



Northern States Power Company

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April 18, 1990

Mr W L Axelson, Chief
Projects Branch 2, Region III
U S Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, Illinois 60137

PRAIRIE ISLAND NUCLEAR GENERATING PLANT
Docket Nos. 50-282 License Nos. DPR-42
50-306 DPR-60

Response to Notice of Violation
Inspection Reports No. 50-282/90002(DRP) and 50-306/90002(DRP)

In response to your letter of March 19, 1990 which transmitted
Inspection Reports No. 282/90002 and 306/90002, the following
information is offered.

Violation

Technical Specification 6.5, Plant Operating Procedures, states
that: "Detailed written procedures, including the applicable
checkoff lists and instructions, covering areas listed below shall
be prepared and followed:" Technical Specification 6.5.A, Plant
Operation, requires that "Surveillance and Testing requirements
that could have an effect on nuclear safety be accomplished." SP-
1546 is a procedure effecting nuclear safety and is required to be
followed.

Contrary to the above, on February 21, 1990, technicians were
performing Procedure SP-1546 which authorizes the control rod lift
coils for Unit 1 to be deenergized, however, the procedure was not
accomplished in that the control rod lift coils for Unit 2 were
deenergized. This action was contrary to the scope of the
procedure and authorization of the test activities, and had the
potential to affect rod position in Unit 2 which was operating at
100%.

This is a Severity Level IV Violation (Supplement 1).

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Response

The cause for the operation of the Unit 2 disconnect switches was personnel error. The event involved two I&C technicians. One of the technicians was an experienced technician but had recently transferred to the Prairie Island plant and was inexperienced with the procedure being performed. The technician with less Prairie Island experience was assigned to operate the disconnect switches for the Unit 1 test; he operated the Unit 2 disconnect switches instead. In addition to the lack of task specific experience, the cabinets which house the disconnect switches were not labeled. Also contributing to the error was the insufficient supervision provided by the Prairie Island experienced technician to the less experienced technician.

Although the Unit 2 disconnect switches were moved to the disconnect position, this was not an abnormal evolution. Disconnect switches for the control rods are routinely put in the disconnect position, at power, during surveillance testing. The control rod system remained operable; the ability to insert rods in response to a trip signal was never lost and actual rod position was unaffected.

Corrective Action Taken and Results Achieved

The control rod lift disconnect switches that had been operated for Unit 2 were returned to the engaged position and the lift coils were energized. The ability to move the Unit 2 control rods was verified.

The Prairie Island Error Reduction Task Force evaluated this event and its recommendations have been incorporated.

Cabinets housing the control rod lift disconnect switches have been labeled.

Locks have been applied to the cabinet doors. The keys for each unit are different and are under the control of the Shift Supervisor.

A meeting was held with the I&C technicians to discuss the event and emphasize the need to understand and verify actions prior to taking them. This was followed up with a memo from the technician's supervisor to technicians regarding supervision of less experienced technicians.

Corrective Action to Avoid Further Violations

All corrective actions have been completed.

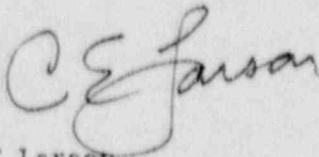
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Date When Full Compliance Will be Achieved

Full compliance has been achieved.

Please contact us if you have any questions related to our response to the subject inspection reports.

A handwritten signature in cursive script, appearing to read "C E Larson".

C E Larson
Vice President
Nuclear Generation

c: Regional Administrator III, NRC
Senior Resident Inspector, NRC
NRR Project Manager, NRC
G Charnoff