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 50-305/88-18.

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November 21, 1988

10 CFR 2.201

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Inspection Report 50-305/88018 (DRP)

Reference 1) Letter from R. C. Knop (NRC) to D. C. Hintz (WPSC) dated
October 21, 1988.

The attachment to this letter provides our thirty-day written response to the
Notices of Violation identified in Reference 1.

Sincerely,

A handwritten signature in cursive script that reads "C. R. Steinhardt".

C. R. Steinhardt
Manager - Nuclear Power

DSN/mjm

Attach.

cc - Mr. Robert Nelson, US NRC
US NRC, Region III

8811290038 881121
PDR ADOCK 05000305
Q PDC

LEO/

Attachment to November 21, 1988 Letter
From C. R. Steinhardt (WPSC) to Document Control Desk (NRC)

NOTICE OF VIOLATIONS

As a result of the inspection conducted from August 16, 1988 through September 30, 1988, and in accordance with 10 CFR Part 2, Appendix C - General Statement of Policy and Procedure for NRC Enforcement Actions (1988), the following violations were identified:

NRC Violation A

10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings" states, in part, "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings." This criterion is implemented by the licensee's Operational Quality Assurance Program, Section 12, "Plant Procedures," which states, in part, "Operating, test and maintenance activities affecting safety shall be described by and performed in accordance with written procedures of a type appropriate to the circumstances."

Contrary to the above, on July 16, 1988, two Instrument and Control Technicians failed to perform routine surveillance in accordance with plant surveillance procedure SP 45-50.17 "Radiation Monitoring Calibration Channel R-17." This action caused an electrical pulse to be generated by activities being performed on radiation monitoring channel R-17 to momentarily spike con-

denser air ejector radiation monitoring channel R-15 resulting in an automatic isolation of steam generator blowdown and sampling, which is an engineered safety feature.

This is a Severity Level IV violation (Supplement 1).

WPSC Response

Two Instrument and Control Technicians were in the process of returning channel R-17 to service after performing a calibration procedure when the spike occurred. One cause of this event was improper procedure performance. When returning the R-17 channel to service a step to deenergize the drawer by removing the fuses was not performed. During the discussion on pulling the fuses both I&C technicians should have been more inquisitive of each other and either performed the step as stated, or followed administrative controls to have the procedure revised to require not deenergizing the drawer.

A contributing cause to this event was an electrical spike of indeterminate origin. The failure to pull the fuses in this case should not have affected the R-15 instrument drawer. The two radiation monitoring channels are powered from the same instrument bus and the drawers are physically located next to each other in the control room panel. It is speculated that the unterminated detector coaxial cable became charged when it was connected to the energized instrument drawer. When the detector end was connected, the instantaneous change in its terminal impedance caused an electrical pulse that was also seen by the R-15 instrument drawer.

Licensee Event Report 88-009 dated 8-25-88 provides a detailed description of the event, cause of the event, analysis of the event, and provided the corrective actions to be implemented. Actions which have been taken to date are:

1. A meeting was held with the two I&C technicians and selected management staff to review the cause of the incident, the importance of procedure compliance, and the responsibilities of the first class technician in performance of surveillance procedures.
2. Meetings were held with the Assistant Manager Plant Maintenance and the entire I&C, Mechanical and Electrical Maintenance staffs to discuss procedural compliance and each individual's attendant responsibilities.
3. The Plant Manager guided an open discussion with his supervisory staff on plant procedures. Topics included the amount of detail in each department's procedures and the documentation which should be included.
4. The I&C department performed testing to determine why the spike on R-17 affected R-15. A power line monitor was installed on the primary power supply to R-15 and the event re-enacted. In four attempts one case produced a spike on R-15, however the source of the electrical pulse could not be identified.
5. To emphasize the importance of proper implementation of, and adherence to, procedures the Plant Manager has sent a letter to each member of the plant

staff detailing his concerns. The theme of this letter stresses his concern for quality over quantity of work being performed, the need to adhere to procedures, and if the procedure does not work to have it properly revised.

Based on the completion of these actions Wisconsin Public Service Corporation (WPSC) is in full compliance.

In addition, the following actions are planned:

Relative to this event and the event described in LER 88-008, additional training on procedures will be provided to the plant staff. The intent of the training will be to ensure all levels of the plant staff fully understand the requirements for procedures, as detailed in ANSI N18.7, and the consequences incurred when procedures are not properly followed. This training will be provided as part of the annual Quality Assurance/Quality Control training program which is anticipated to be completed by January 31, 1989.

NRC Violation B

Kewaunee Technical Specification 6.8.2, states, in part, "Changes to procedures ... which clearly do not change the intent of the procedure shall, as a minimum, be approved by two individuals knowledgeable in the area affected, one of which holds a valid SRO license at Kewaunee."

Contrary to the above, on June 16, 1988, an Instrument and Control technician while performing an approved surveillance procedure, removed the power fuses

for a radiation monitoring channel without first installing jumpers as required by the procedure. This sequential change to the procedure steps had not been approved as required by the Technical Specifications. Implementation of this unapproved change resulted in an actuation of some containment isolation valves, an Engineered Safety Feature.

This is a Severity Level IV violation (Supplement 1).

WPSC Response

The cause of this event was the responsible personnel's failure to recognize that since the actions taken were different from those detailed in the approved procedure, a temporary change to the procedure was necessary. A Plant Administrative Control Directive (ACD 1.12) entitled "Surveillance Procedures," which implements KNPP Technical Specification 6.8.2, requires that a temporary change to a procedure be initiated whenever plant conditions or procedural errors require a change to complete the procedure. The temporary change shall be reviewed and initialed by two members of plant management staff, at least one of which holds a Senior Reactor Operators license. These controls ensure actions to be completed which are different from those detailed in approved written procedures are adequately reviewed and evaluated prior to implementation.

Licensee Event Report 88-008 dated 7-18-88 provided a detailed description, cause, and analysis of the event, and provided the corrective actions to be implemented.

Immediate corrective actions included reinstalling the jumpers on R-15, reopening the steam generator blowdown and blowdown sampling valves, and satisfactorily completing the calibration procedure. The implications of this event have been discussed with the personnel involved. In addition, the licensee event report and a copy of ACD 1.12 has been routed to appropriate personnel to reemphasize the importance of obtaining the necessary reviews and approvals prior to performing actions different from those detailed in approved procedures. Based on the completion of these actions WPSC is in full compliance.

In addition, a design change, which had been initiated prior to this event, will be implemented to enable radiation monitors to be calibrated without requiring removal of additional radiation monitors from service. Based on this event the priority on this design change was increased.