

## WISCONSIN PUBLIC SERVICE CORPORATION



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

January 14, 1982

Mr. R. F. Heishman, Chief  
 Reactor Operations and Nuclear Support Branch  
 U. S. Nuclear Regulatory Commission  
 Region III  
 799 Roosevelt Road  
 Glen Ellyn, IL 60137

Dear Mr. Heishman:

Docket 50-305  
 Operating License DPR-43  
IE Inspection Report No. 50-305/81-18

The subject report was issued following a routine inspection conducted by Messrs. R. L. Nelson and B. E. Fitzpatrick on September 1-30, 1981, of activities at the Kewaunee Nuclear Power Plant. Three items were identified as non-compliances and cited by this report. The attachment to this letter provides our response to these items.

Very truly yours,

*E. R. Mathews*

E. R. Mathews, Senior Vice President  
 Power Supply and Engineering

snf

cc - Mr. Robert Nelson, NRC

Subscribed and Sworn to  
 Before Me This 14th Day  
 of January 1982

*Susan A. Tol*  
 Notary Public, State of Wisconsin

My Commission Expires March 24, 1985

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ATTACHMENT

Response to I.E. Inspection Report 81-18

Item 1: Non-Compliance

Technical Specification 3.3.d.1 states, in part, "The reactor shall not be made or maintained critical unless the following conditions are satisfied....All necessary valves required for the functioning of the Service Water System during accident conditions are operable."

Contrary to the above, on October 16, 1981, while operating at approximately 100% power, the two service water valves (SW-1300A and B), which are required to automatically open during the safety injection sequencing, would not have operated as required in the event of a LOCA with loss of off-site power. This condition existed for approximately 50 minutes.

RESPONSE: A review of this incident revealed that the non-compliance was a result of operator error. Due to unrelated maintenance being performed on 1B Emergency Diesel Generator and 1A Component Cooling Heat Exchanger, the Licensed Personnel involved failed to realize that the two service water valves (SW-1300A and B) would not have automatically opened as required if a LOCA and loss of power would have occurred simultaneously.

In the event of a LOCA with loss of off-site power, the service water supplied by these valves would not have been required before a minimum of 60 minutes into the event. Existing emergency procedures would have specifically directed the operators to manually open the valves prior to their being required to mitigate the accident.

Our review revealed seven independent controls to maintain in-service redundant counterpart equipment. For this event the following administrative means were available to ensure the redundant essential component would remain operable. These included:

- a. Temporary Operating Procedure - Removing 1A Component Cooling Heat Exchanger from Service.
- b. Shift Supervisor's Log
- c. Control Operator's Log
- d. Shift Turnover Checklist
- e. Status Board
- f. Approval of Shift Supervisor to start maintenance activities
- g. Requirement for a licensed operator to remove the component from service.

To prevent recurrence of the error, a discussion was held with the personnel involved, stressing the importance to follow Technical Specifications when critical pieces of equipment are taken out of service and the possible consequences of the event. In addition, another administrative control will be instituted by February 1, 1982, to provide means of reminding the operator to verify that a piece of safeguard equipment can be taken out of service.

Item 2: Non-Compliance

Technical Specification 6.13.1 states, in part, "Each High Radiation Area in which the intensity of radiation is greater than 100 mrem/hr, but less than 1000 mrem/hr, shall be barricaded and conspicuously posted as a High Radiation Area... Each High Radiation Area in which the intensity of radiation is greater than 1000 mrem/hr shall be subject to the above, and in addition locked doors shall be provided to prevent unauthorized entry into these areas.

Contrary to the above, a barrel was found to have a radiation reading of 4500 mrem/hr at 6 inches, with general area readings of 300-400 mrem/hr. Neither the barrel nor the area was barricaded or posted as a high radiation area.

RESPONSE: The barrel contained used filters and was located in the Filter Room. The Filter Room is one of four rooms located off of a shared corridor. The corridor has locked gates at each end to prevent unauthorized entry into any of these four rooms. Due to work being performed in an adjacent room, the gate to the corridor was left open.

Plant and contractor personnel have been reminded of the importance of closing gates and doors used to prevent unauthorized entry into high radiation areas, and have been instructed to close the gates or doors when the areas are unattended. Additionally, to prevent further non-compliances each individual room off the corridor will be provided with a locked gate. These gates will be installed by March 1, 1982.

Secondly, regarding proper posting of high radiation areas, it should be noted that this area was initially posted. However, the sign used had fallen to the floor. Health physics personnel have been reminded of the importance of proper posting of high radiation areas and have been instructed to use proper posting techniques to prevent recurrences of this nature.

Item 3: Non-Compliance

Technical Specification 6.8.1 states, "Written procedures and administrative policies shall be established, implemented and maintained that meet the requirements and recommendations of Section 5.1 and 5.3 of ANSI N18.7-1972."

ANSI N18.7-1972, Section 5.3, states, in part, "Nuclear power plants shall be operated in accordance with written procedures."

Administrative Control Directive (ACD) 4.7 (Shift Supervisors Log) states in part, "All major changes of plant status, plant equipment, or plant systems shall be entered...".

Administrative Control Directive (ACD) 4.8 (Reactor and Control Room Log) states in part, "All significant operating events shall be entered...".

Contrary to the above, a review of the above logs indicated numerous omissions of required entries. As examples, on March 21, 1981, the Shift Supervisor's Log did not indicate that the "B" auxiliary feedwater pump was returned to service, and the Reactor and Control Room Log did not indicate starting and stopping of auxiliary feedwater pumps.

RESPONSE: With regard to the referenced non-compliance, the following corrective action has been or is being accomplished:

- a. An operations memorandum will be issued by February 1, 1982, to all licensed personnel addressing this non-compliance and its significance.
- b. During operator requalification training, the importance of including all pertinent information in the operations logs and shift supervisor logs will continue to be stressed.
- c. The Assistant Superintendent-Operations will continue to perform a review of the contents of all operations logs.