Wisconsin Electric
POWER COMPANY

Point Beach Nuclear Plant
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PBL-97-0034

January 30, 1997

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

Ladies/Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO NOTICE OF VIOLATION
INSPECTION REPORTS 50-266/96012 (DRP); 50-301/96012 (DRP)
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

In a letter from Mr. John A. Grobe dated December 31, 1996, the Nuclear Regulatory Commission forwarded the results of a routine inspection of plant operations which covered the 6-week period from September 24 through November 4, 1996. This inspection report included a Notice of Violation (Notice) which identified one violation of 10 CFR 50 Appendix B, Criterion V, one violation of Point Beach Nuclear Plant Technical Specification 15.6.8.1, and one violation of 10 CFR 50.59(a)(1).

We have reviewed the Notice and, pursuant to the provisions of 10 CFR 2.201, have prepared a written response of explanation concerning the identified violations of NRC requirements. 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 December 31, 1996 letter.

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

Sincerely,

Thomas G Nelson for

Douglas. F. Johnson
Manager-Regulatory Services
and Licensing

TGM

030034

Attachment
cc: NRC Resident Inspector
NRC Regional Administrator, Region III

RESPONSE TO NOTICE OF VIOLATION
INSPECTION REPORTS 50-266/96012 (DRP); 50-301/96012 (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 inspection of plant operations which covered the six-week period from September 24 through November 4, 1996, three violations of NRC requirements were identified. Each of the violations were classified as Severity Level IV. Inspection Report 50-266/96012(DRP); 50-301/96012(DRP) and the Notice of Violation (Notice) transmitted to Wisconsin Electric on December 31, 1996, provide details regarding each violation.

In accordance with the instructions provided in the Notice, our reply to the alleged violations includes: (1) the reason for 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

10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances.

Contrary to the above, procedure RMP 9002-8, Revision 1, "Reactor Coolant Pump Mechanical Seal Drain System Installation and Removal," contained a general note that inappropriately allowed Step 7.3.8 to be performed prior to Step 7.3.1, which on October 9, 1996, resulted in an inadvertent lowering of reactor vessel level through 2CV-302B, the "B" RCP seal water injection vent valve.

This is a Severity Level IV violation (Supplement I).

Response To Violation 1:

Reason for Violation:

The root cause of this event was less than adequate communications and less than adequate administrative controls.

In mid-summer, 1995, Routine Maintenance Procedure (RMP) 2P, "Reactor Coolant Pump, Pump P1," and RMP 2M, "Reactor Coolant Pump Maintenance," were subdivided into eight separate procedures to facilitate the work flow pertaining to the reactor coolant pumps (RCPs). This series was numbered RMP 9002-1 through RMP 9002-8. When the new RMPs were issued, specific danger tag location sheets were developed and issued in October 1995 to replace the existing sheets for work under RMP 2P and RMP 2M. After a revision to the RMP 9002 series in February 1996, new danger tag location sheets were developed and provided to the PBNP work control center for input into the Operations Electronic Tagging Database. However, neither set of updated danger tag location sheets were entered into the Operations Electronic Tagging System. This resulted in the existing danger tag location sheets being

inappropriate for the current RMP procedures. In October 1996, danger tag location sheets, which were based on the outdated danger tag location sheets in the system, were issued for the RCP seal work. The resulting danger tag location sheets, which were the controlling work documents for the RCP seal work valve line-up, caused the valve line-up to be performed out of the intended sequence. This resulted in valve 2CV-302B being opened prior to RCP motor/pump uncoupling, which subsequently caused the inadvertent reactor vessel level drop.

A confusing format to the RMP 9002 series contributed to this event. RMP-9002-4, "Reactor Coolant Pump Uncoupling and Coupling," indicates that the recommended tagout series for that RMP could be found in the Operations group electronic tagout files rather than containing the recommended tagout steps in the associated RMP procedure. In addition, the current RMP 9002 series contains a statement that allows steps to be performed out of the indicated sequence provided that all necessary steps are completed. Had the RMP procedure been the controlling work document for the valve line-up, valve 2CV-302B could have been opened prior to RCP motor/pump decoupling in accordance with the procedure.

Since neither the procedure nor the existing danger tag location sheets provided adequate controls for performing the RCP seal work, both potential barriers to this event failed.

Corrective Action Taken:

Root Cause Evaluation (RCE) 96-15 was completed and issued on December 16, 1996. Recommended corrective actions are summarized below.

Corrective Action Taken to Avoid Further Violations:

We will conduct an overall review of our electronic danger tag system, including the process for creating and updating danger tag series. We expect that this review will result in a better process for controlling electronic danger tag location sheets and form the basis for a validated, pre-approved series of danger tag location sheets. This review will be completed and recommended improvements implemented by December 15, 1997. In the interim, we have heightened the awareness of personnel involved in the danger tag update process to the importance of effective communication and follow-through during danger tag update evolutions.

The RMP 9002 series procedures will be revised to include appropriate tagging series information, require all steps to be performed in the indicated sequence, and require an evolution coordinator to be assigned who will be responsible for coordinating the evolution between the involved work groups and conducting pre-job and post-job briefings. These procedure revisions will be completed prior to next use which will occur during the next Unit 1 refueling outage, currently scheduled to commence on May 9, 1997.

Date When Full Compliance Will Be Achieved:

We will be in full compliance by December 15, 1997, when the recommended electronic danger tag process improvements are implemented.

VIOLATION 2

Technical Specification 15.6.8.1 requires that the plant shall be operated and maintained in accordance with approved procedures. Procedure OI-115, Revision 0, "Spent Fuel Pool (SFP) Service Water (SW) Cooling Isolation for Maintenance," Step 5.14.4, and Attachment C required SFP temperature to be monitored and recorded a minimum of every four hours, as specified by licensee Safety Evaluation Report 96-090.

Contrary to the above, on September 18, 1996, SFP temperature was not monitored and recorded a minimum of every four hours. In addition, no procedure or instruction was provided to align SFP flow to the SFP heat exchanger, HX-13B, after SW flow was restored.

This is a Severity Level IV violation (Supplement I).

Response To Violation 2:

Reason for Violation:

This violation resulted from our failure to properly line up service water to the spent fuel pool (SFP) heat exchangers. The SFP heat exchangers had been intentionally removed from service to support the removal of valves SW-2930A and SW-660 for maintenance. During this time the SFP temperatures had been monitored every four hours in accordance with Procedure OI-115. Plant personnel ceased SFP temperature monitoring after they believed that service water had been restored to SFP heat exchanger HX-13A. However, personnel had inadvertently lined up service water to heat exchanger HX-13B while SFP water continued to be lined up to heat exchanger HX-13A. Hence, SFP cooling had been isolated without monitoring SFP temperature as required by OI-115.

Additionally, Procedure OI-115 was less than adequate due to a lack of guidance to ensure that an operator would verify that service water and SFP water were lined up to the same heat exchanger. Finally, it is a standard expectation that operators continue to monitor plant conditions (such as SFP temperatures) for some time after an evolution is complete to ensure that conditions have stabilized. Contrary to this expectation, the SFP temperature response was not monitored after the heat exchanger lineup was changed.

Corrective Action Taken:

Two immediate corrective actions were taken. This event was discussed with the individual who performed the incorrect line-up and he was reminded of the importance of having a questioning attitude and of second checking his work. A procedure change to Procedure OI-115 was issued on October 2, 1996, which included a note to ensure that SFP and service water flow are lined up to the same heat exchanger.

Corrective Action Taken to Avoid Further Violations:

To determine the root cause of this and previous similar events, and to implement corrective actions to improve our performance in this area, we are currently conducting a generic valve mispositioning root cause evaluation. We are being assisted in this evaluation by a consultant which we have hired to help

improve our root cause/corrective action program. This root cause evaluation will be completed by February 28, 1997. At that time we will review the evaluation team's recommendations for implementation.

Date When Full Compliance Will Be Achieved:

Because the associated procedure has been revised and management expectations have been reemphasized, we believe we are now in full compliance.

VIOLATION 3

10 CFR 50.59(a)(1) states, in part, that the licensee may make changes in the facility described in the safety analysis report without prior Commission approval, unless the proposed change involves an unreviewed safety question. 10 CFR 50.59(b)(1) requires the licensee to maintain records of changes in the facility to the extent that these changes constitute changes in the facility described in the safety analysis report. These records must include a written safety evaluation that provides the bases for the determination that the change does not involve an unreviewed safety question.

Contrary to the above, as of October 21, 1996, the facility as described in the FSAR was changed and no written safety evaluation was performed. Specifically, on October 21, 1996, the Unit 1 boric acid storage tank isolation valve 1SI-826A to safety injection pump suction was found closed, but was shown as open on Figure 6.2-1 of the FSAR. Although this was a permanent change to the facility, no written safety evaluation was performed nor was the FSAR updated to reflect the change.

This is a Severity Level IV violation (Supplement I).

Response To Violation 3:

Reason for Violation:

Modifications were completed which removed the automatic actuation circuits for the SI-826 valves in both units. Each unit's SI-826A valve had been in a normally open position to ensure that a single failure of that valve to open would not prevent the automatic line-up of the boric acid storage tank (BAST) to the safety injection pump suction on a safety injection signal. In April 1996, following removal of the automatic actuation circuits, it was determined that the SI-826A valves should be placed in a normally shut position.

A 10 CFR 50.59 safety evaluation screening was completed on April 18, 1996, to evaluate a change to Checklists (CL) CL-7A and 7B, "Safety Injection System Checklist." One purpose of that change was to revise the normal position of the SI-826A valves. The screening discussed the modifications and reasons for shutting Valve SI-826A. The screening incorrectly determined that a full safety evaluation was not required. The checklists were revised on October 3, 1996, using the screening as justification, to change the SI-826A valve position from normally open to normally shut.

Corrective Action Taken:

Drawing 110E017 was revised to show Valve 1SI-826A as normally closed. The 10 CFR 50.59 safety evaluation screening associated with this event is being upgraded to a full safety evaluation.

Corrective Action Taken to Avoid Further Violations:

Drawing 110E017 will be updated in the FSAR during the normal June 1997 update. Wisconsin Electric had previously committed to make short-term and long-term improvements to the 10 CFR 50.59 safety evaluation process to strengthen its effectiveness. The resulting 10 CFR 50.59 safety evaluation process improvement team has identified several changes to our overall 10 CFR 50.59 safety evaluation process and procedures which will clarify the requirements for completing a screening versus a full 10 CFR 50.59 safety evaluation. These recommendations will be implemented by May 1997 as previously communicated during the September 12, 1996, NRC enforcement conference.

Date When Full Compliance Will Be Achieved:

The upgrade to the 10 CFR 50.59 safety evaluation screening will be completed by February 21, 1997 at which time we will be in full compliance.