UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
799 ROOSEVELT ROAD
GLEN ELLYN, ILLINOIS 60137-5927

November 9, 1993

Docket No. 50-155
License No. DPR-6
EA 93-233

Consumers Power Company
ATTN: Mr. David P. Hoffman
Vice President - Nuclear
Operations
1945 West Parnall Road
Jackson, Michigan 49201

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - $50,000 (INSPECTION REPORT 50-155/93015(DRP))

Dear Mr. Hoffman,

This refers to the special inspection conducted from August 24 through September 14, 1993 at your Big Rock Point facility. The inspection reviewed circumstances surrounding two recent events, and identified several related violations. The first event, which you identified and reported in Licensee Event Report (LER) 93-002, was the existence of a primary containment breach while changing modes from Cold Shutdown to Refueling. The second event was a primary coolant system (PCS) hydrostatic pressure test that inadvertently pressurized the PCS beyond the procedural limit, thus lifting a steam safety relief valve. The report documenting this inspection was sent to you by letter dated October 5, 1993.

On October 12, 1993, we held an enforcement conference in the Region III office with you and other Consumers Power Company representatives to discuss the apparent violations, their causes, and your corrective actions. The enforcement conference summary was sent to you by letter dated October 15, 1993.

The violations in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) involve the loss of control over these two plant evolutions. In the first case, containment integrity was breached on June 27, 1993 by performing a switching and tagging order. The order, developed to drain the feedwater line, failed to convey its effect on containment integrity due to inadequate attention to detail both by the preparer and the subsequent reviewer, the shift supervisor. The shift supervisor authorized implementing the order without determining its effect on plant conditions.

Two days later, with containment integrity still breached, shift supervision approved performing a surveillance test that changed the plant operational mode from Cold Shutdown to Refueling, a change requiring containment

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integrity. Only after completing this test was the containment integrity breach identified.

A contributing cause to this event was your lack of effective corrective actions for past events. The root cause analysis for a December 1991 containment integrity breach was narrowly focused. Similarly, the corrective actions implemented for a 1992 inadequate switching and tagging order event were narrowly focused on the event specifics. Your corrective actions for these events failed to adequately address program weaknesses and plant configuration control weaknesses.

The second evolution was a hydrostatic pressure test of the PCS. During the test, your personnel lost control of the evolution and pressurized the PCS to a level where one of the steam safety valves opened, rupturing four rupture discs. Review of the event found inadequate job briefings, inadequate job planning, shift supervision becoming overly involved in troubleshooting which caused a loss of focus on overall plant status, inadequate communications between the job site and control room, inadequate work practices during the test performance, and insufficient understanding of solid plant operations.

The fundamental problem was a pervasive lack of sensitivity to the potential for a pressure excursion, which engendered a lax approach to conducting the test. Related weaknesses found during review included problems with test configuration (no relief valve at the pump), inadequate maintenance of the public address system, and procedure weaknesses. Management expectations and policy regarding such an evolution were also not effectively understood. As a result, a test that was performed only once per outage and that involved an abnormal solid plant operating condition, was treated as "routine" and implemented without sufficient preparation.

The enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) describes six violations. These violations represent a breakdown in the controls essential for safe conduct of important activities. Although this particular case had minor safety consequences, similar performance under other circumstances might have resulted in more significant consequences.

Furthermore, the disorganized manner in which the hydrostatic pressure test was conducted is unacceptable for nuclear power plant operations. We are concerned that the underlying causes of this event are essentially identical to the causes of a recent Palisades event, for which we held a previous enforcement conference with you on August 10, 1993. After the Palisades control rod withdrawal event, the lessons to be learned were published at Big Rock Point. Given that the Palisades event occurred in June 1993, corrective actions for Consumers Power should have been developed and implemented to preclude similar events at Big Rock Point. We are also concerned that neither your line management nor your Nuclear Performance Assessment Department (NPAD) contributed significantly to ensuring that these types of events do not recur.

Collectively, the violations in the enclosed Notice represent a potentially significant lack of attention toward licensed responsibilities. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC

Enforcement Actions" (Enforcement Policy), 10 CFR Part 2, Appendix C, these violations are classified in the aggregate as a Severity Level III problem.

Your corrective actions included improving visual aids for the containment isolatior valves; notifying operations procedure sponsors of the potential for breaching containment integrity and instructing them to add caution statements in applicable procedures; improving administrative controls for containment isolation valve operations and mode switch manipulation; and improving the man-machine interface for future PCS pressure tests (by modifying the pressure test equipment and the containment paging system). In addition, you specified generic corrective actions, including increased backshift management during abnormal evolutions (refueling outages, all reactivity events, infrequently performed tests and evolutions, etc.); more staff training in human performance evaluation methodology; and better guidance on using the infrequently performed test and evolution process to identify other evolutions for which the process is mandatory.

To emphasize the need for increased management attention to licensed activities, I have been authorized, after consultation with the Director, Office of Enforcement and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations, and Research to issue the enclosed Notice in the amount of $50,000 for the Severity Level III problem.

The base value of a civil penalty for a Severity Level III problem is $50,000. The adjustment factors in the Enforcement Policy were considered. Partial mitigation (25%) was warranted for your identification and reporting of the events. You identified and correctly reported the loss of containment integrity event. The hydrostatic pressure test event was self-disclosing. NRC initiative was required to identify the numerous other contributing violations. In addition, full mitigation (50%) was warranted for your comprehensive corrective actions.

Partial escalation (50%) was assessed for past performance based upon your most recent Systematic Assessment of Licensee Performance (SALP) ratings, more recent inspection findings, and the sometimes narrow scope and ineffectiveness of previous corrective actions. Specifically, at a July 9, 1992 enforcement conference, we discussed violations associated, in part, with inadequate configuration control during the implementation of a switching and tagging order. Additionally, for a 1991 LER involving a previous breach of containment integrity, your corrective actions were narrow in scope and insufficiently implemented. Partial escalation (25%) was also warranted for the prior opportunity to identify, based on your ineffective short-term implementation of the lessons learned from the recent Palisades control rod event.

The remaining factors in the Enforcement Policy were considered and no further adjustments were considered appropriate. Therefore, based on the above, the civil penalty remained unchanged.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice of Violation (Notice) when preparing your

response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response should focus on corrective actions planned or taken to address each of the violations and to resolve the general weakness in your plant configuration management program. After reviewing your response to this Notice and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

J. B. Martin,
Regional Administrator

Enclosure:
Notice of Violation

cc w/enclosure:
Patrick Donnelley, Plant Manager
Big Rock Point Nuclear Plant
OC/LFDCB
Resident Inspector, RIII
James R. Padgett, Michigan Public
Service Commission
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