



Wisconsin Electric POWER COMPANY
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July 30, 1982

Mr. J. G. Keppler, Regional Administrator
Office of Inspection and Enforcement,
Region III
U. S. NUCLEAR REGULATORY COMMISSION
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

DOCKETS 50-266 and 50-301
RESPONSE TO
INSPECTION REPORT 50-266/82-01 and 50-301/82-01
POINT BEACH NUCLEAR PLANT, UNITS 1 and 2

Pursuant to the provisions of 10CFR 2.201 and in response to your letter dated June 21, 1982, we are providing the following responses to the Notice of Violation resulting from the routine safety inspection conducted by Messrs. W. G. Guldemond and R. L. Hague of your office on January 5 through March 31, 1982. Appendix A to your June 21 letter, "Notice of Violation", indicated that certain of the activities at the Point Beach Nuclear Plant appeared to be in non-compliance with NRC requirements. These items are discussed below. The responses include the corrective action taken, corrective steps to be taken to avoid further items of non-compliance, and dates when full compliance will be achieved.

Item 1

This violation concerns Licensee's failure to perform a safety evaluation of a temporary jumper installation to the Unit 1 steam generator's (1HX-1A) steam pressure sensing system, in accordance with the requirements of 10CFR 50.59 and PBNP 3.17, Revision 6. The event is described in Licensee Event Report 82-001/03L-0. To summarize, the white channel (1PT-469) of the Unit 1 "A" steam line pressure sensing system was temporarily "jumpered" to the radwaste steam system, and then to the "A" steam generator's blue channel sensing line, to prevent a spurious safety injection signal and subsequent loss of the unit's generating capacity. Since the white channel sensing line had already frozen and the blue channel, based on recent history, was very susceptible to freezing, there was concern that there may be only a very short time before the second instrument line

would freeze, resulting in either a unit shut-down, per Technical Specification requirements, or a spurious safety injection by automatic initiation from the subject steam line pressure sensor freezing and failing low. Considering that severe Wisconsin winter conditions existed, -23°F , in addition to winds ranging from 21 to 29 miles per hour for a wind chill factor of -90°F , it was felt that an unnecessary unit shut-down was not in the best interest of the public's health and safety.

To allow blowing down of the two operable instrument lines, to prevent freezing, the white channel trip signal had to be removed, and the temporary steam jumper was installed for this purpose. The steam jumper was installed after consultation with, and approval of, the Duty Shift Supervisor and Duty and Call Superintendent.

Upon discovery that the white channel had frozen, it had been declared inoperable and placed in the tripped mode, in accordance with normal procedures. The white channel remained in the tripped mode at all times, except for the short time intervals actually required to blow down the two functional channels. Each of the two functional channels (red and blue) remained operable at all times during blow-down. Removing the trip signal from the inoperable channel, while blowing down the two functional channels, violated the Technical Specification requirements for minimum degree of redundancy, but the minimum channels operable was at all times in compliance with the Technical Specifications.

At approximately 0037 hours on the next day, January 11, 1982, the ice plug in the white channel's sensing line melted. At this time, the temporary cross-connect to the blue channel was physically removed, and the white channel was returned to service.

Upon review of the occurrence, the Manager's Supervisory Staff determined that the actions taken may not have been appropriate with respect to the requirements of administrative procedure PBNP 3.17, "Authorization of Changes, Tests & Experiments, 10CFR 59.59" and 10 CFR 50.59. In addition to hardware design reviews and initiating the corrective action of installation of additional freeze protection, the review of this incident included an emphasis of the commitments of 10CFR 50.59, as outlined in PBNP 3.17, to the members of the Manager's Supervisory Staff and the Duty and Call Superintendents. It should be noted that during the following evening, with less severe weather conditions, freezing of the subject instrumentation lines was again experienced. In this case, proper authorization for preventive measures, in accordance with 10CFR 50.59 and plant procedures could not be obtained in time, and the unit experienced a spurious safety injection and reactor trip resulting from the freezing of the subject instrumentation.

Item 2

This violation concerns the placement of two spent fuel assemblies, with a decay time of less than a year, in locations adjacent to the internal spent fuel pool north/south divider wall. This was later interpreted to be a Technical Specification violation. The event is described in detail in Licensee Event Report 82-005/01T-0.

As discussed in that report, the two fuel assemblies were placed in locations next to the Boraflex I "poison" surveillance specimens. At the time of the fuel placement, the divider wall was considered to be a non-structural wall and not affected by the Technical Specification requirements. Upon further review, this interpretation was found to be incorrect as the divider wall provides seismic support for the west fuel pool wall.

The immediate corrective actions included moving the fuel assemblies in question and educating personnel responsible for fuel positioning that the divider wall is a structural wall and shall be treated as such with respect to the Technical Specification requirements. Full compliance was achieved on February 23, 1982, with the movement of the subject fuel assemblies.

An analysis was performed to determine the effect of the placement of the two fuel assemblies next to the divider wall. The analysis showed that no adverse effect on the spent fuel pool north/south divider wall resulted from this incident.

Presently, engineering studies are being performed to determine if the spent fuel storage rack poison specimen location should be changed or if a Technical Specification change allowing the use of the existing position (with fresh spent fuel) should be pursued. It is anticipated that this issue will be resolved by January 1, 1983.

Item 3

This violation concerns Licensee's failure to realign the valves in the primary sample systems to normal following the removal of a red tag series, in accordance with the requirements of PBNP 4.13, "Equipment Isolation Procedure." This event was reported in accordance with 10CFR 50.72. A synopsis of the incident is provided below.

On the morning of March 5, 1982, during normal operation, a PBNP Chemistry Technician was in the process of collecting hot leg reactor coolant system samples from both units, in accordance with normal practice. The sample systems of

both units had been tagged out of service the day before to accommodate repairs made by the Maintenance Group. After repairs were completed, the red tag series was cleared by Operations Group personnel late the same day. The sampling system valves were left in the "as tagged" position and turned over to the Chemistry Group personnel rather than being returned to their normal positions. The next day the Chemistry Technician established what he thought was recirculation flow to each unit's volume control tank. This is done prior to collecting samples; however, because of the abnormal valve line-up, primary water was instead being directed to the waste hold-up tank via each unit's respective drain header. Flow was also initially directed to the Unit 2 sample sink until isolated by the Chemistry Technician. The sample bomb bypass valve, which the Chemistry Technician would normally open to establish recirculation, was already open as was the flow-meter bypass valve. In Unit 2, because of the improper valve alignment, the estimate sample line flow rate was about 8 gpm versus 0.5 gpm, which is the normal rate. This resulted in abnormally high radiation levels in the sample room, since the primary water in the Unit 2 drain header, which is connected to the auxiliary building floor drains in the area, was off-gasing and the gases were rising up through the floor drains.

The off-gases from the floor drains were collected by the auxiliary building vent system and discharged through the monitored vent stack. Release levels, as monitored by R14, the auxiliary and service building vent stack monitor, increased from 2,000 cpm to a peak of 42,000 cpm, whereas during normal sampling, it only increases to about 5,000 to 8,000 cpm. The maximum release rate was 1.88% of PBNP's annual average allowable rate of 0.2 Ci/sec and 0.188% of the 15-minute maximum average allowed release rate. The total release time, as measured from the start of the increase of R14 until it returned to normal, was 175 minutes, although the actual increased liquid flow rate lasted for only about ten minutes. The total release amounted to 17.4 Ci Xe-133 equivalent based on the average release rate of 1.66×10^{-3} Ci/sec. This is 0.83% Xe-133 equivalent of the annual average allowance rate.

The only personnel exposure recorded during the event was incurred by the Chemistry Technician and equalled about 20 mR. Eight people, including the Chemistry Technician and Duty Shift Supervisor, were slightly contaminated by the off-gasing radionuclides during the event and subsequent sampling. The contamination was mainly gaseous and quickly decayed away. All personnel involved were given whole-body counts, with no increase in biological radioactivity levels detected.

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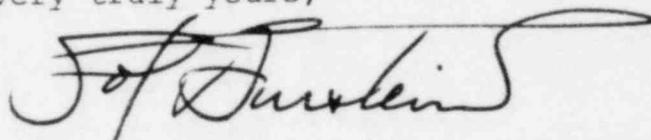
The cause of the event has been attributed to the failure to return the sampling system valve line-up to normal following maintenance and the failure to properly communicate this fact to the appropriate Chemistry Group supervisory personnel after removing the red tags. The event has been determined to be a violation of administrative procedure PBNP 4.13, "Equipment Isolation Procedure."

The corrective actions taken to avoid further events of a similar nature include the following:

1. An "in-house" procedure (Standing Order PBNP 4.12.4) has been revised providing further clarification regarding responsibilities associated with systems that may be used by personnel other than Operations Group personnel.
2. An "in-house" chemistry procedure (CAMP-1000) has been issued which requires sample system valve line-up checks following maintenance of the system.
3. The "red tag" procedure, PBNP 4.13, is being revised to clarify the scope of responsibility and requirements for system/equipment isolation and recovery. This procedure revision should be approved and issued by October 1, 1982.

Please contact us if you have any questions concerning these responses or our corrective actions.

Very truly yours,



Executive Vice President

Sol Burstein

Copy to Resident Inspector