WISCONSIN PUBLIC SERVICE CORPORATION

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

July 20, 1978

Mr. James G. Keppler, Director
Inspection & Enforcement Division
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr. Keppler:

Docket 50-305
Operating License DPR-43
IE Inspection Report No. 50-305/79-09

The reference inspection report addresses a meeting in our office on May 17, 1978, and subsequent evaluations of dose in regard to the reactor cavity "C" radiation exposure incident. The report presents the positions noted by members of the NRC Regional Office; however, we believe that the positions presented by members of Licensee organization were not completely reflected in the report. In an effort to achieve completeness and remove the possibility of misinterpretation, we believe that our positions and opinions expressed should be included in the formal record of that meeting.

Mr. Giesler stated, both at the subject meeting and a subsequent conference call, that had the correct radiation level data been available or by some other means had the shift supervisor known that the radiation levels were in the 2000 R/hr range, the incident would not have occurred.

As a result of our reviewing of the incident and the associated access control procedures, we cannot identify where the operational personnel failed to follow the procedures. It is our understanding that through the Region III review the appropriate procedures were found to be acceptable. It should be recognized that responsible operating personnel must be provided with the latitude to make decisions during emergency situations from information and input from supporting groups available to them at the time. It was not and still has not been acknowledged by your review of the incident that the shift supervisor was acting under a potential emergency situation and that responsibility for specifying conditions for entry into radiation areas rests with the Health Physics group.

In regard to the opinion expressed in your letter that this incident was the most significant event that had occurred at the Kewaunee Plant, we can only concur with that opinion if you meant to confine that statement to the area of Health Physics and personnel radiation protection.

JUL 2 1978

7905300050

We would further like to comment that in the investigation of this incident, there has been far too much emphasis placed on the dose received by the person involved rather than considering plant operations in relation to his actions. This incident should have been evaluated along with the fact that information had reached the shift supervisor that water was observed leaking around the hot and cold legs into the Reactor Coolant Pump vaults probably due to leakage from the reactor refueling seal ring. To evaluate whether there was a danger to personnel or plant equipment and to find what corrective action was required, a judgment decision to enter the reactor cavity area was made based on the information available on hand. We would be in real trouble if responsible operating personnel were overly restricted or hampered by the consequences of hindsight evaluations when such decisions would be a necessity in a real emergency. To best be prepared for emergencies and future events of this nature we can only hope to train to the best of our ability the operating personnel and support group personnel to provide the most accurate information available.

Should you desire to review this matter further, we are at your disposal.

Very truly yours,

E. W. James
Senior Vice President
Power Supply & Engineering

snf