UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
799 ROOSEVELT ROAD
GLEN ELLYN, ILLINOIS 60137

August 29, 1978

MEMORANDUM FOR: Leo B. Higginbotham, Acting Director, Division of Fuel Facilities and Materials Safety Branch

FROM: James G. Keppler Director

SUBJECT: WISCONSIN PUBLIC SERVICE CORPORATION (KEWAUNEE) RECOMMENDED CIVIL PENALTY

We have reviewed Wisconsin Public Service Corporation's response to the Headquarters Notice of Violation and Proposed Imposition of Civil Penalty dated July 19, 1978. It is our view that the licensee has not identified any errors in the Notice of Violation nor shown sufficient reason for mitigation of the proposed civil penalty. Therefore, we recommend that a civil penalty of Ten Thousand Dollars ($10,000) be imposed on the licensee. Attached for Headquarters' use is a draft response to the licensee with attached Order.

In addition to responding to the Headquarters Notice of Violation, the licensee has also responded to our office by letters dated July 20, 1978 and August 15, 1978. The first letter responds to a report of a management meeting which was held with the licensee and the second letter responds to the inspection report. Both of these reports, of course, relate to the incident which led to the civil penalty. We have attached, for your information, copies of these letters from the licensee and our planned response.

Please let me know if you have any questions on this matter.

James G. Keppler
James G. Keppler
Director

Attachments:
1. Draft ltr w/enclosed responses to non-compliance and Order
2. Licensee's ltrs to RIII dtd 7/20/78 and 8/15/78
3. RIII's draft response to incoming ltrs

cc w/attachments:
E. L. Jordon, XOOS
N. C. Moseley, ROI

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PDR FOIA
WILLIAM92-510 PDR

Docket No. 50-305

Wisconsin Public Service
Corporation
ATTN: Mr. P. Ziemer
President
Post Office Box 1200
Green Bay, WI 54305

Gentlemen:

This is in response to your letter dated August 10, 1978, in response to the Notice of Violation and Notice of Proposed Imposition of Civil Penalties sent to you with our letter dated July 19, 1978. The Region III Office has already responded to Mr. James' related letters of July 20, 1978 and August 15, 1978.

The July 19, 1978 letter concerned apparent items of noncompliance found during a Nuclear Regulatory Commission inspection conducted on May 3-5, 18, and June 5, 1978, at your Kewaunee Nuclear Power Plant authorized by NRC Operating License No. DPR-43.

After careful consideration of your August 10, 1978 response and in consideration of the matters discussed in Appendix A to this letter, we conclude that the items of noncompliance did occur as described in the Notice of Violation sent to Wisconsin Public Service Corporation with our July 19, 1978 letter. With regard to item 2 of the Notice of Violation, Wisconsin Public Service Corporations' reply contends

that the job of short duration, which is also described as an emergency, negated the requirement for filing a Radiation Work Permit (RWP). However, without reaching any conclusion as to whether or not the entry into the cavity constituted an emergency, we note that the requirements of this alternative were not fulfilled. Therefore, we conclude that the requirement for an RWP remained in effect. It is the staff's view that no adequate reasons have been stated why the penalty for these items should not be imposed as described in the Notice of Proposed Imposition of Civil Penalties enclosed with that letter. Accordingly, we hereby serve the enclosed Order on Wisconsin Public Service Corporation, imposing Civil Penalties in the amount of Ten Thousand Dollars ($10,000).

We have considered the comments in your August 10, 1978 letter regarding radiation exposure control. Since your letter presents no evidence that the May 2, 1978 exposure incident was unavoidable, we again conclude that the incident resulted from inadequate radiation exposure control, which we regard as a management responsibility. To that extent we do believe there has been a management weakness at the Kewaunee plant.

We also note, with some concern, the final paragraph of your Answer to Notice, which states that ". . . . no safety threat or actual danger was created by the event . . . ." Be assured that we regard as simply fortuitous the lack of a significant overexposure in the May 2, 1978 incident.

During future inspections we will determine the effectiveness of the corrective actions described in your August 10, 1978 letter.

Sincerely,

John G. Davis, Acting Director
Office of Inspection and
Enforcement

Enclosures:
1. Appendix A, Response to Noncompliance
2. Appendix B, Order

Appendix A

Wisconsin Public Service Corporation

License No. DPR-43

After careful consideration of the information provided in your response of August 10, 1978 to the Notice of Violation and Notice of Proposed Imposition of Civil Penalties dated July 19, 1978, we have the following comments:

1. Regarding the first item of noncompliance, you contend that an inaccurate or incomplete radiation survey was made before the shift supervisor's reactor cavity entry on May 2, 1978. We contend that no survey was made in the major radiation fields which the shift supervisor entered. This is a distinction without a difference, because in either case, the survey did not assure that exposure limits would not be exceeded, in violation of 10 CFR 20.201. It was fortuitous that an exposure exceeding 10 CFR 20.101 limits did not result from this inadequacy.

2. Regarding the second item of noncompliance, you contend that the shift supervisor's entry involved a job of very short duration and emergency, allowing "attendance" by an experienced HP person in lieu of a Radiation Work Permit. Health Physics Procedure RC-HP-35 provides for a "continuous escort" by an

experienced Health Physics person in lieu of an RWP in emergencies or jobs of short duration. We presume the purpose of both the RWP and the alternative escort to be ". . . . to protect plant personnel . . . . by informing the worker of the radiation and contamination conditions. . . ." as stated in Procedure RC-HP-35. Because the shift supervisor was neither preceded into the reactor cavity to obtain radiation information for an RWP nor escorted into the reactor cavity for protection purposes in lieu of an RWP, Procedure RC-HP-35 was not followed and Technical Specification 6.11 was therefore violated.

3. You acknowledge that the third item of noncompliance occurred. However, your response misses the issue, which was the failure to provide the shift supervisor a radiation monitoring device which continuously indicates the radiation dose rate, as required by Technical Specification 6.13.1.

Appendix B

UNITED STATES OF AMERICA
NUCLEAR REGULATION COMMISSION

In the Matter of Wisconsin Public Service Corporation P. O. Box 1200 Green Bay, Wisconsin 54305	))))))	Docket No. 50-305 License No. DPR-43

ORDER IMPOSING CIVIL MONETARY PENALTIES

I

Wisconsin Public Service Corporation, P. O. Box 1200, Green Bay, Wisconsin (the "licensee"), is the holder of License No. DPR-43 (the "license"), issued by the Nuclear Regulatory Commission (the "Commission"), which authorizes the licensee to operate the Kewaunee Nuclear Power Plant at Kewaunee, Wisconsin, in accordance with the provisions of the license and the Technical Specifications. The license was issued on December 21, 1973, and has an expiration date of August 6, 2008.

II

An investigation of the licensee's activities under License No. DPR-43 was conducted on May 3-5, 18, and June 5, 1978. As a result of this investigation it appears that the licensee has not conducted its activities

in full compliance with the requirements of the Technical Specifications and the NRC's Title 10, Code of Federal Regulations, Part 20, "Standards for Protection Against Radiation." A written Notice of Violation was served upon the licensee by letter of July 19, 1978 (erroneously dated June 19, 1978) appended hereto as Appendix I, specifying the items of noncompliance, in accordance with 10 CFR 2.201. A Notice of Proposed Imposition of Civil Penalty of July 19, 1978 (erroneously dated June 19, 1978) was served concurrently upon the licensee in accordance with Section 234 of the Atomic Energy Act of 1954, as amended, (42 USC 2282), and 10 CFR 2.205, incorporating by reference the Notice of Violation, which stated the nature of the items of noncompliance and the provision of the NRC regulations with which the licensee was in noncompliance.

An answer from the licensee to the Notice of Violation and to the Notice of Proposed Imposition of Civil Penalties dated August 10, 1978, is appended hereto as Appendix II.

III

Upon consideration of the answer received and the statements of fact, explanation, and argument of mitigation contained therein, the Acting Director of the Office of Inspection and Enforcement has determined that the penalty proposed for the items of noncompliance designated in the Notice of Violation should be imposed.

IV

In view of the foregoing and pursuant to Section 234 of the Atomic Energy Act of 1954, as amended, (42 USC 2282), and 10 CFR 2.205, IT IS HEREBY ORDERED THAT:

The licensee pay a civil penalty in the total amount of Ten Thousand Dollars ($10,000). The penalty may be paid by check, draft, or money order payable to the Treasurer of the United States and mailed to the Director of the Office of Inspection and Enforcement. Payment shall be due and payable within twenty (20) days of the date of receipt of this Order.

V

The licensee may, within twenty (20) days of the receipt of this Order, request a hearing. If a hearing is requested, the Commission will issue an Order designating the time and place of hearing. Upon failure of the licensee to request a hearing within twenty (20) days of the date of receipt of this Order, the provisions of this Order shall be effective without further proceedings and, if payment has not been made by that time, the matter may be referred to the Attorney General for collection.

VI

In the event the licensee requests a hearing as provided above, the issues to be considered at such a hearing shall be:

(a) whether the licensee was in noncompliance with the Commission's regulations in the respect set forth in the Notice of Violation attached hereto as Appendix I; and

(b) whether, on the basis of such items of noncompliance the Order should sustained.

FOR THE NUCLEAR REGULATORY COMMISSION

John G. Davis, Acting Director
Office of Inspection and Enforcement

Dated At Bethesda, Maryland
this ____ day of September, 1978

WISCONSIN PUBLIC SERVICE CORPORATION

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

July 20, 1978

Mr. James G. Keppler, Director
Inspection & Enforcement Division
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr. Keppler:

Docket 50-305
Operating License DPR-43
IE Inspection Report No. 50-305/79-09

The reference inspection report addresses a meeting in our office on May 17, 1978, and subsequent evaluations of dose in regard to the reactor cavity "C" radiation exposure incident. The report presents the positions noted by members of the NRC Regional Office, however, we believe that the positions presented by members of Licensee organization were not completely reflected in the report. In an effort to achieve completeness and remove the possibility of misinterpretation, we believe that our positions and opinions expressed should be included in the formal record of that meeting.

Mr. Giesler stated, both at the subject meeting and a subsequent conference call, that had the correct radiation level data been available or by some other means had the shift supervisor known that the radiation levels were in the 2000 R/hr range, the incident would not have occurred.

As a result of our reviewing of the incident and the associated access control procedures, we cannot identify where the operational personnel failed to follow the procedures. It is our understanding that through the Region III review the appropriate procedures were found to be acceptable. It should be recognized that responsible operating personnel must be provided with the latitude to make decisions during emergency situations from information and input from supporting groups available to them at the time. It was not and still has not been acknowledged by your review of the incident that the shift supervisor was acting under a potential emergency situation and that responsibility for specifying conditions for entry into radiation areas rests with the Health Physics group.

In regard to the opinion expressed in your letter that this incident was the most significant event that had occurred at the Kewaunee Plant, we can only concur with that opinion if you meant to confine that statement to the area of Health Physics and personnel radiation protection.

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We would further like to comment that in the investigation of this incident, there has been far too much emphasis placed on the dose received by the person involved rather than considering plant operations in relation to his actions. This incident should have been evaluated along with the fact that information had reached the shift supervisor that water was observed leaking around the hot and cold legs into the Reactor Coolant Pump vaults probably due to leakage from the reactor refueling seal ring. To evaluate whether there was a danger to personnel or plant equipment and to find what corrective action was required, a judgment decision to enter the reactor cavity area was made based on the information available on hand. We would be in real trouble if responsible operating personnel were overly restricted or hampered by the consequences of hindsight evaluations when such decisions would be a necessity in a real emergency. To best be prepared for emergencies and future events of this nature we can only hope to train to the best of our ability the operating personnel and support group personnel to provide the most accurate information available.

Should you desire to review this matter further, we are at your disposal.

Very truly yours,

E. W. James
Senior Vice President
Power Supply & Engineering

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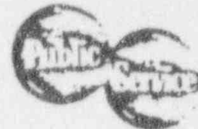
WISCONSIN PUBLIC SERVICE CORPORATION 

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

August 15, 1978

Mr. James G. Keppler, Reg Dir
Office of Inspection & Enforcement
Region III
U. S. Nuclear Regulatory Commission
799 Roosevelt Rd
Glen Ellyn, IL 60137

Dear Mr. Keppler:

Docket 50-305
Operating License DPR-43
I & E Inspection Report 78-07

This letter is to inform your office of the results of our evaluation of the reactor vessel cavity exposure incident of May 2, 1978, and our review of the I & E Inspection Report 78-07 which addresses that event.

The event of May 2, 1978, as presented in the Inspection Report 78-07, indicated a general lack of procedural control and intimidation by a member of our supervisory staff, when in fact, a more complete investigation has revealed that the contrary is true and a personnel error was the cause of the event. The main differences between the investigation performed by members of your staff and our investigation was that the refueling coordinator and the auxiliary operator who also had involvement in the events of May 2, 1978, were included in our interviews. The main points of fact which were identified by inclusion of those individuals were:

1. The lead HP man was fully aware that an entry was desired to the Reactor Cavity and had dispatched a technician from within containment to outside containment for the purpose of acquiring what he apparently believed the necessary equipment to make such an entry assuming the radiation levels were within reason. That manner of dealing with the short term entry into the reactor cavity was consistent with proper control, procedures, and HP practice.

2. The HP technician was not known by the Shift Supervisor prior to the entry. Approximately five minutes after the Shift Supervisor's departure from the cavity area after the entry, the HP technician

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inquired as to whom the individual was that made the entry. At that time he was informed that it was the Shift Supervisor.

3. The HP Supervisor was first informed of the event by the lead HP man on site in such a manner so as to indicate that the exposure was minor in magnitude. At the insistence of the Night Refueling Coordinator, the HP Supervisor was requested to investigate the event immediately.

The above, when considered in the context of the other statements and information discussed in the inspection report, leads us to conclusions significantly different than those presented in the inspection report.

It appears that the implied intimidation by the Shift Supervisor identified in the Inspection Report paragraph f could not have occurred. It is most difficult to accept the scenario when item 2 above is considered in the evaluation.

We find that the lead HP man on site was apparently in concurrence with the decision to enter the reactor vessel cavity and believed that no major problem existed. That position is confirmed by the action taken following the entry and acknowledgement of a full scale dosimeter reading upon exit. Had the lead HP man believed that very high radiation fields existed to the extent that entry would have been precluded, his actions following the entry would have been different. The HP Supervisor was apparently not alerted to the potential of overexposure by the first call by the lead HP man at about 0330 since a second call was necessary to alert him of the significance of the event. That sequence could only have occurred had the lead HP man indicated that no problems of significance existed to the HP Supervisor.

As a result of the above considerations, which were not included in the inspectors investigation, we find that the conclusions presented in the Inspection Report and the subsequent Enforcement Action to be in error. It is clearly evident that the HP group did not acknowledge the existence of a 2000 R field in the Reactor Cavity due to an incomplete survey by one of their contracted personnel which we consider a personnel error. It is also clearly evident that the Shift Supervisor followed proper procedure and established practice in his requesting HP assistance prior to the entry. With the obvious human error by the HP group in the failure to completely assess the hazards within the reactor cavity and the acknowledgement that intimidation could not have occurred, the conclusions presented in the I & E Inspection Report are not supported by fact and we cannot concur with them.

Should you desire to pursue this matter further, please contact me personally.

Very truly yours,

E. W. James
Senior Vice President
Power Supply & Engineering

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Docket No. 50-305

Wisconsin Public Service
  Corporation
ATTN: Mr. E. W. James
  Senior Vice President
  Power Generation and
    Engineering
P. O. Box 1200
Green Bay, WI 54305

Gentlemen:

This letter concerns your letters of July 20, 1978 and August 15, 1978 responding to our letters of June 30, 1978 and July 19, 1978, respectively.

In responding to our letter of June 30, 1978 and its enclosed report (50-305/78-09) of the management meeting held on May 18, 1978, you expressed concern that your positions were not completely reflected in the report. As stated in the report, the purpose of the meeting was to review the findings of our inspection following the reactor cavity exposure incident of May 2, 1978, and to discuss your corrective actions. The report did not present our findings, which were detailed in Inspection Report 50-305/78-07 sent to you on July 19, 1978. Nor was the report intended to present your positions, other than your initial corrective actions, which have been documented in your letters of July 20, 1978 and August 15, 1978, to this office and your letter of August 10, 1978, to our Inspection and Enforcement headquarters. For these reasons we do not intend to change the report to reflect your positions. Of course your July 20, 1978 letter becomes a part of the public record on this matter.

Your July 20 and August 15 letters attempt to relieve the shift supervisor of any responsibility for his entry into an unknown, high radiation field. They imply that the shift supervisor should not be encumbered by radiation hazard evaluations during potential emergency situations. We consider this position contrary to prudent radiation protection practices. We believe that sound radiation protection requires proper performance by the Health Physics Staff and cognizance and cooperation by responsible Operations Staff whose actions can result in changing plant conditions which affect radiation levels. In this regard, we point out that according to the shift supervisor's statement to our inspectors, that he had read IE Circular No. 76-03, which states, "With the thimbles or detectors withdrawn into the cavity, however, exposure rates of hundreds or possibly thousands of roentgens per hour can exist. Overexposures can occur in seconds." Furthermore, we believe that the shift supervisor and other senior employees should set a good example for the remainder of your staff by ensuring that their actions are always in accordance with established procedures.

Your August 15 letter suggests that our inspection (50-305/78-07) of May 3-5, 18, and June 5, 1978, failed to include interviews with the refueling coordinator and the axuiliary operator. Our first knowledge

of the involvement of the refueling coordinator resulted from your August 10, 1978 letter. Although the refueling coordinator's involvement before the entry appears only to be peripherally related to the radiation protection aspects of the incident, his involvement should have been made known to our inspectors during the inspection, not as an afterthought.

Regarding the auxiliary operator, our report (78-07) clearly shows (Paragraph 4.c) that the auxiliary operator was interviewed during the inspection.

We do not understand how these individuals could have had direct knowledge of the three "main points of fact," which your letter claims to be a major difference between our investigation and yours. Be that as it may, we will address these three "facts":

1. For whatever reason, the lead health physics technician appears not to have specified that the "necessary equipment" include high range dosimetry and a radiation monitoring device. In our view, such an omission is not ". . . . consistent with proper control, procedures, and HP practice."

2. Our interview with the health physics technician indicated that he was aware that the person making the reactor cavity entry was a person of authority. However, we are not certain that he knew tne person's name and title before the entry.

3. The first paragraph under 4.d of our report 78-07 states our understanding of the health physics supervisor's notifications. As stated earlier, our inspectors were not informed of the refueling coordinator's involvement.

Notwithstanding your August 15 letter, we continue to believe that our inspection report 78-07 contains an accurate account of the facts pertinent to the May 2, 1978 reactor cavity exposure incident.

Please let me know if you have further questions regarding these matters.

Sincerely,

James G. Keppler
Director