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JOSEPH A. TIERNAN
VICE PRESIDENT
NUCLEAR ENERGY

October 19, 1988

U. S. Nuclear Regulatory Commission
Washington, DC 20555

ATTENTION: Document Control Desk

SUBJECT: Calvert Cliffs Nuclear Power Plant
Unit Nos. 1 & 2; Docket Nos. 50-317 & 50-318
Combined Inspection Report No. 50-317/88-20; 50-318/88-20

REFERENCE: (a) Letter from Mr. R. R. Bellamy (NRC) to Mr. J. A. Tiernan (BG&E), dated September 9, 1988, same subject

Gentlemen:

This is in response to Reference (a) and the exit interview held on August 19, 1988, at Calvert Cliffs. Appendix A is a Notice of Violation of 10 CFR 20.201, "Surveys." Enclosure (1) provides a response to the Notice of Violation, as required by Reference (a). Our response includes a request that the issuance of the Notice of Violation be retracted. Information is provided in Enclosure (1) which we feel is adequate to justify retraction of the Notice of Violation.

We appreciate your assessment and constructive criticism of our Radiation Safety Program and welcome your comments and insights on this response as we seek to improve in our quest for excellence at Calvert Cliffs. Should you have any further questions regarding this matter, we will be pleased to discuss them with you.

Very truly yours,

JAT/CDS/dlm

Enclosure

IE01
1/1

Cert No. P407 418 432

cc: D. A. Brune, Esquire
J. E. Silberg, Esquire
R. A. Capra, NRC
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ENCLOSURE (1)

RESPONSE TO APPENDIX A OF NRC INSPECTION REPORT 50-317/88-20; 50-318/88-20

Appendix A of NRC Inspection Report 50-317/88-20; 50-318/88-20 is a Notice of Violation of 10 CFR 20.201, "Surveys." We agree with the description of events in Reference (a), in that an inadequate pre-job survey was performed at Calvert Cliffs Unit 1. We also agree that the inadequate pre-job survey constitutes a violation of 10 CFR 20.201, "Survey," as stated in the Notice of Violation.

We believe, however, that the violation qualifies for enforcement discretion per 10 CFR 2 Appendix C, V.G, and thus, we are requesting a retraction of the Notice of Violation. 10 CFR 2 Appendix C, V.G states, in part, that the "NRC will not generally issue a notice of violation for a violation that meets all of the following criteria:

a. It was identified by the licensee;
b. It fits Severity Level IV or V;
c. It was reported, if required;
d. It was or will be corrected, including measures to prevent recurrence, within a reasonable time; and
e. It was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation."

The NRC inspector indicated that "the violation potentially qualifies for enforcement discretion as a licensee identified violation as provided for in 10 CFR 2, Appendix C," but that "mitigation of the violation was not appropriate." The inspection report indicates that the reason for the mitigation of the violation not being appropriate was that prompt and aggressive action to prevent recurrence was not initiated.

We believe that pertinent corrective and preventive measures were taken in a prompt fashion to prevent recurrence of the event and that the violation did, in fact, qualify for enforcement discretion per 10 CFR Appendix C, V.G. To support this conclusion, we furnish the information provided below. Based upon this information, we request that the issuance of the Notice of Violation be retracted.

Upon discovery that the workers had been exposed to higher than expected dose rates, the Radiation Safety (RS) technician who had performed the initial survey immediately re-surveyed the area. He discovered a radiation "hot spot" four to five feet from the actual work area. He then re-posted the area as a High Radiation Area Exclusion Area and notified his supervisor of the situation. A more thorough survey was subsequently performed.

Later that same day, the RS technician was verbally counselled for not having performed an adequate pre-job survey at the valve alley. All corroborated information and events involved in the incident were discussed with all RS technicians beginning with their daily morning meeting at 0700 on June 22, 1988. No formal documentation of these discussions were made, however, which may have lead the NRC inspector to the conclusion that the RS technicians were not briefed concerning the details of the event until the week of his inspection or August 19, 1988.

This incident prompted the Radiation Safety Section to request that a formal investigation of the incident be performed. The results of this investigation identified the contributing causes of the incident and suggested corrective measures to prevent recurrence. The results were presented to the Plant Operations and Safety Review Committee (POSRC), which recommended to the Manager-Calvert Cliffs Nuclear Power Plant that the incident, and the lessons learned from it, be reviewed with all RS technicians during their normal required training courses and that this training and all those who attended it be formally documented. All RS technicians were apprised of the incident through this training vehicle by August 19, 1988. This was the first formally documented case of RS technicians being apprised of the incident.

As stated in Reference (a), there was a difference of opinion between the Radiation Safety Section and the auditor who performed the formal investigation. This difference opinion centered around the issue of whether or not it was possible for the RS technician to perform a proper survey in this particular situation without crossing the step-off pad and proceeding into the valve alley. Radiation Safety personnel argued that a proper survey could have been done with a telescoping instrument which is available on site. There was never any disagreement between the two parties that an inadequate survey had been performed in this particular case.

We believe that the corrective actions noted above were prompt and aggressive, and were sufficient to preclude recurrence of the incident. No further incidences of performance of inadequate surveys have since occurred at Calvert Cliffs.

Additional corrective actions, which have been taken since the NRC exit meeting on August 19, 1988, are as follows:

- The General Orientation Training syllabus has been modified to include a discussion of the incident.
- Requalification training will include a discussion of the event in its 1989 training cycle.
- During a review of the Special Work Permit (SWP), we determined that the SWP used by the workers may have contributed to the incident. What constitutes a "routine" (blanket) SWP has been more tightly defined. The SWP form has been revised to include limits on area radiation dose rates and individual dose. As a result of this change, fewer routine SWPs will be issued effective September 6, 1988.