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POWER COMPANY

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NRC-93-084

July 12, 1993

Document Control Desk
U.S. NUCLEAR REGULATORY COMMISSION
Mail Station P1-137
Washington, DC 20555

Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO NOTICE OF VIOLATION
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

In a letter from Mr. L. R. Greger dated June 11, 1993, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for the Point Beach Nuclear Plant. the results of a routine safety inspection performed by Messrs. K. R. Jury and J. Gadzala from April 1 through May 24, 1993. This inspection report included a Notice of Violation (NOV). The NOV describes a violation of 10 CFR Part 50, Appendix B, Criterion XVI, Corrective Action.

We have reviewed this NOV and, pursuant to the provisions of 10 CFR 2.201, have prepared a written response of explanation concerning the identified violation. Our written response is included as an attachment to this letter.

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires in part that conditions adverse to quality, such as malfunctions and deviations, be promptly identified and corrected. For significant conditions, established measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The identification of significant conditions shall be documented and reported to appropriate levels of management.

IE01

This violation is based upon two perceived instances of noncompliance. The first example is characterized as a failure to properly document an equipment malfunction and the second, an example of inadequate corrective actions taken to avoid recurrence. As discussed in the attached reply, we believe that the first example is not a violation of 10 CFR 50, Appendix B, Criterion XVI. We agree that the second example is accurately described and constitutes a violation of Criterion XVI. The attached reply documents the basis for our position and we believe is responsive to your concerns and the requirements identified in your June 11, 1993, letter.

If you have any questions or require additional information regarding this response, please contact us.

Sincerely,

Bob Link
Vice President
Nuclear Power

KVA/jg

Attachment

cc: NRC Resident Inspector
NRC Regional Administrator

RESPONSE TO NOTICE OF VIOLATION

WISCONSIN ELECTRIC POWER COMPANY
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
DOCKETS 50-266 AND 50-301
LICENSE NOS. DPR-24 AND DPR-27

During a routine safety inspection performed by Messrs. K. R. Jury and J. Gadzala from April 1 through May 24, 1993, one violation of NRC requirements was identified. The identified violation was classified as a Severity Level IV. Inspection Report Nos. 50-266/93009(DRP) and 50-301/93009(DRP) and the Notice of Violation (NOV) transmitted to Wisconsin Electric on June 11, 1993, provide details regarding the violation.

In accordance with the instructions provided in the NOV, our reply to the alleged violation includes: (1) the reason for the violation, or if contested, the basis for disputing the violation; (2) corrective action taken and results achieved; (3) corrective action to be taken to avoid further violations; and (4) the date when full compliance will be achieved.

VIOLATION

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires in part that conditions adverse to quality, such as malfunctions and deviations, be promptly identified and corrected. For significant conditions, established measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The identification of significant conditions shall be documented and reported to appropriate levels of management.

1. Contrary to the above, on or about April 20, 1993, a failure of the emergency diesel generator fuel oil sump level control switch was not documented and reported to appropriate levels of management. (266/93009-01A)

2. Contrary to the above, on April 8, 1993, inadequate corrective actions were taken to preclude repetition of not maintaining the temporary third door to the Unit 1 containment personnel hatch closed during refueling operations. (266/93009-01B)

We do not believe that the events and circumstances described in the first example constitute a violation of 10 CFR 50, Appendix B, Criterion XVI. We agree that the events and circumstances described in the second example are accurately characterized and constitute a violation of Criterion XVI.

RESPONSE TO VIOLATION

Response to example (1), documentation of equipment failure.

1. BASIS FOR DISPUTING EXAMPLE (1) OF THE VIOLATION

On the morning of April 20, 1993, Emergency Diesel Generator (EDG) G-01 was taken out of service for testing in accordance with Technical Specification Test TS-1, "Emergency Diesel Generator G-01 Biweekly." Because of the testing, the diesel was declared inoperable and a seven day Limiting Condition for Operation (LCO) was entered in accordance with Technical Specifications Section 15.3.7, "Auxiliary Electrical Systems," Specification B.1.g. Towards the end of the test, with the EDG still running, the operator attempted to manually fill the diesel fuel oil sump from the day tank per precedure. The fuel oil transfer pump ran for a short time and then tripped. After several unsuccessful attempts to manually refill the sump, the EDG was secured.

Maintenance Work Request (MWR) 931852 was written for the fuel oil sump high/low level control switch because a malfunction of the high level switch was suspected. Later in the morning of April 20, 1993, Site Engineering and Instrument and Control (I&C) personnel closely monitored the fuel oil sump level control system while test TS-1 was performed again. The manual and automatic fuel transfer functions were tested, and the EDG was subjected to several speed and load conditions. All attempts to recreate the faulty condition were unsuccessful. As no cause for the fault could be identified, the diesel was declared back in service and the LCO exited.

The EDG manufacturer, MKW Power Systems, was contacted to discuss the problem. They indicated that although a different fuel oil sump level control switch is now specified, retrofit was not recommended. We further determined that replacement of other parts which did not show signs of definite failure was not warranted.

A search of the MWR history for the diesels in general and the fuel oil sump level control switches in particular was conducted. No previous switch malfunctions were identified.

The modification referred to in Inspection Report 50-266/93009 and 50-301/93009 is Modification Request (MR) 90-015. This modification was written by I&C to replace or move the fuel oil sump level control switches due to difficulties experienced when calibrating the switches. In order to calibrate the switches, the EDG must be operating. The vibration of the EDG makes calibration of these mercury switches difficult, but has never inhibited the operation of the fuel oil transfer pumps.

Operations, Engineering, I&C, and Regulatory Services personnel discussed whether a condition report should be written for the fuel oil sump level control switches. It was decided that a condition report was not required for the following reasons:

- Although the high level switch was suspected, the component(s) which caused the fuel oil transfer pumps to trip could not be explicitly identified.

- Troubleshooting attempts could not recreate the problem and all systems performed as designed.

- Plant engineering personnel believed that, had the fuel oil sump level reached the low level setpoint during the initial performance of test TS-1, the fuel oil transfer system would have operated properly.

- The suspected problem with the fuel oil sump level control switches was documented in the MWR system. Searches of this system are performed to identify previous failures of components as was done for the fuel oil sump level control switches. The data in this system is readily available to the operating experience review program.

- A search of the MWR database indicated that there was no failure history or adverse trends associated with the fuel oil sump level control switches.

- As stated in Quality Procedure (QP) 15-3, "Condition Reports," Attachment 3, "Guidance for the Initiation of Condition Reports," other programs or procedures may be implemented which provide for the identification and disposition of nonconforming conditions (such as MWRs). The condition reporting system is not intended to replace or duplicate the functions provided by these programs.

Therefore, we believe that this condition was appropriately documented using the MWR system, and do not agree that a condition report was required for this case.

MWR 931852 was initially screened as not being reportable in the Nuclear Plant Reliability Data System (NPRDS). Based on further review and discussion with the Institute of Nuclear Power Operations (INPO), we will document this issue in NPRDS as a degraded equipment performance of the EDG fuel oil transfer pumps as no specific equipment failure was identified. This action will be completed by August 20, 1993. The information in NPRDS is readily available to the operating experience review program.

Response to example (2), inadequate corrective actions.

1. REASON FOR VIOLATION

This event occurred on April 8, 1993, with Unit 1 shut down for refueling operations. A temporary third door was in place outside the personnel hatch on the 66 foot level of containment. A sign was posted on both sides of the door which states "Refueling In Progress, Keep This Door Closed, Do Not Block Open." A plant employee found the door tied open with a length of rope. A security officer, who is posted at the containment personnel hatch when the containment is open for access, did not remember seeing anyone tie open the temporary third door. The person responsible for tying the door open has not been identified.

An evaluation was performed to determine the root causes and contributing factors related to this event. Signs were posted on both the inside and outside of the door by operations personnel as required by Refueling Procedures RP-1A, "Preparation for Refueling," and RP-1C, "Refueling." These signs indicate that refueling operations are in progress and the door is to remain closed. We have determined that the signs are adequate for their intended purpose. These signs were ignored by the responsible party.

The posting instructions for the security officers stationed at the containment accesses indicate that the officers will be notified by Health Physics personnel when fuel movement is in progress and that the door is to remain closed. Health Physics personnel were unaware of this requirement in the posting instructions and did not make the required notification. Also, the officer at the access was not notified that refueling was in progress. Therefore, the security officer was not monitoring and controlling the position of the third door.

2. CORRECTIVE ACTION TAKEN

The door was immediately closed by the plant employee that discovered the situation.

Security officers posted at the accesses to the containment were briefed on the requirement for the door to remain closed during refueling operations.

3. CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

In the Licensee Event Report which documents this event (LER 266/93-004-00), we stated that the appropriate refueling procedures and checklists would be revised to require operations personnel to notify security of the requirement for the door to remain closed when the signs are posted on the door and informing security of the continuing requirement to verify the temporary third door remains shut. We also stated that the posting

instructions for the security officer stationed at the containment would be revised to direct the officer to ensure the door remains closed at all times when the signs are posted on the door.

Pending changes to 10 CFR 73, "Physical Protection of Plants and Materials," will likely delete the requirement to have a security officer posted at the containment hatch during fuel motion. As such, these permanent procedure revisions will not suffice as long-term corrective actions. Therefore, until the changes to 10 CFR 73 are implemented, the content of the procedure revisions will be incorporated into an Operations Standing Order or Night Order Book entry.

As a long-term permanent corrective action, we are evaluating alarms or other suitable means to positively verify the position of the containment hatch temporary third door. These means would be in effect when the signs mentioned above are posted on the door.

4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The content of the procedure revisions mentioned in LER 266/93-004-00 will be incorporated into an Operations Standing Order or a Night Order Book entry prior to the next Unit 2 maintenance and refueling outage, currently scheduled to start on September 25, 1993. We will be in full compliance at that time. Security personnel will continue to monitor the containment hatch temporary third door until other means of positively verifying the door position are established.