Brunswick 1

Initiating Events

Mitigating Systems

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Procedure 0PM-STU500, Service Water Intake Structure Inspection and Cleaning
Green. An inadequate implementation of Preventive Maintenance Procedure 0PM-STU500, Service Water Intake Structure Inspection and Cleaning, resulted in the 1A Nuclear Service Water (NSW) pump becoming inoperable, with a loss of function, due to the pump's discharge strainer becoming clogged with oyster shells during a diving evolution. A non-cited violation of TS 5.4.1a was identified. This issue was considered to be more than minor because it affected a cornerstone attribute and an associated cornerstone objective. The mitigating systems cornerstone objective to ensure reliability, availability, and capability of systems that respond to initiating events was affected by equipment performance and human error. The finding was determined to be of very low safety significant because the risk was mitigated by the availability of the conventional service water pumps which were utilized in accordance with the abnormal operating procedures to restore service water flow.
Inspection Report# : 2002004*(pdf)*

Significance: G Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO HAVE INSTALLLED 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)*

Barrier Integrity

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Procedure 0ENP-54, Building Ventilation Pressure Control Program
Green. An inadequate implementation of Procedure 0ENP-54, Building Ventilation Pressure Control, resulted in a breach of the control room habitability envelope that exceeded the allowable leakage criteria to maintain both units' control room emergency ventilation (CREV) systems operable. A non-cited violation of Technical Specification (TS) 5.4.1a was identified. This issue was considered to be more than minor because it affected a cornerstone attribute and an associated cornerstone objective. The barrier integrity objective and containment functionality attribute of configuration control and human performance in post-accident and event performance were affected. Additionally, if this issue was left uncorrected, it would have been a more significant safety concern. The finding involved the barrier integrity cornerstone in which the control room barrier was degraded and represented a degradation of the barrier function of the control room against smoke and a toxic atmosphere. This issue was evaluated to be very low safety significant. The impact of chlorine gas intrusion (toxic atmosphere) into the control room during the period the door was blocked open was limited to the human factors concern of control room response while wearing breathing apparatus. Also, the CREV systems for both units were returned to operable status within the TS allowed time frame. Operator actions of interest were those required to respond to an initiating event that happened during the short time of vulnerability.

Inspection Report# : 2002004*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G 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

Miscellaneous

Last modified : March 25, 2003