# CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9707160002 DOC.DATE: 97/07/09 NOTARIZED: NO DOCKET #
FACIL:50-305 Kewaunee Nuclear Power Plant, Wisconsin Public Servic 05000305
AUTH.NAME AUTHOR AFFILIATION
MARCHI,M.L. Wisconsin Public Service Corp.
RECIP.NAME RECIPIENT AFFILIATION
Document Control Branch (Document Control Desk)

SUBJECT: Responds to NRC 970609 ltr re violations noted in insp rept 50-305/97-06.Corrective actions:counseled personnel on need for verification of sys conditions prior to initiation of work & emphasized communications between groups.

DISTRIBUTION CODE: IE01D COPIES RECEIVED:LTR 1 ENCL 1 SIZE: 7
TITLE: General (50 Dkt)-Insp Rept/Notice of Violation Response

NOTES:

| | RECIPIENT ID CODE/NAME | COPIES LTTR | COPIES ENCL | RECIPIENT ID CODE/NAME | COPIES LTTR | COPIES ENCL |
|---|---|---|---|---|---|---|
| | PD3-3 PD | 1 | 1 | LAUFER,R | 1 | 1 |
| INTERNAL: | ACRS | 2 | 2 | AEOD/SPD/RAB | 1 | 1 |
| | AEOD/TTC | 1 | 1 | DEDRO | 1 | 1 |
| | FILE CENTER | 1 | 1 | NRR/DISP/PIPB | 1 | 1 |
| | NRR/DRCH/HHFB | 1 | 1 | NRR/DRPM/PECB | 1 | 1 |
| | NRR/DRPM/PERB | 1 | 1 | NUDOCS-ABSTRACT | 1 | 1 |
| | OE DIR | 1 | 1 | OGC/HDS2 | 1 | 1 |
| | RGN3 FILE 01 | 1 | 1 | | | |
| EXTERNAL: | LITCO BRYCE,J H | 1 | 1 | NOAC | 1 | 1 |
| | NRC PDR | 1 | 1 | NUDOCS FULLTEXT | 1 | 1 |

C A T E G O R Y 1 D O C U M E N T

NOTE TO ALL "RIDS" RECIPIENTS:
PLEASE HELP US TO REDUCE WASTE! CONTACT THE DOCUMENT CONTROL DESK, ROOM OWFN 5D-5(EXT. 415-2083) TO ELIMINATE YOUR NAME FROM DISTRIBUTION LISTS FOR DOCUMENTS YOU DON'T NEED!

TOTAL NUMBER OF COPIES REQUIRED: LTTR 20 ENCL 20

NRC-97-73

**Public Service Corporation**
(a subsidiary of WPS resources corporation)
Kewaunee Nuclear Power Plant
North 490, Highway 42
Kewaunee, WI 54216-9510
414-388-2560

July 9, 1997

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 97-006

Reference: Letter from G. E. Grant (NRC) to M. L. Marchi (WPSC) dated June 9, 1997 (NRC Integrated Inspection Report 50-305/97006 and Notice of Violation).

In the reference, the Nuclear Regulatory Commission (NRC) provided Wisconsin Public Service Corporation (WPSC) with the results of the NRC inspection activities conducted March 31 through May 12, 1997.

During the inspection, NRC identified two Severity Level IV violations. The Level IV violations were cited due to failure to follow plant procedures. The first violation was related to work activities being performed on the service water system piping without proper isolation of equipment. The second was associated with the manner in which scaffolding was erected and controlled.

According to the instructions contained in the Notice of Violation, WPSC was only requested to respond to the first violation. Attached is our response to the notice. If you should 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

9707160002 970709
PDR ADOCK 05000305
Q PDR

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

July 9, 1997

Re: Reply to Notice of Violation, Inspection Report 97-006

NRC Notice of Violation 97-006-02 (305/97006-02)

Technical Specification 6.8.a requires that procedures be established and maintained. General Nuclear Procedure GNP 3.3.1 (Revision D), "Tagout Processing," directs that work on a system component may proceed only after tagout posting and verification and upon approval from the Control Room Supervisor.

Contrary to the above, the licensee identified that on April 22, 1997, work on a service water pipe union was commenced prior to tagout posting and verification and without the approval of the Control Room Supervisor.

WPSC Response

Wisconsin Public Service Corporation (WPSC) does not contest this violation. WPSC's assessment of the event concluded that work was performed without proper verification of component isolation. The causes of the event are attributed to inadequate communications between the individuals involved in performance of the maintenance activity and personnel error. WPSC's assessment of the consequences of the event revealed that at no time was the plant in a condition outside of design nor was nuclear safety challenged.

Reason For Violation

On April 22, 1997, while the plant was in Refueling shutdown, an Instrument Control (I&C) technician obtained authorization to install a temporary flow transmitter on the service water (SW) outlet piping of the B Safety Injection (SI) pump. As required, the I&C technician requested tags be hung by the Operations group to isolate the segment of piping where the temporary instrument would be installed. In order to install the instrument, the Mechanieal Maintenance group needed to remove a segment of piping. All the work was being performed using the Kewaunee work request process.

To support the instrument installation, a maintenance mechanic was instructed to provide support to I&C by removing a segment of the SW piping. Accordingly, the mechanic

proceeded to prepare a pipe union for disassembly in the segment of piping where the instrument was to be installed. This consisted of applying a penetrating lubricant and mechanically agitating the union in order to loosen any corrosion at the union. Without confirming that the system piping was properly isolated, the mechanic then began to loosen the union. Upon observing the mechanic applying force to the union as though to loosen it, the I&C technician quickly isolated the piping section. The I&C technician did not inform the mechanic that the system piping was not isolated nor did he stop the mechanic from attempting to loosen the union.

The errors that occurred were: 1) the mechanic involved failed to confirm the segment of pipe he was working on was isolated and tagged, 2) the I&C technician failed to inform the mechanic of the system status, and 3) the I&C technician failed to stop the mechanic when he observed the mechanic's actions.

According to the requirements of General Nuclear Procedure (GNP) 3.3.1, "Tagout Processing," following tag posting and verification, the Control Room Supervisor (CRS) informs the requestor that work may proceed. According to the requirements of the WPSC safety rules, the individual in charge of the work is responsible for requesting tags. The individual requesting the tags is also responsible for ensuring that tags are properly placed before work begins. The mechanic assumed that the presence of the I&C technician, who was the individual in charge, meant the system conditions were acceptable for work to proceed.

Additional factors found to be contributors to this event were:

1) The plant computer system was out of service. The Operations group normally initiates tags and tag control sheets using a computerized system. The operating shift was not aware that there was an urgent need for the tags which delayed

their issuance and hanging. This delay was attributed to ineffective communications between the personnel performing the work and the Operations crew.

2) The personnel in the field felt a sense of urgency to complete the work before the end of shift. Both the I&C technician and Mechanic felt that the work needed to be done promptly. Delays in the development of the tags delayed work and increased worker anxiety.

3) There was no prejob briefing on the work activity.

WPSC also recognizes that the inspection report noted that, "minimal supervisory oversight," was a contributing cause to the event. However, our assessment efforts did not identify this as a contributing factor.

Corrective Actions

The I&C and Maintenance groups were counseled on the need for verification of the system conditions prior to work being initiated. Emphasis was placed on not assuming systems are in the proper condition. Regardless of which group has responsibility for the work, each individual is responsible for ensuring that system conditions are acceptable before beginning work. Although this does not require that all participants in the work activity physically verify that tags are in place, they should be aware that the system is properly isolated. Emphasis was also placed on communications between groups to ensure full understanding of the nature of tasks being performed and ensuring understanding of system conditions prior to work.

The corrective actions described above are specific to communication problems as they relate to the event cited in the violation. However, we need to conduct further reviews of the other

factors found to be contributors to the event.

In addition to the actions needed to address the subject of this violation, WPSC needs to perform further reviews of plant data for similar occurrences. Similar events have been identified by our plant staff and entered into our self assessment/corrective action programs. A preliminary review of these events suggests that additional emphasis on procedural compliance issues is warranted. Further detailed review of the data from our self assessments will be performed, and appropriate corrective actions will be defined and implemented. The implementation schedule for those corrective actions will be developed based on the scope of the actions.

Although further review of corrective action program data is required, WPSC has initiated actions to correct previously identified personnel performance issues. An "Operational Performance Self-Assessment Team (OPSAT)," was developed to address personnel performance issues within the Operations group. The OPSAT submitted a comprehensive report to the Plant Operations Review Committee (PORC) which identified a large number of factors which contribute to poor personnel performance. The PORC requested the results of the OPSAT effort be distributed to all plant organizational groups. Plant wide distribution of this information was recognized as being beneficial in helping improve personnel performance.

Compliance Schedule

The corrective actions specific to communications for the violation have been completed. Further review of the contributing factors and data review from our corrective action programs will be performed. Definition of corrective actions based on these reviews will be completed by mid-October, 1997. Implementation of any additional corrective actions will be scheduled based on the scope of the actions. Corrective actions are estimated to be completed within an additional six months.