UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

August 12, 1997

EA 97-197

Mr. K. P. Powers
Plant General Manager
Big Rock Point Nuclear Plant
Consumers Energy Company
10269 US 31 North
Charlevoix, MI 49720

SUBJECT: NOTICE OF VIOLATION
(NRC Inspection Report No. 50-155/97005(DRS))

Dear Mr. Powers:

This refers to the inspection conducted on March 3, 1997, through April 28, 1997, at the Big Rock Point Nuclear Plant facility. This inspection included a review of your radiation protection program. The written results of this inspection were provided to you on May 19, 1997. You responded to this inspection report in a letter dated June 18, 1997, discussing your reasons for the apparent violations, the corrective steps taken, and the results achieved.

Based on the information developed during the inspection and the information that you provided in your June 18, 1997, response to the inspection report, the NRC has determined that violations of NRC requirements occurred. These violations are cited in the enclosed Notice of Violation (Notice) and the circumstances surrounding them are described in detail in the subject inspection report. Three events occurred in the first quarter of 1997 which resulted in these violations. On January 20, 1997, an individual entered a high radiation area without meeting the appropriate procedural requirements. Specifically, the individual was not authorized to enter the high radiation area without radiation protection technician coverage. On February 2, 1997, a tour of a high radiation area was conducted without plant staff performing a proper evaluation of the radiological hazards which could have been present. During this tour, two individuals received dosimetry alarms and failed to exit the high radiation area as procedurally required. Finally, on February 24, 1997, radioactive waste filters were transferred without a proper evaluation of the potential radiological hazards. During this transfer, the ventilation configuration was outside of the evaluated design basis, resulting in radioactive contamination being spread throughout the turbine building.

The failure of plant staff to adequately plan for jobs and to evaluate radiological conditions in the job area beforehand indicates a programmatic deficiency in the areas of pre-job planning, ALARA planning, and radiological assessment. In these events, your staff failed to carefully prepare for radiological jobs; to properly assess the current and potential radiological conditions in the job area; to be familiar with procedural and radiation work permit requirements for the job; and to ensure the proper training and qualification of everyone entering the area. In addition, the failure to follow procedures

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during the February 2, 1997, tour raises significant regulatory concerns since it is imperative that nuclear power plant employees understand the importance of procedural compliance.

The consequence to safety of each event was low since there was not a substantial potential for personnel exposures in excess of regulatory requirements. However, the number, frequency, and similar root causes of these events indicate a breakdown in the radiation protection program, particularly in the areas of pre-job planning, ALARA planning, and radiological assessment. The failures to a perform evaluations of potential radiological hazards in the February 2, 1997, event, and the February 24, 1997, event, are violations of 10 CFR 20.1501. The failures to comply with Technical Specification-required procedures governing high radiation area access during the January 20, 1997, and the February 2, 1997, events were violations of Technical Specification 6.11. Finally, the failure to perform an evaluation of the design change to the ventilation paths, and the failure to update the Final Hazards Safety Report for this change were violations of 10 CFR 50.59 and 10 CFR 50.9. Collectively, these violations represent a significant lack of attention and carelessness toward licensed responsibilities. Therefore, these violations have been categorized in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600 as a Severity Level III problem.

In accordance with the Enforcement Policy, a base civil penalty in the amount of $55,000 is considered for a Severity Level III problem. Because your facility has been the subject of escalated enforcement actions within 2 years prior to the date of these violations[1], the NRC considered whether credit was warranted for *Identification* and *Corrective Action* in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. The NRC determined that credit was warranted for Identification since each violation was either identified by your staff or self-revealed. Both high radiation area events were identified and documented through condition reporting system. Your staff's evaluation of the February 2, 1997, event identified that a primary contributor to the problems encountered during the tour event was the inadequate evaluation of the work to be performed. While the filter transfer event on February 24, 1997, was essentially self-revealed, your investigation determined that an inadequate evaluation again contributed to the problem, along with the failure to complete a safety analysis for the design change to the ventilation system. The NRC also determined that credit was warranted for Corrective Actions. Corrective actions completed to improve the ability to properly evaluate the extent of radiation levels and the potential radiological hazards that could be present included additional training for all station personnel, as well as reorganization of the radiation protection department to provide stronger oversight of radiation protection related activities and ALARA planning. Corrective actions were also developed to prevent similar problems with future filter transfers including specifying engineering controls for future evolutions.

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[1] A Severity Level III violation with a Civil Penalty of $50,000 was issued on May 24, 1995 for violations associated with the fire system and the neutron monitoring system (EA 95-057).

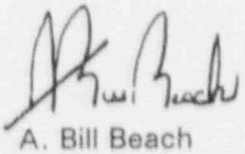
Additionally, the station ventilation airflows were balanced in accordance with the design bases. Finally, training was provided to station personnel regarding the correct performance of work in high radiation areas and the importance of procedural adherence.

Therefore, to encourage prompt identification and comprehensive correction of violations, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, significant violations in the future could result in a civil penalty.

The NRC has concluded that information regarding the reason for the violation, the corrective actions taken and planned to correct the violation and prevent recurrence is already adequately addressed on the docket in Inspection Report Nos. 50-155/97005(DRS), and your response to the inspection report dated June 18, 1997. Therefore, you are not required to respond to this letter unless the description in the docketed materials referenced above does not accurately reflect your corrective actions or your position. In that case, or if you choose to provide additional information, you should follow the instructions specified in the enclosed Notice.

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 (PDR).

Sincerely,



A. Bill Beach
Regional Administrator

Docket No. 50-155
License No. DPR-06

Enclosure: Notice of Violation

cc w/encl: Robert A. Fenech, Senior Vice
President, Nuclear, Fossil
and Hydro Operations
James R. Padgett, Michigan
Public Service Commission
Michigan Department of
Environmental Quality
Department of Attorney General (MI)

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