



231 W Michigan, P.O. Box 2046, Milwaukee, WI 53201

(414) 221-2345

VPNPD-93-003

NRC-93-002

January 7, 1992³

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

Gentlemen:

DOCKETS 50-266 AND 50-301
RESPONSE TO NOTICE OF VIOLATION
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

In a letter from Mr. L. Robert Greger dated December 8, 1992, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for Point Beach Nuclear Plant, the results of a routine safety inspection conducted by Messrs. K. R. Jury, J. Gadzala, and G. F. O'Dwyer from October 13 through November 22, 1992. This inspection report included a Notice of Violation (Notice). The Notice describes a violation of Point Beach Nuclear Plant Technical Specification 15.6.8, "Plant Operating Procedures," Section 15.6.8.1.

We have reviewed this Notice and, pursuant to the provisions of 10 CFR 2.201, have prepared a written response concerning the identified violation. Our written response is included as an attachment to this letter.

The violation identified in the Notice pertains to the failure of a maintenance electrician to properly perform actions directed in Routine Maintenance Procedure (RMP) 74, "B Train Degraded and Loss of Voltage Relay Test." This RMP is performed monthly to test the degraded voltage and undervoltage relays associated with 2A06, the "B" train 4160 volt safeguards bus, and 2B04, the "B" train 480 volt safeguards bus.

During the portion of the procedure that tests the undervoltage relays for bus 2A06, the initial step requires the person performing the test to remove the cover to test switch 2-TS1/A06, open its left-most knife blade switch, and remove the 2A06 bus undervoltage test switch test point cover. The technicians performing this step failed to open the knife blade switch, but

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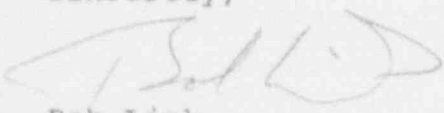
initialed for completion of the step. This knife blade switch is required to be opened in order to defeat one of the undervoltage stripping functions to the 2A06 bus supply and tie breakers. This is a violation of Technical Specification 15.6.8, which requires that the plant be operated and maintained in accordance with approved procedures.

In order to test the undervoltage relays, a trip/test button is depressed on the undervoltage sensing relay to simulate an undervoltage condition on the bus. This step was performed, as required by the procedure. Since the undervoltage stripping function had not been defeated, depressing the trip/test button caused the supply breaker to 2A06 to actually trip, de-energizing the bus. The loss of 2A06 also resulted in the de-energization of 2B04. When 2A06 de-energized, the associated emergency diesel generator, G02, automatically started, as designed, and re-energized both 2A06 and 2B04.

Unit 2 was in a reduced inventory condition at the time of the event with the "B" train Residual Heat Removal Pump running to remove core decay heat. The de-energization of 2B04 resulted in a loss of power to this pump. Upon recognizing that the running RHR pump had been lost, an operator manually started the "A" train RHR pump, restoring RHR flow. There was no indication of any reactor coolant system temperature increase during the one-minute period when neither pump was running.

Following the event, a Human Performance Enhancement System (HPES) evaluation was conducted to determine the underlying causes of the event. Based on the results of this evaluation, several corrective actions have been taken or are planned to be taken to respond to the identified deficiencies. We believe that these corrective actions are responsive to the concerns and fulfill the requirements identified in your December 8, 1992, letter. If you have any questions or require further information regarding this response, please contact us.

Sincerely,



Bob Link
Vice President
Nuclear Power

FDP/jg

Enclosure

cc: NRC Regional Administrator, Region III
NRC Resident Inspector

REPLY TO NOTICE OF VIOLATION

WISCONSIN ELECTRIC POWER COMPANY
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
DOCKETS 50-266 AND 50-301
LICENSE NOS. DPR-24 AND DPR-27

During the routine safety inspection conducted at our Point Beach Nuclear Plant from October 13 through November 22, 1992, one violation of NRC requirements was identified. The identified violation was classified as a Severity Level IV. Inspection Report Numbers 50-266/92023(DRP) and 50-301/92023(DRP) and the Notice of Violation (Notice) transmitted to Wisconsin Electric on December 8, 1992, provide details regarding the violation. We agree that the event and circumstances in the Notice are accurately characterized.

In accordance with the instructions provided in the Notice, our reply to the alleged violation includes: (1) the reason for the violation, (2) corrective action taken and the results achieved, (3) corrective action to be taken to avoid further violations, and (4) the date when full compliance will be achieved.

VIOLATION

"Technical Specification 15.6.8 requires that the plant be operated and maintained in accordance with approved procedures. Procedure RMP 74, 'B Train Degraded and Loss of Voltage Relay Test,' Step 3.2.1, directs opening a knife blade switch in preparation for testing. Step 3.2.3 directs depressing the relay test button. A caution statement preceding Step 3.2.1 warns the technician that the knife blade switch is to be opened first."

"Contrary to the above, on October 26, a maintenance electrician did not open the isolation knife switch as required by procedure RMP 74 prior to depressing the relay test button."

RESPONSE TO VIOLATION

1. REASON FOR THE VIOLATION

The event cited in the Notice of Violation occurred on October 26, 1992, with the unit in a reduced inventory condition, during the performance of Routine Maintenance Procedure (RMP) 74. During the portion of the procedure that tests the undervoltage relays for Bus 2A06, the "B" train 4160 volt safeguards bus, the initial step requires the person performing the test to remove the cover to Test Switch 2-TS1/A06, open its left-most knife blade switch, and remove the 2A06 bus undervoltage test switch test point cover. The technicians performing this step

failed to open the knife blade switch, but initialed for completion of the step. This knife blade switch is required to be opened in order to defeat one of the undervoltage stripping functions to the 2A06 bus supply and tie breakers.

An evaluation conducted following the event determined that there were two principal causes. First, the two maintenance electricians assigned to perform the procedure, failed to completely perform a step within the procedure. This allowed the undervoltage stripping function to still be available to the supply breaker for 2A06. The breaker then tripped when the undervoltage relay test button was depressed. There is a caution label installed in the vicinity of the undervoltage relay test button that addresses the concerns about knife blade switch positioning. These workers had successfully completed the identical procedure on Unit 1 prior to performing the procedure on Unit 2.

Second, the procedure was not fully adequate. The step that was improperly performed directed the technician to, "Remove the cover to 2-TS1/A06 and open the left-most knife blade switch. Also remove the test point cover." The problem with this step is that it identifies three separate actions that must be performed, with only one sign-off block. The procedure did, however, provide a caution statement immediately prior to the step that was incompletely performed. This caution statement adequately addresses the concerns about the positioning of the knife blade switches.

This violation is also significant because the testing resulted in the momentary loss of residual heat removal flow with the unit in reduced inventory. Reduced inventory is defined as a period when reactor vessel water level is less than 55 percent. We believe that safeguards surveillance testing should not be conducted when in reduced inventory without some form of evaluation of the safety significance of the testing taking place prior to its performance.

There are existing controls that could have prevented this procedure from being performed during reduced inventory, but these were not effectively utilized. The performance of the testing on Unit 2 was not discussed during the daily outage planning meeting. This meeting is held daily during the outage to review and discuss activities planned for the next 24-hour period. The performance of the testing was discussed immediately following the meeting's termination, which resulted in the testing not being placed on the major items work list, and prevented a thorough review of the safety significance of this testing from being performed. Discussion of the testing during the outage planning meeting may have precluded its performance when in reduced inventory.

2. CORRECTIVE ACTIONS TAKEN

In response to this event, several corrective actions have already been taken, and additional actions are also planned. These actions have been taken to prevent recurrence of similar events.

A. IMMEDIATE CORRECTIVE ACTIONS

- (1) A Human Performance Enhancement System (HPES) evaluation was initiated to determine the underlying causes of this event. The adopted recommendations of this evaluation are documented in Licensee Event Report 92-007-00, dated November 23, 1992, and are also discussed in this reply.
- (2) The two maintenance electricians were counselled by the manager of the maintenance group concerning this event and the implications of their actions.

B. ADDITIONAL CORRECTIVE ACTIONS TAKEN TO DATE

- (1) RMP 74 and its "A" train counterpart, RMP 73, and the associated procedures for Unit 1 have been revised to provide separate steps and sign-off blocks for each required action item, as well as to add requirements to perform voltage checks following the repositioning of the knife switches in order to verify their positions. These procedures were also revised to preclude their performance when the respective unit is in reduced inventory. These revisions were implemented on November 20, 1992.
- (2) The Outage Planning and Safety Evaluation Groups evaluated methods to ensure that an improved review of maintenance and testing activities is conducted should such activities be required when the reactor is in a reduced inventory condition. These improved methods will be implemented in a revision to Point Beach Nuclear Plant Administrative Procedure (PBNP) 3.1.5, "Outage Planning, Scheduling, and Management," as discussed below.

3. CORRECTIVE ACTION TO BE TAKEN TO PREVENT RECURRENCE

- A. Point Beach Nuclear Plant Administrative Procedure (PBNP) 3.1.5, "Outage Planning, Scheduling, and Management," is being revised. The new revision will require that a safety assessment be performed on the following activities before they are performed when a unit is in a reduced inventory condition:

- 1) All safety-related work activities
- 2) All electrical work activities
- 3) All primary system work activities on the unit in reduced inventory
- 4) All testing activities on either unit

Any of these activities that are pre-scheduled will undergo the safety assessment by the Safety Evaluation Group before they are placed on the outage schedule. Any emergent work activities will undergo the safety assessment by the Shift Outage Coordinator and will be authorized by the Production Planning Manager before they are placed on the outage schedule. These reviews will ensure that a proper safety assessment is performed before any work activities that could affect decay heat removal capability are performed when a unit is in reduced inventory.

This information has been promulgated in Point Beach Memo (PBM) 92-1376, dated December 8, 1992. The associated revision to PBNP 3.1.5 will be in place prior to the 1993 Unit 1 refueling and maintenance outage.

4. DATE OF FULL COMPLIANCE

All corrective actions, identified above, which we believe will result in full compliance with Technical Specification 15.6.8 have been completed, or will be completed by March 31, 1993. This will ensure that all corrective actions are completed prior to the 1993 Unit 1 refueling and maintenance outage.