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JUL 25 1988

Docket No. 50-324
License No. DPR-62
EA 88-131

Carolina Power & Light Company
ATTN: Mr. E. E. Utley
Senior Executive Vice President
Power Supply and Engineering
and Construction
P.O. Box 1551
Raleigh, NC 27602

Gentlemen:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY
(NRC INSPECTION REPORT NOS. 50-325, 324/88-15 AND 50-325, 324/88-18)

This refers to the Nuclear Regulatory Commission (NRC) inspections conducted on April 1-30, and May 1-June 3, 1988, at the Brunswick Steam Electric Plant. The inspections included a review of several operational events involving operator error and less than adequate attention to detail which are discussed below. The reports documenting these inspections were sent to you by letter dated May 23, 1988 and June 29, 1988. As a result of these inspections, failures to comply with NRC regulatory requirements were identified. The NRC concerns relative to the inspection findings were discussed in an Enforcement Conference held on May 27, 1988, and a summary of this conference was sent to you by letter dated June 17, 1988.

The violations described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) involve several events which resulted in Technical Specification (TS) noncompliance. Individually, the violations do not have serious safety significance. The significant issue manifested by the collective violations is operator error and inattention to detail, an issue of critical importance to the safe operation of your plant. The operations staff must be aware of the operational status of plant equipment at all times.

Violation A in the enclosed Notice involved Unit 2 entering into Operational Condition 2 without Division II of the residual heat removal (RHR) system being aligned for automatic low pressure coolant injection (LPCI) initiation and without primary containment being established. This evolution appeared to have been handled in a confused atmosphere. The violation was caused, in part, by an incorrect verbal verification of LPCI alignment, an alignment that had been performed many times before by the operations staff, which raises a concern about the degree of attention to detail being practiced by the operations staff on shift. In this regard, Division II RHR may not have been

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aligned for automatic LPCI initiation but for questioning from the NRC inspector who was in the control room at the time.

Violation B in the enclosed Notice involved a second occurrence within a four month period where shutdown cooling was inadvertently interrupted and plant heatup went unnoticed by the operations staff. This Unit 2 occurrence continued for four and a half hours, and revealed a lack of adherence to a procedure whereby a valve, that by procedure had to be either fully opened or fully closed, was used as a throttle valve to maintain reactor temperature control. This error notwithstanding, the operations staff should have been alerted sooner had appropriate attention been used in monitoring other available temperature indications. Taken in its entirety, it is evident that a major cause of this incident was the inadequate attention to plant status by the operations staff.

Violation C in the enclosed Notice involved an incident in Unit 2 where control rod 10-39 was in the fully withdrawn position with the shorting links installed in violation of the TS. Aside from the lack of attention to the status of a shutdown plant by the operations staff in neglecting to reinsert the control rod after testing, the lack of attention is further highlighted by the fact that no one on the operations staff recognized that the green "full-in" light for control rod 10-39 was not illuminated to indicate that the control rod was fully inserted, as assumed by the operations staff for 17 hours. This is especially significant because the red light which would have indicated the control rod was fully withdrawn was known to be inoperable and should have caused the operators involved, in the two shift-turnovers which occurred during this event, to be especially sensitive to the position of this particular control rod.

These three events occurred during a three month period from March to May 1988. In January 1988, there had been an event similar to that described in Violation B. The NRC staff's concern is that the indications of lack of attention to detail are not restricted to an isolated incident or to one individual, but appear to be permeating the operations staff and possibly other plant organizations interfacing with that staff. Each event could have been prevented had your staff properly monitored plant conditions. The NRC staff considers the lack of attention to detail by the licensed operators during these events to have significant safety implications which must be corrected immediately. Management must evaluate this apparent trend, identify the root cause, and implement corrective action.

To emphasize the importance of the operations staff to maintain the highest degree of awareness and attentiveness to all aspects of plant operation, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Regional Operations, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty in the amount of Seventy-five Thousand Dollars ($75,000) for the violations described in the enclosed Notice. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," in 10 CFR Part 2, Appendix C (1988) (Enforcement Policy), the violations described in the enclosed Notice have been

categorized in the aggregate as a Severity Level III problem. The base value of a civ l penalty for a Severity Level III problem is $50,000. The escalation and mitigation factors were considered, and the base civil penalty amount has been increased by 50 percent because of poor past performance. Specifically, the lack of attention to detail on the part of the operations staff has allowed inadvertent heatups to occur twice in a four month period. The operations staff did not learn from the first event. Having a technical problem with the same type valve, whose inadvertent closure resulted in the January 1988 heatup, should have caused the operations staff to focus on that valve again in May 1988. In addition, the throttling of the valve, which contributed to the inadvertent closure in January 1988, was in violation of the applicable operating procedure. This earlier event should have motivated your staff to aggressively pursue plant design or procedural changes so as to preclude recurrence. Thus, the similar event which occurred in May 1988 could have been avoided. Additional escalation for past performance was considered but, because of the plant's generally acceptable performance in the operations area and the relatively short period during which the violations occurred, escalation was found not to be appropriate.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions 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 Section 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, 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.

Should you have any questions concerning this letter, please contact us.

Sincerely,

J. Nelson Grace
Regional Administrator

Enclosures:
Notice of Violation and Proposed
Imposition of Civil Penalty

cc w/encls:
P. W. Howe, Vice President
Brunswick Nuclear Project
C. R. Dietz, Plant General Manager