Commission

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A. Ferko, Regulatory Assurance Manager
M. Aguilar, Assistant Attorney General
Illinois Department of Nuclear Safety
State Liaison Officer
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NAME	CNolan for FCongel	BClayton	JGrobe		
DATE	5/31/01	5/3/01	6/11/01		

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¹ OE concurrence received from Chris Nolan, OE, on May 31, 2001.

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Enclosure 1

SUMMARY OF OFFICE OF INVESTIGATIONS REPORT 3-2000-051

NRC Region III Office of Investigations (OI) Report Number 3-2000-051 completed on April 25, 2001, concerns an incident at the Braidwood Station described in condition report CR A2000-03990 in which a contractor boilermaker employed by GNV Venture exited the protected area after alarming two separate gatehouse portal monitors. Contamination was subsequently found on the boilermaker's boot.

On October 23, 2000, a contractor boilermaker left the protected area to retrieve some tools. Upon exiting the gatehouse, the individual twice alarmed a portal radiation monitor, entered a second monitor that also alarmed twice, and finally exited the gatehouse after entering a third monitor that did not alarm according to the individual. The station procedure applicable to the use of the portal monitors required that when you receive an alarm, the individual step back out and perform a second frisk after the monitor reset itself and notify the radiation protection department if the monitor alarms a second time. The boilermaker twice alarmed two separate portal monitors at the gatehouse and did not contact the radiation protection department.

The boilermaker's activities were observed by personnel of the radiation protection department via closed circuit television. The radiation protection department contacted the boilermaker's management who subsequently brought the boilermaker back into the protected area.

Based on the above information and the boilermaker's training, it appears that the boilermaker deliberately violated the portal monitor procedure when the individual failed to notify the radiation protection department after receiving a second alarm on two separate monitors.