

## Brunswick 2

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### Initiating Events

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### Mitigating Systems



**Significance:** Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

#### **SITE MANHOLE CORRECTIVE ACTIONS**

A Non-cited Violation (NCV) was identified for the failure to promptly identify and correct conditions adverse to quality involving 57 underground safety-related manholes subject to flooding and containing safety-related alternating current and direct current cables. This was determined to be of very low safety significance because no operability problems on safety-related equipment were identified from an engineering review of the deficiencies.

Inspection Report# : [2000004\(pdf\)](#)



**Significance:** Jul 01, 2000

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

#### **FAILURE TO ADEQUATELY ESTABLISH A PROCEDURE TO DEMONSTRATE THE OPERABILITY OF THE ENGINE DRIVEN FIRE PUMP 24 VOLT BATTERY CHARGER AND BATTERY**

A non-cited violation of the fire protection program was identified for a failure to establish an adequate procedure to demonstrate the operability of the engine driven fire pump (EDFP) 24 volt battery charger and battery. This failure resulted in the inability of the engine driven fire pump to start when called upon to accomplish its fire or risk-related function. The licensee performed satisfactory troubleshooting, timely repair of the damaged battery charger, and replacement of the dedicated fire batteries. The motor driven fire pump and jockey pumps were unavailable for a short time while the EDFP was considered inoperable; therefore, the issue was found to be of very low safety significance.

Inspection Report# : [2000003\(pdf\)](#)



**Significance:** Mar 31, 2001

Identified By: NRC

Item Type: FIN Finding

#### **INOPERABILITY OF SAFETY RELATED MOTOR CONTROL CENTERS 2XD AND 2XM**

Green. The inoperability of two safety-related 480 volt feeder breaker overcurrent trip devices resulted in an unrecognized increase in risk while the plant was operating over the past three years. The inoperability of the overcurrent trip devices had a credible impact on safety in that if a fault occurred on the 2XD and 2XM motor control centers a loss of the division II accident mitigating systems could have occurred. The following systems were affected: core spray, residual heat removal, standby liquid control, emergency diesel generator 4, 250 volt battery charger, and service water. This issue was of very low safety significance (Green) based on the small probability of a bus fault actually occurring. No violations of NRC requirements were identified because the licensee met regulatory requirements associated with maintenance and quality controls of the breaker components.

Inspection Report# : [2000006\(pdf\)](#)

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### Barrier Integrity

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### Emergency Preparedness

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## Occupational Radiation Safety

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**Significance:** Jul 01, 2000

Identified By: Licensee

Item Type: NCV NonCited Violation

### **FAILURE TO ISSUE FUNCTIONING DOSIMETERS IN ACCORDANCE WITH TS REQUIREMENTS**

A non-cited violation of Technical Specification requirements was identified for the licensee's failure to provide occupational radiation workers with functioning personnel radiation monitoring dosimetry. Technicians entering the Unit 2 drywell on May 6, 2000, were provided electronic dosimeters that were not properly configured to measure the worker's personnel radiation exposure. This issue was characterized as having very low safety significance because the ability to assess dose was not compromised, and no over-exposure occurred.

Inspection Report# : [2000003\(pdf\)](#)

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## Public Radiation Safety

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## Physical Protection

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**Significance:** Sep 29, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

### **FAILURE TO SUSPEND UNESCORTED ACCESS FOR AN EMPLOYEE WHOSE ACCESS HAD BEEN DENIED DUE TO AN ONGOING INVESTIGATION.**

An access control violation of security procedures was identified by the licensee. Brunswick operating license condition 2D, the Brunswick Physical Security Plan, and security implementing procedures SEC-NGGC-2130, Revision 10 and Operating Security Instruction (OSI)-09, Revision 83 require that unescorted access be suspended for individuals who have had their access denied based on an ongoing investigation. From September 19, 2000 through October 4, 2000, an employee whose access had been denied based on an ongoing investigation, continued to maintain the capability of gaining unescorted access to the Brunswick Nuclear Plant.

Inspection Report# : [2001003\(pdf\)](#)

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## Miscellaneous

**Significance:** N/A Sep 01, 2000

Identified By: NRC

Item Type: FIN Finding

### **PROBLEM IDENTIFICATION AND RESOLUTION**

Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program was acceptable with concerns noted. The licensee was generally effective at identifying problems and placing them into the corrective action program as evidenced by the inspectors review of external operating experience, Corrective Action Program Trend Reports, and items from system health reports and through plant tours. However, several instances where the licensee had not initiated condition reports were noted. When conditions adverse to quality were identified, the licensee generally identified the appropriate causes and developed and implemented effective corrective actions. The inspectors determined that the licensee properly classified discrepant conditions, but did not use risk when classifying/assigning prioritization of these items. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. Based on discussions with plant employees from various departments, the inspectors determined that employees felt free to report safety concerns.

Inspection Report# : [2000007\(pdf\)](#)

**Significance:** N/A Sep 14, 2001

Identified By: NRC

Item Type: FIN Finding

### **PROBLEM IDENTIFICATION AND RESOLUTION**

Based on the results of the inspection, no findings of significance were identified. The implementation of the corrective action program was acceptable. The licensee was effective at identifying problems and placing them into the corrective action program as evidenced by the review of

corrective action program documents, corrective action program trend reports, operating experience review items, and items from system health reports. When conditions adverse to quality were identified, the licensee generally identified the appropriate causes, and developed and implemented effective corrective actions. For some complex issues, corrective action documentation did not adequately reflect those actions that were actually taken to correct the problem and prevent repetition. Based on discussions conducted with plant employees from various departments, the inspectors determined that a reluctance to report safety concerns did not exist.

Inspection Report# : [2001008\(pdf\)](#)

Last modified : March 28, 2002