WISCONSIN PUBLIC SERVICE CORPORATION



P.O. Box 1200, Green Bay, Wisconsin 54305

December 23, 1982

Mr. R. L. Spessard, Director Division of Project & Resident Programs U.S. Nuclear Regulatory Commission Region III 799 Roosevelt Road Glen Ellyn, IL 60137

Dear Mr. Spessard:

Docket 50-305 Operating License DPR-43 IE Inspection Report No. 50-305/82-18

The subject report was issued following routine inspection conducted by Mr. R. L. Nelson on September 1 - October 31, 1982, of the activities at the Kewaunee Nuclear Power Plant. One item of non-compliance was identified and cited by this report.

The attachment to this letter addresses our response to this alleged item of non-compliance.

Very truly yours,

C. W. Giesler

Vice President - Nuclear Power

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Attach.

cc - Mr. Robert Nelson, US NRC

Attachment

Response to Inspection Report 50-305/82-18

As a result of the inspection conducted on September 1-October 31, 1982, and in accordance with the NRC Enforcement Policy, 47 PR 9987 (March 9, 1982), the following violation was identified:

Technical Specification 4.1.a states, "Calibration, testing, and checking of protective instrumentation channels and testing of logic channels shall be performed as specified in Table 4.1-1" Technical Specification Table 4.1-1, item 19, requires a monthly test of all Radiation Monitoring System Channels. Technical Specification 4.1.c states, in part, "Specified time intervals may be adjusted plus or minus 25% to accommodate normal test procedures."

Contrary to the above, the monthly Surveillance Test for Radiation Monitoring Channels R-11 and 12 was performed on September 2, 1982, and subsequently, performed on October 23, 1982. This time interval exceeds the requirements of your Technical Specifications 4.1.a and 4.1.c.

This is a Severity Level IV violation (Supplement I).

RESPONSE

The monthly channel functional test interval for Radiation Monitor channels R-11 and R-12 was exceeded due to an oversight on the part of plant supervisory staff. When the monthly test became due, the procedure was started but then terminated because R-21, the backup radiation monitor to R-11 and R-12, was out of service waiting for parts. With R-21 out of service the automatic safeguards actions (closing of containment ventilation dampers and valves) could not be tested because the failure signal placed the dampers and two redundant isolation valves in the tripped condition. The surveillance procedure was set aside anticipating R-21 would be back in service prior to exceeding the testing period. Parts were not received during this interval, thus, the testing interval was exceeded. Upon discovery, R-21 was jumpered

out allowing the dampers to be opened and the safeguard actuation test on R-11 and R-12 to be performed. This test was successfully completed on October 23, 1982. Since the containment ventilation isolation function was not needed during this period because the vent valves were inhibited from being opened, we contend that testing of the safeguards function is not required until the vent system is returned to service. This interpretation is consistent with similar interpretations concerning safeguards pumps or components that are out of service. No testing on the out of service component is required until that component is declared back in service.

Technical Specification 3.1.d.5 requires leakage detection through use of radiation monitoring to be operable. This function was not inhibited by the missed surveillance since daily checks were performed per T.S. Table 4.1-1 and the instrumentation was within the annual calibration period. Although the monthly test does require an additional operational source check, this is a procedural requirement and not interpreted to be a Technical Specification requirement. This interpretation is consistent with the definitions provided in T.S. 1.i.1, 2 and 3 as applied to these and other safeguard instruments. Therefore, radiation monitoring channels R-11 and R-12 were in service and available to meet the requirements of T.S. 3.1.d.5.

Based on the above review of the alleged non-compliance we believe that no non-compliance with Technical Specifications existed. We do acknowledge,

have attributed to a non-compliance. To correct this situation we have investigated the surveillance program requirements and procedures and have determined that the existing procedures should have prevented this occurrence had all personnel followed the procedures explicitly. Thus this event and the potential consequences were discussed with the personnel involved to prevent a reoccurrence of this incident.

We sequest that you reconsider the non-compliance in lieu of the arguments and interpretations presented above. Should you still consider it a non-compliance, no required safeguard functions were inhibited and only a paper-work oversight was made, thus relegating this incident to no higher than a level V non-compliance. The corrective action stated above has been completed and no further action is contemplated at this time.