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MARCHI, M. L. Wisconsin Public Service Corp.
RECIP. NAME RECIPIENT AFFILIATION
 Document Control Branch (Document Control Desk)

SUBJECT: Forwards response to NRC 950801 ltr re violaitons noted in
insp rept 50-305/95-08 on 950526-0709. Corrective actions:
PMP 42-12-2 has been revised & processed.

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WISCONSIN PUBLIC SERVICE CORPORATION

600 North Adams • P.O. Box 19002 • Green Bay, WI 54307-9002

August 31, 1995

10 CFR 2.201

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

Ladies/Gentlemen:

Docket 50-305
Operating License DPR-43
Kewaunee Nuclear Power Plant
Reply to Notice of Violation, Inspection Report 95-008


Reference: Letter from M. J. Farber (NRC) to M. L. Marchi (WPSC) dated August 1, 1995 (Inspection Report 95-008).

In the reference, the Nuclear Regulatory Commission (NRC) provided Wisconsin Public Service Corporation (WPSC) with the results of the routine safety inspection conducted May 26 through July 9, 1995.

During the inspection, the NRC identified two Severity Level IV violations. The first concerned inadequate procedure process controls to preclude the use of procedures that are in the revision process. The second concerned inadequate surveys of work activities under radiological conditions to preclude personnel overexposure. Attached are our responses to the violations.

In addition, the Notice directs us to distribute a copy of our response to the "NRC Resident Inspector at the Callaway Nuclear Power Plant." According to discussions held with the Senior Resident Inspector at Kewaunee, the distribution should be changed from the Callaway Resident to the Kewaunee Resident. Therefore, we are distributing this reply accordingly.

Sincerely,


Mark L. Marchi
Manager - Nuclear Business Group

GIH

Attach.

cc: US NRC Senior Resident Inspector
US NRC Region III

9509050261 950831
PDR ADOCK 05000305
PDR

ATTACHMENT 1

Letter from M. L. Marchi (WPSC)

To

Document Control Desk (NRC)

Dated

August 31, 1995

Re: Reply to Notice of Violation, Inspection Report 95-008

Document Control Desk
August 31, 1995
Attachment 1, Page 1

NRC Notice of Violation 95-008-001

10 CFR 50, Appendix B, Criterion VI, "Document Control," requires that measures to control procedures which prescribe activities affecting quality shall assure that changes are distributed to and used at the location where the prescribed activity is performed.

Contrary to the above, on or about April 7, 1995, measures to control procedure PMP 42-12-2, "DG 1B Associated Relays 60 Month Test and Calibration," were inadequate to prevent its use without a revision having been incorporated.

WPSC Response

Wisconsin Public Service Corporation does not contest this violation.

Reason For Violation

This specific event was caused by a failure to place a notice in the plant Preventive Maintenance Procedure (PMP) working files indicating the procedure in question was in the revision process. This resulted in an unexpected restart of the 1B emergency diesel generator following testing.

A similar unexpected restart of the diesel occurred prior to the 1994 refueling outage. As a result, Design Change Request (DCR) 2746 was implemented during the outage. This DCR raised the setpoint of the diesel shutdown timing relay. Consequently, a revision to PMP 42-12-2 was submitted to raise the relay calibration setpoint.

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August 31, 1995
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During the 1995 refueling outage a decision was made to verify the relay setpoint to confirm its setting from 1994. This required using PMP 42-12-2. Normally this procedure would not have been scheduled to be performed until 1999, sixty months from its last performance. The decision to perform the procedure during the 1995 outage was a conservative measure to confirm the stability of the relay setting after a year of operation. Since the procedure revision submitted as part of the DCR had not been completed before the 1995 calibration, and controls were not implemented to forewarn personnel of the revision in process, the relay setpoint was returned to the pre-DCR value.

The maintenance group has a procedure control process which requires placing a notice in the working files when a procedure is in revision. The purpose of this notice is to inform personnel of any restrictions placed on the procedure which must be given consideration prior to the procedure being used. Personnel involved in processing the revision to the subject procedure failed to perform this activity.

Why the personnel involved in the procedure revision process failed to place the notice is not specifically known. The lack of guidance in the plant directives which provide for development and processing of changes to procedures is considered a contributor to the cause of this event. Plant procedure processing directives do not provide for this function; as such, there are no prescribed actions which personnel are required to follow to implement the actions to preclude

use of procedures which are in revision. Secondly, no personnel responsibilities are described as to who is responsible for implementing the controls. An additional contributing factor may have been that the individual(s) involved with initiating the revision may not have been familiar with the process.

Corrective Actions

Preventive Maintenance Procedure (PMP) 42-12-2 has been revised and processed. Planned corrective actions are to hold discussions as to the extent and appropriate location for changes to plant directives to ensure adequate procedure revision processing controls.

The primary objective of future discussions will be to determine the most appropriate method for implementation of formal guidance to control procedures in revision. A secondary objective will be to determine the most beneficial mechanisms to control procedures which are workable among the various groups which will be impacted by any proposed changes.

At this time it is anticipated that revisions to Nuclear Administrative Directive (NAD) No. 3.1, "Nuclear Administrative Directives," and NAD No. 3.2, "Plant Procedures," will be made. These are the primary plant guidance documents for developing and revising plant procedures. The proposed revisions will likely include specific actions to be performed to determine and document whether restrictions should be placed on the use of plant procedures while they are

in the revision process. The revisions will likely also include specific directions on how to implement any control mechanisms that are determined to be needed.

In addition to, or as an alternative to, revisions to the directives described above, revisions to individual groups procedure development and revision processing directives may be necessary. The need and extent of revising the necessary directives will be based upon the outcome of the discussions among the responsible groups. It is our intent to implement a revision control process that least impacts our existing procedure control programs and best suits the needs of the various groups which will be impacted.

Compliance Schedule

The actions described above are expected to be completed by December 31, 1995. We believe this time frame to be acceptable to provide ample review of any proposed changes and incorporate additional changes that may be found to be necessary during the revision review process. Additionally, the urgency for the need for change is not considered to be great. Although there is basis for the violation and the need for corrective actions are evident, failure to properly control procedures in the revision process is not a pervasive problem at Kewaunee.

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NRC Notice of Violation 95-008-002

10 CFR 20.1501 requires that each licensee make or cause to be made surveys that may be necessary for the licensee to comply with the regulations in Part 20 and that are reasonable under the circumstances to evaluate the extent of radiation levels and the potential radiological hazards that could be present.

Pursuant to 10 CFR 20.1003, *survey* means an evaluation of the radiological conditions and potential hazards incident to the presence of radioactive material or other sources of radiation.

Contrary to the above, during the steam generator repair work performed during the 1995 refueling outage, the licensee did not perform surveys to assure compliance with 10 CFR 20.1201(a)(1), which requires, in part, that the licensee control the occupational dose to individual adults to an annual limit of 5 rems (0.05 Sv), total effective dose equivalent. Specifically, the licensee failed to evaluate the full extent of work necessary for the steam generator annular search, and as such, failed to evaluate the potential dose to the upper arms of workers performing the specific work.

WPSC Response

Wisconsin Public Service Corporation does not contest this violation.

Reason for Violation

This specific event was caused by a failure to relocate whole body dosimetry from the chest to the upper arm during Steam Generator Annular Search. This resulted in the upper arm of several workers being exposed to a highly non-uniform radiation field without proper dosimetry placement leading to a potential for overexposure.

During the refueling outage the steam generators are drained and the secondary side of the tube bundle is washed and sludge is removed. After this is complete, video equipment is used to record and inspect the steam generator tubesheet annulus per KNPP procedure PMP 06-04. Access to the secondary side of the steam generators is through a 6" flanged handhole.

During the annular search a small video probe is used to inspect the tubesheet annulus. Typically a "fish tape" is inserted around the annulus and the video probe is pulled through the annulus during inspection. During the 1995 Outage, the sludge lance group leader decided to push the video probe through the annulus and perform the inspection. This saved time and exposure by not having to insert the smaller "fish tape." During this evolution the camera and cable would bind on the tube bundle and an operator would need to insert an arm past the elbow into the generator handhole to move the camera. This evolution was done several times without the Radiation Protection (RP) group moving whole body dosimetry from the chest to the upper arm. Additionally, during the "A" Steam Generator Annular search, the worker saw a small piece of metal. Also, the loose part was retrieved from the annular area without moving dosimetry.

During a normal routine inspection of containment a Radiation Technician observed a worker reaching into the "B" Steam Generator handhole. The worker's dosimetry was not in the correct position, and the technician halted the work in progress to instruct the worker and move the

dosimetry to the upper arm location. The work in the "A" Steam Generator was already completed.

The worker completed the task with the dosimetry on the upper arm. Upon completion of the task several minutes later, the worker noticed that the two Self Reading Pocket (SRD) ion chambers were offscale high (0-200 and 0-500 mR scale). The worker immediately notified Radiation Protection. A Radiological Occurrence Report (ROR 95-04) was generated to investigate the incident, determine root cause, and recommend corrective actions.

As a whole, the cause of this event is attributed to a lack of common understanding of the full work scope. This is attributed to insufficient communications between the RP group and the group performing the activities in the generators. Additionally, expectations of the individuals involved in this event were not effectively communicated.

Corrective Actions

Immediate actions were performed to determine and assign dose per 10CFR20.1201(c). A Radiological Occurrence Report (ROR 95-04) was generated to investigate the incident.

A group discussion was held with RP personnel and several plant personnel to discuss ROR 95-04. The purpose of the group discussion was to clarify the issues along with identifying

corrective actions to prevent recurrence. During the discussions, it was agreed that successful radiation protection practices require a mutual effort by workers and radiation protection personnel. Workers should have the basic knowledge to safely perform assigned tasks and feel free to question changes in conditions or clarify anything with which they are not comfortable. The Radiation Technologists (Techs) should have adequate knowledge to answer questions and identify and correct conditions adverse to established radiation protection and safety policies. The Techs and workers must approach all situations with mutual respect.

Proposed corrective actions are:

- 1) Provide training so workers and Techs will be better prepared for situations where the unknown exists. General Employee Training (GET), Initial and Refresher, training will be strengthened to include the following :
 - a. Concentration on the different classifications and dose limits for the body.
 - b. Stressing that the dosimetry devices should be worn in the location where the whole body is exposed to the highest source of radiation and that the SRD should be checked regularly.
 - c. The worker should question placement of dosimetry but should only move dosimetry devices to other areas of the body after consultation with RP personnel.

- 2) The pre-refueling safety meeting will be utilized by RP personnel to refresh workers on radiation protection concerns. The safety meeting is held just prior to each outage.
- 3) WPSC Techs along with contracted Techs will receive refresher training prior to each outage. The training will include ALARA pre-brief material for jobs scheduled during the outage. It will also include reviews of significant events and lessons learned from previous outages along with a schedule of work planned for the upcoming outage.
- 4) ROR 95-04 will be included in future ALARA briefings as lessons learned and will be included in required reading for all Techs.
- 5) Procedure changes will include additional guidance on dosimetry placement and monitoring of the whole body and extremities.

During the group discussion it was agreed that all special situations cannot be planned for. However, through training and continued education of the worker and the RP Techs, the ability to recognize special situations when they occur will be improved and, knowledge will empower the individuals to make correct and safe decisions.

Compliance Schedule

Those corrective actions completed immediately were; determined the exposure to affected personnel; and initiated the ROR. Further corrective actions already taken included the discussions amongst the RP group and plant personnel who require their support.

The status of yet to be completed corrective actions are:

- 1) The lesson plans in Item 1 above have been changed and GET Initial training is in progress.
- 2) Items 2, 3 and 4 will be completed prior to the next scheduled refueling outage in September 1996.
- 3) Item 5 will be completed by December 31, 1995.