UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report Nos.: 50-325/95-20 and 50-324/95-20

Licensee: Carolina Power and Light Company
P. O. Box 1551
Raleigh, NC 27602

Docket Nos.: 50-325 and 50-324 License Nos.: DPR-71 and DPR-62

Facility Name: Brunswick 1 and 2

Inspection Conducted: September 2-30, 1995

Lead Inspector: C. A. Patterson 10/17/95
C. A. Patterson, Senior Resident Inspector Date Signed

Other Inspectors: P. M. Byron, Resident Inspector
M. T. Janus, Resident Inspector

Approved By: D. M. Verrelli 10/17/95
D. M. Verrelli, Chief Date Signed
Reactor Projects Branch 1A
Division of Reactor Projects

SUMMARY

Scope:

This routine resident inspection included the areas of operations, maintenance and surveillance, engineering, and plant support.

Results:

In the Operations area, plant operators responded to a Unit 1 reactor trip without any complications, paragraph two. Inconsistencies in logkeeping were noted. Improvements in operator turnover meetings were made to put Operations in charge with adequate support personnel present.

In the Maintenance and Surveillance area, a scram discharge header vent valve failed twice, paragraph three. The root cause of these failures had not been determined. Several circulating water traveling screen high differential pressure alarms were disabled during power operation. This was due to using an ambiguous wiring sketch in an old modification package. An inspector unresolved item was identified to review old outstanding design modification packages.

In the Engineering area, the licensee determined that the failure of two residual heat removal heat exchanger outlet flow control valves was due to galling of the inconel valve disc and cartridge, paragraph four. The licensee determined this was not reportable. This issue is an apparent violation and

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will be tracked as EEI 325,324/95-20-03. As a result of a series of deficient engineering products over the past six months, a stop work was directed for all engineering products that physically modify the plant.

In the Plant Support area, a noncited violation was identified concerning an unlocked high radiation area door, paragraph five. The licensee identified this violation. The violation is of concern because attention to detail could have corrected this problem on two occasions.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*W. Campbell, Vice President, Brunswick Nuclear Plant
*G. Barnes, Manager, Training
*A. Brittain, Manager, Security
*N. Gannon, Manager, Maintenance
*J. Gawron, Manager, Environmental & Radiological Control
R. Lopriore, General Plant Manager
*J. Holden, Acting Manager, Brunswick Engineering Support Section
*G. Honma, Supervisor, Licensing
*W. Levis, Director, Site Operations
J. Lyash, Manager, Operations
*D. Hicks, Manager, Regulatory Affairs
*M. Marano, Acting Manager, Site Support Services
N. Schlichter, Acting Manager, Nuclear Assessment
M. Turkal, Supervisor, Regulatory Compliance

Other licensee employees or contractors contacted included licensed reactor operators, auxiliary operators, craftsmen, technicians, and public safety officers, in addition to quality assurance, design, and engineering personnel.

NRC Personnel

*C. Patterson, Senior Resident Inspector
*P. Byron, Resident Inspector
*M. Janus, Resident Inspector

*Attended exit meeting.

Acronyms and initialisms used in the report are listed in the last paragraph.

2. Operations

a. Operational Safety Verification (71707)

<u>Unit Status</u>

Unit 1 operated continuously during the month until a reactor trip occurred on September 30, 1995. The trip is discussed further in this report. With the trip, the unit ended 75 days of continuous operation.

Unit 2 operated continuously during the month and at the end of the period had been on-line 457 days. The unit began power coastdown in the present control rod pattern. The first phase of feedwater temperature reduction was implemented to extend power levels. At the end of the period, power was 92%.

Unit 1 Reactor Trip

On September 30, 1995, the Unit 1 reactor tripped on low water level. A scheduled downpower was planned to clean a debris filter on one of the condenser circulating water boxes. The unit was at 58% power when a transient occurred in the feedwater and condensate system. Low suction pressure alarms were received on the condensate pumps, condensate booster pumps, and feedwater pumps. This caused level to decrease from the normal 187 inches to 168 inches, the low level one scram setpoint. All control rods fully inserted. Level decreased to just below low level two (112 inches) causing RCIC and HPCI to automatically initiate. RCIC injected and along with the running feedwater pumps quickly restored level before HPCI completed the time required to inject. HPCI and the feedwater pumps then tripped on high vessel level. The MSIVs remained open and all other group isolations were normal.

The resident inspector responded to the site after the trip and toured the control room. Plant conditions were stable with no complications. The licensee initiated a site incident investigation team to review the trip. Initial results were that during on-line maintenance to replace a conductivity cell, air inleakage into the condensate pump suction piping caused the low suction pressure alarms. The internal seal of the cell designed to limit air inleakage had failed and resulted in increased air inleakage. Additionally, the standby condensate pump did not automatically start as designed. This could have mitigated the problem. The pressure switch was found to be wired incorrectly and was not functional.

At the end of this report period the unit was shutdown pending PNSC review of the SIIT report and restart assessment. The inspector will continue to review these activities as part of the routine inspection program.

Logkeeping Consistency

On September 7, 1995, a licensee contractor experienced a minor oil spill while dredging the intake canal. The initial report attributed the leak to a winch on the dredge. The licensee ceased dredging operations until the winch was repaired. They made the appropriate notifications to the state through the corporate environmental group. The Coast Guard was notified of the spill and responded. They boarded the dredge and investigated the apparent cause of the spill. The investigation revealed that a new member of the crew had pumped the bilges overboard which resulted in oil accruing on the surface. The Coast Guard issued a violation and fined the dredge operator. The licensee was informed of the Coast Guard's findings and actions. Dredging operations were suspended until the dredge operators had been retrained. The residents were kept informed of the changing events as was the corporate environmental group who notified the appropriate agencies. The licensee notified the NRC via ENS in accordance with 10 CFR 50.72(b)(2)(vi). On September 8, the inspector reviewed the Unit 1 and 2 logs and noted that both unit logs contained entries for the spill and the initial cause. Neither log contained entries describing the Coast Guard's presence, findings, the licensee's actions relating to the dredge operator, nor the ENS notification to the NRC. The inspector informed licensee management of this finding and an entry was made in the Unit 1 log to include the updated entry. The inspector observed that the entry did not include a late entry notation as recommended by Section 5.1.7 of Procedure OI-71, Operations Shift Logs.

The inspector reviewed OI-71 and noted that it has no requirements, only recommendations. All actions are conditioned by "should." Section 5.1.1 recommends that narrative logs, which include the unit log, should be written in sufficient detail to enable the reconstruction of events or evolutions including resolutions of any abnormal occurrences. Section 5.3.11 states that the Shift Supervisor's log entries should include events requiring notification or reports including the type of report, the organization reported to, and the name of the person receiving the report. The Shift Supervisor is supposed to review the logs for completeness. The inspector noted the absence of entries discussed above relating to the oil spill. The inspector concluded that the identified log keeping deficiencies are indicative of inattention to detail. Improvements were noted after the deficiencies had been identified. A review of the unit logs reveals that the operators do not comply with many of the OI-71 recommendations nor are they consistent with their implementation of the recommendations.

<u>Operator Turnover Meetings</u>

The inspector discussed the Operations morning turnover meeting held at 7:30 a.m., in IR 50-325,324/95-15. It was an opportunity for the support organizations to interface with Operations and become aware of work efforts which could affect them. The inspector was concerned that there appeared to be a lack of commitment by some of the support organizations. Subsequently, site management attended the meetings and have elevated their stature. The meeting has been moved to the O&M Building and superintendent level support personnel are required to attend. The meetings are well supported and issues are dealt with directly. Frequently, decisions by support organizations are made at the meeting which reduces communication delays and makes supervision aware of issues. The meeting is chaired by the Shift Superintendent and it is currently in the development or evolutionary mode.

The licensee formerly held a thrice weekly status meeting for managers at 8 :30 a.m. This meeting was frequently not substantive. The expanded Operations Turnover meeting has resulted in the management meeting being held once a week and with a reduction in attendees. The meeting has changed from a status meeting to one at which issues and problems are discussed. The inspector attends both meetings and finds both to be productive. The inspector has observed that the restructured weekly management meeting has improved communications.

b. Followup - Operations (92901)

(CLOSED) LER 2-95-01, Invalid Technical Specification Surveillance Due to Improper Assembly of a Hydrogen/Oxygen Analyzer System Drain Valve.

On January 5, 1995, an investigation into the failure of the Unit 2 Containment Hydrogen/Oxygen Analyzer Drain Tank drain valve indicated that the valve had been improperly reassembled following a system modification in 1987. As the result of the improper reassembly, the valve would not pass flow even thought all indications were that the valve was open. This failure of the valve to pass flow subsequently rendered all Unit 2 TS required Primary Containment Leakage surveillance tests performed since August 1993, on the Hydrogen/Oxygen Analyzer invalid. The valve has been included in these surveillance tests since August of 1993, when the procedures were revised to open the valve and test connections downstream of the valve. In response to the identification of the failed valve, the licensee initiated a root cause investigation. The root cause determined that the failure was the result of inadequate reassembly of the valve following maintenance. The corrective action involved: reassembling the failed valve and bench testing it prior to installation; testing and verifying that the other division II valve in Unit 2, and both the division I and II valves in Unit 1 operated; reviewing installed valves of a similar design to ensure they functioned properly; and reviewing the corrective maintenance procedure for disassembly/reassembly of the valve and the required PMT for adequacy. The licensee completed the last of the these corrective actions on June 14, 1995. The inspector has reviewed the completed corrective actions, and finds them acceptable for the closure of this item.

No violations or deviations were identified

3. Maintenance and Surveillance

a. Maintenance Observation (62703)

Failure of the Scram Discharge Volume Vent Valve

On September 26, 1995, the licensee experienced a failure of the Unit 1 Scram Discharge Volume outboard vent valve (1-C11-V139).

During the performance of 0-PT 14.0, Control Rod Drive System Valve Operability Test, the valve failed to fully stroke closed as required by the TS surveillance. The failure of the valve to stroke fully closed resulted in it being declared inoperable. This required the licensee to enter the LCO for TS 3.1.3.1.c, for more than 8 control rods inoperable, and be in at least HOT SHUTDOWN within 12 hours.

The licensee entered the LCO at 1:26 p.m. and started its investigation into the cause of the valve failure. During the troubleshooting investigation, the licensee determined that the actuator spring was shorter than the one from stock, theorizing it had compressed, reducing its closing force. It was removed and replaced. The valve was then successfully cycled several times to demonstrate operability. The licensee exited the LCO at 6:45 p.m. with the successful completion of the spring replacement and PMTR. Due to the recent failure of this valve in July, the licensee initiated an OI-4, LCO Evaluation and Follow-up investigation to address the repetitive failure of this valve.

A condition of the OI-4 investigation was to stroke the valve every 24 hours for the next seven days while the investigation was being conducted. During the stroke test conducted the following day on September 27, the valve again failed to stroke fully closed, and the licensee was forced to re-enter the TS LCO for control rod operability at 1:00 p.m. In response, maintenance and engineering formulated a repair plan to correct the problems with the valve. The plan involved the complete changeout of the valve actuator and internals, and an inspection of all valve internals to identify any possible causes of the failure to close.

The inspector followed the preparation process for the work, noting the availability of replacement parts, and the hanging of the proper isolation clearance. As part of the preparation, the inspector observed the maintenance crew practicing the disassembly and reassembly of the valve actuator and internals prior to performing the actual job. The inspector then observed the actual field removal and replacement activities and noted that they were well coordinated and completed with no adverse impact on the plant. Following the removal of the valve actuator and internals, the inspector viewed these items looking for indications of a problem. The inspector questioned the buildup of what appeared to be a white gum-like substance at the base of the stem and was informed it was from the packing material rubbing on the stem. The inspector questioned whether this rubbing could have caused the problems experienced and was informed that further testing and analysis of the removed parts was required, and that the root cause of the failure was to be determined.

Following completion of the repair activities, the inspector observed the manual stroke testing of the valve to ensure it operated freely. During these tests, the valve appeared to stroke smoothly and quickly with minimal effort. Following these activities, the clearance was removed and the valve successfully tested in accordance with the PT. The valve was declared operable and the licensee exited the LCO at 7:40 p.m.

At the close of the reporting period, the licensee had completed the OI-4 investigation, which stated that the newly installed valve actuator and internals were functioning properly. However, the repetitive nature of this valve failure, required the licensee to initiate a root cause analysis to determine the cause of the valve failure. This determination is scheduled to be completed in two weeks. The inspector will review and evaluate the conclusions of the root cause at that time.

Disabled Circulating Water Traveling Screen Annunciators

On September 22, 1995, it was identified that the unit 2 control room annunciators for the Circulating Water traveling screens were not operating. This was identified during troubleshooting activities for problems associated with the 2C CW intake pump traveling screen. During this investigation, it was identified that the annunciator cables from all four traveling screens and the CW trash rack were lifted. Subsequent investigation indicated that the leads were lifted and spared during work activities associated with Plant Modification 82-220L. Further review of the sketches associated with this modification indicated that these leads were lifted in error. The wire termination sheets completed as part of this work package indicated that the wires were lifted, spared, and verified on September 14, 1995. The A, B, C, and D CW traveling screens control room annunciators for high differential pressure or stopped, and the CW trash rack control room annunciator for high differential pressure were inoperable for a period of 8 days. The licensee had intake canal dredging activities ongoing during 7 of these 9 days.

Initial investigation into the cause of the problem indicates that the sketches associated with the modification package were not clearly understood by the craft personnel performing the work. The inspector reviewed the sketches in question, and noted that the sketch includes three revisions directed by lineouts and mark-up bubbles. The sketch did not appear to the inspector to be easy to follow or to understand which leads are to be lifted and terminated.

The inspector questioned why work on a 1982 plant modification was being performed in 1995. Additionally, the inspector questioned whether this modification package had been subjected to the ongoing review process for all old design packages. The inspector was informed that the reviews had started the day after work had begun on the modification package and thus it had not been reviewed prior to implementation. Noting that this work was on an open 1982 modification, the inspector requested a listing of all open modifications to review and determine the number of old design packages remaining to be implemented and the systems which they impact. This was inconsistent with past licensee presentations which indicated the engineering backlog was nearing zero. In addition to providing the answers to these questions, the licensee initiated a root cause determination for this current problem. The inspector will review the root cause determination as well as the other issues identified by this event. These issues will be identified as Unresolved Item URI 325,324/95-20-01, Old Outstanding Design Modification Packages.

b. Followup - Maintenance (92902)

(CLOSED) IFI 325,324/95-03-01, Independent Verification Program Changes.

This IFI was opened to address the inspector's concerns over the use of IVs during the conduct of maintenance and surveillance activities. The inspector had noted during the observation of a particular surveillance that the procedure required a large number of IVs. Later, he discussed this observation with the maintenance manager. The manager concurred with the observation and stated that many of the steps currently performed as IV could be satisfied through the use of concurrent or dual verification. This would eliminate the need for the two individuals to be separated by time and distance while performing a specific task. In response to the inspectors concern, the manager stated that they were looking at the issue and would be revising the verification process. The IFI was opened to track the implementation of this change. Since the time of initial observation, the licensee has defined the expectations for the performance of IV; revised PLP-21, Independent Verification procedure; revised the maintenance procedure writer's guide to reflect these new expectations; and reviewed and revised approximately 50 procedures in an ongoing procedure upgrade process. Based on the review of these actions, and the ongoing work, the inspector concludes the actions taken regarding this item are acceptable for closure.

(CLOSED) LER 1-95-10, Loss of RPS Bus A Power and Associated ESF Actuations.

On May 11, 1995, with Unit 1 operating in Mode 4, a loss of power to the 1A RPS Bus resulted in a series of ESF actuations. The loss of power to the 1A RPS bus was caused by RPS bus 1A EPA, breakers 1 and 2 tripping on under frequency. This resulted in a half reactor scram and half groups 1, 2, 3, 6, and 8 isolation signals. The underfrequency sensed by the EPA breakers was caused by the transfer of the emergency bus power supply from the DG to the normal offsite feeder. When the operator transferred the DG from AUTO to CONTROL ROOM MANUAL, a frequency transient resulted which was sensed by the EPA breakers. The transfer of the DG from

AUTO to CONTROL ROOM MANUAL changed the operating modes of the DG governor from Isochronous operation to Droop mode of operation. In isochronous operation DG speed and voltage frequency are maintained at a constant as bus load varies; however, in droop operation the DG speed and frequency vary with load. The procedure in use, 0-OP-50.1, Diesel Generator Emergency Power System Operating Procedure, did not provide any guidance or information about the potential for causing a frequency transient. The licensee identified the deficient procedure as the root cause of the event.

In response to the event, the licensee committed to perform the following corrective actions: revising the procedure to provide additional guidance on transferring the DG from isochronous to droop mode of operation, and providing instruction on and including simulation of this event in the 4th phase of Licensed Operator Requalification. The inspector has reviewed the guidance provided in the revised 0-OP-50.1, dated 7/28/95, and found it acceptable. Additionally, the LOR class rosters and training material were reviewed and found acceptable for the closure of this item.

No violations or deviations were identified.

4. Engineering

a. On Site Engineering (37551)

<u>RHRSW Flow Control Valve Failures</u>

On August 24, 1995, Valve 2-E11-PDV-F068B, RHR Heat Exchanger SW Discharge Valve, failed to stroke full open during the performance of a routine surveillance test. This valve is used to regulate SW flow through its corresponding RHR heat exchanger for Suppression Pool cooling or Containment Spray. Disassembly of F068B revealed that the plug had seized in its retainer basket and galling was evident between the plug face and the retainer. Investigation by the licensee revealed that both components were made from Inconel 625. The licensee determined that three of the four valves had Inconel retainers. Subsequent testing of 1-E11-PDV-F068A revealed that it failed to stroke fully closed. Disassembly revealed similar conditions as were found in the 2-E11-PDV-F068B valve. The third Inconel retainer was installed in valve 1-E11-PDV-F068B. On August 25, the licensee performed Performance Test OPT-8.1.4B, to verify operability of valve 1-E11-PDV-F068B with no adverse observations. VOTES testing was performed on this valve with expected currents observed for both directions of travel. ESR 95-01395 was written to perform an operability evaluation for valve 1-E11-PDV-F068B. The evaluation concluded that the valve was operable. The inspector reviewed the ESR and found it to be acceptable. The 1A and 2B valves were declared inoperable when they failed the PT. The Inconel retainers were replaced with the original Aluminum-Bronze retainers, successfully tested, and declared operable. This event was documented by CR No. 95-02148.

The licensee's investigation revealed that during May 1992, the licensee approached VALTEK for recommendations for replacement of the installed Aluminum-Bronze retainers which had shown signs of excessive wear due to erosion. The vendor recommended either Monel K-500 or Inconel 625, with Inconel having the longer life. The licensee selected Inconel retainers and in January 1993, three retainers were ordered as non safety related. The valves are safety related but the licensee determined with the vendor that the retainers were not safety related as they did not provide a pressure boundary. The licensee prepared Specification Waiver Form No. SWN-248-112-A to evaluate the change in material. They also performed a material equivalency evaluation in accordance with Engineering Procedure 0-ENP-03.4, Equivalent Component Evaluation, Revision 0. The inspector reviewed SEEF No. 93-0091 which documented the evaluation. The evaluator noted that there was a material difference but only evaluated the physical differences. The mechanical effects of the new material were not evaluated with respect to its function. The inspector noted that the vendor assigned a different part number to the replacement retainer but the licensee assigned the same part number to the original and replacement retainers though they were not the same.

The licensee has determined that the galling was caused by the interaction of two identical weldable metals. This interaction was aided by a sharp surface on the bottom of the plug and wear in a bushing which guides the plug. The two galled Inconel retainers were immediately replaced with the original Aluminum-Bronze retainers. The vendor recommended that the Inconel plugs be hard surfaced when used with Inconel retainers. The licensee has purchased one hard surfaced plug to place in the 1B valve. The inspector has reviewed the original evaluations, the operability ESR 95-01395, installation WR/JOs, and CR 95-02148. The CR and ESR were thorough and the evaluations were adequate. The inspector considered that the SEEF was inadequate in that it did not address material properties and allowed for different items to be warehoused as identical.

10 CFR 50 Appendix B Criterion III, Design Control, requires that measures shall be established for the selection and review for suitability of application of material that are essential to the safety-related functions of the components and shall provide for verifying or checking the adequacy of the design. Design changes shall be subject to design control measures commensurate with the original design.

The licensee failed to verify the adequacy of the material selection of the replacement channelstream retainers for the E11-DPV-F068A/B valves. The licensee did not consider the effects of the mating of two Inconel surfaces when it performed the equivalency evaluation was using Engineering Procedure, 0-ENP-03.4, Equivilant Component Evaluation, Revision 0 and documented in Attachment 1, SEEF No. 93-0091. The failure to perform an adequate evaluation and review, resulted in the galling of the plug and retainer of one RHR Heat Exchanger Discharge Valve (F068) in each unit, rendering them inoperable.

This item will be tracked as Apparent Violation EEI 325,324/95-20-03, Design Review Renders RHRSW Valves Inoperable. Unresolved Item URI 325,324/95-19-03, Service Water Heat Exchanger Flow Control Valve Failures, is administratively closed.

b. Self Assessment (40500)

Stop Work

Based on a series of deficient engineering products, identified within the past six months, principally relating to modification design review and installation, a stop work was directed on September 20, 1995. This applies to all engineering products which physically modify the configuration of plant systems or structures. This further applies to minor modifications, decommissioning packages, and temporary modifications, as well as major modifications.

If needed during the stop work directive to support the safety or reliability of operations, work will require the written authorization of the Plant Manager. The conditions to lift the stop work are completion of an engineering standdown, review of all modifications in progress, and concurrence by the Site Vice President that modification work can resume.

As part of the corrective action each new product will have a product quality affirmation signed. The inspector concluded these actions are appropriate to address the continuing problems such as the issues addressed in this report. Many of the older design package have been around for years. While the rest of the site has made significant progress, the older engineering products, unless subjected to a rigorous review to today's standard, resurface old problems at the site.

Reporting of RHRSW Valve Failure

The inspector questioned why the failures were not reported in a LER. On Unit 1, the 1A valve failed and 1B valve had similar Inconel material. This could have resulted in the failure of RHRSW flow to both heat exchangers and the inability to cool the suppression pool or go into shutdown cooling. In a recent reactor trip with a closure of the MSIVs, which occurred on July 13, 1995, SRVs lifted and suppression pool cooling was needed. This type of trip concurrent with the valve failures could lead to overheating of primary containment.

The licensee stated that the valve failed in the partial open condition and could have performed its intended function. The inspector had previously inspected one of the failed valve in the maintenance shop noting scoring along the entire length of the valve retainer. This implied failure could have occurred at any position of valve travel. Thus, the inspector does not agree with this position. This will be tracked under EEI 325,324/95-20-03.

One apparent violation and no deviations were identified.

5. Plant Support (71750)

Plant Nuclear Safety Committee

The inspector attended the PNSC meeting held on September 15, 1995, and listened to the engineering presentation relating to the operation of Unit 2 with reduced FW temperature. Unit 2 is presently in coastdown and the licensee plans to extend reactor power levels by reducing FW temperatures and increasing recirculation flow. The presentation was thorough and well thought out. The PNSC members' questions were broad based and substantive. The FW temperature would be reduced approximately 30F by eliminating extraction steam from the No. 5 feedwater heaters which would increase power an additional four percent. The PNSC was informed that the next phase to extract additional power during coastdown was to reduce FW an additional 40F but that engineering had not determined how this was to be achieved.

Unlocked High Radiation Door

On September 14, 1995, at 2:00 p.m. an AO, accompanied by an RC technician, performed Performance Test PT-2.2.4a, Primary Containment Integrity-Containment External on PCIS Valve 2-B21-V161. The valve is at the 75 foot level of the Unit 2 Reactor Building and located in a locked high radiation area. This area is accessed by a ladder located at the 50 foot level in the Southwest section of the reactor building. Access is controlled by a barrier attached to the ladder by a chain and padlock. Upon completion of the surveillance the RC technician attached the chain to the barrier and the ladder. When he placed the padlock on the chain and secured the lock he failed to place the hasp through both ends of the chain. Procedure OE&RC-0040, High Radiation Area Key Control, Section 10.1.2.d requires the RC technician to verify all doors are locked after the exit of the work group. The technician failed to verify that the barrier was locked in place when he and the AO departed from the work area. 10 CFR 20.1601(a)(3) requires the licensee shall ensure that each entrance or access point to a high radiation area has positive control over each entry for each locked entryway. TS 6.12.2 requires locked doors be provided to prevent unauthorized entry into high radiation areas. The licensee did not ensure positive control to the access to a high radiation area nor did it provide a locked door when it failed to lock the access barrier to valve 2-B21-V161. The failure to lock the access to a high radiation area will be a Non-Cited Violation NCV 325,324/95-20-02, Unlocked High Radiation Area Door. This licensee-identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII of the NRC Enforcement Policy.

The night shift RC technician looked at the padlock and thought both ends of the chain were locked but did not physically verify it. The error was discovered by the Unit 2 dayshift RC technician on September 15. OE&RC-0040, Section 10.3.1 requires the security of locked high radiation doors be verified once per calendar day by RC personnel. The licensee informed the inspector that it was their expectation that this be accomplished swiftly as the operators did when it was their responsibility. The inspector questioned why this expectation was not proceduralized and was informed that it was part of the technician's training. The inspector noted that Appendix A of OE&RC-0040 requires the individual assigned the key to a locked high radiation area door to verify that they closed the door but does not require that they verify the door has been locked. He discussed this observation with the licensee who concurred within his concern. The inspector considers this to be another inattention to detail issue.

One non-cited violation and no deviations were identified.

6. Exit Interview

The inspection scope and findings were summarized on October 6, 1995, with those persons indicated in paragraph 1. The inspectors described the areas inspected and discussed in detail the inspection findings listed below. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors. Dissenting comments were not received from the licensee. In addition, a phone conversation was held with the licensee on October 17, 1995, to discuss the change in status of URI 325,324/95-19-03 and the addition of EEI 325,324/95-20-03.

Item Number	Status	Description/Reference Paragraph
325,324/95-20-01	Open	URI, Old Outstanding Design Modification Packages, paragraph 3.
325,324/95-20-02	Open/Closed	NCV, Unlocked High Radiation Area Door, paragraph 5.
325,324/95-20-03	Open	EEI, Design Review Renders RHRSW Valves Inoperable, paragraph 4.
2-95-01	Closed	LER, Invalid Technical Specification Surveillance Due to Improper Assembly of a Hydrogen/Oxygen Analyzer System Drain Valve, paragraph 2.
325,324/95-03-01	Closed	IFI, Independent Verification Program Changes, paragraph 3.

1-95-10	Closed	LER, Loss of RPS Bus A Power and Associated ESF Actuations, paragraph 3.
325,324/95-19-03	Closed	URI, Service Water Heat Exchanger Flow Control Valve Failures, paragraph 4.

7. Acronyms and Initialisms

AO Auxiliary Operator
CFR Code of Federal Regulations
CP&L Carolina Power and Light
CR Condition Report
CW Circulating Water
DG Diesel Generator
ENS Emergency Notification System
EPA Electrical Protection Assembly
ESR Engineering Service Request
FW Feedwater
HPCI High Pressure Coolant Injection
IFI Inspector Followup Item
IR Inspection Report
IV Independent Verification
LER Licensee Event Report
LCO Limiting Condition for Operation
LOR Licensed Operator Requalification
MSIV Main Steam Isolation Valve
NCV Non-Cited Violation
NRC Nuclear Regulatory Commission
NRR Nuclear Reactor Regulation
OI Operating Instruction
PCIS Primary Containment Isolation System
PLP Plant Program Procedure
PMTR Post Maintenance Test Requirement
PNSC Plant Nuclear Safety Committee
PT Periodic Test
RC Radiation Control
RCIC Reactor Core Isolation Cooling
RHRSW Residual Heat Removal Service Water
RHR Residual Heat Removal
RPS Reactor Protection System
SEEF Equivalency Evaluation Form
SIIT Site Incident Investigation Team
SW Service Water
TS Technical Specification
URI Unresolved Item
WR/JO Work Request/Job Order

NUCLEAR REGULATORY COMMISSION

Revision of the NRC Enforcement Policy

AGENCY: Nuclear Regulatory Commission.

ACTION: Policy statement.

SUMMARY: As a result of an assessment of the Nuclear Regulatory Commission's (NRC) enforcement program, the NRC has revised its General Statement of Policy and Procedure for Enforcement Actions (Enforcement Policy or Policy). By a separate action published today in the **Federal Register**, the Commission is removing the Enforcement Policy from the Code of Federal Regulations.

DATES: This action is effective on June 30, 1995, while comments are being received. Submit comments on or before August 14, 1995. Additionally, the Commission intends to provide an opportunity for public comments after this revised Enforcement Policy has been in effect for about 18 months.

ADDRESSES: Send written comments to: The Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, DC 20555. ATTN: Docketing and Service Branch. Hand deliver comments to: 11555 Rockville Pike, Rockville, Maryland, between 7:45 am and 4:15 pm, Federal workdays. Copies of comments received may be examined at the NRC Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC.

FOR FURTHER INFORMATION CONTACT: James Lieberman, Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555, (301) 415–2741.

SUPPLEMENTARY INFORMATION: On May 13, 1994, the NRC's Executive Director for Operations established a review team to assess the NRC enforcement program. In its report (NUREG–1525,[1] "Assessment of the NRC Enforcement Program," April 5, 1995), the review team concluded that the existing NRC enforcement program, as implemented, is appropriately directed toward supporting the agency's overall safety mission. This conclusion is reflected in several aspects of the program:

- The Policy recognizes that violations have differing degrees of safety significance. As reflected in the severity levels, safety significance includes actual safety consequence, potential safety consequence, and regulatory significance. The use of graduated sanctions from Notices of Violation to orders further reflects the varying seriousness of noncompliances.
- The enforcement conference is an important step in achieving a mutual understanding of facts and issues before making significant enforcement decisions. Although these conferences take time and effort for both the NRC and licensees, they generally contribute to better decision-making.
- Enforcement actions deliver regulatory messages properly focused on safety. These messages emphasize the need for licensees to identify and correct violations, to address the root causes, and to be responsive to initial opportunities to identify and prevent violations.
- The use of discretion and judgment throughout the deliberative process recognizes that enforcement of NRC requirements does not lend itself to mechanistic treatment.

However, the Review Team found that the existing enforcement program at times provided mixed regulatory messages to licensees, and room for improvement existed in the Enforcement Policy. The review suggested that the program's focus should be clarified to:

- Emphasize the importance of identifying problems before events occur, and of taking prompt, comprehensive corrective action when problems are identified;
- Direct agency attention at licensees with multiple enforcement actions in a relatively short period; and
- Focus on current performance of licensees.

In addition, the review team found that the process for assessing civil penalties could be simplified to improve the predictability of decision-making and obtain better consistency between regions.

As a result of its review, the review team made several recommendations to revise the NRC Enforcement Policy to produce an enforcement program with clearer regulatory focus and more predictability. The Commission is issuing this policy statement after considering those recommendations and the bases for them in NUREG–1525.

The more significant changes to the current Enforcement Policy are described below:

I. Introduction and Purpose

This section has been modified to emphasize that the purpose and objectives of the enforcement program are focused on using enforcement actions:

(1) As a deterrent to emphasize the importance of compliance with requirements; and

(2) To encourage prompt identification and prompt, comprehensive correction of violations.

IV. Severity of Violations

Severity Level V violations have been eliminated. The examples at that level have been withdrawn from the supplements. Formal enforcement actions will now only be taken for violations categorized at Severity Level I to IV to better focus the inspection and enforcement process on safety. To the extent that minor violations are described in an inspection report, they will be labeled as Non-Cited Violations (NCVs). When a licensee does not take corrective action or repeatedly or willfully commits a minor violation such that a formal response would be needed, the violation should be categorized at least at a Severity Level IV.

The NRC staff will be reviewing the severity level examples in the supplements over the next 6 months. The purpose of this review is to ensure the examples are appropriately focused on safety significance, including consideration of actual safety consequence, potential safety consequence, and regulatory significance.

V. Predecisional Enforcement Conferences

Enforcement conferences are being renamed "predecisional enforcement conferences." These conferences should be held for the purpose of obtaining information to assist NRC in making enforcement decisions when the agency reasonably expects that escalated enforcement actions will result. They should also normally be held if requested by a licensee. In addition they should normally be held before issuing an order or a civil penalty to an unlicensed individual.

In light of the changes to the Enforcement Policy, the Commission has decided to continue a trial program of conducting approximately 25 percent of eligible conferences open to public observation pending further evaluation. (See 57 FR 30762; July 10, 1992, and 59 FR 36796; July 19, 1994). The intent of open conferences is not to maximize public attendance, but is rather for determining whether providing the public with an opportunity to observe the regulatory process is compatible with the NRC's ability to exercise its regulatory and safety responsibilities. The provisions of the trial program have been incorporated into the Enforcement Policy.

[1] Copies of NUREG–1525 may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Mail Stop SSOP, Washington, DC 20402–9328. Copies are also available from the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161. A copy is also available for inspection and copying for a fee in the NRC Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC 20555–0001.