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VPNPD-92-217  
NRC-92-064

June 15, 1992

U. S. NUCLEAR REGULATORY COMMISSION  
Document Control Desk  
Mail Station P1-137  
Washington, D. C. 20555

Gentlemen:

DOCKETS 50-266 AND 50-301  
RESPONSE TO NOTICE OF VIOLATION  
INSPECTION REPORT 50-266/92009(DRP);  
50-301/92009(DRP)  
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

Your letter dated May 15, 1992, transmitted a Notice of Violation which was supported by the findings documented in Inspection Report 50-266/92009(DRP); 50-301/92009(DRP). The Notice of Violation cited two examples of failure to conform with the requirements of 10 CFR 50, Appendix B, Criterion V. This criterion requires that activities affecting quality be prescribed in documented procedures, instructions, and drawings appropriate to the situation.

The first cited example occurred on April 29, 1992, during preparations for hydrostatic testing of a portion of the Residual Heat Removal (RHR) System. The hydrostatic test was being performed as part of the acceptance testing for a modification performed during the most recent refueling outage for our Point Beach Nuclear Plant, Unit 1. This modification installed test lines capable of passing full flow from the RHR pumps and was performed to address concerns with operating the pumps on recirculation at reduced flow and to allow more meaningful testing of the pumps. During the lineup of the system, prior to filling the piping, a vent valve was inadvertently left open. When the RHR pump suction and discharge valves were opened to fill the piping with water, the water began discharging from the open vent valve into the containment spray pump room in the Primary Auxiliary Building. Approximately 200 gallons of water were discharged. The spill resulted in approximately 600 square feet of floor near the safety injection and containment spray pumps becoming contaminated. No personnel contaminations occurred.

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The RHR suction and discharge valves, which had been opened from the control room to fill the RHR piping, were immediately closed when water was reported discharging from the vent line. The hydrostatic test was suspended to assess the incident and take corrective action. The valve lineup utilized during the test was reviewed for accuracy. This review identified the vent valve which had been inadvertently left open during the filling process. To ensure the completeness of the valve lineup during the completion of the testing process, a detailed valve lineup check list was developed to establish the test boundaries; the valve lineup was performed; and the test completed without further incident.

During our review of this event, we determined that the change to the design of the test line modification to include this vent valve was made during installation of the modification utilizing the Engineering Change Request (ECR) process. This process is controlled by Quality Assurance Procedure QP 3-4, "Engineering Change Requests." This procedure presently requires identification of drawings that require update but does not require update prior to the performance of post-modification testing. PBNP 3.2.5, "Pressure Test Program," currently does not require that a formal valve lineup sheet be used while establishing the boundaries for a pressure test. The procedure suggests that a sketch be prepared defining the extent of the pressure test and boundary. The operators used a separate marked-up sketch during the valve lineup which they had updated to reflect this vent path. The controlled drawing in the control room had also been updated to include the vent path. However, the informal sketch in the hydrostatic test package did not reflect the new vent valve.

A revision to PBNP 3.2.5 is being written to require that a formal valve lineup be prepared and utilized, along with the appropriate verification, when performing system lineups for pressure tests. Requirements will also be established to ensure that the test boundaries are shown on appropriate plant documents rather than on informal sketches. This revision will be incorporated into our current review and complete rewrite of PBNP 3.2.5. This complete rewrite is being conducted in support of our upgrade to the Point Beach repair and replacement program as defined in ASME Section XI, "Rules for In-Service Inspection of Nuclear Power Plant Components;" Article IWX-4000, "Repair Procedures;" and IWX-2000, "Replacements." The complete procedure rewrite, including this revision, will be issued by September 30, 1992.

In addition to the revision to PBNP 3.2.5, we are evaluating our ECR and modification procedures to strengthen the controls and linkage between these procedures. We will complete these evaluations and subsequent revisions to our Engineering Change Request and modification procedures by September 1, 1992.

Also, we will continue to stress with our personnel the importance of good, timely communications and the need to remain cognizant of the status of all ongoing evolutions. This will be emphasized in continuing training.

When the described procedural revisions are completed addressing pressure test evolutions and the ECR process, we will be in full compliance to 10 CFR 50, Appendix B, Criterion V for this cited example.

The second cited example occurred on April 28, 1992. This event occurred during the inspection of safeguards bus 1A06 when the wrong potential transformer cubicle was entered. Potential transformers, which sense bus voltage, for 4160V safeguards buses 1A05 and 1A06 are located within the same cubicle, 1A00-62, on bus 1A06 but behind separate doors. The doors were uniquely identified with small labels. The maintenance electrician and his supervisor, directed to inspect the potential transformer for bus 1A06, thought the cubicle contained only components associated with bus 1A06, which was deenergized. The electrician failed to read the identifying labels and opened the door associated with the potential transformer for bus 1A05, which was energized. Opening the door, which is interlocked with the undervoltage relays for the bus, resulted in the undervoltage relays for the safeguards bus 1A05 sensing the bus as deenergized. This caused diesel generator G01 to automatically start and bus 1A05 to deenergize and be reenergized by the diesel generator. Normal power was restored to the bus in approximately 10 minutes and the diesel generator secured and placed in standby. Procedures for this evolution did not adequately describe the location and configuration of the cubicle. This event and the corrective actions taken are described in detail in Licensee Event Report 266/92-003-00, dated May 27, 1992.

A Human Performance Enhancement System Evaluation (HPES) has been performed and concluded the event was attributable primarily to human error. This event was discussed with the individuals involved. The consequences of the event will be included in future training sessions on operation and maintenance of switchgear.

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The Plant Manager issued a statement to plant and contractor personnel summarizing the event, its precursors, and the importance of self-checking.

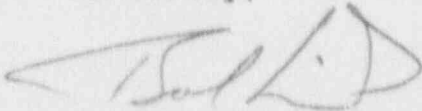
A caution statement has been added to Routine Maintenance Procedures (RMP) 29c, 29d, 29e, and 29f to alert personnel that opening a door to a potential transformer will result in deenergization of the associated bus. The procedures will also indicate, where appropriate, that potential transformers for both A05 and A06 are located in close proximity to each other. The doors for the potential transformers for buses A01, A02, A03, A04, A05, and A06 have been labeled to indicate that opening the door will result in deenergizing the bus. Labels have also been applied to the outside of cubicles 1A00-62 and 2A00-71 to indicate train A and train B safeguards components are located inside.

We believe that these actions have satisfactorily addressed this issue and will preclude a similar event in the future. We are now in compliance with 10 CFR 50, Appendix B, Criterion V for this cited example.

We agree that these events occurred as described in the Notice of Violation and accompanying Inspection Report. The events are appropriately characterized, in the aggregate, as a Severity Level IV violation.

Please contact us should you require additional information or have questions regarding this response.

Sincerely,



Bob Link  
Vice President  
Nuclear Power

Copies to NRC Regional Administrator, Region III  
NRC Resident Inspector