NRC-83-106

WISCONSIN PUBLIC SERVICE CORPORATION

P.O. Box 1200, Green Bay, Wisconsin 54305

Rec'd 5/16/83
DCS

May 11, 1983

Mr. Richard C. DeYoung, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Response to Notice of Violation and Proposed Imposition of Civil Penalty

References: See Enclosure 3

The enclosures to this letter provide our response to the Notice of Violation and Proposed Imposition of Civil Penalty transmitted by Mr. Keppler's letter of April 11, 1983 (reference 5). The violation concerned the capped containment pressure sensing lines discovered by Kewaunee Plant personnel on October 4, 1982. Enclosure 1 is our response to the Notice of Violation, addressing the matters described in 10CFR§2.201 in accordance with Mr. Keppler's directions on page two of the Notice. Enclosure 2 is our response to the Proposed Imposition of Civil Penalty, again in accordance with the directions on page two of the notice and 10CFR§2.205. Enclosure 3 is a list of references used in the preparation of these responses.

You will note that WPSC is protesting the proposed civil penalty and the classification of the violation, for the reasons detailed in enclosure 2. Strict application of the NRC's enforcement policy (Appendix C to 10CFR Part 2) requires that no penalty be imposed. In addition, even if a monetary penalty were proper, the mitigating actions undertaken by WPSC and the mitigating circumstances of this case compel a different conclusion than that reached by the NRC. In accordance with the NRC enforcement policy, it is WPSC's position that the proposed civil penalty was inappropriately escalated "due to a lack of post-accident information," and due to the duration of the violation. Indeed, as noted above, we believe the penalty if any, should have been mitigated.

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I trust you will consider our responses carefully and sincerely; as always, we will be happy to discuss these responses with you. Finally, although we obviously disagree with the conclusions and action taken by the NRC, we appreciate the close cooperation and communication you have maintained with us through the Kewaunee Senior Resident Inspector throughout your investigation.

Very truly yours,

P. D. Ziemer
President and Chief Executive Officer

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Enc.

cc - Mr. S. A. Varga, US NRC
Mr. Robert Nelson, US NRC
Mr. J. G. Keppler, US NRC, Region III
Mr. Tsun-Lit Poon, PSCW

Enclosure 1 to Letter dated May 11, 1983

from P. D. Ziemer (WPSC) to R. C. DeYoung (NRC)

Response to Notice of Violation Concerning Capped Containment Pressure Sensing Lines

Docket 50-305

Operating License DPR-43

Kewaunee Nuclear Power Plant

May 11, 1983

RESPONSE TO NOTICE OF VIOLATION

This enclosure provides Wisconsin Public Service Corporation's response to the Notice of Violation transmitted by Mr. J. G. Keppler's letter to Mr. P. D. Ziemer, dated April 11, 1983 (reference 5)[1]. The violation reads, in part:

> Contrary to the above (requirements of the technical specifications), the plant operated continuously at power from May 24, 1982 to October 4, 1982, without having any operable channels of containment pressure instrumentation because the sensing lines had been erroneously capped inside containment.

This response is formatted and numbered in accordance with the directions provided in Mr. Keppler's letter.

1. Admission or Denial of Alleged Violation

WPSC acknowledges the occurrence of the above noted event, and accepts responsibility for same. The event was discovered by Kewaunee Plant personnel on October 4, 1982, as a result of operator observations on that day regarding the fact that venting the KNPP containment building had not been necessary to maintain pressure below the acceptable limit during the previous summer. This observation led the operator to question the operability of the containment pressure monitors. He then requested that the instrument lines inside containment be checked. This resulted in the discovery of the caps located on the instrument lines. Upon discovery, WPSC took prompt and immediate action to return the containment pressure monitors to an operable condition, assure that all other instrument sensing lines were in their appropriate status, notify the NRC senior

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[1] A list of references is provided in enclosure 3.

resident inspector, notify the NRC operations center, and investigate the cause and potential impact of the event. A follow-up report, in the form of a telegram (reference 1), was submitted to NRC-Region III within 24 hours, in accordance with the requirements of the KNPP technical specifications. A formal Licensee Event Report, 82-030, was submitted to the NRC within the following 14 days (reference 2), with subsequent updates submitted on February 1, 1983 (reference 3) and May 6, 1983 (reference 6).

In a coordinated effort between the plant and corporate nuclear staff, WPSC promptly took extensive actions to investigate the event and perform safety analyses to identify the safety significance of the event.

The investigation involved a comprehensive research of records and interviews with many members of the plant staff. This investigation was successful in identifying the cause of the event and formed the basis for many of the corrective actions taken, as discussed in section three, below.

The safety analyses involved a review of the Safety Analysis Report, Technical Specifications, and specifically, the accident analyses to determine the possible consequences of this event. Additionally, WPSC contracted with Westinghouse Electric Corporation and Fluor Engineers, Inc. to independently perform sensitivity studies of the containment pressure response to a loss of coolant accident.

These investigations and analyses involved hundreds of hours of effort, and were substantially complete prior to the enforcement conference held on October 22, 1982. This extensive and comprehensive work was

acknowledged during the enforcement conference by the NRC, who noted that WPSC's presentation was one of the best they had heard.

2. Reasons for the Violation

As noted above, WPSC immediately began an investigation to determine the cause of this event upon its discovery. After a review of activities performed during the spring, 1982 refueling/maintenance outage, and subsequent discussions with appropriate personnel, WPSC concluded that the event was caused by activities related to local leak rate testing of containment penetrations, which are governed by the surveillance procedure SP-56-090.

SP-090 is a very complex procedure, governing leak rate testing of 86 different penetrations. In all, there are 161 separate tests. The majority of these tests require several caps to be removed and reinstalled. Ten penetrations are different in that no caps are removed inside containment. The procedure is performed during scheduled plant outages; it entails so much work and coordination, that it is normally performed during a four to five week time-span, utilizing several different crews.

Generally, the procedure required isolating a segment of a process line passing through containment, removing several caps from various vent or drain lines, connecting the leak rate tester, performing the leakage measurement, and returning the penetration to the as-found condition by realigning valves and recapping vents or drains. Each penetration normally has more than one test. As the end of the 1982 outage drew near,

the test coordinator instructed personnel assigned to him for performance of local leak rate testing to reverify that the tested penetrations were recapped and if they found any that weren't to recap them. He wanted to ensure that all lines were recapped to ensure that containment integrity would not be violated by inadvertently leaving a vent or drain cap off of a line. As soon as he was made aware that caps were discovered on the pressure sensing lines, he realized the significance of the instructions he had given, and if interpreted literally by the personnel performing the work, could have led to those pressure sensing lines being capped.

This information was presented to the NRC during the enforcement conference held on October 22, 1982.

3. Corrective Steps Which Have Been Taken and Results Achieved

Upon discovery of the capped instrument lines, WPSC immediately identified comprehensive corrective actions to remove the caps and to assure that similar, "generic" incidents would not occur in the future. Most of these were identified prior to, and reported to the NRC during the enforcement conference held on October 22, 1983. The corrective actions are summarized below.

a. Immediately upon identification of the event, the caps were removed from the sensing lines, returning the containment pressure transmitters to operable status, and placing the plant in full compliance with technical specifications Table 3.5-3, column 3, item 1.b and 2.b; and Table 3.5-4, column 3, item 2.c. This action was completed by 4:05 P.M. on October 4, 1982, within one hour of the discovery of the event.

b. All containment penetrations that are to be left uncapped during normal operation have been identified and labeled with a plastic and metal tag warning that the penetrations should remain uncapped. This action was completed on October 21, 1982 prior to the enforcement conference.

c. The containment integrity checklist, N-O-01-CLD, has been revised to include a step to insure that the appropriate containment pressure sensing lines are uncapped. This action was completed on November 29, 1982.

d. All safety related instrumentation valve (instrument manifold valves) positions will be reverified prior to startup following local leak rate testing. This corrective action is intended to correct a potentially generic concern. These valves are similar to the containment pressure sensing lines in that they were not covered on any system lineup checkoff list. The appropriate procedures, ICP 87.36, ICP 87.37 and ICP 87.38 were approved by the Plant Operations Review Committee (PORC) on February 10, 1983.

e. An on-site engineer from the technical group located at the Kewaunee Plant has been assigned responsibility for performance of local leak rate testing. This engineer will be responsible for planning and coordinating the activities, and reviewing results. This assignment will provide continuity in future leak rate testing, and will provide direct supervision of the activities by WPSC supervisory personnel. This assignment was made on October 21, 1982.

f. SP-56-090, the procedure governing local leak rate testing, has been given an in-depth review covering the technical adequacy, clarity and correctness of the procedure. The procedure has been expanded to include the normal line-up of the system or penetrations under test. If the system is left in a condition other than normal, it will be documented and reviewed prior to startup following leak rate testing. These revisions were completed prior to February 20, 1983, and received final review and approval by the plant operations review committee (PORC) on February 21, 1983.

g. Tours of the containment are performed monthly by senior plant personnel. These tours are rotated among the Plant Manager, Operations Superintendent, Maintenance Superintendent, Technical Supervisor, and Assistant Superintendent-Operations. This program will keep the plant management informed of the condition of the plant, thus increasing the likelihood of identifying safety concerns. This program was placed in effect in November, 1982.

h. Instruction was given to the plant staff on the serious consequences that can result from going beyond the requirements of a step-by-step procedure on safety systems without approval of the shift supervisor. This instruction was given during the safety meetings held on November 17, 1982, at the Kewaunee Plant.

i. A review of Quality Assurance and Quality Control activities was performed to determine if changes should be made to the activities performed by these groups during outages. While this review concluded

that no changes were necessary, it identified (independently) recommendations to provide additional assurance that this type of event does not happen again. Of these, one recommendation has been implemented (item b, above) and the second reviewed and found not to be practical (item j). Additionally, this review elicited support in identifying problems at the plant by virtue of increased awareness on the part of the QA and QC inspectors. This review was complete on October 11, 1982.

j. The possibility of precluding another event of this type by installing special fittings on the instrumentation lines which are to be left uncapped has been investigated. After much discussion of various alternatives, the plant management concluded that this was not a viable corrective measure. This conclusion was based on the following observations:

--the corrective measures already taken are comprehensive and complete, and will, by themselves, prevent recurrence,
--the level of awareness of the plant staff, in conjunction with the corrective measures regarding the correct status of the instrument penetrations is such that the probability of recurrence in the near or distant future is extremely low,
--Notwithstanding the above two items, any special fitting, no matter how creatively designed, is subject to capping, albeit inadvertently and perhaps even with good intentions, by personnel utilizing the same level of creative design that was used for the cap.

This item was reviewed by the PORC on December 20, 1982 (meeting 82-120).

An additional corrective action involving a "hardware fix" was also considered. This action would have involved eliminating the ability to cap the instrumentation lines by removing the fittings altogether. Unfortunately, this would also have resulted in an inability to perform local leak rate testing on these lines. Consequently, WPSC concluded that this was not a viable option, since it is viewed that the ability to leak-test these penetrations provides a margin of safety that outweighs the remote possibility of the penetrations being inadvertently capped again.

4. The Corrective Steps Which Will be Taken to Avoid Further Violations

As noted in the response to item 3, WPSC took immediate, comprehensive, and complete action upon discovery of the violation. As a result, no further corrective actions are planned or necessary at this time. Many of the actions identified above, however, are ongoing. These include:

--extension of procedures to verify appropriate system lineups, including these penetrations, prior to startups
--supervision of local leak rate testing by plant supervisory personnel
--tours of the containment by senior management, and
--use of an improved local leak rate test procedure.

These corrective actions are already in place.

5. The Date When Full Compliance is Achieved

As noted above, full compliance was achieved within one hour after disco-

very of the violation. Additionally, numerous corrective measures have been identified and implemented to prevent recurrence.

In conclusion, Mr. Keppler requested in his letter of April 11, 1983, that we specifically address the corrective actions we have taken "to improve the management effectiveness for ensuring that technical specification requirements are met and for ensuring personnel performing safety-related activities are properly trained." We feel that this violation occurred not because of a lack of management effectiveness, but was an isolated occurrence due to the zealousness of the personnel involved and their intent in doing each task completely, and in excess of regulatory requirements. In our opinion, it is this zeal which has enabled WPS to achieve and maintain the exceptional operating record of the Kewaunee Nuclear Plant--a record which includes not only an extraordinary availability and capacity factor, but also similar successes in the areas of regulation, maintenance, radiation protection (ALARA) and housekeeping. In our opinion, it is the challenge of management and regulators not to stifle this kind of motivation, but to encourage it and channel it appropriately into activities that will continue the successful operation of the Kewaunee Plant. In our opinion, the corrective actions noted above achieve this; in particular, and specifically in response to Mr. Keppler's request, we refer you to items e, g, h and i, in section 3, above.

Enclosure 2 to Letter dated May 11, 1983

from P. D. Ziemer (WPSC) to R. C. DeYoung (NRC)

Response to Proposed Imposition of Civil Penalty for Violation Concerning Capped Containment Pressure Sensing Lines

Docket 50-305

Operat ng License DPR-43

Kewaunee Nuclear Power Plant

May 11, 1983

RESPONSE TO PROPOSED IMPOSITION OF CIVIL PENALTY

The intent of this enclosure is to respond to the proposed imposition of Civil Penalty for the violation wherein the sensing lines for the containment pressure monitors were capped during operation of the Kewaunee Nuclear Plant. For the reasons discussed below, WPSC is protesting the categorization of this event and the proposed civil penalty and requesting that it be mitigated to zero, based on appropriate application of the NRC's General Statement of Policy and Procedure for Enforcement Actions (reference 7)[1], hereafter referred to as the enforcement policy.

A. Application of the Enforcement Policy to Determine Severity Category

This event has been categorized as a Severity Category III by the NRC in concurrence with WPSC's presentation to the NRC during the enforcement conference held on October 22, 1983. It should be noted, however, that the categorization of this violation as a level III cannot result from strict application of the enforcement policy. In fact, in our opinion, a rigorous application of the enforcement policy would result in placing this violation in severity category IV or V, as explained below.

Section C of Supplement 1 to the enforcement policy defines the severity category III for Reactor Operations as

> C. Severity III--Significant violations involving:
> 1. A Technical Specification Limiting Condition for Operation being exceeded where the appropriate Action Statement was not satisfied that resulted in:
> (a) Loss of a safety function; or
> (b) A degraded condition, and sufficient information existed which should have alerted the licensee that he was in an Action Statement condition;
> 2. A system designed to prevent or mitigate a serious safety event not being able to perform its intended function under certain conditions (e.g., safety system not operable unless offsite power is available; materials or components not environmentally qualified):

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[1] A list of references is provided in Enclosure 3.

3. Serious dereliction of duty on the part of personnel involved in licensed activities;
4. Changes in reactor parameters which cause unanticipated reductions in margins of safety;
5. Release of radioactivity offsite greater than the Technical Specifications limit; or
6. 10CFR50.59 such that a required license amendment was not sought.

The violation involved the loss of all containment pressure indication, and along with it, certain engineered safety feature activation signals. A careful analysis of the consequences (references 3 and 6) has revealed that had an accident occurred during this event, i. (1) would not have resulted in a decrease in the margin of safety afforded the public by the design of the Kewaunee Plant, and (2) would not have resulted in consequences less conservative than assumed in the FSAR. Furthermore, the containment would have been sufficiently cooled during a design basis LOCA so as to maintain containment integrity, and the operators would not have been mislead into erroneous action due to a lack of containment pressure indication. In fact, all safety questions relating to this event have been analyzed in an acceptable and satisfactory manner compelling the conclusion that there was no safety significance arising from this event (references 3 and 6). The NRC has independently reviewed and analyzed these questions and has concurred with this conclusion of no direct safety significance (reference 4).

Therefore, it can be stated, in the words of the Enforcement Policy, that

1. While the violation resulted in a Technical Specification Limiting Condition for Operation being exceeded where the appropriate action statement was not satisfied, it did not result in
   a. loss of a safety function, or

b. a degraded condition where sufficient information existed which should have alerted the licensee he was in a degraded condition (see also item B, below);

2. A system designed to prevent or mitigate a serious safety event (in this case a combined system providing containment cooling) was degraded but was still able to perform its intended function automatically;
3. This violation did not involve serious dereliction of duty on the part of personnel involved in licensed activities;
4. This violation did not involve changes in reactor parameters which caused unanticipated reductions in margins of safety;
5. This violation did not involve a release of radioactivity greater than the Technical Specifications limits; and
6. This violation did not involve a 10CFR50.59 change.

Consequently, rigorous application of the enforcement policy would require that this event be categorized as a severity level IV or V. The most likely categorization is item D.2 of supplement 1 to the enforcement policy: "Failure to meet regulatory requirements that have more than minor safety or environmental significance," or item E "(v)iolations that have minor safety or environmental significance." Indeed, in light of the submitted safety analysis and the NRC's agreement with the same, it is arguable that this violation of technical specifications does not even rise to a level V.

This conclusion notwithstanding, WPSC recognized the seriousness of this event, though this seriousness is not directly safety related. WPSC

feels that exceeding a technical specification limiting condition for operation is significant by the mere fact that it happened. Furthermore, an event that results in a loss of engineered safety feature actuation signals and indication of a diagnostic parameter is significant, even if it results in a loss of only redundant systems and cannot materially mislead the operator. In light of its own significant concern about this event, WPSC was treating it as if it were a severity category III in accordance with section B.III of the enforcement policy: "Severity Level III violations are cause for significant concern." This was so even though the event does not meet the defined circumstances for a level III violation.

As noted above, this attitude was reported to the NRC during the enforcement conference held on October 22, 1982. It should be noted that the NRC understood the conclusion and the logic: during the enforcement conference, one NRC representative remarked that WPSC's presentation, if accepted, led to the conclusion that the event was a category IV.

WPSC's recognition of and response to this event as important and serious, however, does not relieve the NRC of the obligation to apply its enforcement guidelines fairly, as written. Indeed, the fact that WPSC may have overreacted to this event should be cause for commendation rather than condemnation. The proposed escalation of the penalty, after characterizing the event as a Level 3 violation, effectively penalizes prompt, cooperative and complete self-identification and correction of a problem by a licensee. Such a result turns the purpose of the enforcement policy on its head.

It should also be noted that based on the pure merits of this violation, it could have been placed in a category where no enforcement action would have been considered. Section IV.A of the enforcement policy discusses notices of violation and states that generally, a notice will not even be issued for a violation that meets all of the following tests:

1. It was identified by the Licensee (it was).
2. It fits in severity level IV or V (it could be easily argued as a IV or V and should probably be categorized as such).
3. It was reported, if required (it was).
4. It was or will be corrected, including measures to prevent recurrence, within a reasonable time (it was); and
5. It was not a violation that could reasonably be expected to have been prevented by the licensee's corrective action for a previous violation (again, this was the case).

This part of the policy does not excuse personnel errors and thus is not strictly applicable. However, such considerations are important in determining the ultimate enforcement action.

B. Escalation of Proposed Civil Penalty

The proposed civil penalty includes an escalation of $20,000 "because of the duration of the violation," and because of its "added significance when it is realized that containment pressure indication would not have been available if an accident occurred thereby denying operations personnel and reviewers valuable post accident data." WPSC feels that neither of these reasons are appropriate or supportable in consideration of the enforcement policy.

While the enforcement policy does not provide any specific guidance on escalation of a proposed civil penalty, there are several passages where general guidance is given. WPSC has reviewed this guidance and feels that it is not applicable to this violation and the circumstances surrounding it. It is noteworthy that the only escalating factors identified are duration and the unavailability of post accident information. No contention is or could be made that this event involved a knowing violation, ineffective identification or correction, WPSC's enforcement history, prior notice of similar events or multiple occurrences.

Specifically, section B.III notes that the "NRC expects licensees to provide full, complete, timely and accurate information and reports." This specific paragraph is addressing failure to make a report; however, if applied to this violation it would not call for escalation since WPSC met or exceeded all reporting requirements. In fact, WPSC did more than could have been expected to perform at great expense of time and money the appropriate safety analyses and investigations of this event such that all safety questions could be answered at the enforcement conference held on October 22, 1982.

Section IV.B states that "ineffective licensee programs for problem identification or correction are unacceptable. In cases involving willfulness, flagrant NRC-identified violations or serious breakdown in management controls, NRC intends to apply its full enforcement authority..." This is clearly <u>not</u> the case for this violation. WPSC identified the violation and took immediate and very extensive corrective action.

Section IV.B goes on to state that "NRC reviews each proposed civil penalty on its own merits and adjusts the base civil penalty values upward or downward appropriately." This section goes on to discuss mitigating circumstances. It seems clear that this is perhaps one of the clauses used by the NRC in escalating the fine, in this case due to the "added significance" of not having post accident information. It is our opinion that this application is in error, for three reasons:

--First, the "added significance" referred to by the NRC is the sole possible justification (and a doubtful one) for treating this event as a level III instead of a level IV or V. It would be a double penalty to increase the civil penalty for the same reason, which is unwarranted and not comtemplated by the enforcement policy.

--Secondly, WPSC feels strongly that a loss of post-accident information should not be the basis for escalated enforcement, or any enforcement proceeding. It is the objective of the NRC to assure the health and safety of the public. While post-accident review of data may be helpful in analyzing an event and <u>possibly</u> preventing its recurrence, it is not directly related to the health and safety of the public. Consequently, it is not within the NRC's purview to base regulatory action on the availability or unavailability of post-accident information. The unavailability of certain data (which may even be of limited or no use) in the most unlikely event of a serious accident is an unsubstantiated basis for increasing the significance of an event having <u>no</u> direct safety consequences. Furthermore, it should not be blindly assumed that this data could not be reconstructed through analytic or other means, should the need arise.

--Thirdly, even accepting the loss of diagnostic information and certain redundant engineered safety feature activation signals as a basis for placing this violation in severity level III, it is interesting to note that the enforcement policy, section IV.B states that NRC imposes different levels of penalties for different severity level violations and different classes of licensees. Tables 1A and 1B of the enforcement policy show the base civil penalties for various reactor, fuel cycle, and materials programs. These tables themselves take into account the gravity of the violation as a primary consideration and the ability to pay as a secondary consideration.

In other words, the significance of an event has been taken into account in establishing the base penalty. Having labeled this event a level III, its significance has been accounted for in the base penalty.

The second reason for escalation of the civil penalty was stated as "the duration of the event." WPSC cannot agree with the NRC's determination that this violation should have been identified sooner. This is discussed in detail in section C.5, below.

Based on these discussions (here and item C.5, below), we submit that even if a civil penalty were warranted, there is no basis for increasing it, for the reasons given in the notice of proposed imposition of civil penalty, or for any other reason. In fact, WPSC feels that the fine should be mitigated in accordance with the provisions of the enforcement policy, as discussed in the next section.

C. Consideration for Mitigation

The notice of penalty fails to provide any analysis of mitigating factors, implying that they were not even considered, even though mitigation is an integral part of the enforcement policy.

Section IV.B of the enforcement policy notes that:

> NRC attaches great importance to comprehensive licensee programs for detection, correction, and reporting of problems that may constitute, or lead to, violation of regulatory requirements. This is emphasized by giving credit for effective licensee audit programs when licensees find, correct, and report problems expeditiously and effectively. To encourage licensee self-identification and correction of violations and to avoid potential concealment of problems of safety significance, application of the adjustment factors set forth below may result in no civil penalty being assessed for violations which are identified, reported (if required), and effectively corrected by the licensee, provided that such violations were not disclosed as a result of overexposures or unplanned releases of radioactivity or other specific, self-disclosing incidents.

WPSC feels that mitigation, based on this discussion and the five specific items discussed below should have been considered by the NRC in its review of this violation. Specifically,

1. Prompt Identification and Reporting

It is WPSC's opinion that this violation was discovered as soon as could have reasonably been expected. The concept of prompt identification is related to duration which is discussed in more detail in item C.5, Multiple Occurrences, below.

The other aspects of this mitigation factor can be applied very favorably to this violation and WPSC's response. WPSC immediately notified the NRC of the event. Notification of the Senior Resident Inspector was complicated and probably not required since he was off-

site at the time of the discovery. Nevertheless, WPSC did make a special effort to reach him successfully within one hour of the discovery of the violation. The NRC operations center was also notified within that hour.

WPSC took extraordinary steps to perform the safety analyses necessary to respond to the NRC's questions. The initial analyses were completed in time for presentation to the NRC during the enforcement conference held on October 22, 1982. Subsequent analyses were performed and reports prepared and forwarded to the NRC, usually in a matter of days of the request.

Based on this factor, the penalty should be mitigated by 50%. However, no credit was given to WPSC for any of the above.

2. Corrective Action to Prevent Recurrence

Upon identification of this event, WPSC immediately took complete and comprehensive action to correct this violation, to prevent it from recurring, and to prevent events of a similar nature from recurring. Most of the corrective actions were completed prior to the enforcement conference, all were completed by February 21, 1983, about four months after the event. It is also noteworthy that WPSC's response to this event included corporate nuclear and quality assurance personnel as well as plant personnel, attesting to our resolve to correct this event.

Based on these actions the penalty should have been mitigated by 50%. However, no credit was given to WPSC for any of these items.

3. Enforcement History

WPSC has an exceptional enforcement history, certainly with no events similar to this violation. This also supports mitigation of the base penalty. WPS is proud of the exceptional record it has achieved, as evidenced by the 1982 SALP report (reference 8).

4. Prior Notice of Similar Events

To our knowledge, there were no events similar to this that could have alerted us of the problem. In fact, we are aware that at least two plants have identified similar occurrences subsequent to the identification of the violation at KNPP (references 9 and 10). Thus this factor does not bar mitigation.

5. Multiple Occurrences

The first two factors identified in this category are that unlike this event, where KNPP identified the problem, the violation was found by the NRC, or also unlike this event, the violation was a self-disclosing incident. The third factor is the duration of the violation. The NRC has judged and WPSC disagrees, that this violation could have been detected sooner.

The basis for our disagreement is that there was no clear indication of this problem, as required by the enforcement policy:

> Generally, for situations where a licensee is unaware of a condition resulting in a continuing violation, a separate violation and attendant civil penalty may be considered for each day that the licensee clearly should have been aware of the condition or had an opportunity to correct the condition, but failed to do so. Civil penalties in excess of 3.75 times the maximum civil penalty for a single Severity Level I violation for each type of licensee require specific Commission approval in accordance with guidance set forth in Section VI below.

In fact, the primary indication of containment pressure, the pressure indication in the control room, was behaving as though it were responding to the containment environment. This was evident through the slight changes in the pressure readings which occurred from day to day. Upon closer analysis, we have determined that these fluctuations were due to variations in barometric pressure, as sensed by the pressure transmitters.

Given this fluctuation and the large number of variables that can affect containment pressure either positively or negatively (e.g., service water intake temperature, ambient temperature, air and mass leakage into the containment, venting history) a "clear indication" that the problem existed was not evident.

The NRC has stated that the licensee should have known of the violation as early as late June of 1982 and no later than early August, 1982, based on a review of containment pressure trends compared to service water conditions and the daily logging of containment pressure. We disagree with this because

1. The mere fact that a trending of data was necessary for the NRC to reach this conclusion shows that it was not a "clear indication." (In fact, the NRC review was made after the fact, and after months of reflection, with the intent of identifying a trend. Operating personnel monitor many parameters for trends. A subtle trend such as occurred in this cas would be difficult to recognize and certainly could not be classified as a clear indication.)
2. There was no requirement that a specific variable (or comparison

of variables) be trended by the operating crew. Hence, the basis of trending a specific variable cannot be used to satisfy the "clear indication" requirement.

3. The Kewaunee containment was vented on July 20 and July 21, 1982, thereby starting a new trendline and further masking what was already an unclear indication of the situation.
4. The fact that a window of approximately six to eight weeks is given as the time when the situation should have been discovered (notwithstanding the fact that the containment was vented in that time-frame) shows that the proposed "indication" is ambiguous and debatable.

It is our opinion that the fact that the violation was discovered at all during the cycle is a credit to the competence of the operating crew and better than could have been expected. As noted earlier, there are other instances where capped containment pressure sensing lines were discovered only after a full cycle of operation. In those cases, it should have been easier to detect the violation because only one of several indications was capped. This would have provided a clear indication due to the discrepancy between channels indicating the same parameter. Yet, in these cases, the penalties involved were not increased for the "duration" of the violation.

The failure of the notice to give effect to (or even analyze and discuss) the mitigating factors and circumstances is most troubling to WPSC. The company is proud of the prompt and extensive actions undertaken in response to this event. At the enforcement conference these

efforts were acknowledged and commended. Failure to recognize these efforts in the enforcement action ignores the clear intent and requirements of the enforcement policy. Furthermore, it constitutes the unwanted signal to licensees that prompt action is of no importance to the NRC. The extraordinary efforts of WPSC should be recognized by mitigating the proposed penalty to zero.

D. Application of the Enforcement Policy Should Be Uniform Throughout the Industry

WPSC is aware of several recent events in the nuclear industry which involved some degradation of containment cooling systems. These are summarized as follows:

Licensee	Event	Proposed Fine	Reference
Alabama Power, Farley Plant	Containment spray system manually valved out for one cycle, from May 5, 1981 To October 5, 1982	$40,000	11
Arkansas Power & Light, ANO-1	Two inoperable reactor building pressure transmitters for one cycle, February 1981, to December, 1981	$40,000 mitigated to $20,000	10
Southern California Edison, San Onofre	Both trains of containment cooling and one train of spray out for two hours	$40,000	12
Northern States Power, Prairie Island	One containment pressure transmitter found capped on November 21, 1982	None	9

In several significant respects, these other incidents involved circumstances more aggravated than this event. Yet, no escalation of penalty was imposed. In one instance, the penalty was mitigated. The unfairness of the proposed penalty in this case compared to these others

is manifest. Note, for example, in the Farley incident (reference 13) that:

1. The duration was nearly three times the duration of this event.
2. Positive checks of the valve position at Farley were ineffective. KNPP did not have a mechanism to provide a positive check of the pressure transmitters.
3. The containment spray system was locked out; it would have taken considerable operator action at the location of the valves to place the system in operation. In contrast, at KNPP the containment spray system could have been manually activated from the control room.
4. The consequences of the event at Farley were of a considerably higher magnitude than at KNPP. For example, the analyses of the Farley event indicated that containment design pressure would have been exceeded for certain accidents, and offsite doses would have exceeded 10CFR Part 100 limits for a loss of coolant accident, given the unavailability of the containment spray system. The event at KNPP, however, had no adverse safety consequences.

The duration of the event that occurred at Arkansas Nuclear One, unit one, was for an entire cycle. It could be argued that in this case, the problem should have been diagnosed more easily than the event at KNPP, due to the fact that not all channels were affected. This should have resulted in disparate readings between channels, raising a "flag" to the operators. In the ANO-1 case, the civil penalty was mitigated for the prompt and extensive corrective action that Arkansas Power and Light took

to correct the problem. Yet, for KNPP, where the event was of a shorter duration, no credit was given for WPSC's prompt and extensive corrective action.

The event which occurred at Southern California Edison's San Onofre plant had much more severe safety significance than the KNPP event, since the available containment heat removal system had been reduced to one spray pump. Yet the penalty proposed was less than that proposed for WPSC.

The event which occurred at Northern States Power Company's Prairie Island plant was also similar in nature, but probably of much longer duration. This event resulted in no more than a citation to Northern States Power.

Finally, IE Information Notice 83-23, dated April 25, 1983 (Reference 14), discusses many similar occurrences throughout the industry. Many of the events listed in this notice had durations far exceeding the event at KNPP. This notice serves to clarify two important points. First, events of this nature are not unique to KNPP; therefore, WPSC should not be singled out in terms of enforcement. Secondly, events of this nature are very difficult to detect: it is a credit to the KNPP personnel that this event was identified as soon as it was, especially considering the fact that there were no clear indications of the problem. Based on this, the duration of the event cannot be considered a factor for escalation; in fact, it should more appropriately be considered for mitigation.

Clearly, there are inequities in the manner in which the enforcement policy is being applied. Because it is essential that the NRC have a uniform enforcement policy, and because the intent of a civil penalty is to

provide increased assurance that a given violation will not reoccur, we encourage the NRC to review this violation and the circumstances around it, and reconsider the proposed civil penalty.

In our opinion, this event should be characterized as a severity level IV or V, and no penalty should be imposed. Alternatively, any penalty should be mitigated to zero based on the mitigating factors numbered IV.B.1 and IV.B.2, as discussed above.

Enclosure 3

List of References

1. Telegram, D. C. Hintz (WPSC) to J. Streeter (NRC - Region III), dated October 5, 1982.

2. LER 82-030/01T-0, submitted by letter from C. W. Giesler (WPSC) to J. G. Keppler (NRC - Region III), dated October 18, 1982.

3. LER 82-030/01X-1 (Update Report), submitted by letter from C. W. Giesler (WPSC) to J. G. Keppler (NRC - Region III), dated February 1, 1983.

4. Inspection Report 50-305/82-19, transmitted by letter from J. G. Keppler (NRC - Region III) to P. D. Ziemer (WPSC), dated April 11, 1983.

5. Notice of Violation and Proposed Imposition of Civil Penalty, transmitted by letter from J. G. Keppler (NRC - Region III) to P. D. Ziemer (WPSC), dated April 11, 1983.

6. LER 82-030/01X-2 (Update Report), submitted by letter from C. W. Giesler (WPSC) to J. G. Keppler (NRC - Region III), dated May 6, 1983.

7. General Statement of Policy and Procedure for Enforcement Actions, Appendix C to Title 10, Code of Federal Regulations, Part 2 (47FR46, 3-9-82).

8. Letter from J. G. Keppler (NRC - Region III) to C. W. Giesler (WPSC), dated July 20, 1982, transmitting inspection report 82-12, Systematic Assessment of Licensee Performance.

9. Letter from J. F. Streeter (NRC - Region III) to C. E. Larson (Northern States Power Company), dated December 27, 1982, transmitting Inspection Report 50-282/82-20.

10. Letter from John T. Collins, Regional Administrator, (NRC - Region III) to John M. Griffin, Vice-President - Nuclear Operations, Arkansas Power and Light, dated March 8, 1983, Docket 50-313.

11. Letter from James P. O'Reilly, Regional Administrator, (NRC - Region II), to R. P. McDonald, Vice President, Nuclear Generation, Alabama Power Company, dated February 2, 1983, Docket 50-364.

12. Letter from R. H. Engleken, Regional Administrator, (NRC - Region V), to Dr. L. T. Papay, Vice President, Advanced Engineering, Southern California Edison Company, dated March 24, 1983, Docket 50-361.

13. Power Reactor Events, NUREG/BR-0051, Volume 4, Number 6, published April, 1983.

14. IE Information Notice 83-23, dated April 25, 1983, "Inoperable Containment Atmosphere Sensing Systems."