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January 12, 1990

U. S. NUCLEAR REGULATORY COMMISSION  
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Gentlemen:

DOCKETS 50-266 AND 50-301  
REPLY TO NOTICE OF VIOLATION  
INSPECTION REPORT 50-266/89030(DRP);  
50-301/89030(DRP)  
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

This letter is in response to a Notice of Violation enclosed with your letter of December 13, 1989. The Notice of Violation is associated with a routine safety inspection conducted by Messrs. C. L. Vanderniet and J. Gadzala during the period October 16 through November 30, 1989. The results of that inspection were reported in Inspection Report 50-266/89030(DRP); 50-301/89030(DRP).

The violations identified in the inspection report and described in the Notice of Violation involve (1) failure to meet Technical Specifications requirements regarding operability of auxiliary feedwater flow rate instrumentation and (2) failure to comply with Administrative Procedure PBNP 3.4.1, "Ignition Control", which requires that a fully charged, suitably sized fire extinguisher be provided at a work site involving hot work.

Wisconsin Electric agrees that the conditions described in the inspection report have been properly classified as two Severity Level IV violations. Our discussions on each of the violations, including the apparent cause, corrective actions taken, actions taken to prevent recurrence, and date when full compliance was achieved are provided in the attachments to this letter.

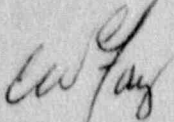
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If you have any questions concerning this information, please  
contact us.

Very truly yours,



C. W. Fay  
Vice President  
Nuclear Power

Attachments

Copies to NRC Regional Administrator, Region III  
NRC Resident Inspector

ATTACHMENT 1

REPLY TO NOTICE OF VIOLATION  
DOCKET NO. 50-266  
POINT BEACH NUCLEAR PLANT  
VIOLATION NUMBER 266/89030-04

DESCRIPTION OF THE VIOLATION:

Technical Specification Table 15.3.5-5 requires one channel of auxiliary feedwater to be operable during reactor operations. DCS 3.1.3, "Technical Specification Interpretation, Auxiliary Feedwater Flow Rate," broadens the interpretation to include one channel of each of the installed groups of feedwater flow indication.

Contrary to the above, on November 20, 1989, the licensee discovered that Unit 1 AFW flow transmitters 1FT 4036 and 1FT 4037 were isolated. These flow transmitters provide AFW flow indication in the control room. A review of the event found that the transmitters were isolated for three days. This is a violation of Technical Specifications (TS) Table 15.3.5-5.



DISCUSSION:

On November 17, 1989, Unit 2 was in a shutdown condition for its annual refueling and maintenance outage and Unit 1 was at 100% normal power operation with the auxiliary feedwater system in a standby condition.

In preparation for a tubesheet crevice flush of the Unit 2 steam generators, an I&C technician was assigned to isolate the instrumentation identified in Attachment C of RP-6A, "Steam Generator Crevice Flush (Vacuum Mode)." Included among that instrumentation are two flow transmitters, FT-4036 and FT-4037, that provide the control room with direct indications of the total auxiliary feedwater flow to steam generators A and B, respectively. For the flushing process, a 20-inch vacuum is drawn on the steam generators to facilitate boiling at less than 200°F. Because of uncertainty as to how the transmitters would hold up to a 20-inch vacuum, the procedure calls for their isolation as a precautionary measure.

RP-6A identifies the two transmitters as FT-4036 and FT-4037 and does not include the unit identifier. Only the tags on the actual instruments themselves make any distinction between the two units: The alphanumeric identifiers associated with Unit 1 are prefixed with numeral "1" and those that are associated with Unit 2 are prefixed with the numeral "2." Thus, 1 FT-4036 and 1 FT-4037 identify the actual transmitters for Unit 1 and the transmitters for Unit 2 are identified by tags that read 2 FT-4036 and 2 FT-4037. Both pairs of the Unit 1 and the Unit 2 transmitters are physically located in the primary auxiliary building (PAB). The procedure in question, RP-6A, identifies the El. 26' of the PAB as the location of the transmitters; but in fact, only the flow transmitters for Unit 1 (1 FT-4036 and 1 FT-4037) are on the El. 26' while 2 FT-4036 and 2 FT-4037 are actually on the El. 8' of the PAB.

At about 1400 hours on November 17, 1989, an I&C technician inadvertently isolated 1 FT-4036 and 1 FT-4037. In the process of restoring the procedure-referenced instrumentation to service, other I&C technicians discovered that 2 FT-4036 and 2 FT-4037 had never been isolated. Subsequent investigation revealed the extent of the error and upon discovery on November 20, 1989, at approximately 1300 hours, 1 FT-4036 and 1 FT-4037 were expeditiously restored to service.

APPARENT CAUSE OF VIOLATION:

The circumstances surrounding this violation were reported in Licensee Event Report (LER) 50-266/89-010-00 enclosed with our letter of December 19, 1989. The LER stated:

The cause of this event is the direct result of an error in an approved procedure together with a personnel cognitive error. The procedure directed the technician to the flow transmitters located on the El. 26' [. . . of the primary Auxiliary Building rather than to their actual location on El. 8'.] Although the technician was aware of the need to isolate the Unit 2 transmitters, he was under the mistaken impression that the transmitters to the El. 26' of the PAB were common to both units and verified only the last four characters of the alphanumeric identifiers. The flow transmitters at the discharge of the motor-driven auxiliary feedwater pumps are common instruments to both units.

CORRECTIVE ACTIONS:

When the error was discovered, the Unit 1 auxiliary feedwater flow transmitters (1 FT-4036 and 1 FT-4037) were immediately valved back into service.



ACTIONS TAKEN TO PREVENT RECURRENCE:

A revision to procedure RP-6A, "Steam Generator Crevice Flush (Vacuum Mode)" has been initiated. The procedure revision will correct the error which resulted in this violation. The location of the Unit 2 auxiliary feedwater flow transmitters (2 FT-4036 and 2 FT-4037) will be correctly identified as being on the El. 8' of the PAB.

This procedure change will be made prior to its next use during the Unit 1 refueling outage in the spring of 1990.

In addition, with regard to the personnel cognitive error, the technician involved in the event has been counseled by the PBNP superintendent of Instrumentation and Control. That counseling stressed the importance of verifying unit identifiers when isolating or returning instrumentation to service.

The PBNP Training group will perform a Training Needs Analysis (TNA) in regard to the event and will revise training materials and/or conduct training if deemed necessary as a result of that analysis.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED:

Full compliance was achieved when the Unit 1 auxiliary feedwater flow transmitters (1 FT-4036 and 1 FT-4037) were valved back into service. This occurred at approximately 1300 hours on November 20, 1989.



ATTACHMENT 2

REPLY TO NOTICE OF VIOLATION  
DOCKET NO. 50-301  
POINT BEACH NUCLEAR PLANT  
VIOLATION NUMBER 301/89030-03

VIOLATION:

Technical Specification 15.6.8.1 requires that the plant be operated and maintained in accordance with approved procedures. Administrative procedure PBNP 3.4.1, "Ignition Control," requires that a fully charged, suitably sized fire extinguisher be provided at a work site involved with hotwork.

Contrary to the above, on November 16, 1989, personnel were performing hotwork to remove a circular staircase in the Unit 2 containment area with no fire extinguisher present at the job site.

DISCUSSION:

On November 16, 1989, Unit 2 was in a refueling outage. Work was being performed in the Unit 2 containment that involved welding and grinding to remove a spiral staircase. An ignition control permit had been issued for the job in accordance with administrative procedure PBNP 3.4.1, "Ignition Control Procedures," and a fire watch of five individuals had been assigned. The ignition control permit covered work on El. 66', El. 46' and El. 21'. The fire watch for the job was comprised of one individual assigned to each of the three elevations and two roving watches. In addition to the 12 fire extinguishers mounted in containment for normal fire protection, three additional fire extinguishers had been brought into containment specifically for this job. The work and fire watch responsibilities were being performed by personnel working under contract during the refueling/maintenance outage.

One member of the fire watch was interviewed by the resident inspector. Based upon the results of his interview, it is apparent that this member of the fire watch was not fully aware of his responsibilities, nor did he know the location of the nearest fire extinguisher.

Our investigation of the event involved interviews with the contractor supervisor, members of his crew, the PBNP fire protection and safety coordinator, and the WE-contractor liaison engineer. The fire watch person interviewed by the resident inspector was not available to be interviewed during our investigation of the incident.

Although this one individual apparently did not know the location of the nearest fire extinguisher, it is our position, because four other persons were also assigned to the fire watch and because those members of the fire watch were aware of their responsibilities and the locations of fire extinguishing equipment, that the hotwork associated with the job was conducted safely and in a manner consistent with the intent of the PBNP ignition control procedure.

APPARENT CAUSE OF VIOLATION:

The apparent cause of the violation was failure of the job supervisor to adequately brief one member of a five-man fire watch regarding his responsibilities and the location of fire extinguishers.



CORRECTIVE ACTIONS:

The aberrant member of the five-man fire watch was made aware of the location of a nearby fire extinguisher. Our investigation was not able to determine if that awareness was achieved as a result of actions taken by the job supervisor or as a result of the worker's interview with the NRC inspector.

ACTIONS TAKEN TO PREVENT RECURRENCE:

The PBNP fire protection and safety coordinator routinely performs surveillance of work performed under the ignition control procedure. This surveillance involves interviews with persons assigned to a fire watch to assure that they are aware of their responsibilities, know the location of fire extinguishing equipment and are aware of nearby communications capabilities to report fires to the control room. This random surveillance program has been escalated effective January 5, 1990.

DATE WHEN FULL COMPLIANCE WAS ACHIEVED:

Full compliance was achieved on November 16, 1989, shortly after the inspector's observations, when the aberrant member of the fire watch was made aware of the location of the nearest fire extinguisher.