

# CATEGORY 1

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SUBJECT: Responds to NRC 961018 ltr re violations noted in insp rept  
50-305/96-06.Plant operating procedure for control room air  
conditioning sys has been revised to include administrative  
LCO.

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**WISCONSIN PUBLIC SERVICE CORPORATION**

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

November 18, 1996

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 96-006

- References:
- 1) Letter from J. L. Caldwell (NRC) to M. L. Marchi (WPSC) dated October 18, 1996 (NRC Integrated Inspection Report 50-305/96006).
  - 2) Letter from G. E. Grant (NRC) to M. L. Marchi (WPSC), dated October 25, 1996 (NRC Engineering and Technical Support Inspection Report No. 50-305/96008).
  - 3) Letter from J. M. Caldwell (NRC) to M. L. Marchi (WPSC), dated September 13, 1996 (NRC Integrated Inspection Report 50-305/96005).

In reference 1, the Nuclear Regulatory Commission (NRC) provided Wisconsin Public Service Corporation (WPSC) with the results of NRC inspection activities conducted June 28 through August 12, 1996.

During the inspection, NRC identified three Severity Level IV violations. The violations were: 1) failure to place hold tags to control equipment during maintenance as required by plant procedure, 2) failure to implement corrective actions in a timely manner by not establishing administrative controls on the control room cooling system, and 3) use of a surveillance procedure acceptance criteria that was inconsistent with the small break loss-of-coolant accident analysis. The first condition was cited as being contrary to Kewaunee Technical Specification 6.8.3, the second was contrary to 10 CFR 50, Appendix B, Criterion XVI, and the third was contrary to 10 CFR 50, Appendix B, Criterion V.

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Attached is our response to the notice. If you have any questions with regard to this response, please contact me or a member of my staff.

Sincerely,



Mark L. Marchi  
Manager - Nuclear Business Group

GIH

Attach.

cc: US NRC Senior Resident Inspector  
US NRC Region III

ATTACHMENT 1

Letter from M. L. Marchi (WPSC)

To

Document Control Desk (NRC)

Dated

November 18, 1996

Re: Reply to Notice of Violation, Inspection Report 96-006

NRC Notice of Violation 96-006-001

Technical Specification 6.8.a requires implementation of procedures that meet the requirements of ANSI 18.7-1976, "Administrative Controls and Quality Assurance for the Operational Phase of Nuclear Power Plants". Section 5.2.2, "Procedure Adherence", of ANSI 18.7-1976, requires that procedures be followed. Procedure CMP 21-1 (Revision D), "Spent Fuel Pool Filter 1A and 1B Filter Replacement", requires the use of hold tags when replacing spent fuel pool filters.

Contrary to the above, on October 20, 1995, the spent fuel pool filters were replaced without the use of hold tags as required by procedure CMP 21-1.

WPSC Response

Wisconsin Public Service Corporation (WPSC) does not contest this violation. Our assessment of the condition has concluded that the personnel involved failed to implement maintenance procedure requirements. Our assessment of the significance of the condition specific to the event concluded that there were no significant safety hazards involved. There were no personnel injuries and no risks to plant personnel. Plant equipment during the maintenance process was properly isolated to preclude personnel injury notwithstanding the failure to place hold tags. However, our assessment of this event has concluded that a broader problem is evident; plant personnel do not appear to be adhering to procedures as expected at all times.

Reason For Violation

This event was caused by personnel failing to implement procedural requirements.

Spent Fuel Pool (SFP) system filters are changed routinely as they become plugged. Corrective Maintenance Procedure (CMP) 21-1, "Spent Fuel Pool Filter 1A and 1B Filter Replacement," lists the steps to perform the task. CMP 21-1 specifies the valve configurations and sequence for isolating, draining and restoring the filters to service. In addition to listing the required steps for performing filter replacement, the CMP directs the placement of hold tags on the valves used for

isolation. In this case personnel involved in changing the filters did not place hold tags on the isolation valves as the procedure required.

Discussions with the personnel involved revealed that they had not referred to the procedure when performing the task. The personnel relied on 'skill of craft' as opposed to having the procedure present. This is not unusual in that the task is not complex and is performed routinely on the SFP and other systems requiring filter replacement with the basic actions being similar in all cases.

Skill of craft is an acceptable manner in which various tasks can be performed. However, when this practice is used, the individual(s) involved shall have the procedural requirements committed to memory such that having the procedure present is not necessary. In this case, since the requirement for tagging was not performed, the personnel did not have the procedure memorized and should have referred to the procedure prior to performing, or had the procedure in hand while performing the task.

This event along with other recent events is viewed as an indication that personnel performance is not up to the standards expected at Kewaunee. A number of unacceptable work practices have been identified which could have been avoided had existing procedures been followed. Although the consequences of this and other events individually have been insignificant, they indicate that personnel performance is not meeting our expectation. This is viewed as a significant concern at WPSC.

A contributing factor in this event is a discrepancy between procedure CMP 21-1 and procedure CMP21-2. CMP 21-2, "SFP Demineralizer Prefilter & Postfilter, Filter Replacement," is used to change other SFP system filters. The conditions of the SFP system are the same (the filters are

isolated from the remainder of the operating SFP system); however, CMP 21-2 does not require the use of hold tags. Given the nature of the task and the condition of the system under which the filters are changed, the requirements for tag usage should be the same.

Regardless of the differences between the procedures, expectations are that procedures be adhered to, or if problems are identified, properly changed using existing administrative controls. Personnel performance has been the subject of a number of previous events identified internally and both by the NRC (reference 3) and INPO. Although training and discussions have been held with individual plant groups, these efforts do not appear to have been fully effective in preventing recurring problems.

#### Corrective Actions

Actions taken to date have included discussions and training with various plant groups. This event was also used as an example during non-licensed operator continuing training on the Kewaunee internal corrective action process. Reviews of the Operations tagging data base indicates that hold tags have been used during recent SFP filter replacements.

WPSC has been and continues to monitor personnel performance issues. We recognize the need to determine where we may have deficiencies in the guidance we provide to plant personnel. Our objective is to identify where the needs for corrective actions are and implement them. Although there is no evidence to indicate that the problem has grown to a point where there is a significant safety concern, WPSC recognizes the need to implement further corrective measures to gain better control of the issue.

WPSC has previously committed to implement corrective actions in regard to personnel performance following an external assessment. It is our intent to conduct more evaluations and training dealing with personnel performance and management expectations.

The inconsistency between the SFP system filter changing procedures will be corrected.

#### Compliance Schedule

It is our intent to complete corrective measures to address personnel performance issues during the first quarter of 1997. The procedure revisions are expected to be completed by January 1, 1997.

#### NRC Notice of Violation 96-006-002

10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action", requires that conditions adverse to quality be promptly identified and corrected.

Contrary to the above, as of August 12, 1996, the lack of administrative controls for control room cooling system operability, a condition adverse to quality, had not been corrected. This condition was initially identified in September 1992.

#### WPSC Response

WPSC does not contest this violation. Our assessment agrees with the NRC's assessment that the corrective actions for Incident Report (IR) 92-129, could have been implemented in a more timely manner. IR 92-129 recommended an administrative limiting condition for operation (LCO) be developed for the control room chillers. Implementation of an administrative LCO for the control room chillers would decrease the probability of both chillers being inoperable at the same time. WPSC's assessment also determined that although the corrective actions could have been implemented in a more timely manner, failure to do so had no safety impact. Furthermore, implementation of the administrative LCO was an internal commitment which exceeded the requirements identified in Kewaunee's Technical Specifications. As a result, personnel involved in the event did not persistently pursue the completion of the task.



Reason for the Violation

The evaluation for IR 92-129 was presented to the Plant Operations Review Committee (PORC) in September and October of 1992. During these meetings the PORC did not endorse the recommendation to institute an administrative LCO for the control room chillers. The PORC believed that existing operating philosophy and procedures were sufficiently conservative to ensure safe operation of the plant and, therefore an administrative LCO was not needed.

The engineer who evaluated the IR was given an action item to provide additional justification for the proposed allowed out of service times. In January of 1995, the IR evaluation was again presented to the PORC for its acceptance of the recommendation or to close the IR without endorsement of the recommendation. At this time, the PORC accepted the recommendation and added a request that an analysis be performed to determine what affect control room chiller inoperability has on equipment in the relay room and control room. In April of 1996, it was determined that a detailed analysis of the heating loads would not result in any additional operational flexibility.

The recommendation was given to the Operations Group for disposition of the recommended action. However, it was not clear to the responsible individual that the issue of concern was equipment cooling. Rather, the focus appeared to be upon the need for Control Room Air Conditioning (CRAC) fan operation to support the design air flow for the Control Room Post Accident Recirculation (CRPAR) system. Again, the Operations Group did not sense an urgency to implement the Administrative LCO.

A review of Abnormal Operating Procedures along with electrical logic drawings resulted in an internal letter dated March 11, 1996. This letter indicated the system would perform as required post accident and solicited further information on the results of heat removal analysis before

initiating an Administrative LCO. The response to that solicitation was that an analysis would be required to avoid the imposition of an Administrative LCO but probably would never be needed as a contingency for one or both trains of CRAC exceeding an LCO. Therefore, it was deemed prudent to initiate a procedure revision for an Administrative LCO.

Although this event was caused by contributing factors which resulted in a lack of aggressive pursuit in implementing the corrective actions, we recognize a need for further evaluation of timeliness in completing corrective actions from the IR process. A review of the IR data base revealed a significant backlog of open corrective actions. This backlog has also been recognized as part of the overall backlog of engineering activities during a recent NRC inspection (reference 2).

#### Corrective Actions

The plant operating procedure for the control room air conditioning system has been revised to include the administrative LCO.

A more detailed review of the open IR corrective actions will be performed. The purpose of this review will be to determine:

- 1) the significance of the items that remain open,
- 2) whether the corrective actions are still necessary, and
- 3) if any common factors exist which may have caused untimely implementation of the corrective actions.

Based upon what is identified in 2), we will establish a deadline for implementation of any outstanding corrective actions. If item 3) concludes there is a common causal factor, we will determine the appropriate actions to preclude further occurrence.

### Compliance Schedule

Due to the scope of the intended corrective actions it is anticipated that a considerable amount of effort will be necessary. Therefore, we expect that we will be able to complete these actions before July 1, 1997.

### NRC Notice of Violation 96-006-003

10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings", requires that procedures include appropriate acceptance criteria for determining that important activities have been satisfactorily accomplished.

Contrary to the above, on July 19, 1996, the inspectors identified that the 50 gpm acceptance criteria used in procedure SP 33-191 (Revision M), "Safety Injection Flow Test", was inconsistent with the 30 gpm maximum difference between cold leg flow rates assumed in the small break loss-of-coolant accident safety analysis.

### WPSC Response

WPSC does not contest this violation. Our assessment of the condition concluded that the discrepancy between Surveillance Procedure (SP) 33-191 and the accident analysis was the result of an administrative error. Our assessment of the consequences of the error revealed that at no time was the plant operated in an unanalyzed condition. Reviews of surveillance data records indicate that the recorded flows remained within the analyzed limits.

### Reason For Violation

The discrepancy between the SP and the accident analysis data is attributed to an administrative error that occurred when the acceptance criteria were added to the procedure.

SP 33-191, "Safety Injection Flow Test," procedure revision records were reviewed. This review revealed that the error occurred with revision G of the SP dated August 1, 1985. Included in the

revision records was the 'revision tracking sheet.' This tracking sheet documented adding the cold leg flow balance acceptance criteria. However, the basis as stated on the revision tracking sheet does not specifically identify the source of information used to develop the revisions.

Reviews of Incident Report records and discussion with plant staff revealed that the procedure revision occurred subsequent to performing flow adjustments and testing on the SI system in 1985. The flow adjustments were necessary following a 1984 event where throttled valves in the SI system were inadvertently repositioned. Subsequent to this mispositioning, corrective actions were taken to determine the impact on system flow. These corrective actions were to test and adjust the SI system in accordance with pre-startup testing processes.

In order to determine the extent of work required and to ensure acceptable system performance, plant staff contacted Westinghouse for guidance on system design requirements. Westinghouse provided a memo from the Westinghouse Site Services Manager, dated 3/7/85. This memo referred to Westinghouse letter WPS-S-230 dated October 23, 1972. The subject of Westinghouse letter WPS-S-230 was the SI system acceptance criteria. Included in the letter was the cold leg flow balance acceptance criteria.

Subsequent to the testing, revision G to the SP was initiated. The revision was initiated in part due to the results of the system performance testing. The individual involved recalls that when the acceptance criteria was added to the procedure it was based upon the guidance provided in the Westinghouse letter. Since the appropriate design basis information was being used to support the procedure revision, the error found in SP 33-191 can be assumed to be caused by administrative oversight.

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Corrective Actions

Revision N to SP 33-191 was issued on 10/1/96. The revised procedure incorporates the proper acceptance criteria. No further corrective actions are necessary. This event is considered an isolated occurrence.

Compliance Schedule

None, all the corrective actions necessary have been completed.