50-400 02 I-JI-17 9/7/84 JI 17

Attachment I-39(r)

NRC VIOLATIONS

Resp to Joint interrogatories

Shearon Harris Nuclear Power Plant

Date of Response to Notice of Violation	Summary of Incident	Action Taken
11/17/81	Tests were improperly performed on concrete cylinders due to excessive loading.	Concrete Compressive Testing certification for the technician involved was rescinded until the technician passed both oral and written exams.
3/25/82	Weld inspector failed to identify report deficiencies because he did not see them.	Employee responsible was removed from pipe weld inspection, pending reinstruction.
4/23/82	Weld inspector either overlooked or arbitrarily failed to reject defects in welds	Employee responsible was removed from pipe weld inspection and is no longer employed by CP&L.

Date of Incident		
4/83	performed and inspected own work	counseled
prior to 7/29/82	improper inspection of welds	employee resigned before action could be taken
4/82	suspected of improper initialing of seismic I inspection reports	employee resigned while investigation being conducted
4/21/83	unsatisfactory performance of weld inspections	certification invalidated, retraining, retesting and recertification required
12/82	unsatisfactory performance of weld inspections	certification rescinded; recertification required. Warning given.
prior to 2/3/82	evidence of use of cocaine	terminated
2/84	Failure to comply with work procedure	suspension (probation)

H.B. Robinson Unit 2

Date of Response to Notice of Violation		
7/26/78	A chain holding up a radiation area sign had broken loose from the wall and a Radiation Control Technician was instructed to submit a trouble ticket for the repair of the chain. The technician failed to perform this task.	Employee involved was reprimanded and counseled.
8/22/79	Individuals entered the reactor containment, which was a locked, high radiation area, without entering their names on a valid radiation work permit.	Employees were counseled.
2/5/80	Fire protection program states that every connection from a yard main to a building be equipped with a post indicator valve, and large yard main systems must be provided with sectional controlling valves at appropriate points. However, the yard main connection to the Auxiliary Building interior fire hose system was not provided with a post indicator valve and a post indicator sectional control valve was not provided for the northeast portion of the water main loop. This was a result of an FCR (field change request) made by Construction that was disapproved by Engineering but the change was actually made.	All parties involved were made aware of the incident and cautioned to prevent further occurrence.
11/12/80	Field documents used to verify the as-built for safety-related system ISO-RC-4 did not have any records of inspection of clearances for the wall penetrations.	Employees involved were cautioned and counseled.
7/30/81	An Auxiliary Operator was climbing in the overhead piping in the Boric Acid Evaporator Room wearing only shoe covers and gloves instead of anti-contamination clothing which were required.	Employee involved was reprimanded.

1/29/82	An individual was observed in the Boric Acid Evaporator Room without a dose rate survey instrument.	Employee involved was reprimanded.
6/17/81	Radiation surveys of the hot leg compartment inside Steam Generators A, B, C performed 9/17/80 were not maintained or preserved.	Employees involved were cautioned as to the importance of retaining all survey documentation.
9/10/81	Changes were made in the Gas Calibration step of procedure RCP-1, without prior review by Plant Nuclear Safety Committee or approval by the General Manager.	Employees involved were cautioned.
12/22/81	An operator failed to follow valve lineup procedure OP-38A for positioning of valve RHR-764 from locked open to locked shut position	Employee involved was counseled regarding the seriousness of improper performance of valve lineups.
4/15/82	Equipment control policy was not implemented in that Local Clearance and Test Request 113 listed incorrect auxiliary feedwater system valves for the maintenance performed, and clearance was canceled without opening the isolation valve for a local suction pressure gauge.	Employees directly involved were admonished.
12/2/82	QA audits were not performed within the 24 month frequency	Employees (CQA) responsible were counseled by the Corporate QA, not by the HBR management.
3/4/83	Various Fuel Shuffle procedures were not implemented during the 12/26-12/28 fuel movement	Employee involved had disciplinary action taken against him involving loss of pay. The employee's Shift Foreman was counseled.
6/22/83	Disposal of 1 gallon of liquid waste containing licensed material by way of Chem-Nuclear Systems, Inc., SC, who was not authorized to receive liquid waste	Employees responsible were admonished and counseled.

Date of Incident		
2/83	failure to follow plant procedures	periodic increase in pay deferred for 6 months

5/83	improper performance of valve lineups	employee sent home; resigned before further disciplinary action could be taken
3/83	noncompliance with administrative procedures	counseled
2/83	failure to sign out on R.W.P.	counseled
2/83	conviction of possession of controlled substance off the job (on his own time)	terminated
2/83	failure to follow procedure. Sodium hydroxiden 2 supply valve left out of position.	counseled
2/10/83	failure to follow plant procedures	periodic pay increase deferred for 6 months
1/11/83	failure to implement all aspects of special procedure for moving spent fuel in spent fuel pit	counseled; required to review special procedure and administrative requirements for procedures compliance; 2 days suspension without pay.
2/19/84	Violation of H.P. procedures	1 week without pay
2/19/84	Violation of H.P. procedures	1 week without pay

Brunswick Steam Electric Plant

Date of Response to Notice of Violation		
5/30/78	Individual was observed not wearing the required protective clothing as specified.	Employee involved was counseled on importance of radiation control techniques.
3/12/79	After an individual had received an exposure in excess of 5 rem (whole body), Licensee failed to submit a written report within 30 days.	Employees involved were counseled on value of prompt submittals.
4/2/79	Reviewers failed to notice out of specification stroke time for valve F046 during RCIC Pump and Valve Operational Test.	Employee involved was counseled.
7/24/79	Two Auxiliary Operators without lab coats entered a contamination area in the Reactor Building which required lab coats for entry.	Employees involved were counseled by the Shift Foreman.
10/25/79	QA Test results had discrepancies that had not been identified by Licensee's review process.	Employees involved were cautioned about seriousness of not recognizing and evaluating deficiencies.
12/20/79	A fire protection sprinkler and standpipe system for the No. 3 Diesel Generator was isolated and the continuous fire watch was not stationed.	Employees involved were counseled regardi the proper actions to take.
1/13/81	Valve lineup verification documentation showed that locked valve PT46.1, RCIC, and HPCI turbine exhaust manual stop check valves were verified open, when in fact both were closed.	Appropriate corrective or disciplinary action for employees were taken - two Shift Foremen received no nuclear license supplement pay for one week; two Auxiliary Operators given one day off with no pay.

12/30/80	Sampling and analysis of airborne particulate radioactivity was inadequate: 40% of total particulate activity in Reactor Building roof vents were not identified.	Involved RC&T technicians were counseled.
2/3/81	Training requirements for BSEP QA Surveillance Personnel, which had not been revised since 9/75, referenced procedures that no longer existed and did not cover more than 25 standards and procedures that were then a part of QA Control.	Appropriate employees were counseled.
12/18/81	Various vent monitors were found to be inoperable due to lack of maintenance.	Technicians responsible were counseled.
7/1/81	Approval requirements for temporary changes made to procedures RC-ER-12 and RC-ER-18 were not met.	Employees involved were counseled.
8/26/81	As a result of operator error, the reactor mode switch was taken out of the refueling mode, placed in startup, and controlled withdrawal commenced with the A-loop RHR torus suction valve shut.	Disciplinary action was taken with the employees involved. Letter of reprimand placed in file for one year period.
10/30/81	Radiation Hazards Survey concerning repair of a valve was inadequate, causing a worker to exceed dose limit.	All three employees involved were counseled and disciplinary action was taken - one employee was given two weeks off without pay; two employees were assigned to Caswell Beach Pumping Station.
10/6/81	Two employees were observed in posted radiation areas without proper dress.	Employees involved were counseled.
10/12/81	An inadvertent release of approximately 300 gallons of liquid waste from the "B" floor drain sample tank without prior sampling for gross activity.	Employee involved was counseled.
	Temporary changes to PT-A3 Rev. 0 and OP-50.1 Rev. 13 were approved by Plant Nuclear Safety Committee in 16 and 17 days instead of the required 14 days from implementation date.	Operations employees were cautioned.
11/2/81	Inoperable instrumentation channel was not placed in the tripped mode within one hour of determination that this instrumentation could not be calibrated.	All Senior Reactor Operators were counseled as well as I&C periodic testing personnel.

11/30/81	Temporary change to Liquid Radioactive Waste Processing System Procedure was not reviewed although it remained in effect through August 1981.	Operations employees were cautioned.
3/11/82	A primary coolant sample taken at 2100 hours exceeded .2 UCi/gram dose equivalent I-131, and the subsequent samples required once per 4 hours were not taken.	Employees involved were counseled.
8/16/82	Reactor vessel water level low instrumentation (transmitter), required by Technical Specifications, was inoperable. However, trouble ticket was prepared, stating that the transmitter was not required by Technical Specifications.	Employees involved were counseled.
4/30/82	Shift Foremen failed to complete an Event Evaluation Check Sheet or make entry in the Shift Foremen's log when informed that the Standby Liquid Control heat tracing circuits were inoperable.	Employees involved were counseled.
7/2/82	1A-1 battery charger was momentarily not positioned as per clearance procedure, and service water vital header crosstie valve was not positioned as per operating procedure.	Two operators responsible were counseled.
8/5/82	Contrary to Technical Specification 6.8.1(a), Regulatory Guide 1.33 Appendix A was not implemented in that safety-related equipment maintenance instruction was not correctly performed.	Technician involved was counseled.
6/24/83	Reactor Water Cleanup System was not isolated, as required by Table 3.3.2-1 Item 3.a, within one hour.	Senior Reactor Operator was removed from licensed duties for two weeks and during that time was counseled.

8/11/83	Unit 2 augmented off-gas system was out of service and the air ejector off-gas monitors were inoperable, yet a reactor shutdown was not initiated.	On-shift personnel (excluding radioactive waste and fire protection) were immediately counseled. One Control Operator was removed from licensed duties with loss of license supplement pay for 14 days. Approximately 10 Shift Operating Supervisors, Shift Foremen, and Control Operators involved were given verbal reprimands evidenced by memo to their files.
8/4/83	A representative air sample was not collected in an individual's breathing zone while he was splitting radioactive waste bags containing material with unknown contamination levels and radiation levels of 30 mrem/hr.	The Health Physics Technician involved was been counseled.

Date of Incident or Action		
2/12/83	use of unapproved procedure in loading cask	5 days suspension without pay and written reprimand
12/81	failure to adhere to established health physics procedures	3 days suspension without pay
9/81	failure to adhere to established health physics procedures	3 days suspension without pay
3/83	two radiation safety violations within 60 days	letter placed in file with performance evaluation review to be made in 6 months
4/83	allowed an employee to sign verification sheet for a periodic test performed by another	letter placed in file
4/83	Improper clearance - failed to	one day suspension

		exercise supervisory overview	without pay, letter of reprimand included in file
	3/17/83	improper review of periodic test	letter of caution
	3/17/83	failure to sign off a step of a periodic test	written reprimand
	7/81	allowed worker to exceed calculated stay time resulting in over-exposure	2 weeks suspension without pay
	10/15/81	Radiation safety violation. False information about age.	counseling
	12/20/82	failed to have QC verify cleanliness of hold point	letter of reprimand
	2/5/83	improper attention to procedures related to waste casks	letter placed in personnel file for 1 year
	8/81	Level 2 radiation safety violation	1 day suspension without pay and 1 day training with health physics.
	12/82	failure to do required testing in time specified on diesel generator	letter of reprimand
*	1/83	failure to enter into action statement as required - Technical Specifications violation	suspension of license pay for 2 weeks
	2/83	failure to perform safety related activity in accordance with procedure	5 day suspension without pay
	5/83	failure to maintain awareness of power plant status	removed from contol floor

January 10, 1984	Failed to exercise management control and demonstrate job responsiveness; three incidences.	Letter of reprimand.
January 10, 1984	Falsified time associated with procedure completion.	Two (2) days suspension without pay.
January 25, 1984	Failure to accurately complete calculation associated with PT.	Memo to personnel file.
January 26, 1984	Procedural noncompliance; improper work authorizations.	Memo to personnel file.
January 27, 1984	Deviation from procedure.	One (1) day suspension without pay.
January 31, 1984	Procedure violation.	One (1) day suspension without pay.
February 2, 1984	Failure to accurately research information and misrepresented conditions through negligence.	Memo to personnel file.
* March 5, 1984	Nonconservative interpretation of Tech Specs resulting in failure to initiate a LCO.	Memo to personnel file.
March 8, 1984	Lost 0.27 uCi source thru negligence and failed to follow sign out procedure.	Memo to personnel file.
March 22, 1984	Poor judgement and failure to notify supervision of occurrence resulting in airlock seal damage.	Memo to personnel file.
March 23, 1984	Failure to maintain attention to detail resulting in improper LCO handling/clearance.	Memo to personnel file.
April 11, 1984	Valving error resulting in reactor scram; demonstrated poor judgement in surveillance and communication.	One (1) day suspension

March 8, 1984	Failure to follow control procedure on Q-list weld rods resulting in a nuclear plant procedures report.	Two days off without pay and a letter of reprimand.
March 19, 1984	Violated two health physics rules related to moving tools to an uncontaminated tool room.	First violation - written reprimand. Second violation - two days off without pay.
February 15, 1984	Worked on equipment prior to preparation	2 days without pay; written reprimand