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

Gentlemen:

DOCKETS 50-266 AND 50-301
REPLY TO NOTICE OF VIOLATION
INSPECTION REPORTS 50-266/94016 (DRS); 50-301/94016 (DRS)
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

On September 15, 1994, the Nuclear Regulatory Commission forwarded to Wisconsin Electric Power Company, licensee for Point Beach Nuclear Plant, the results of an engineering and technical support inspection conducted by Messrs. Mendez, Replogle, and Salehi. This inspection contained two Severity Level IV violations.

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

If you have questions regarding this response or require additional information, please contact us.

Sincerely,

Frank Palmieri for R.E. Link.

Bob Link
Vice President
Nuclear Power

FAF/jg

Enclosure

cc: NRC Regional Administrator
NRC Resident Inspector

IE01
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RESPONSE TO NOTICE OF VIOLATION

Wisconsin Electric Power Company
Point Beach Nuclear Plant, Units 1 and 2
Docket Nos. 50-266 and 50-301
License Nos. DPR-24 and DPR-27

During an engineering and technical support inspection conducted by Messrs. Mendez, Replogle, and Salehi; two violations of NRC requirements were identified. The violations were classified as Severity Level IV. Inspection Report Nos. 50-266/94016 (DRS) and 50-301/94016 (DRS) and the Notice of Violation (NOV) transmitted to Wisconsin Electric on September 15, 1994, provide details regarding the violations.

VIOLATION 1

10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Procedure NP 5.3.1, Revision 0, "Condition Report System," requires that events or conditions potentially adverse to quality are promptly identified, evaluated, and corrected.

Contrary to the above:

a. Between 1988 and July 26, 1994, the licensee identified water in the P-029 turbine driven auxiliary feedwater pump bearing oil approximately every six months; however, corrective actions to resolve this condition were not taken until July 29, 1994.

b. The licensee's actions to correct a condition identified in NRC Inspection Report Nos. 266/301-92024 in which the licensee failed to close out modification packages within the required time were not effective in precluding repetition. Modification Package 91-11 was not closed out within the required time and no waiver was issued.

Reason for Violation Example 1.a:

This example states that water was found in the outboard bearing oil of the 1P29 turbine-driven auxiliary feedwater pump (TDAFWP) on a regular (approximately 6-month) basis since 1988, with no corrective action being taken. The violation also states that no condition reports were issued until July 28, 1994, to document the problem.

The maintenance work request (MWR) system was the mechanism that was previously used to document the inspection results. During the period of 1988 to mid-1994, preventive maintenance call-ups and inspections of the bearings during turbine overhauls identified no evidence of damage to the bearings as a result of water being present in the lubricating oil. Furthermore, all surveillance tests of the 1P29 TDAFWP were completed satisfactorily. These surveillance tests included operation of the pump/turbine, monitoring of pump vibration levels, and monitoring of pump bearing temperatures. No unusual trends were identified, even during extended runs. As a result, maintenance and engineering staffs did not recognize that the situation may have been a condition adverse to quality, and therefore did not identify a need to further investigate and take corrective action.

A formal program for monitoring lubricating oils was established in late 1993. This oil analysis program aided plant personnel in identifying this problem. The individual who administers the program raised the question of whether water emulsified in the lubricating oil reduces the oil's ability to lubricate and remove bearing heat. He subsequently consulted the manufacturer to determine if this situation could be tolerated. The manufacturer stated that the pump and bearings could operate in this condition for an extended period but did not provide specific values.

Corrective Actions Taken:

As noted in the inspection report, Condition Report 94-293 was issued on July 28, 1994. Additionally, Root Cause Evaluation 94-23 was issued on September 14, 1994. The root cause evaluation focused upon the problems encountered during the turbine outage and not specifically upon the issue of water in lubricating oil. Two recommendations from this evaluation specifically pertain to this violation and are as follows:

a. An evaluation of acceptable limits for water in 1P29 TDAFWP lubricating oil was completed via Engineering Work Request 94-223 on September 8, 1994.

b. Several programmatic enhancements to the oil analysis program were identified, including the ability to perform on-site oil analysis. We have acquired

equipment to perform these analyses and are now performing them on-site. Also, a continuing training lesson plan, LP2191, "Lubrications Review," was developed. This lesson plan was presented to all mechanical maintenance personnel during May and July of 1994. It will replace the initial training lesson plan on lubrications currently contained in the maintenance repairer training program.

In addition to the above two recommendations, several corrective actions were taken during the July TDAFWP outage. The seal housing on the turbine of the pump was replaced because of pitting on the surface between the carbon seals and housing. Additionally, the space between the seal housing and the turbine case was sealed with a different gasket material. We believe that these corrective actions will adequately address the water problem.

Corrective Actions to be Taken:

A root cause evaluation of the TDAFWP water in lubricating oil problem will be completed by February 28, 1995. The effectiveness of our July corrective maintenance actions will also be assessed during this evaluation.

The priority for revising our oil analysis program was upgraded. The applicable administrative procedure will be revised by February 28, 1995. This revision will include guidance describing when an engineering evaluation should be performed, should water be discovered in the TDAFWP lubricating oil. The oil analysis program will be fully implemented for safety-related pumps by February 28, 1995.

Date When Full Compliance Will be Achieved:

Both of the corrective actions described above will be completed by February 28, 1995.

Reason for Violation Example 1.b:

Inspection Report 266/301-92024 dated April 2, 1993, identified a failure to close out modification requests (MRs) in the timeframe required by procedure. This example noted that the closeout of MR 91-011 exceeded the time frame allowed in QP 3-1 with no waiver being documented. The waivers were, in fact, documented and are included in the MR package as required. Although delays were encountered during the closeout, the delays were not the result of inadequacies in the modification process. We believe

that this example is inappropriately characterized as a repetitive occurrence related to the modification process and is not a violation of 10 CFR 50, Appendix B, Criterion XVI.

The procedural requirement to close out MR packages states, "After acceptance of the modification, the Responsible Engineer has 180 days to complete all document updates required for closeout. If all updates cannot be completed, the Responsible Engineer shall request an extension from the final design group head in writing." MR 91-011 was accepted for operation on May 6, 1993, requiring that the submittal of document updates to be complete prior to November 6, 1993. Although only one waiver would have been required, the responsible engineer submitted two waivers, extending the closeout time frame to February 6, 1994. The document updates were submitted for processing and the responsible engineer signed off the MR package on February 4, 1994, satisfying procedural requirements.

Our clerical staff also monitors the closeout process. A modification request is not microfilmed until all document updates are submitted and processed. During the clerical check of this MR package in May 1994, it was noticed that one drawing change notice (DCN) had not been returned from review for processing. The responsible engineer was notified and a new DCN was submitted. A waiver dated May 12, 1994, was submitted to cover an additional month for the new DCN.

The issue with this modification request is that a DCN was misplaced during the review process. In fact, the misplaced DCN was the basis for one of the documented waivers in the MR package.

The timeliness of DCN processing and incorporation onto plant drawings was an area previously self-identified as being a weakness. As a result, a drawing control process improvement team was chartered on March 2, 1994. The process improvement team's final report, issued August 8, 1994, contained 12 recommendations specific to the DCN process.

All of the DCN-related recommendations were completed on September 30, 1994, with issuance of revised NP 1.4.3, "Drawing Change Notice Procedure," and associated form PBF-1508, "Drawing Change Notice." The changes streamline the DCN review and approval process to eliminate multiple, identical reviews of the initiated DCN and revised drawing, simplify drawing administrative processing routines by support personnel, and reduce the level of authority required to approve DCNs and revise drawings.

Since the procedures were followed as intended, we believe that the actions taken in response to the previously identified weakness have been effective, ensuring that modification requests are closed out in accordance with procedural requirements.

VIOLATION 2

10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires that activities affecting quality shall be prescribed by and accomplished in accordance with documented instructions or procedures.

a. QP 3.6, "Calculation Procedure Review and Approval," Revision 2, requires that calculations shall provide information stating the documented assumptions, references and inputs.

b. Procedure PBNP 3.4.25, "Exclusion of Foreign Material from Plant Components and Systems," paragraph 7.10, requires that the maintenance work supervisor or QC inspector shall perform and document the closure inspection for the system or component.

Contrary to the above:

a. Calculations P-89-037, P-90-004, P-93-004, P-94-013, and N-04-012 did not include documented assumptions, references, and inputs.

b. The inspection for foreign materials, associated with work performed on Valve 1-SI-854A, was not documented and there was no evidence that the inspection was performed by a maintenance supervisor, a work supervisor, or QC inspector.

Reason for Violation Example 2.a:

In response to the NOV, each of the five calculations were reviewed. With one exception, we believe that the calculations do contain documented assumptions, references, and inputs as required. However, we did identify a lack of consistency in how the required information is presented within a calculation. We also identified a number of other weaknesses with the calculation process in an internal assessment discussed below. Lack of attention to this issue on our part also contributed to the problem identified in the NOV.

Corrective Action Taken:

Prior to the NRC inspection, an internal assessment (A-P-94-08) identified weaknesses in our calculation process. The weaknesses identified during this assessment are documented in Quality Condition Report (QCR) 94-028, dated June 14, 1994. An evaluation dated July 15, 1994, was performed in response to this QCR. A copy of the QCR and its evaluation were provided to the inspection team.

Corrective Actions to be Taken:

A committee within Engineering was established to review design consistency. This committee is reviewing the design process and our compliance with FSAR design control commitments. A review of the calculation procedure is part of this effort. The Engineering Review Committee will complete its evaluation of our design processes by December 31, 1994. The procedure governing calculations will be revised by February 28, 1995, implementing any needed revisions to the calculation process.

Date Full Compliance Will be Achieved:

Full compliance will be achieved by February 28, 1995, upon issuance of the revised calculation procedure.

Reason for Violation Example 2.b:

In response to the NOV, discussions were held with maintenance personnel. We ascertained that the FME closeout inspection was performed by the worker rather than the maintenance supervisor, work supervisor, or QC supervisor. This was done to minimize radiation exposure for ALARA considerations and was not recognized at the time as a procedural noncompliance. Additionally, the closeout inspection forms could not be located; therefore, adequate documentation of this inspection is not available. There was a QA surveillance (work monitoring report); however, that indicates the inspection had been performed and documented.

Corrective Actions Taken:

PBNP 3.4.25, "Exclusion of Foreign Material from Plant Components and Systems," was revised and incorporated into a new administrative procedures manual as NP 8.4.10. The revised procedure was issued on September 7, 1994. The revision provides a better definition on the applicability of FME requirements and adds requirements for temporary closures and evaluations during standard work practices evolutions. Additionally, the revision deletes the requirement for the FME evaluation form to be included in the work procedure, but allows for inclusion of the sign off steps to be incorporated into a procedure or work plan in lieu of separate forms. The worker has also been included, in the revision, as a potential cleanliness inspector in addition to the maintenance supervisor, work supervisor, or QC inspector. An informational message was issued to alert personnel of the procedure changes.

The maintenance manager also held a team meeting with representatives from several plant groups on September 8, 1994, to review condition reports generated during the previous Unit 1 refueling outage which identified potential FME problems. As a result of this review, several additional actions were recommended by the team to reinforce our FME control program. These action items are being tracked via the condition reporting system. It is planned that a similar meeting will be held following the completion of the Unit 2 refueling outage.

Additionally, the maintenance manager issued a memo to the Nuclear Power Business Unit on September 19, 1994, establishing his expectation that FME is the responsibility of all personnel on site. The memo provides general guidance which is delineated in NP 8.4.10. It also provides specific instructions and controls for entry of personnel into the FME area established for the refueling cavity, as well as requests that FME be discussed during pre-outage meetings and routinely during pre-job briefings.

On October 3, 1994, the maintenance manager briefed the NRC resident inspectors regarding FME program changes and enhanced controls which have been implemented during the Unit 2 refueling outage.

The maintenance manager is conducting periodic inspections and evaluations of work areas to ensure that FME controls have been established as needed and are being appropriately maintained. These inspections are being performed to reinforce our expectations for FME controls.

Date Full Compliance was Achieved:

Full compliance was achieved on September 8, 1994, with issuance of revised procedure NP 8.4.10 and the accompanying informational message.