Wisconsin Electric POWER COMPANY
231 W. MICHIGAN, P.O. BOX 2046, MILWAUKEE, WI 53201

November 13, 1979

Mr. Harold R. Denton, Director
Office of Nuclear Reactor Regulation
U. S. NUCLEAR REGULATORY COMMISSION
Washington, D. C. 20555

Attention: Mr. D. G. Eisenhut, Acting Director
Division of Operating Reactors

Gentlemen:

DOCKET NOS. 50-266 AND 50-301
SURVEILLANCE TESTING ERRORS
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

On October 8, 1979, we received your letter dated September 21, 1979. This letter redistributed a June 26, 1979 letter regarding an inadvertent reactor scram during monthly surveillance testing which we had not previously received. The June letter also requested all Pressurized Water Reactor Licensees to conduct certain specified reviews and report the results of these reviews in accordance with 10 CFR Section 50.54(f).

We have reviewed the events described in your letter and the attached inspection report to determine whether similar errors have occurred, or could occur, at the Point Beach Nuclear Plant. Two events with some similar characteristics to the event described in your letter occurred at Point Beach. The first event involved the inadvertent opening of a pressurized power operated relief valve (PORV) during a periodic setpoint verification test. A step of the procedure was missed by the instrumentation technician which directed that the pressure channel be placed in the defeat mode. When the simulated pressure signal was inserted, the PORV opened. The transient was terminated when the technician realized his mistake and removed the test signal allowing the PORV to shut. This event occurred prior to Unit 1 initial criticality.

A similar error occurred in 1972 and resulted in a reactor trip. During periodic analog testing of the safeguard channels on Unit 1, a plant technician inadvertently placed the test switch in defeat for the white instrument channel while testing the blue channel. Because the blue channel had not been defeated, the pressure control system received a low pressure signal. This energized all pressurizer heaters. As actual system pressure increased, alarms were received in the control room. These alarms were recognized by the operator, but were assumed to be a normal result of the analog testing. After about five minutes, the reactor tripped on a high pressure signal. No other safeguards or protective functions were actuated.

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When elements of written procedure are skipped, the potential for events or mistakes similar to those described in your letter certainly remains. Great emphasis is impressed upon all plant personnel to follow procedures step by step. These events and the event described in your letter, along with all Licensee Event Reports, are reviewed with the plant operators and are included in their periodic retraining to remind them of the importance of following procedures.

Your letter also requested that management policies and procedures be reviewed and strengthened as necessary to assure that multiple equipment failures in safety-related systems will be vigorously pursued and analyzed to identify potential failure modes not previously considered that could lead to a significant reduction in the ability of safety systems to function as required. Plant administrative procedures have been reviewed for this requirement and are considered sufficient. All Licensee Event Reports are reviewed in accordance with the Plant Technical Specifications by both onsite and offsite safety review committees. These committees are the Manager's Supervisory Staff and the Offsite Review Committee (OSRC), respectively. The Manager's Supervisory Staff must investigate, review and report on all reportable occurrences. It periodically reviews all plant operations for nuclear safety hazards. Investigations of events and hazards include, as necessary, reports, evaluations, and recommendations to prevent recurrence of the events. Such reviews also include consideration of the consequences of related or similar failures in other plant systems, if appropriate.

The OSRC, which is a review group independent of the Plant operational staff, also reviews all Point Beach Nuclear Plant reportable occurrences and violations of license requirements, interval procedures, specifications, statutes, or codes. Their review is geared toward determining whether such occurrences or violations had nuclear safety significance and whether any previously unreviewed safety questions are involved. The OSRC also periodically audits the results of actions taken by the Plant staff to correct actual and potential deficiencies.

Finally, your letter requested that we review our engineered safety system surveillance procedures to determine whether appropriate cautions are included and to ensure that plant operators and supervisors are aware of the importance of avoiding challenges to the protective features of our facility. The engineered safety system surveillance procedures at the Point Beach Nuclear Plant include precautionary notes to the operators reminding them of the necessity to accomplish specific steps and to make them aware of potential Technical Specification limitations. A review of these procedures is ongoing to determine whether additional cautions are appropriate. The importance of avoiding challenges to the protective features of the facility is not taken lightly. As briefly described above, early in the operation of the Point Beach Nuclear Plant, unnecessary challenges to the protective system occurred. By improving the procedures and the training of operators and technicians and, most importantly, by emphasizing the need for good communication between the personnel performing the surveillance testing and those at the control board, the number of inadvertent challenges is reduced to as close to zero as is possible.

The primary goal of the Point Beach Nuclear Plant operations is to provide a reliable and efficient source of electrical energy while assuring that operation of the plant does not present any undue hazards to the health and safety of the public or to the health and safety of the employes who are charged with its safe operation and maintenance. The operating procedures are subjected to continued scrutiny. The minutes of the Manager's Supervisory Staff reflect this process of continued review, including change and approval in accordance with the Technical Specifications governing plant procedures, when appropriate.

In addition to the reviews of plant events and occurrences, potential failure modes not previously considered which could result in a loss of safety function to the extent that there is a major reduction in the degree of protection provided to public health must be considered and reported in accordance with 10 CFR Part 21 or in accordance with the Plant Technical Specifications (LER). All personnel associated with Wisconsin Electric Power Company's nuclear operations who suspect a substantial safety hazard in any nuclear plant related activity, procedure, or system are directed and encouraged to report the details of the situation. Such reports are then evaluated in depth by the Safety Review Committee of the Nuclear Projects Office. Any defect identified in this matter would, of course, be vigorously examined and analyzed to determine the proper corrective action necessary.

Very truly yours,

Sol Burstein

Executive Vice President

Subscribed and sworn to before me
this 13th day of November, 1979.

Notary Public, State of Wisconsin

My Commission expires July 6, 1980.