

DOD/DOE  
(1.10.92)

January 10, 1992

Docket No. 50-266; 50-301  
License No. DPR-24; DPR-27  
EA 91-149

Wisconsin Electric Power Company  
ATTN: Mr. James J. Zach, Vice President  
Nuclear Power Department  
231 West Michigan, Room 308  
Milwaukee, Wisconsin 53201

Dear Mr. Zach:

SUBJECT: NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTIES -  
\$150,000 (INSPECTION REPORTS NO. 50-266/91025; 50-301/91025)

This refers to the special inspection conducted on October 1 - November 1, 1991, at the Point Beach Nuclear Power Station. The inspection included a review of the circumstances surrounding the September 29, 1991, failure of the Unit 2 main steam isolation valves (MSIVs) to close upon demand from the control room during a plant shutdown for a scheduled refueling outage. The report documenting this inspection was sent to you by letter dated November 15, 1991. As a result of the inspection, significant violations of NRC requirements were identified. An enforcement conference was held on November 22, 1991, with you and members of your staff to discuss the violations, their causes, and your corrective actions.

The violations described in the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice) involve (1) the failure to report MSIV malfunctions, (2) failure to properly test MSIVs, and (3) the failure to take adequate corrective action to prevent recurrence of the MSIV malfunctions. Collectively, these violations resulted in the Unit 2 MSIVs being inoperable for an indeterminable period of time during the last operating cycle. Of particular concern to the NRC is that throughout the operational history of the Point Beach Nuclear Power Station, the MSIVs repeatedly failed to function as described in the Safety Analysis Report (SAR) and facility Technical Specifications (TS), i.e., close within five seconds with low steam flow, and station management failed to adequately address the potential significance of this problem, which was generally known to the operations and maintenance staff.

Information developed by the inspection indicated that it was routine for plant personnel to use a sledge hammer to "manually assist" MSIV closure during shutdowns and not document those actions. NRC inspectors found hammer blow marks on each MSIV in both units. Operators interviewed by the NRC stated that

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they did not consider the majority of the MSIV problems to be an operability concern, as most occurred during system shutdown when the valves were not undergoing TS surveillance testing. This practice has occurred in both units since the start of commercial operation. Consequently, a comprehensive record of the MSIV problems was not developed and effective corrective actions were not taken to assure the operability of this safety component.

It appears that station personnel only focused on the "as-left" condition of the valves prior to startup since testing could only be performed during an outage and there was no Technical Specification limiting condition for operation (LCO). Plant documents indicated that station personnel often rationalized that steam flow would assist in the closure of the MSIVs during operation. This reasoning was flawed because the MSIVs are expected to shut automatically under low steam flow conditions and in some cases, when called upon to operate, the MSIVs remained in their full open position which prevented steam flow from assisting valve closure.

The root causes of the violations and your subsequent corrective actions were discussed during the November 22, 1991, enforcement conference. You indicated that the major factor contributing to the violations appears to have been a mind-set of plant personnel specific to the operability of MSIVs. This led to the failure to properly document component deficiencies so that the root cause could be evaluated. To correct this problem, you indicated at the conference that you planned to: (1) conduct a written survey of operations and maintenance personnel to determine if chronic or repetitive problems exist with other safety-related equipment; (2) perform a systematic review of equipment histories for the past five years to determine if repetitive problems exist with other safety-related equipment; (3) request an INPO Operating Experience Assist Visit to seek advice on root cause analysis; (4) compare assumptions made for accident analyses between the Final Safety Analysis Report, the Limiting Conditions for Operations Section and the Surveillance Section of the Point Beach Technical Specifications; (5) ensure that the equipment addressed in item (4) is adequately covered in the preventive maintenance program; and (6) add a requirement in the Maintenance Work Request tagging process to consider whether a condition is reportable to the NRC.

Violation 1.A concerns multiple failures to report the safety function problems encountered with the MSIVs. This was caused in part by the failure of station personnel to document known equipment problems, the failure of management to set adequate reportability thresholds, and the failure to have promptly elevated information concerning the September 29, 1991, event to the appropriate level of management. The NRC is concerned about the narrow view adopted by the station in the past regarding what constituted a reportable event for the MSIVs.

Violation 1.B involves inadequate MSIV testing. The testing performed under procedure No. IT-280/285, "Inservice Testing of Main Steam Stop Valves," did not demonstrate that the MSIVs would perform satisfactorily in service due to preconditioning of the valves by other procedures. Point Beach Procedure OP-13A,

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"Secondary System Startup," which sequenced IT-280/285, to perform the test of record during startup, was deficient in that it directed the operators to cycle and precondition the valves prior to testing. Additionally, the valves were not timed when initially closed per Point Beach Procedure OP-13B, "Secondary System Shutdown." Had this been done, it is not likely that the MSIV performance problems would have gone undetected.

Taken collectively, Violations I.A and I.B represent a potentially significant lack of attention or carelessness towards licensed responsibilities in assuring that the MSIVs would perform satisfactorily. Therefore, in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (Enforcement Policy) 10 CFR Part 2, Appendix C (1991), Violation I has been classified as a Severity Level III violation.

Violation II involves the failure to evaluate identified MSIV malfunctions and institute effective corrective actions to preclude repetition. This violation is distinct from Violation I in that on several occasions, problems with MSIV No. 2MS-2017 were identified and entered into the station corrective action system. However, the 1987 and 1990 valve problems were not adequately reviewed to determine the root cause and consequently, adequate corrective action was not taken to prevent recurrence. Had this been done, it is not likely that the September 29, 1991, MSIV failures would have occurred. Therefore, in accordance with the NRC Enforcement Policy, Violation II has been categorized at Severity Level III.

The consequence of these violations is that the MSIVs, which are part of a system designed to mitigate a serious safety event, would either not close, or not close on a timely basis, and therefore may not have performed their intended safety function. Therefore, to emphasize the need for timely notification and reporting of events, and the prompt identification and correction of significant deficiencies, I have been authorized after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalties (Notice) in the amount of \$150,000 for the violations described in the enclosed Notice. The base amount of a civil penalty for each Severity III violation or problem is \$50,000. Violation I was assessed a civil penalty of \$50,000, while Violation II was assessed a civil penalty of \$100,000. The escalation and mitigation factors set forth in the Enforcement Policy were considered for each Severity Level III violation as discussed below.

The base civil penalty for Violation I was escalated by 50 percent for NRC identification of the reporting and testing deficiencies. A 50 percent mitigation was applied for your corrective actions, which were discussed above. An additional 100 percent mitigation was applied for your overall good past performance as exemplified by your most recent Systematic Assessment of Licensee Performance (SALP) and good enforcement history in these areas, notwithstanding one reporting violation in the safeguards area. However, a 100 percent escalation was applied for the factor of multiple examples based on the four reporting examples described in the citation and the numerous examples of failure to

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properly test the MSIVs. The other factors were considered and no further adjustments were deemed warranted.

For Violation II, the base civil penalty was escalated 50 percent for NRC identification of the deficiencies in your corrective action program. No adjustment was made for your corrective actions, once the problem was identified to you. Though you addressed the equipment trending deficiencies and the mismatch between equipment required by the Technical Specifications versus the Safety Analysis Report, no additional management oversight or audits were proposed at the enforcement conference to ensure that corrective actions were effective in preventing recurrent component failures. We acknowledge that following the conference you proposed additional corrective action. An additional 50 percent escalation was applied for your past poor performance in this area, as evidenced by a civil penalty of \$87,500 issued in April 1990 (see EA 89-254) for your failure to effectively implement a program to correct identified deficiencies in a timely manner. The remaining factors were considered and no further adjustment to the base civil penalty is considered appropriate.

Finally, you committed to a number of actions following the enforcement conference in a letter to us dated December 3, 1991. If you plan to deviate from any of those commitments, please advise us in advance of the deviation.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your responses will be placed in the NRC Public Document Room.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96-511.

Sincerely,

*(Signature)*  
A. Bert Davis

A. Bert Davis  
Regional Administrator

Enclosure: Notice of Violation  
and Proposed Imposition of  
Civil Penalty

(SEE ATTACHED CONCURRENCE)

See Distribution Next Page

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Regional Administrator

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\* HENOGUE - IS CONCURRENCE RECEIVED BY FRX 1/9/92

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cc w/enclosure:

DCD/DCB(RIDS)

OC/LFDCB

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Virgil Kanable, Chief Boiler Section

Charles Thompson, Chairman

Wisconsin Public Service Commission

Robert M. Thompson, Administrator

Wisconsin Division of Emergency Government

Chief, Radiation Protection Section

Wisconsin Dept. of Health and Social Services

Wisconsin Electric Power Company

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