Wisconsin Electric
POWER COMPANY

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VPNPD-94-104
NRC-94-071

October 5, 1994

Document Control Desk
U.S. NUCLEAR REGULATORY COMMISSION
Mail Station P1-137
Washington, DC 20555

Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO NOTICE OF VIOLATION
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

In a letter from Mr. M. J. Farber dated September 6, 1994, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for the Point Beach Nuclear Plant, the results of a routine safety inspection performed by Messrs. T. Kobetz and A. McMurtray from July 11 through August 19, 1994. This inspection report included a Notice of Violation (Notice). The Notice describes a violation of Point Beach Technical Specification 15.3.6.A(a) and a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action."

We have reviewed this Notice and, pursuant to the provisions of 10 CFR 2.201, have prepared a written response of explanation concerning the identified violation. Our written response is included as an attachment to this letter.

Point Beach Technical Specification 15.3.6.A(a) requires that "the containment integrity shall not be violated when the nuclear core is installed in the reactor unless the reactor is in the cold shutdown condition." Contrary to this requirement, while at 100% power on August 12, 1994, containment integrity was breached during stroke testing of Safety Injection valves.

10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires in part, that measures be established to assure that conditions adverse to quality, such as deviations and nonconformances, be promptly identified and corrected. For significant conditions, established measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

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Contrary to this requirement, the corrective actions for the breach of containment integrity during stroke testing of low head safety injection valves, identified on July 13, 1994, were not sufficient to prevent recurrence on August 12, 1994.

We believe that the attached reply is responsive to your concerns and fulfills the requirements identified in your September 6, 1994, letter.

If you have any questions or require additional information regarding this response, please contact us.

Sincerely,

for

Bob Link
Vice President
Nuclear Power

KVA/jg

Attachment

cc: NRC Resident Inspector
NRC Regional Administrator

RESPONSE TO NOTICE OF VIOLATION

WISCONSIN ELECTRIC POWER COMPANY
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
DOCKETS 50-266 AND 50-301
LICENSE NOS. DPR-24 AND DPR-27

During a routine safety inspection performed by Messrs. T. Kobetz and A. McMurtray from July 11 through August 19, 1994, two violations of NRC requirements were identified. The identified violations were classified as Severity Level IV. Inspection Report Nos. 50-266/94013 and 50-301/94013 and the Notice of Violation (Notice) transmitted to Wisconsin Electric on September 6, 1994, provide details regarding the violation. We agree that the events and circumstances described in the Notice are accurately characterized.

In accordance with the instructions provided in the Notice, our reply to the alleged violation includes: (1) the reason for the violation, or if contested, the basis for disputing the violation; (2) corrective action taken; (3) corrective action to be taken to avoid further violations; and (4) the date when full compliance will be achieved.

VIOLATION 1:

Point Beach Technical Specification 15.3.6.A(a) requires that "the containment integrity shall not be violated when the nuclear core is installed in the reactor unless the reactor is in the cold shutdown condition."

Contrary to this requirement, while at 100% power on August 12, 1994, containment integrity was breached during stroke testing of safety injection valves.

VIOLATION 2:

10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," requires in part, that measures be established to assure that conditions adverse to quality, such as deviations and nonconformances, be promptly identified and corrected. For significant conditions, established measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to this requirement, the corrective actions for the breach of containment integrity during stroke testing of low head Safety Injection valves, identified on July 13, 1994, were not sufficient to prevent recurrence on August 12, 1994.

RESPONSE TO VIOLATION:

1. REASON FOR VIOLATIONS

An event causing a breach of containment integrity similar to the event described in Violation 1 occurred on July 13, 1994, and is documented in Licensee Event Report (LER) 266/94-007-00, dated August 12, 1994. The corrective action for this event was to revise the applicable procedures to require the stationing of a dedicated operator at the drain and vent valves when the valves are open during the performance of the test. The drain valves are boundary valves for the closed residual heat removal (RHR) system outside of containment. When the drain valves are open, the closed system is open and containment integrity is not met. These procedure revisions were to be issued prior to the next scheduled performance of the test. The applicable procedures are:

- IT-40, "Safety Injection Valves (Quarterly) Unit 1,"
- IT-40A, "Safety Injection Valves 1SI-850A&B (Quarterly, Increased Frequency) Unit 1,"
- IT-45, "Safety Injection Valves (Quarterly) Unit 2," and
- IT-45A, "Safety Injection Valves 2SI-850A&B (Quarterly, Increased Frequency) Unit 2."

The revised procedures were issued during the day shift on August 12, 1994. The next performance of the stroke test of the SI-850 and SI-851 valves was scheduled for Unit 1 on August 14, 1994, using IT-40. However, the operating crews have some scheduling flexibility on when to perform the tests for which they are responsible. The operating crew responsible for the next performance of IT-40 began their week on the midshift of August 12, 1994. The Duty Shift Superintendent (DSS) made the decision to perform IT-40 during that shift. Thus, the test was performed several hours prior to the issuance of the revised procedures.

The DSS and the operating crew were unaware of the July 13, 1994, event and the pending procedure changes to IT-40, 40A, 45, and 45A. Operating crews are normally made aware of reportable events, their causes, and corrective actions by placing a copy of the LER in the Operations Notebook in the Control Room for operators to review. The LER documenting the July 13, 1994, event was issued on August 12, 1994, and was therefore not in the Operations Notebook during the midshift earlier that morning.

The Operations Planner who assembled the work package for that operating crew considered including a directive stating that a revision to IT-40 was to be issued on August 12, 1994, and to wait for that revision prior to performing the test. However, since the test was scheduled for August 14, 1994, he believed the directive was not necessary.

2. CORRECTIVE ACTION TAKEN

A Condition Report was initiated on August 15, 1994, documenting the occurrence in Violation 1. This report was used to document the condition and initiate corrective action. A Root Cause Evaluation was initiated to determine the root cause for this event and determine appropriate corrective actions.

All Operations personnel were informed of the event and of the many potential opportunities that should have prevented it, such as the directive on the work package and the DSS and operating crew being aware of the July 13, 1994 event.

Procedures IT-40, IT-40A, IT-45, and IT-45A were revised to require stationing a dedicated operator at drain valves 1(2)SI-D14 or 1(2)SI-D15 when either of these valves are open during the associated procedure. The dedicated operator would shut the associated drain valve should an event occur that would require containment isolation, thereby restoring containment integrity. The revised procedures were issued on August 12, 1994.

As a matter of information, Procedures IT-40A and IT-45A were canceled on September 8, 1994, as we determined that performing the tests on an increased frequency (more than quarterly) was no longer needed.

3. CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

All Condition Reports associated with a reportable event are now placed in the Operations Notebook following the reportability determination. In this way, operators can be made aware of reportable events prior to issuance of the related LER. When the LER is issued, it will be placed in the Operations Notebook along with the associated Condition Report.

Additionally, Technical Specification Change Request 163 was submitted to the NRC on November 23, 1993. This change request was submitted in order to propose revisions that will clarify operability requirements for containment penetrations. The proposed revisions in this change request are similar to specifications included in the Westinghouse Owner's Group Improved Standard Technical Specifications (NUREG 1431). This change request will allow intermittent operation of valves associated with containment penetrations if a dedicated operator is stationed at the penetration to isolate it should an event occur which requires containment isolation.

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

We believe we are presently in full compliance with NRC requirements.