WISCONSIN PUBLIC SERVICE CORPORATION

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

August 15, 1978

Mr. James G. Keppler, Reg Dir
Office of Inspection & Enforcement
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Rd
Glen Ellyn, IL 60137

Dear Mr. Keppler:

Docket 50-305
Operating License DPR-43
I & E Inspection Report 78-07

This letter is to inform your office of the results of our evaluation of the reactor vessel cavity exposure incident of May 2, 1978, and our review of the I & E Inspection Report 78-07 which addresses that event.

The event of May 2, 1978, as presented in the Inspection Report 78-07, indicated a general lack of procedural control and intimidation by a member of our supervisory staff, when in fact, a more complete investigation has revealed that the contrary is true and a personnel error was the cause of the event. The main differences between the investigation performed by members of your staff and our investigation was that the refueling coordinator and the auxiliary operator who also had involvement in the events of May 2, 1978, were included in our interviews. The main points of fact which were identified by inclusion of those individuals were:

1. The lead HP man was fully aware that an entry was desired to the Reactor Cavity and had dispatched a technician from within containment to outside containment for the purpose of acquiring what he apparently believed the necessary equipment to make such an entry assuming the radiation levels were within reason. That manner of dealing with the short term entry into the reactor cavity was consistent with proper control, procedures, and HP practice.

2. The HP technician was not known by the Shift Supervisor prior to the entry. Approximately five minutes after the Shift Supervisor's departure from the cavity area after the entry, the HP technician

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inquired as to whom the individual was that made the entry. At that time he was informed that it was the Shift Supervisor.

3. The HP Supervisor was first informed of the event by the lead HP man on site in such a manner so as to indicate that the exposure was minor in magnitude. At the insistence of the Night Refueling Coordinator, the HP Supervisor was requested to investigate the event immediately.

The above, when considered in the context of the other statements and information discussed in the inspection report, leads us to conclusions significantly different than those presented in the inspection report.

It appears that the implied intimidation by the Shift Supervisor identified in the Inspection Report paragraph f could not have occurred. It is most difficult to accept the scenario when item 2 above is considered in the evaluation.

We find that the lead HP man on site was apparently in concurrence with the decision to enter the reactor vessel cavity and believed that no major problem existed. That position is confirmed by the action taken following the entry and acknowledgement of a full scale dosimeter reading upon exit. Had the lead HP man believed that very high radiation fields existed to the extent that entry would have been precluded, his actions following the entry would have been different. The HP Supervisor was apparently not alerted to the potential of overexposure by the first call by the lead HP man at about 0330 since a second call was necessary to alert him of the significance of the event. That sequence could only have occurred had the lead HP man indicated that no problems of significance existed to the HP Supervisor.

As a result of the above considerations, which were not included in the inspectors investigation, we find that the conclusions presented in the Inspection Report and the subsequent Enforcement Action to be in error. It is clearly evident that the HP group did not acknowledge the existence of a 2000 R field in the Reactor Cavity due to an incomplete survey by one of their contracted personnel which we consider a personnel error. It is also clearly evident that the Shift Supervisor followed proper procedure and established practice in his requesting HP assistance prior to the entry. With the obvious human error by the HP group in the failure to completely assess the hazards within the reactor cavity and the acknowledgement that intimidation could not have occurred, the conclusions presented in the I & E Inspection Report are not supported by fact and we cannot concur with them.

Should you desire to pursue this matter further, please contact me personally.

Very truly yours,

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

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