

Brunswick 1

Initiating Events

Mitigating Systems

Significance:  Sep 28, 2002
Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO HAVE INSTALLED FIXED FIRE SUPPRESSION SYSTEMS THAT ARE CAPABLE OF MINIMIZING FIRE DAMAGE TO SAFE SHUTDOWN CABLING DURING FLOOR LEVEL TRANSIENT COMBUSTIBLE FIRES IN THE UNIT 1 AND 2 CSRs

Green. The licensee failed to install fixed fire suppression systems that were capable of minimizing damage to safe shutdown cabling caused by floor level transient combustible fires in the Unit 1 and Unit 2 Cable Spreading Rooms (CSRs). The systems were determined to be unable to fulfill their intended function of limiting fire damage to the preferred trains of safe shutdown cables and safety-related cables in the CSRs. The finding was of very low safety significance based on the initiating event likelihood for this event in conjunction with the remaining mitigation capability in the Unit 1 and Unit 2 CSRs.

Inspection Report# : [2002003\(pdf\)](#)

Significance:  Sep 29, 2001
Identified By: NRC

Item Type: FIN Finding

INOPERABILITY OF SAFETY RELATED 480 VOLT FEEDER BREAKER OVERCURRENT TRIP DEVICE

The inoperability of the DGB motor control center (MCC) safety-related 480 volt feeder breaker overcurrent trip device was a degraded condition that was an unrecognized increase in risk while the plant was operating over the past three years. If a fault occurred on MCC DGB, the MCC DGB feeder breaker would not operate and therefore the E-6 bus supply breaker would trip open to isolate the fault. This would result in the loss of the entire E-6 substation and the loss of emergency diesel generator number 2. The finding was of very low safety significance based on the small probability of a bus fault actually occurring.

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

Significance:  Sep 29, 2001
Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CORRECT UNIT 1 BATTERY DEFICIENCIES

A Non-Cited violation for inadequate corrective actions was identified when the Unit 1, 125 VDC 1B-2 battery was found to be inoperable following a quarterly battery surveillance test. The inspectors determined that inadequate actions were taken by the licensee to maintain battery cells 3 and 57, located in the 1B-2 battery, within TS limits. The finding was of very low safety significance because no actual loss of safety function occurred, in that a loss of DC supplied loads did not occur.

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

Significance:  Sep 29, 2001

Identified By: NRC

Item Type: FIN Finding

MAINTENANCE RULE CONDITION MONITORING CRITERIA FOR BATTERY SPECIFIC GRAVITY EXCEEDED

The licensee failed to identify that a deficient 1B-2 battery cell condition related to specific gravity had lead to exceeding the licensee's appropriate Maintenance Rule (MR) condition monitoring threshold criteria. As a result, this condition existed without pursuit of the expected MR activities such as recognition of the condition, determination of the cause, and goals to fix and restore optimum battery performance. The finding was of very low safety significance because no actual loss of safety function occurred in that a loss of Direct Current (DC) supplied loads from the 1B-2 battery did not take place.

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

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: N/A Sep 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CONSIDER UNIT 1 BATTERY UNAVAILABILITY

No Color. An NCV was identified for the failure to adequately monitor system unavailability hours and take appropriate corrective actions, when the 1A safety-related battery exceeded the licensee established goal for unavailability. This was an isolated failure which did not result in any unidentified equipment failures and was dispositioned outside the SDP as a no color NCV.

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\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 30, 2002

Identified By: Licensee

Item Type: NCV NonCited Violation

FAILURE TO MEET TS PERSONNEL RADIOLOGICAL MONITORING REQUIREMENTS

Technical Specification (TS) 5.7.2 prescribes licensee requirements for personnel entering high radiation areas with dose rates greater than 1.0 rem/hour (at 30 centimeters from the radiation source or from any surface penetrated by the radiation), but less than 500 rads/hour (at 1 meter from the radiation source or from any surface penetrated by the radiation). TS Section 5.7.2.d prescribes acceptable monitoring requirements for personnel entering such an area. The licensee failed to meet these requirements on March 2 when an individual entered the Unit 1 drywell without a dosimeter and remained in the area for approximately 10 minutes. The inspectors noted that the licensee had met part of the monitoring requirements of TS 5.7.2.d.3 during the drywell entry, in that a health physics technicians accompanied the individual and monitored radiation levels as they worked. This item is described in licensee corrective action program AR 56719, Individual Entered LHRA Without Electronic Dosimeter.

Inspection Report# : [2001005\(pdf\)](#)

Public Radiation Safety

Physical Protection

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\(pdf\)](#)

Miscellaneous

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\(pdf\)](#)

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\(pdf\)](#)

Last modified : December 02, 2002