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 SCHROCK, C.A. Wisconsin Public Service Corp.
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SUBJECT: Forwards response to violations noted Insp Rept
 50-305/93-22. Corrective actions: different crew successfully
 unloaded several shipping containers previous day.

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February 11, 1994

U.S. Nuclear Regulatory Commission
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Washington, DC 20555

Ladies/Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reply to Notice of Violation - Inspection Report 93-022

Reference: Letter from L. R. Greger (NRC) to C. A. Schrock (WPSC) dated January 12, 1994 (Inspection Report 93-022)

In the reference, the Nuclear Regulatory Commission (NRC) provided Wisconsin Public Service Corporation (WPSC) with the results of a routine inspection conducted from November 9 through December 22, 1993. During the inspection, the NRC identified one violation concerning the receipt inspection of new fuel. The attachment to this letter provides our response to this violation.

In the cover letter, the inspector noted that there appears to be a high threshold for documentation of personnel errors and procedure deficiencies and that this may be indicative of a weakness in communicating management's expectations for documentation of problems to the plant staff. This statement was made as a result of hesitation to document the problem identified by the notice of violation using the Incident Report Program.

Kewaunee uses various programs to identify problems and to determine causes and corrective actions. Some of Kewaunee's programs for identifying and documenting problems and weaknesses include: Quality Assurance (QA) Audits, Quality Control (QC) Inspection Checklists, Safety System Functional Inspection Program, Corrective Action Reports,

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Radiological Occurrence Reports, and Surveillance Procedure Exception Reports. All of these programs are used by individual departments to document and correct problems associated with their specific scope of responsibilities. The Incident Report Program is used to document problems that may require reportability and operability determinations, or problems that may signify weaknesses which could lead to more significant events, or any problem that may require further review.

In the specific instance which resulted in the notice of violation, the responsible supervisor took immediate corrective action as discussed in the attachment to this letter. An Incident Report was not immediately initiated because: the problem was isolated, no reportability or operability concerns existed, and the safety significance of the event was minimal. Therefore, the responsible supervisor concluded the problem did not meet the threshold for an Incident Report. QC personnel were present and documented the problem in a QC Inspection Checklist and QA personnel noted it in their report as an "Observation". Therefore, even if an Incident Report was not initiated, the problem with procedure compliance was documented for appropriate management review. If an Incident Report had not been initiated for this event, one could have been initiated at any time during notification and/or discussion with Plant Licensing or management personnel if it was decided that further review into the cause of this event was warranted.

WPSC's corrective action programs are under continuous review for improvement. The threshold for initiation of an incident report is being reviewed as part of this process. This particular event will be considered in this review. In addition, methods to track and trend the findings from other corrective action programs are being considered.

Sincerely,



Charles A. Schrock
Manager - Nuclear Engineering

DLR

Attach.

cc - US NRC, Region III
US NRC Senior Resident Inspector

ATTACHMENT 1

to

Letter From C.A. Schrock (WPSC)

to

Document Control Desk (NRC)

Dated: February 11, 1994

Re: Inspection Report 93-022

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NRC Notice of Violation

Technical Specification 6.8.a requires implementation of procedures that meet the requirements of Section 5.3 to ANSI N18.7-1976, "Administrative Controls and Quality Assurance for the Operational Phase of Nuclear Power Plants." Paragraph 5.3.4.5 of Section 5.3 to ANSI N18.7-1976 states that fuel handling (including receipt inspection of fuel) shall be performed in accordance with written procedures. Procedure RE-22, "Receipt and Inspection of New Fuel," implemented this requirement and specified in steps 4.4.14 through 4.4.17 the sequence for removing a fuel assembly from a shipping container.

Contrary to the above, on December 14, 1993, an individual improperly implemented procedure RE-22 by not removing the fuel hold down clamps in the sequence specified. (305/93022-01 (DPR)).

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

WPSC Response

WPSC agrees that this event was a failure to follow fuel handling procedure RE-22, "Receipt and Inspection of New Fuel," as required by Technical Specification 6.8.a. WPSC has determined that the cause of this event is attributable to personnel inattention to detail. A contributing cause was ineffective on-the-job training.

After this event occurred, the two fuel assemblies in the shipping container were removed without further incident. The Reactor Engineering Supervisor then stopped the unloading process and held a discussion with the crew. This discussion stressed personnel safety, the need to follow procedures, and that there were no schedule constraints and therefore no reason to hurry. Following this discussion, the remaining shipping containers were unloaded without incident. Similar discussions were held following any crew changes.

WPSC recognizes that improvements can be made to minimize the probability of a similar event. Procedure RE-22 and the video tape used to train personnel on receipt of new fuel, identifies that the upper half clamp is not to be removed from a fuel assembly until the new fuel handling tool is attached and the slack in the sling is taken up. The on-the-job training provided to individuals did not include a discussion at each step in the process during the actual unloading of a fuel assembly. Normally, a member of the reactor engineering department is present whenever a new crew is assigned to new fuel receipt and observes the unloading process while providing input as deemed necessary. The following examples show that the training, in general, had been adequate to ensure successful unload of new fuel: 1) the crew involved with this incident had successfully unloaded one container (two assemblies) prior to this incident; 2) A member of this crew was also responsible for identifying the failure of the individual to follow the procedure; 3) A different crew had successfully unloaded several shipping containers the previous day.

However, the training does not require each specific procedure step to be performed by the same individual for each fuel assembly. In this event, the person responsible for prematurely removing the top half clamps had not performed this task on the other shipping container that was unloaded that day. Therefore, the on-the-job training was ineffective in training each crew member to the same level of knowledge.

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WPSC will provide more detailed on-the-job training to each new crew by providing detailed guidance during the unloading of their first fuel cask. The level of detail of this on-the-job training will be commensurate with the experience and demonstrated knowledge of each individual involved with the process. This will ensure that individuals involved will have success unloading a fuel assembly with reactor engineering supervision present and will be provided the opportunity to ask questions to enhance the training. It will also be stressed to follow the procedure and to stop the process if any questions or problems arise during unloading in order to resolve the issue prior to continuing. WPSC believes this will ensure that each crew member is knowledgeable of the total fuel unloading process and not an isolated portion of it.