



**Wisconsin Electric** POWER COMPANY  
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October 15, 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:

DOCKET NOS. 50-266 AND 50-301  
REPLY TO INSPECTION REPORT NOS.  
50-266/82-12 (DETP) AND 50-301/82-12 (DETP)  
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

This is in response to your letter of September 15, 1982 which transmitted the special safety inspection conducted on May 3, 4, and June 15, 1982 by Messrs. P. C. Lovendale and R. L. Hague. Although combined for the purpose of the inspection report, there are two distinct areas of concern involved in this Notice of Violation. These include an improper entry into the Unit 1 containment building during reactor operation and access control to areas (within containment) where radiation levels exceed 1000 mRem/hr. With this distinction in mind, specific comments on the violations are made below.

The first section of the Severity Level III violation and the entire Severity Level IV violation are the result of the improper containment entry. The crux of the Severity Level III violation seems to be the NRC-judged "inconspicuous" visual entry control device and the lack of positive control of the containment key; however, we believe the specific initiating event in this violation to be an isolated instance of individual inattentiveness on the part of a plant operator. In support of our judgment, consider the following:

1. The door to the Unit 1 containment was locked whereas the door to the Unit 2 containment was open.
2. The two containments are in different locations and have different physical arrangements.

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3. Even if the operator was unaware of the current status of Unit 2, as a Unit 1 turbine hall watchstander, he should have been aware that Unit 1 was at power. He also should have recognized that OP-4D, "Draining of the Reactor Coolant System", is an inappropriate procedure for an at-power unit.
4. Numerous procedures were violated as noted in the Severity Level IV violation.
5. The background noise, higher ambient temperature, and reduced lighting were indicative of an at-power unit.
6. There was communication with the operator in the control room immediately prior to the improper containment entry.

Recognition of any (or part) of the above should have been sufficient to alert the operator to question the appropriateness of the particular procedure he was following, before he had operated the valves on the wrong unit. We believe the evidence clearly demonstrates that the sole cause of this incident was the inattentiveness of an individual. Because of the potential for serious results and the glaring errors in judgment related to this incident, as well as the inability of the individual to satisfactorily explain his actions, this individual has been removed from all duties connected with the operation or maintenance of the Point Beach Nuclear Plant. Therefore, for the procedural violations noted in the Severity Level IV violations (except as noted below) corrective action and procedural compliance with respect to violations 2b and 2d were achieved on June 29, 1982 when the operator was removed from any nuclear-related duties.

Other actions taken to correct the procedural inadequacies identified in the September 15 inspection report included a review of containment entry control procedures. The control and interchangeability of the keys utilized to open the containment personnel doors has been changed to try to prevent the repetition of this event. Each containment lock now requires a different key which allows access only to that containment and cannot open the other. Further, the keys have been removed from the control of the security guard and have been placed under the control of the Duty Shift Supervisor and the Health Physicist. This revised policy has been formally implemented in procedure HP 2.9, "High Radiation Area Key Control", issued October 8, 1982. In addition, procedure HP 10.7, "Containment Entry Check-In/Check-Out System", has been reviewed

to determine the appropriateness of requiring use of a time card and time recorder system for containment entry as noted in citation 2a. Our review indicates that use of a time card system should not be mandatory and this procedure will be modified to delete the requirement for use of this system.

Citation 2c which stated that procedure HP 8.2, "Radiation Surveys", was violated in that a survey was not completed prior to the operators' entries is inappropriate and should be withdrawn. Recognizing that performance of a survey may require greater radiation exposure than the actual task for which the survey would be requested, procedure HP 2.7, "Radiation Work Permits", allows variance from the radiation work permit and survey requirements in certain circumstances. Although the conditions listed in Section 4.0 of HP 2.7 were not satisfied in this situation, this is a violation of HP 2.7 not a violation of HP 8.2. The violation of HP 2.7 was identified under the Notice of Violation 2b and, therefore, we believe Notice of Violation 2c should be withdrawn.

Because of the circumstances surrounding this event, it is difficult, if not impossible, to devise a set of procedures which can absolutely preclude future events of this nature. The best that can be expected from a system of controls is to alert an individual that he is placing himself or the equipment at risk. When an individual ignores or fails to heed these warning systems and controls, it becomes a failure of the individual not of the administrative or warning systems. This concept is demonstrated in the intent of 10 CFR 20.203 in which awareness is emphasized over positive control. There are, however, actions which we are taking to enhance that awareness.

In order to make the present containment access visual system more conspicuous, a modification request is being prepared to provide an audible alarm in addition to the present visual alarm. This modification may also include a relocation of the visual alarm. At present, most valves bear a tag identifying the valve. It is doubtful that in an event such as this, where the operator violated numerous procedures, entered the wrong containment, ignored the visual and audible signals of an operating unit's containment, would then be halted because the valves are of a different color. However, the containment hatches could be better identified and a modification-request will be issued to investigate and implement a suitable method for this type of unit identification.

Mr. J. G. Keppler

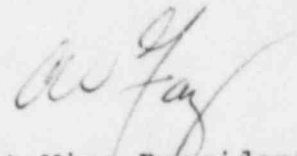
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With respect to control of areas (within containment) where the radiation level exceeds 1000 mRem/hr, it is necessary that we request an extension of the time period for responding to these violations to allow for a detailed review of alternative plant modifications which could be implemented. We ask that an additional 45 days be allowed to respond to this issue. We intend to provide a written response on this matter by November 29, 1982. In the interim, actions are being taken to control access to areas (within containment) where the radiation level exceeds 1000 mRem/hr. As an example, during the recent Unit 2 maintenance outage, the containment area was surveyed and all areas above 1000 mRem/hr were provided with a locked barricade.

We believe the above actions should serve to satisfy your concerns. Please feel free to call us if you have any further questions regarding these matters.

Very truly yours,



Assistant Vice President

C. W. Fay

Copy to NRC Resident Inspector