Wisconsin Electric
POWER COMPANY

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VPNPD-96-683

October 7, 1996

Document Control Desk
US NUCLEAR REGULATORY COMMISSION
Mail Station P1-137
Washington, DC 20555

Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO NOTICE OF VIOLATION
INSPECTION REPORTS 50-266/96006 (DRP); 50-301/96006 (DRP)
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

In a letter from Mr. James L. Caldwell dated September 5, 1996, the Nuclear Regulatory Commission forwarded the results of a routine safety inspection performed by Messrs. T. Kobetz and A. McMurtray from June 12, 1996, through August 8, 1996. This inspection report included a Notice of Violation (Notice) related to the 10 CFR 50 Appendix B, Criterion V requirement that activities affecting quality be prescribed by procedures appropriate to the circumstances and accomplished in accordance with these procedures. The violation is based on a failure to implement a logkeeping procedure requirement to record Limiting Conditions for Operation (LCOs). The Notice identified that the licensee had failed to declare the Unit 1 containment airlock outer door cut-of-service in the official Station Log when test data from the previous test was determined to be invalid.

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 of a Point Beach procedure. Our written response is included as an attachment to this letter.

We believe that the attached reply is responsive to your concerns and fulfills the requirements identified in your September 5, 1996 letter.

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

Sincerely,

Bob Link
Vice President
Nuclear Power

Attachment

cc: NRC Resident Inspector
NRC Regional Administrator, Region III

RESPONSE TO NOTICE OF VIOLATION
INSPECTION REPORTS 50-266/96006 (DRP); 50-301/96006 (DRP)

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 June 12 through August 8, 1996, a violation of 10 CFR 50 Appendix B Criterion V was identified. This violation occurred due to the failure to implement a logkeeping procedure requirement to record Limiting Conditions for Operation (LCOs). The Notice identified that WE personnel had failed to declare the Unit 1 containment airlock outer door out-of-service in the official Station Log when test data from the previous test was determined to be invalid.

The identified violation was classified as Severity Level IV. Inspection Report Nos. 50-266/96006 and 50-301/96006 and the Notice of Violation (Notice) transmitted to Wisconsin Electric on September 5, 1996, provide details regarding the violation. We agree that the events and circumstances described in the Notice of Violation 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:

"10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires that activities affecting quality be prescribed by documented procedures of a type appropriate to the circumstances and be accomplished in accordance with these procedures.

Point Beach Nuclear Plant Operations Manual Procedure OM 3.9, "Guidelines for Watchstanding, Logbooks, Records, and Status Control," Step 6.4.2, requires that all major changes to the plant status, plant equipment or plant systems, including Limiting Conditions for Operations, be entered into the Station Log; and Step 6.4.3, requires control operators to log any significant equipment failures or operational problems encountered during the watch into the Control Room Narrative Log.

Contrary to the above, on July 28, 1996, the licensee failed to declare the Unit 1 containment air-lock outer door out-of-service in the official Station Log or the Unit 1 Control Room Narrative Log when the test data from the previous test was determined to be invalid. In addition, both logs failed to specify that Unit 1 was in a Limiting Condition for Operation for verifying that the inner door was locked closed once per 31 days."

RESPONSE TO VIOLATION:

1. REASON FOR VIOLATION

Technical Specification surveillance 15.4.4.II.C.1.d requires that personnel airlocks opened during periods when containment integrity is established be tested within 3 days after being opened. This test is performed with PBNP procedure TS-10A, "Containment Airlock Door Seal Testing".

On July 28, 1996, TS-10A Appendix A was initiated as a post-maintenance test (PMT) following a routine overhaul of the containment hatch door seal test pump (1P-77A). TS-10A Appendix A develops a performance curve for the test pump based upon an induced measured leak rate and differential pressure. During the test, erratic results were received. Preliminary investigation of the testing equipment indicated a significant amount of grease in the sensing line from the door seals to 1P-77A test pump. At this point, shift personnel questioned the validity of previous seal leakage tests performed per TS-10A Appendix B. TS-10A Appendix B tests the containment hatch door seal leak rate using the performance curve developed by TS-10A Appendix A. Shift personnel, believing that this condition constituted a surveillance not performed within its specified frequency, applied Technical Specification 15.4.0.3. From the time the missed surveillance is discovered, this specification allows 24 hours to conduct the surveillance or declare the equipment out of service.

Because the door seal was not suspect and there was still ample time to fix the test equipment and complete the test within the Technical Specification time limit, on-shift personnel did not declare the door inoperable. Therefore, no log entry to that effect was made. Although the Duty Shift Superintendent (DSS) did not consider the door inoperable at this time, he implemented the actions described in the Technical Specifications for an inoperable door. A Station Log entry was made that accurately reflected those actions. (Station Log Entry 0920 on July 29th) Discussions were held with operations management, the duty and call superintendent, and the plant manager on day shift July 29th relative to the status of the door. The plant manager directed that the door be declared inoperable and that appropriate actions including log entries be taken. A Station Log entry was made at approximately 1600 hours on July 29th following that meeting which stated that "operability of the outer door will be determined later." This entry was written in the Station Log as a late entry for 2100 hours on July 28th. The log entry was not clear. The DSS did not write a log entry that clearly communicated the status of the door. This led to uncertainty with subsequent shifts until corrected by management the morning of July 30th.

Immediately, the on-shift personnel focused on restoration and testing of the test equipment. An action plan was developed and presented. The problem with the tubing was corrected and the outer door was satisfactorily tested per TS-10A Appendix A and B on July 31, 1996.

Plant Operations management has reviewed the circumstances of this violation in context with ongoing efforts to improve performance of control room operations. This event was the result of individual performance. Although the on-shift personnel did initiate compensatory measures for the condition, their failure to make the appropriate log entries was a procedural error and contributed to subsequent shifts not clearly understanding the status of the door .

2. CORRECTIVE ACTION TAKEN

At 0925 hours on July 31, 1996, an entry was made to the Station Log; clarifying the original entry of 2100 hours on July 28, 1996. This entry explicitly stated that the Unit 1 containment upper hatch outer door was inoperable until a satisfactory containment hatch test (TS-10A Appendix B) was completed. This entry also stated the Technical Specification requirements to lock shut the inner door and verify it shut once per 31 days.

As stated in the Station Log entry of 1830 hours on July 31, 1996, the containment hatch test (TS-10A Appendix A and B) was completed with satisfactory results. The Station Log declared that the Unit 1 66' outer hatch had returned to service.

3. CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

As discussed at the Predecisional Enforcement Conference on September 12, 1996, the expectations for precise logkeeping practices were reinforced with the shift supervisors. This meeting was conducted on August 27, 1996. *The lessons learned from this incident were explicitly discussed at that meeting and will be included in the Operations required reading material.*

In addition, logkeeping practices will be a topic in the next Operations training cycle, which is scheduled to start in January 1997. This training is planned to be complete by the end of March 1997.

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance will be achieved March 31, 1997.