UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

June 7, 2011

Mr. Michael J. Annacone
Vice President
Brunswick Steam Electric Plant
P.O. Box 10429
Southport, NC 28461-0429

SUBJECT: BRUNSWICK STEAM ELECTRIC PLANT – NRC SUPPLEMENTAL INSPECTION REPORT 05000325/2011009 AND 05000324/2011009

Dear Mr. Annacone:

On May 5, 2011, the U.S. Nuclear Regulatory Commission (NRC) staff completed a supplemental inspection pursuant to Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area", at your Brunswick Steam Electric Plant, Units 1 and 2. The enclosed inspection report documents the inspection results that were discussed at the exit meeting on May 5, 2011, with Mr. E. Wills and other members of your staff.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed because a finding of low to moderate safety significance (White) was identified in the third quarter of 2010. This issue was documented previously in NRC Inspection Reports (IR) 05000325/2010010 and 05000324/2010010. The NRC was informed on January 18, 2011, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and contributing causes of risk significant performance issues were understood; (2) the extent of condition and extent of cause of risk significant performance issues were identified; and (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license.

The inspectors determined that your staff performed a comprehensive evaluation of the (White) finding. Your staff's evaluation identified an insufficient augmentation drill frequency and responder proficiency, and an inadequate emergency response augmentation strategy as the two primary root causes. All immediate and long term corrective actions have been completed with the exception of the final effectiveness review currently scheduled for June 2011.

Based on the results of this inspection, no findings were identified.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/ RA /

Brian R. Bonser, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket Nos.: 50-325, 50-324
License Nos.: DPR-71, DPR-62

Enclosure:
Inspection Report 05000325/2011009 & 05000324/2011009
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

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Electronic Mail Distribution

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Based on the results of this inspection, no findings were identified.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of ADAMS is accessible from the NRC Website at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

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Inspection Report 05000325/2011009 & 05000324/2011009
w/Attachment: Supplemental Information

cc w/encl: (See page 3)

Distribution w/encl:
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ADAMS: X Yes ACCESSION NUMBER: **ML111580573** X SUNSI REVIEW COMPLETE X FORM 665 ATTACHED

OFFICE	RII: DRS	RII: DRS	RII: DRS	RII: DRP			
SIGNATURE	**RA**	**RA**	**RA**	**RA**			
NAME	M. SPECK	J. BEAVERS	B. BONSER	R. MUSSER			
DATE	06/01/2011	06/01/2011	06/07/2011	06/01/2011			
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: G:\DRSII\PSB1\EMERGENCY PREPAREDNESS\BRUNSWICK\INSPECTION PLAN AND INPUT\FY2011\BRUNSWICK DRAFT REPORT-95001 REV1.DOCX

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.:	05000325, 05000324
License Nos.:	DPR-71, DPR-62
Report No.:	05000325/2011009, 05000324/2011009
Licensee:	Carolina Power and Light Company
Facility:	Brunswick Steam Electric Plant, Units 1 and 2
Location:	Southport, NC
Dates:	May 2, 2011, through May 5, 2011
Inspectors:	M. Speck, Senior Emergency Preparedness Inspector J. Beavers, Emergency Preparedness Inspector
Approved by:	Brian Bonser, Chief Plant Support Branch 1 Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

IR 05000325/2011009, 05000324/2011009; 05/02/2011 – 05/05/2011; Brunswick Steam Electric Plant, Units 1 and 2; Supplemental Inspection for a White finding in the Emergency Preparedness Cornerstone.

A senior emergency preparedness inspector and an emergency preparedness inspector performed this inspection. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

Cornerstone: Emergency Preparedness

The NRC staff conducted this supplemental inspection in accordance with Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the failure to timely augment on-shift staffing during the June 6, 2010, Alert declaration. The NRC staff previously characterized this issue as having low to moderate risk significance (White) in NRC Inspection Reports (IR) 05000325/2010010 and 05000324/2010010.

During this supplemental inspection, the inspectors determined that the licensee had performed a comprehensive evaluation of the self-revealing failure to timely augment on-shift staffing during the June 6, 2010, Alert declaration.

The licensee identified the two root causes of the issue to be: first, insufficient augmentation drill frequency and responder proficiency; and second, an inadequate emergency response augmentation strategy. All immediate and long term corrective actions have been completed with the exception of the final effectiveness review scheduled for June 2011. The licensee made significant changes to activation processes, associated equipment and procedures, Emergency Response Organization (ERO) training and individual accountability. The increased frequency and rigor of unannounced augmentation drills has improved ERO responder proficiency allowing a more critical evaluation of the augmentation process by licensee management.

Given the licensee's acceptable performance in addressing the failure to timely augment on-shift staffing, the White finding associated with this issue will only be considered in assessing plant performance until the end of the second quarter 2011, in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program". Implementation of the licensee's corrective actions will be reviewed during a future inspection.

Findings

No findings were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 SUPPLEMENTAL INSPECTION (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001, to assess the licensee's evaluation of a White finding that affected the emergency preparedness cornerstone in the reactor safety strategic performance area. The inspection objectives were to provide assurance that the:

- root and contributing causes of risk significant issues were understood
- extent of condition and extent of cause of risk significant performance issues were identified
- licensee's corrective actions for risk significant performance issues were sufficient to address the root and contributing causes and prevent recurrence

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the third quarter of 2010, as a result of one inspection finding of (low to moderate safety significance (White). The finding was associated with the failure to timely augment on-shift staffing during the June 6, 2010, Alert declaration. The finding was characterized as having (White) safety significance as discussed in NRC IR 05000325/2010010 and 05000324/2010010.

The licensee informed the NRC staff on January 18, 2011, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause investigation documented in Nuclear Condition Report (NCR) 403477, to identify weaknesses that existed in various organizations and processes that resulted in the risk-significant (White) finding.

The inspectors reviewed the licensee's Root Cause Evaluation (RCE), and other assessments conducted in support of and as a result of the root cause investigation. The inspectors reviewed corrective actions taken to address the identified root and contributing causes. The inspectors interviewed licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood, and corrective actions were appropriate to address the causes and preclude repetition. The inspectors observed a weekly performance of an event classification drill and subsequent activation of the augmentation system by Control Room and Secondary Alarm Station (SAS) personnel. Additionally, the inspectors observed the activation of the Emergency Response Data System (ERDS) by the Shift Technical Advisor.

.02 Evaluation of Inspection Requirements

02.01 Problem Identification

a. Determine that the evaluation identifies who (i.e., the licensee-identified, self-revealing, or NRC-identified), and under what conditions the issue was identified.

The licensee characterized the failure to timely augment the Brunswick emergency response facilities during an Alert classification event on June 6, 2010, as self-revealing.

The inspectors verified that this information was documented in the licensee's evaluation.

b. Determine that the evaluation documents how long the issue existed and prior opportunities for identification.

The licensee identified that management did not place sufficient priority on testing Emergency Response Organization (ERO) preparedness because of past success with augmentation drills. Only one failure to augment the emergency response facilities during a drill was documented since 1999. The low frequency and lack of rigor associated with the augmentation drill performance process did not provide sufficient opportunities to assess the entire process, and prevented the identification of the problems associated with the White finding by licensee management or oversight organizations. The licensee identified a number of precursors to the problem in the root cause investigation:

- no guidance or training placed emphasis on the priority and time constraints of ERO activation;
- augmentation tests were changed from monthly to quarterly;
- requirements for SAS operators to demonstrate proficiency in augmentation processes were removed;
- manual activation of the ERO group page activation was never performed;
- the ERO response process was not consistently understood; and
- changes in local population density and traffic patterns affected response times.

The inspectors determined that the licensee's evaluation and assessments were adequate with respect to identifying how long the issue existed and the prior opportunities for identification.

c. Determine that the evaluation documents the plant-specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined this issue was a White finding, as documented in NRC IR 05000325/2010010 and 05000324/2010010 dated December 21, 2010. The licensee also documented the associated finding in their Reply to Notice of Violation: EA-10-192

dated January 18, 2011. In addition, the RCE documented the consequences of the issue, including potential adverse impacts on the ability of the site to mitigate the effects of events during an emergency and the licensee's responsibility to protect the health and safety of the public.

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the finding.

d. Findings

No findings were identified.

02.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

a. Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.

The licensee investigation was performed by a diverse qualified team using licensee procedure CAP-NGGC-0205, Significant Adverse Condition Investigations, and Adverse Condition Investigations-Increased Rigor, Revision 11. The following systematic methods were used to perform the causal evaluation:

- Event Time Line;
- Event and Causal Factor Chart;
- Barrier Analysis;
- Cause and Effect Analysis;
- Human Performance Analysis; and
- Support/Refute Matrix.

The license performed a self-assessment (NCR 433593) of the completed RCE to assure all issues were addressed and documented.

The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

b. Determine that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

The licensee's root cause investigation performed interviews of involved personnel, reviewed plant operator logs, plant security vehicle access control point and protected area access reports, Dialogic system reports, and voice server logs to construct and validate the time line. Event and causal factor analysis of actions performed by the Shift Manager (Control Room Site Emergency Coordinator (CR-SEC)), Dialogic system operator (Secondary Alarm Station (SAS) Operator), back up ERO notification process attempts (Control Room Emergency Coordinator (CREC)), and ERO minimum staffing

responders was performed. Barrier analysis identified failed barriers in procedure adequacy, performer self-checking, procedure use, equipment and staffing, Emergency Preparedness training, pager activation and response, management expectations of on-duty status and response, human performance, and operational experience.

A cause and effect analysis was used to analyze five areas: unclear expectations on reporting requirements, lack of urgency to respond to ERO pages, unclear pager messages, inability to timely sign into the facility, and untimely activation of the Brunswick Emergency Notification System (BENS). Three of the five areas analyzed showed a lack of proficiency as a root cause. Analysis of the other two areas showed a second root cause of an inadequate organization response strategy. The licensee also identified numerous contributing causes.

Based on a review of the root cause evaluation and supporting documentation, the inspectors concluded that the evaluation was conducted to a level of detail commensurate with the significance of the problem.

c. Determine that the root cause evaluation included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

The licensee's root cause investigation included an evaluation of internal and external Operating Experience (OE). As a result of this review, long term OE revealed that elements of this event were evident in previous industry events. Most of these events occurred prior to 2005. The Brunswick Emergency Preparedness (EP) Staff had addressed each separately. On an individual basis, there was little in common with Brunswick methodology or processes. NCRs 320766 and 323254 were reviewed which pertained to augmentation drills and notification capability for the two years prior to the Alert. No precursors were identified.

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's root cause investigation included a consideration of prior occurrences of the problem and knowledge of prior operational experience.

d. Determine that the root cause evaluation addressed the extent of condition and the extent of cause of the problem.

The licensee's evaluation considered the extent of condition associated with all affected positions responsible for the timely notification and augmentation of on-shift staffing. Similar problems with the ERO response were considered at the other Progress Energy nuclear sites as well as with the industry in general. Internal OE (NCR 424828) and external OE (NCR 31656) were initiated.

The licensee's evaluation also considered the extent of cause associated with a lack of proficiency and inadequate organization response strategies. The proficiency related extent of cause was evaluated in NCR 422039 and corrective actions were implemented with an Emergency Preparedness Short Term Alignment/Improvement Plan. The inadequate response strategy extent of cause was reviewed against other processes and was found to apply to the licensee's Forced Outage Response Team (FORT) response process.

The inspectors concluded that the licensee's root cause investigation addressed the extent of condition and the extent of cause of the issue.

e. Determine that the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0305.

The licensee found a weakness in the cross-cutting aspect of Human Performance, specifically in the component of Decision making. This specifically related to the priority of activating the notification system (BENS). An additional weakness was found in the cross-cutting aspect of Other Components, specifically in Accountability. The workforce did not demonstrate the proper safety focus on the importance/urgency of activating the ERO facilities.

A quick hit self-assessment (NCR 433593), conducted by the EP staff on the root cause evaluation determined that a RCE Nuclear Safety Culture Aspects statement, "Line management does not display an urgency or importance of the ERO which leads to the lack of sense of importance by the workforce," was not identified as a problem statement in the corrective actions/correcting cause section of the root cause evaluation and was not specifically linked to any corrective actions. This was addressed with additional corrective actions in NCR 444465. With regard to the two root causes and number of contributing causes, various aspects of safety culture were identified, but no singular component was identified as a root or contributing cause.
The inspectors determined that the licensee's root cause investigation included a proper consideration of whether a weakness in any safety culture component was a root cause or significant contributing cause of the issue.

f. Findings

No findings were identified.

02.03 Corrective Actions

a. Determine that appropriate corrective actions are specified for each root and contributing cause or that the licensee has an adequate evaluation for why no corrective actions are necessary.

The licensee acted immediately to restore the capability to provide adequate augmentation of on-shift staffing for emergency response through the following actions:

- Action 1: SAS Operator Proficiency (Interim Action); Issued security standing order for each Alarm Station Operator to demonstrate proficiency for activating the Brunswick Emergency Notification system (BENS) prior to assuming any Alarm Station Operator duties.

- Action 2: Timely Notify Security to Activate BENS by Control Room Site Emergency Coordinator (Interim Action); Issued standing order to have the CR-SEC notify Security within 5 minutes of the event declaration to activate BEN with the appropriate code.

- Action 3: Control Room Emergency Communicator (CREC) Group Page Initiation proficiency (Interim Action); Issued standing order to have the CREC demonstrate proficiency by simulating activation of a Group Page IAW 0PEP-02.6.21, Attachment 4A with the SM observing and document completion at the beginning of each shift.

- Action 4: ERO Personnel man facilities until capability assured (Immediate Action); ERO personnel remained stationed until determined that immediate corrective and compensatory actions were in place to ensure timely activation of the facilities in the event of another emergency declaration.

- Action 5: On-Duty Secondary Alarm Station (SAS) Operator Proficiency (Interim Action); verified on-duty SAS Operator was proficient at activating BENS.

- Action 6: ERO Management Expectations (Interim Action); Plant General Manager and EP Supervisor addressed all ERO members on expectations, response requirements, ERO proficiency, and seriousness of the event.

- Action 7: Inadequate Response Strategy for Staffing Emergency Facilities; changed ERO callout methodology from on-duty minimum staffing to respond to All Call/All Come methodology.

- Action 8: Nuclear Alarm Station Operator On-the-Job-Training Proficiency; added task to demonstrate proficiency to activate BENS back in the Nuclear Alarm Station Operator training requirements.

- Action 9: Secondary Alarm Station Digital Phone problems; installed an analog phone line for direct connection of SAS with the Main Control Room.

- Action 10: Weekly ERO Muster Meeting; Initiated a Monday morning 0815 muster meeting to verify ERO staffing personnel are assigned and ready to respond.

- Action 11: Disciplinary Action; Control Room SEC and ERO Staffing.

- Action 12: Text Paging to Cell Phones as a Back-up; implemented Carbon Copy program to allow text paging to cell phones in parallel with the ERO Group Page Message.

- Action 13: Manual Group Page Deficiencies; corrected manual group page process deficiencies.

- Action 14: Vehicle Access Control Point Delay; improved access efficiency by opening an additional lane during event response.

- Action 15: Delays Due to filling out Fitness-For-Duty (FFD) Forms; made forms available in ERO facilities.

- Action 16: ERO Management Expectations; Site management and Emergency Preparedness provided clear expectations to all ERO members with signature acknowledgement requirements.

- Action 17: Health Physics (HP) Technician Minimum Staffing Response; developed processes to ensure minimum staffing response by HP Technicians at all times.

- Action 18: Communications for ERO Minimum Staffing; issued ERO cell phones for all personnel filling a required ERO staffing position.

The licensee identified the following root causes and implemented corresponding corrective actions:

- Insufficient augmentation drill frequency and responder proficiency: The licensee increased frequency of unannounced augmentation drills from one every two years to at least one per year to ensure ERO proficiency and to verify that the facilities can be activated within required times and provided more rigorous criteria for drill conduct and evaluation.

- An inadequate emergency response augmentation strategy: The licensee made significant changes to activation processes, activation procedures and equipment, ERO training, and expectations for individual accountability.

The licensee implemented other corrective actions to address contributing causes not covered by the immediate actions. Among those causes and actions:

- SAS Digital Phone problems; revised procedures to reflect new SAS analog phone number.

- Inability to Perform Manual Group Page; added requirement to demonstrate manual group page of ERO during EP training or drills.

- Confusing Numeric Page Messages; replaced numeric code paging with text paging for manual group paging.

- Unclear Expectations; all ERO members signed affirmation letters stating they understand their EP roles and responsibilities and are proficient at their assigned tasks.

- Ambiguous ERO Response Times; implemented standardized verbiage to remove ambiguity between the Emergency Response Plan (ERP) and the implementing procedures concerning the required 60-75 minute response times.

- Inadequate Pager Test/Drill Frequency; changed the frequency of pager tests from quarterly to monthly.
- Invalid Expectations of Response Times; performed a time validation study to determine the current 60 minute response area to the plant and took appropriate action to ensure all minimum staffing positions are within this area.

- Invalid Travel Times/Phone Numbers of ERO Members; validated travel times and phone numbers for ERO personnel.

- Insufficient EP Training Standards; aligned EP training for task performance closer to that of the accredited training programs.

- Unclear Management Expectations of ERO: promulgated letter from site management outlining expectations, stressing responsibility and accountability to entire ERO.

- Improve Operations Training in Area of EP Communications: Added training topics to appropriate ERO members and added task for Operations Training Instructors to verify that the CR-SEC activates BENS per OPEP-02.1.1 following emergency classifications during simulator scenarios.

- Formalize Weekly ERO Muster Meeting; formalized Monday morning 0815 Muster Meeting, included revision of plant procedures to provide specific agenda/review of status/expectations.

The inspectors determined that the corrective actions were appropriate and addressed each root and contributing cause.

b. Determine that corrective actions have been prioritized with consideration of risk significance and regulatory compliance.

The licensee took immediate interim corrective actions to ensure that an effective ERO response strategy was in place to ensure sufficient augmented staff for event response in key functional areas was maintained at all times. These interim actions were completed on June 7, 2010.

The license completed a root cause evaluation and a subsequent assessment to determine contributing causes and developed appropriate corrective actions. These corrective actions were appropriately prioritized with consideration of risk significance and full regulatory compliance, and were completed on December 17, 2010.

The inspectors determined that the corrective actions were adequately prioritized with consideration of the risk significance and regulatory compliance.

c. Determine that a schedule has been established for implementing and completing the corrective actions.

The licensee established due dates for the corrective actions in accordance with their corrective action program. A task list project report was reviewed identifying owners and due dates. The inspectors determined that an appropriate schedule had been established for implementing the corrective actions with the only remaining action, Final Effectiveness Review, scheduled for completion in June 2011.

d. Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.

As documented in NCR 403477, the licensee established metrics for determining the effectiveness of the corrective actions. These included specific acceptance criteria for CR-SEC and SAS notification times during drills and actual events, success rates for

facility activation times during drills and actual events, and pager call-out response performance. Additionally, the licensee established several secondary performance indicators to better evaluate any performance erosion prior to it becoming a regulatory concern. The licensee established several specific opportunities to evaluate effectiveness including a self-assessment, an interim effectiveness review and a final effectiveness review.

The licensee completed these with the exception of the Final Effectiveness Review scheduled in June 2011. The inspectors independently reviewed the available data and the results of these reviews and the determined that quantitative and qualitative measures of success had been developed for determining the effectiveness of the corrective actions to preclude repetition.

e. Determine that the corrective actions planned or taken adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable.

The licensee's response described: (1) corrective actions taken and the results achieved; (2) actions which will be taken; (3) the date when full compliance as achieved; and (4) the reasons for the violation. During this inspection, the inspectors confirmed that the licensee's root cause investigation and actions completed or planned adequately addressed the NOV. The licensee restored full compliance on December 17, 2010.

f. Findings

No findings were identified.

4OA6 Exit Meeting

On May 5, 2011, the inspectors presented the inspection results to Mr. E. Wills, and other members of the staff who acknowledged the results. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information. At the conclusion of the exit meeting, Mr. J. Munday, Regional Director of the Division of Reactor Safety conducted a regulatory performance meeting with licensee management to discuss the issue and actions taken and proposed.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel
C. Burgwald, EP Specialist
K. Crocker, Supervisor Emergency Preparedness
J. Frisco, Plant General Manager
S. Gordy, Manager Operations
L. Grzeck, Supervisor (Acting) Licensing/Regulatory Programs
R. Ivey, Manager NOS
J. Kessel, EP Specialist
M. Kinney, EP Specialist
M. McKoy, EP Specialist
P. Mentel, Manager Support Services
T. Sherrill, Licensing Specialist
J. Stephenson, Corporate Emergency Preparedness
E. White, EP Specialist
E. Wills, Director of Site Operations

ITEMS OPENED AND CLOSED

Opened

None

Closed

05000325, 05000324/2010007-01	VIO	Failure to Timely Augment On-Shift Staffing

DOCUMENTS REVIEWED

Plans and Procedures

CAP-NGGC-0205, Significant Adverse Condition Investigations and Adverse Condition Investigations-Increase Rigor, Rev. 12
CAP-NGGC-0205 Attachment 18, Worksheet for Evaluation of NRC Safety Culture Aspects, Rev. 11
EMG-NGGC-1000, Minimum Expectations/Guidelines for Weekly ERO Muster Meetings, Rev. 1

Corrective Action Documents

NCR 403461, Delays in logging onto WEB EOC
NCR 403477, Root Cause Evaluation for the June 6, 2010, Alert
NCR 422039, Quick Cause Evaluation
NCR 433593-04, Quick Hit Assessment of Root Cause Evaluation
NCR 433593-08, Proceduralize Actions Taken at VACP During ERO Activation
NCR 433593-15, Develop Key PI to Measure ERO Notification Performance
NCR 434889, NRCR 433593-04 identified two missing corrective actions assignments
NCR 444465, Advocacy of ERO by plant management
NCR 444574, Quick Hit Assessment of ERO Effectiveness New Process All Call
NCR 458365, Identify/resolve open issues identified prior to the NRC 95001 inspection

Miscellaneous Documents

Brunswick 95001 inspection Evaluation
Brunswick Corrective Action Program Cause Codes
Emergency Preparedness Short Term Alignment/Improvement Plan, Rev. 04/11/11

ACRYNOMS

BENS	Brunswick Emergency Notification System
CREC	Control Room Emergency Coordinator
CR-SEC	Control Room Site Emergency Coordinator
ERDS	Emergency Response Data System
ERO	Emergency Response Organization
EP	Emergency Preparedness
FORT	Forced Outage Response Team
HP	Health Physics
IMC	Inspection Manual Chapter
INPO	Institute of Nuclear Power Operations
IP	Inspection Procedures
IR	Inspection Report
NCR	Nuclear Condition Report
NRC	Nuclear Regulatory Commission
NOV	Notice of Violation
OE	Operating Experience
PARS	Publicly Available Records
RCE	Root Cause Evaluation
SAS	Secondary Alarm Station
SOER	Significant Operating Experience Report