

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region III

POINT BEACH

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/18/2000	1999019	Pri: OPS Sec: MAINT	NRC	MISC	Pri: 2A Sec: Ter:	Minor leakage from insolatable primary system pressure boundary check valve. Licensee attempts to repair a body-to-bonnet leak on an unisolatable primary system pressure boundary valve (Unit 1 valve 853C) had been unsuccessful as of the end of the inspection period. The inspectors verified that the repairs were being conducted in accordance with the applicable safety evaluation. Primary system leakage remained well below Technical Specification limits.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
12/10/1999	1999018	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	Start-up activities. The conduct of operations associated with the Unit 1 refueling outage shutdown and startup was very good. Operators were attentive to control board indications and improvements were observed in the testing of the turbine-driven auxiliary feed water pump.
Dockets Discussed: 05000266 Point Beach 1						
12/10/1999	1999018	Pri: OPS Sec: MAINT	NRC	POS	Pri: 1A Sec: 3A Ter:	Refueling surveillance tests. Overall conduct of three complicated Unit 1 refueling outage surveillance tests was good. The surveillance test activities involved several high risk significance, safety-related systems, and required the coordination of numerous personnel, located in several areas of the plant, and from several departments.
Dockets Discussed: 05000266 Point Beach 1						
10/18/1999	1999016-01	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 3A Ter:	Flow path through a leaking containment isolation valve was not isolated within the specified time limit. Operators violated plant Technical Specifications when the flow path through a leaking containment isolation valve was not isolated within the specified time limit. This failure occurred because the operators did not recognize the valve's containment integrity function, as described in the Final Safety Analysis Report. One Non-Cited Violation was identified with a tracking number of 50-301/99016-01(DRP).
Dockets Discussed: 05000301 Point Beach 2						
10/18/1999	1999016	Pri: OPS Sec: MAINT	NRC	MISC	Pri: 1B Sec: 2A Ter:	Response to loss of instrument air. Operators responded very well to the loss of the only operable instrument air compressor. Actions were prompt and deliberate. Procedure use was appropriate. Air compressor equipment problems had continued to be a reoccurring challenge for operators.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
08/26/1999	1999301	Pri: OPS Sec:	NRC	NEG	Pri: 3B Sec: Ter:	Procedures used in operator licensing. Station personnel recently revised many of the station's operating and administrative procedures. Deficiencies in two procedures that had not been revised confused several applicants during administration of the operating job performance measures.
Dockets Discussed: 05000266 Point Beach 1						

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08/26/1999	1999301	Pri: OPS Sec:	Self	POS	Pri: 3B Sec: Ter:	Operator licensing exam. The applicants were well prepared for the operating test and written examination. In general, they displayed good operating and communicating practices during the operating test. The small number of questions missed by more than 50% of the applicants indicated a comprehensive training program that met the needs of the applicants.
Dockets Discussed: 05000266 Point Beach 1						
07/13/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 1C Ter: 2A	Real-time risk insight. Operations department personnel were actively and effectively using the on-line Safety Monitor, a computer-based system that provided advanced and real-time risk insights for proposed and current plant equipment configurations.
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05/27/1999	1999008	Pri: OPS Sec:	NRC	MV	Pri: 3A Sec: Ter:	Procedure use and adherence problem. The inspectors identified that an operating crew failed to properly apply the licensee's procedure use and adherence policy during a Unit 1 shutdown. The violation was minor because of the minimal direct safety consequence; however, the inspectors were concerned because the involved crew had recently completed remedial training for a previous procedure violation.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/27/1999	1999008	Pri: OPS Sec:	NRC	NEG	Pri: 5C Sec: 3C Ter:	Slow corrective actions for cultural aspects of the procedure use and adherence problems. The licensee had initiated corrective actions to address process and cultural problems that underlay procedure use and adherence problems. However, plant material condition discrepancies and some management approved responses to these discrepancies had complicated efforts to address the cultural aspects of the procedure use and adherence problems.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/27/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter:	Good performance following manual trip. The Unit 1 reactor was manually tripped on May 14, 1999, due to a rupture of the 4B feedwater heater. The operators followed conduct of operations procedural requirements and exercised conservative decision-making throughout the event. The inspectors considered the observed performance to be particularly good. Emergency safety features system equipment functioned as designed.
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05/27/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: Ter:	Good approach-to-criticality evolution. Operators performed their duties in an appropriate manner during the observed portions of two Unit 1 startups. The approach-to-criticality evolution continued to be a licensee strength, with thorough and focused attention being paid to critical plant parameters.
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04/10/1999	1999006	Pri: OPS Sec:	NRC	MISC	Pri: 3A Sec: Ter:	Self-corrected control room decorum problems. The inspectors noted increases in the noise level and the number of distracting activities being performed in the control room. This declining trend was stopped in the latter stages of the inspection period.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: OPS Sec:	Licensee	NEG	Pri: 1A Sec: 3A Ter:	Unanticipated cooldown. Operators pulled control rods to increase primary power in response to an unanticipated cooldown caused by an increase in secondary power. This action was inconsistent with plant management's expectation that unanticipated secondary power changes normally be corrected, if possible, rather than responded to with changes of primary power.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 3A Ter:	Pre-sync problem. The conduct of control room activities was not measured and deliberate during the shift immediately prior to paralleling the Unit 2 turbine generator to the electrical distribution grid. Activities were directed in a manner that distracted a control room reactor operator involved with preparation for paralleling the unit to the grid. The duty shift superintendent (the lead senior reactor operator) did not maintain the supervisory role of "big picture" control room oversight.
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04/10/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	Reactor startup. The Unit 2 reactor was made critical in a deliberate and controlled manner on February 26, 1999. The pre-job briefing conducted prior to making the reactor critical was conducted well. The duty shift superintendent (the lead senior reactor operator) ensured that the control room environment was quiet and restricted access to limit distractions during this activity.
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04/10/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	Connected to grid. The Unit 2 turbine generator was connected with the electrical distribution grid in a controlled and deliberate manner on March 7, 1999. The Unit 2 operations supervisor (a senior reactor operator) in charge of the evolution displayed strong command and control of the activities.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3B Ter: 5C	Good training in response to performance problems at the plant. The licensee initiated required training for all nuclear business unit employees. This training focused on cultural issues associated with recent performance problems at the station. Given the events documented in recent inspection reports, the inspectors considered the training to be innovative and appropriately focused.
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04/10/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 5A Sec: 2A Ter: 3B	Licensee identification of need for effective corrective actions for longstanding problems. The licensee's corrective action program effectively documented continuing equipment status control problems, including the lack of awareness of reactor operators that some control room computer alarms had been removed from service. The quality verification (quality assurance) organization, the off-site review committee, and senior plant management recognized the need to increase the existing focus on establishing effective corrective actions for longstanding problems in this area.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-04	Pri: OPS Sec:	Licensee	NCV	Pri: 3A Sec: 1A Ter:	Operator's failure to trip the reactor when reactor coolant temperature decreased below 540 degrees Fahrenheit During the performance of a turbine-driven auxiliary feedwater pump surveillance test, operators were not adequately prepared to respond to a cooldown in the primary system caused by operation of the pump. The primary system cooldown exceeded a procedurally specified reactor trip criterion. Due to an inadequate turnover, the operators were unaware of the trip criterion and did not trip the unit. A non-cited procedural violation was identified and assigned a tracking number of 50-301/99006-04(DRP).
Dockets Discussed: 05000301 Point Beach 2						
03/31/1999	1999004-01	Pri: OPS Sec: MAINT	NRC	NCV	Pri: 1A Sec: 2B Ter:	Failure to maintain a required procedure current following system modification. The inspectors identified that an alarm was not associated with the pipe cited in the facade freeze protection procedure for the given alarm. The licensee found several more errors after the inspectors questioned the accuracy of the procedure. The inspectors concluded that the licensee had failed to maintain the procedure current following modification work. This failure was considered to be a non-cited violation of plant Technical Specifications (NCV 50-266/99004-02(DRP)). The licensee's failure to identify the procedure and alarm inconsistency also reflected poorly on the thoroughness of the immediate corrective actions following the safety injection line freeze-up identified 3 days earlier.
Dockets Discussed: 05000266 Point Beach 1						
03/10/1999	1999-001-00	Pri: OPS Sec: MAINT	Self	LER	Pri: 2A Sec: 2B Ter:	Emergency diesel generator output breaker failed to remain closed during surveillance test. The unanticipated loss of all power to the Unit 2 "A" train electrical bus resulted in the allowed surveillance test exemption not being satisfied. This placed the Unit outside of the Technical Specification-allowed conditions for operable residual heat removal systems. This violation is being treated as a Non-Cited Violation with a tracking number of 50-301/99006-02(DRP).
Dockets Discussed: 05000301 Point Beach 2						
02/22/1999	1999002	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: Ter:	Impact of degraded non-Technical Specification equipment. The licensee did not routinely evaluate the impact of inoperable, degraded, or nonconforming equipment unless the equipment was required by Technical Specifications. While acceptable within the regulations, this practice made the licensee vulnerable when the failure of non-Technical Specification-required equipment had an impact on the operability of equipment with more safety significance, as in the facade freeze protection case described in Inspection Report 50-266/99004(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: OPS Sec:	NRC	NEG	Pri: 3C Sec: Ter:	Lack of alarm response instructions for plant computer alarms. The inspectors identified that the licensee lacked alarm response instructions for operationally significant alarms generated by the plant process computer system and did not have procedural controls for disabling control room alarms.
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02/22/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 2A Sec: Ter:	Post-outage containment condition. The inspectors performed an inspection of the Unit 2 containment to assess cleanliness and safety-related system and component readiness for unit restart. Other than minor items which the licensee addressed, systems, components, and general housekeeping were appropriate for unit startup.
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02/22/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: Ter:	Good supervisory activities in control room during reactor startup. During the Unit 1 startup, the duty shift superintendent (the lead senior reactor operator) performed a thorough pre-job brief and provided effective overview of control room activities.
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02/22/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 5A Sec: 3A Ter:	Thorough response to recent industry experience with a breaker. The licensee promptly and thoroughly evaluated an industry operating experience bulletin on a certain type of electrical circuit breaker. The licensee demonstrated an appropriately conservative operating philosophy in declaring inoperable several of these breakers and shutting down the operating unit after a similar breaker in a nonsafety-related application was found to be physically degraded. While the licensee's initial operability determination for this issue failed to identify all the potential system impacts, the questioning attitude of an on-shift operating crew led to the conservative decision to shut down the Unit until the problem was resolved.
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02/22/1999	1999002-01	Pri: OPS Sec:	NRC	VIO IV	Pri: 1C Sec: Ter:	Abnormal and emergency operating procedure (AOP and EOP) use and implementation. The inspectors identified four areas of concern with the licensee's use and implementation of abnormal operating procedures and emergency operating procedures: the procedure deviation process, immediate operator actions, reference procedure use, and AOP exit requirements. Two examples of a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," were identified. The tracking number for this violation is 50-266/99002-01a&b(DRP); 50-301/99002-01a&b(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002-02	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: 3A Ter:	Operation of the Unit 2 reactor core at an actual average reactor power of 1519.1 megawatts thermal for an ei This issue was described in Licensee Event Report (LER) 50-301/98004. The LER documented the licensee's identification that Unit 2 operated with an actual average reactor power of 1519.1 megawatts-thermal for an 8-hour shift. The condition resulted from the inadvertent return to service of a faulty input into one of the plant computers used to calculate reactor thermal output. This licensee-identified violation of the operating licensee is being treated as a Non-Cited Violation (50-301/99002-02(DRP)).
Dockets Discussed: 05000301 Point Beach 2						
02/22/1999	1999004	Pri: OPS Sec:	Self	MISC	Pri: 1B Sec: 3B Ter: 5B	Simulator runs of safety injection (SI) system problems. The SI pump minimum flow function was required to prevent pump failure during a limited set of small- to intermediate-size reactor coolant system pipe failures. The licensee performed simulator runs which indicated that operator actions would prevent the core from becoming uncovered during a small-break loss-of-coolant accident, even if both SI pumps failed.
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02/22/1999	1999004	Pri: OPS Sec:	Self	MISC	Pri: 5C Sec: Ter:	Corrective actions for frozen safety injection pipe. The licensee's intermediate-term corrective actions for the frozen safety injection minimum flow path were appropriate. Long-term corrective actions had not been identified at the end of the inspection.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 2A Ter:	Freeze protection procedure weakness. The operations department procedure for placing the facade freeze protection system into service and operating it did not specify minimum material condition requirements.
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02/22/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: 1A Ter:	Potentially inoperable safety injection and containment spray. The inspectors identified that a failed heat trace circuit on the Unit 1 refueling water storage tank inlet line had the potential to affect safety injection (SI) system operability under the cold outdoor temperatures being experienced at the plant. The licensee followed-up on the inspectors' concern and identified that the SI pump minimum flow path was blocked by ice. The licensee declared both trains of SI and both trains of containment spray inoperable, and commenced a unit shutdown in accordance with the Technical Specifications.
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02/22/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: 4B Ter:	No formal assessment of operability. Out-of-service heat trace elements were only documented by work order. A formal assessment of the impact of the degraded condition, such as by the formal operability determination program, was not required by plant procedures.
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02/22/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: 5C Ter:	Corrective actions for previous cold weather problems. The licensee had experienced equipment challenges from inadequate cold weather preparations and freeze protection system failures from 1994 to the most recent inspection period. The licensee took appropriate, timely corrective actions for each individual problem. However, not until late December 1998, had the licensee identified the need to perform a root cause evaluation of the continuing equipment problems with the facade freeze protection system. The inspectors concluded that the licensee's corrective actions had been adequate, but had not been broad enough in scope to prevent the January 5, 1999, event.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Power reduction. Operators reduced Unit 1 power by approximately 80 percent without significant problem. All regulatory requirements and most licensee expectations for the conduct of operations were met.
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02/04/1999	1999-001-00	Pri: OPS Sec:	Licensee	LER	Pri: 2A Sec: 3A Ter: 5B	Safety injection recirculation line to refueling water storage tank frozen. In response to a question from the NRC resident inspectors, the licensee determined that the Unit 1 common mini-recirculation flow line return to the refueling water storage tank for the safety injection and containment spray pumps would not pass flow. The line was frozen due to a partial failure of the freeze protection heat tracing for this pipe. The licensee reported this issue in Licensee Event Report 50-266/99001-00, which was closed in Inspection Report 50-266/99004(DRP).
Dockets Discussed: 05000266 Point Beach 1						
01/18/2000	1999019-01	Pri: MAINT Sec:	NRC	URI	Pri: 2B Sec: 3A Ter:	Procedural deficiencies for pump maintenance. The inspectors identified that procedural deficiencies with the work instructions for maintenance on two safety-related pumps (the "D" service water pump and a component cooling water pump) were not appropriately documented or reviewed by the licensee (Sections M1.1 and M1.2). An unresolved item (50-266/99019-01(DRP); 50-301/99019-01(DRP) was identified for the modification of the "A," "B," "C," "E," and "F" service water pumps with an inaccurate drawing referenced in the work plan, possibly introducing a mechanism for a common cause failure.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
12/10/1999	1999018	Pri: MAINT Sec:	NRC	MISC	Pri: 3A Sec: Ter:	Refueling maintenance activities. Unit 1 outage modification work activities observed by the inspectors were generally conducted well. Department managers and Operational Assessment (quality assurance) personnel were in the field observing work. Three minor examples of failure to properly implement maintenance procedures for safety-related pumps, identified by the inspectors, were the only exceptions to the otherwise good performance.
Dockets Discussed: 05000266 Point Beach 1						
12/10/1999	1999018-01	Pri: MAINT Sec: ENG	Self	NCV	Pri: 2B Sec: Ter:	Work order resulted in unintended switch bypass. An inadvertent engineered safety feature actuation occurred as the result of an inappropriate work instruction. No fuel was in the Unit 1 vessel at the time. Spent fuel pool cooling was lost as a result of the actuation, but the pool temperature did not increase significantly. One non-cited violation was identified with a tracking number of 50-266/99018-01(DRP); 50-301/99018-01(DRP).
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11/19/1999	1999017	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Lack of independent field observations. There was a lack of independent field observation with qualified personnel during audits of nondestructive test examinations. This demonstrated a weakness in the quality assurance audit program for the conduct of performance based audits of the Inservice Inspection Program.
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11/19/1999	1999017	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Radiographic exams performed acceptably. The inspector concluded that the radiographic examinations reviewed were performed in accordance with applicable procedures by certified personnel. Contractor and licensee personnel performing nondestructive examination were qualified and certified in accordance with regulatory requirements.
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11/19/1999	1999017	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Inservice inspection program met Code requirements. The Class 1 and 2 weld procedure specifications and procedure qualification records reviewed met the American Society of Mechanical Engineers Code requirements. The nondestructive examination procedures and associated examination data complied with American Society of Mechanical Engineers Code Section V and Section XI requirements. Overall, the implementation of the Inservice Inspection Program Plan was consistent with Code and NRC relief request commitments.
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07/13/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 3A Ter:	Limited LCO time on maintenance. Through effective work control and interdepartmental coordination, the licensee completed repairs to the "E" service water pump motor in a timely manner; thereby, limiting the amount of time in a limiting condition for operation.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
07/13/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Properly dispositioned functional failures. With a single nonsafety-significant exception, selected functional failures were documented in the 1998 annual maintenance rule report, were accurately classified and counted, and were appropriately dispositioned.
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07/13/1999	1999009-01	Pri: MAINT Sec: ENG	Licensee	NCV	Pri: 2B Sec: Ter:	Technical specification violation. Missed ASME [American Society of Mechanical Engineers] Section XI Pressure Test Program Surveillance. An increased-frequency surveillance test was not performed because scheduling personnel missed the notification of the surveillance test frequency change. The valve passed subsequent testing. The failure to perform the increased-frequency test was a violation of T/S 15.4.2.B.3. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV) consistent with Appendix C of the NRC Enforcement Policy (NCV 50-301/99009-01(DRS)). This issue was reported to the NRC in Licensee Event Report 50-301/98003.
Dockets Discussed: 05000301 Point Beach 2						
06/18/1999	1999012	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Improved inservice test program. The revised inservice test program and associated surveillance procedures included a number of improvements, which ensured the applicable safety-related components were properly tested as required.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
06/18/1999	1999012	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Inservice testing background document. The scoping of components for the three systems reviewed was good. The inservice testing background document was considered a good tool to compile component bases and design requirements in one location.
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06/18/1999	1999012-02	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Failure to declare relief valve test failures. Inappropriate positions on relief valve acceptance criteria for determining test failures (non-cited violation) and the inadequate justification for deferring quarterly testing of manual valves indicated some further inservice test program refinements were appropriate. The tracking number for this non-cited violation is 50-266/99012-02(DRS); 50-301/99012-02(DRS).
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06/18/1999	1999012	Pri: MAINT Sec: ENG	NRC	NEG	Pri: 2A Sec: 2B Ter: 4B	GL 96-05 status is open. Based on a review of a sample of motor-operated valves (MOVs), licensee submittals, calculations, procedures, and condition reports, the inspectors determined that the licensee was still engaged in its effort to establish a program to provide long-term assurance that MOVs within the scope of Generic Letter 96-05, "Periodic Verification of Design-Basis Capability of Safety-Related Motor-Operated Valves," were capable of performing their design-basis safety functions. As such, Temporary Instruction 2515/140, "Periodic Verification of Design-Basis Capability of Safety-Related Motor-Operated Valves (GL 96-05)," could not be closed.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
06/18/1999	1999012	Pri: MAINT Sec: ENG	NRC	NEG	Pri: 2B Sec: 4B Ter: 5C	Post-GL 89-10. Weaknesses were identified that resulted from the delay in the implementation of the long-term motor-operated valve (MOV) program following completion of Generic Letter 89-10, "Safety-Related Motor-Operated Valve Testing and Surveillance." The three most significant weaknesses needing attention included: (1) the establishment of a dynamic diagnostic test plan to provide information on potential valve age-related degradation, (2) the establishment of a plan to trend qualitative and quantitative information on MOV performance and to periodically assess that information, and (3) resolution of the large backlog of condition reports on MOV performance.
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05/27/1999	1999008	Pri: MAINT Sec: OPS	Self	NEG	Pri: 2A Sec: Ter:	Secondary system problems. The plant continued to experience secondary system failures and malfunctions that challenged plant operators and required resource intensive response and corrective maintenance. Reaction to equipment problems, while appropriate, diverted resources from desired equipment and process improvement efforts.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/27/1999	1999008	Pri: MAINT Sec: OPS	NRC	POS	Pri: 2A Sec: Ter:	Proactive efforts to resolve material condition issues. The licensee executed a Unit 1 mid-cycle maintenance outage to bolster reliability prior to peak summer electrical demand and as a proactive means to address material condition problems before they became a challenge to reactor operators.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: MAINT Sec:	Licensee	POS	Pri: 5A Sec: 5B Ter: 5C	Self-identified problems in rework and equipment-induced operational challenges. The maintenance department recognized declining performance trends in the areas of rework and equipment induced operational challenges. A self-assessment, using personnel from other sites, was performed. The licensee identified the need to improve administrative processes, such as the use of work package procedures. Improvement initiatives were being planned at the conclusion of the inspection period.
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04/10/1999	1999006-01	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Improper valve alignment during containment spray surveillance testing; improper throttle valve position foll The licensee experienced equipment status control problems during surveillance testing for the restart of Unit 2 after the refueling outage. Examples included a case where auxiliary operators (non-licensed) failed to position a containment spray system valve as prescribed in a required procedure, and a case where reactor operators mispositioned auxiliary feedwater pump discharge valves following a required surveillance test. Two examples of a non-cited violation for failing to follow Technical Specification-required procedures were documented. The tracking number for this non-cited violation is 50-301/99006-01(DRP).
Dockets Discussed: 05000301 Point Beach 2						
04/10/1999	1999006-05	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Failure to have procedures appropriate to the circumstances. The licensee identified that the previous use of dedicated operators during inservice testing of the containment spray system constituted an operation prohibited by Technical Specifications. This item was reported in Licensee Event Report 50-266/97044; 50-301/97044 and is being treated as a Non-Cited Violation, tracking number 50-266/99006-05(DRP); 50-301/99006-05(DRP)
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-06	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Failure to perform monthly testing. The licensee identified that portions of the service water system logic circuits were not being tested monthly in accordance with Technical Specification Table 15.4.1-1, Item 44, "Reactor Protection System and Emergency Safety Feature Actuation System Logic." This issue was reported in Licensee Event Report 50-266/98027; 50-301/98027 and is being treated as a Non-Cited Violation, tracking number 50-266/99006-06(DRP); 50-301/99006-06(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-07	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Failure to perform refueling shutdown testing. The licensee identified that portions of the service water system logic circuits were not being tested every refueling shutdown in accordance with Technical Specification Table 15.4.1-2, Item 15, "Service Water System." This issue was reported in Licensee Event Report 50-266/98027; 50-301/98027 and is being treated as a Non-Cited Violation, tracking number 50-266/99006-07(DRP); 50-301/99006-07(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: MAINT Sec: OPS	Self	MISC	Pri: 2A Sec: 1A Ter: 5C	Equipment problems challenge operators. Operators were challenged by condenser steam dump malfunctions during the Unit 2 startup. Condenser steam dump problems had been experienced in prior startups and shutdowns. Maintenance and engineering personnel had addressed each problem on an individual basis until operators and station management requested a more thorough evaluation and effective, comprehensive repairs or modifications. Two modifications were subsequently made to the valves and the valve controllers, and no further problems were experienced.
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04/10/1999	1999006	Pri: MAINT Sec: OPS	NRC	POS	Pri: 2A Sec: 5C Ter:	"Restart readiness" process is improving. The licensee continued to improve their "restart readiness" process to manage and ensure resolution of identified conditions adverse to quality prior to the restart of Unit 2.
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02/22/1999	1999002	Pri: MAINT Sec:	Self	NEG	Pri: 2B Sec: Ter:	Maintenance-related problems. There were several examples of safety-related equipment that failed post-maintenance testing and periodic surveillance tests and an instance where foreign material (pieces of a cloth rag) was left in the reactor coolant system after maintenance activities and caused a minor water hammer in the chemical and volume control system. The maintenance-related problems were more significant than those observed during previous outages.
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02/22/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Major refueling outage modifications. The licensee completed many important to safety modifications during the Unit 2 refueling outage. Examples included reactor vessel baffle bolt replacement, main control board wire separation, and over-pressure protection for containment penetrations and motor operated valves.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002-03	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Failure to perform quarterly testing of portions of containment spray logic circuits. This issue was documented in Licensee Event Report (LER) 50-266/98010-00 and -01; 50-301/98010-00 and -01. The licensee identified that portions of the containment spray logic circuits were not being tested quarterly in accordance with Technical Specifications. This licensee-identified failure is being treated as a Non-Cited Violation (50-266/99002-03(DRP); 50-301/99002-03(DRP)).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: MAINT Sec:	NRC	WK	Pri: 2A Sec: Ter:	Weak maintenance of facade freeze protection system. Significant weaknesses were identified in the facade freeze protection system maintenance program and its implementation.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: MAINT Sec: OPS	Self	NEG	Pri: 2A Sec: Ter:	Deficiencies in breaker maintenance program result in reactor shutdown. Better maintenance practices and more timely completion of a breaker replacement project could have eliminated the need to shut down the operating unit.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: MAINT Sec: OPS	NRC	NEG	Pri: 3A Sec: Ter:	Slow operator response to surveillance test problem. Operators failed to promptly enter applicable abnormal operating procedures following an unanticipated loss of power to safety-related buses. Restoration of power to the buses took considerably longer than during a similar event in 1997 because of a less focused operator response.
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02/22/1999	1999002	Pri: MAINT Sec: OPS	NRC	POS	Pri: 3A Sec: Ter:	Surveillance test performance. Two major refueling outage surveillance tests were conducted well. All safety-related equipment functional requirements were satisfied. Operators displayed good questioning attitude in response to the questionable performance of several valves during a third surveillance test, and the operations test director suspended the testing activity.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
01/18/2000	1999019	Pri: ENG Sec: OPS	NRC	NEG	Pri: 1C Sec: Ter:	Cold weather preparations. The licensee made significant progress in addressing the facade freeze protection system deficiencies identified during the previous winter. However, the inspectors identified that improvements had not been made in other aspects of the facility's cold weather preparations. Based upon the inspectors' reviews, the facility was adequately prepared for cold weather, but was still vulnerable to equipment, procedure, and corrective action problems similar to those experienced in January 1999 (Section O2.2).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
12/10/1999	1999018	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: Ter:	Resolution of post-maintenance testing deficiency. Post-maintenance testing of the "B" train safety injection pump identified non-conforming pressure at one particular pump flow rate. The inspector determined that the initial response by system engineering personnel was not appropriate in that it incorrectly attributed the unacceptable test data to instrument inaccuracy. An appropriate operability determination was subsequently developed.
Dockets Discussed: 05000266 Point Beach 1						
12/10/1999	1999018-02	Pri: ENG Sec:	Self	NCV	Pri: 4B Sec: Ter:	Violation of technical specification requirement for steam safety valves. Licensee surveillance testing revealed that two main steam safety valves were set to lift at pressures in excess of those assumed in the accident analysis. This condition had existed for more than one operating cycle, but was not safety significant. One NCV was identified with a tracking number of 50-266/99018-02(DRP).
Dockets Discussed: 05000266 Point Beach 1						
12/10/1999	1999018-04	Pri: ENG Sec: OPS	NRC	NCV	Pri: 4C Sec: 4B Ter: 1B	Chlorine dioxide treatment of service water for zebra mussels lacked acceptance criteria. Two NCV's were issued for the zebra mussel treatment completed in September, 1999. This action closed the apparent violation documented in the previous inspection report (50-266/301-99016(DRP)). One NCV was for the lack of acceptance criteria in the work plan for the chlorine dioxide treatment of the service water. The tracking number for this NCV is 50-266/99018-04(DRP); 50-301/99018-04(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
12/10/1999	1999018-05	Pri: ENG Sec: OPS	NRC	NCV	Pri: 4C Sec: 4B Ter: 1B	Failure to take corrective action in 1998 for zebra mussels. Two NCV's were issued for the zebra mussel treatment completed in September 1999. This action closed the apparent violation documented in the previous inspection report (50-266/301-99016(DRP)). One NCV was for the failure to take effective corrective actions when zebra mussels were identified in 1998. The tracking number for this NCV is 50-266/99018-05(DRP); 50-301/99018-05(DRP).
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10/18/1999	1999016-02	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	Differential pressure limitation for service water system strainers not appropriately incorporated into procedure The inspectors identified that the service water (SW) system operating instruction, abnormal operating procedure, and setpoint document did not include the limiting differential pressures for the SW system rotating strainers. The licensee subsequently identified that the limiting differential pressures used in the system flow model had not been adequately translated to limiting differential pressure values for normal system operation. The error in translation was non-conservative and of significant magnitude. The licensee promptly initiated compensatory actions. The inspectors concluded that the licensee response was excellent after the inspectors' questioned system parameters, but that the licensee had missed prior opportunities to identify and correct the problem during the validation of the SW flow model. One Non-Cited Violation was identified with a tracking number of 50-266/99016-02(DRP); 50-301/99016-02(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
10/18/1999	1999016	Pri: ENG Sec: OPS	NRC	NEG	Pri: 4B Sec: 2A Ter:	No operability review for degraded pipe support. The inspectors identified that a known discrepancy in the loading of a required pipe support for the safety-related service water (SW) system had not been evaluated for impact on system operability. The licensee concluded that personnel error had led to the failure to perform an operability determination. The licensee subsequently identified an analytical error affecting the seismic qualification of an adjacent section of the same SW system pipe header. In both cases, the licensee's follow-up analysis concluded that the SW system remained operable.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
10/18/1999	1999016-03	Pri: ENG Sec: OPS	Self	E EI	Pri: 4C Sec: 4B Ter: 1B	Failure to provide appropriate acceptance criteria in procedure for chlorine dioxide treatment for SW system The licensee performed a chlorine dioxide treatment of the service water (SW) system to kill zebra mussels. Plant staff recognized that safety-related components could be rendered inoperable as a result of plugging by dead zebra mussels, but had concluded that multiple trains of equipment would not be affected. However, multiple safety-related components, including containment fan coolers and emergency diesel generators, were rendered inoperable or were otherwise degraded as a result of the treatment. Some of the equipment affected by the zebra mussel shells included equipment that the licensee had concluded would not be affected. The inspectors identified that the procedure used for the chlorine dioxide treatment did not contain adequate criteria for monitoring the effect of zebra mussel shells on safety-related component operability. The licensee initiated a high-level self-evaluation of the evolution. One Apparent Violation was identified with a tracking number of 50-266/99016-03(DRP); 50-301/99016-03(DRP).
Dockets Discussed: 05000266 Point Beach 1						
08/30/1999	1999013-02	Pri: ENG Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Code nonconformance of head closure plug. During the June 1998 refueling outage, the licensee installed reactor vessel head plugs on Unit 1 that did not conform with the Final Safety Analysis Report (FSAR) and did not comply with Section III of the American Society of Mechanical Engineers boiler and pressure vessel code. The licensee closed the corrective action item for this issue without requesting the required relief from the NRC for code noncompliance until August 1999 and without addressing the nonconformance with the FSAR. The tracking number for this Non-Cited Violation is 50-266/99013-02(DRP). (Section E1.2) Licensee engineers responsible for implementing the American Society of Mechanical Engineers, Section XI program performed well in taking the initiative to submit a relief request for a Section III code noncompliance after the issue had been closed in the licensee's corrective action program. (Section E1.2)
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07/13/1999	1999009	Pri: ENG Sec:	NRC	MISC	Pri: 4B Sec: Ter:	Review of Y2K readiness of computer systems at nuclear power plants. The inspectors conducted an abbreviated review of Y2K activities and documentation using Temporary Instruction (TI) 2515/141, "Review of Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants." This TI is closed.
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07/13/1999	1999009-02	Pri: ENG Sec:	Licensee	NCV	Pri: 2A Sec: 4A Ter:	Design basis violation. Containment Accident Fan Motor Cooler Exchanger Flow Rates Found to be Outside the Design Basis of the Plant. The licensee identified that the design basis cooling flow to the fan motor coolers had not been appropriately translated into the procedures for establishing the flow rates. The problem was caused by inappropriate translation of system pressure drops into indicated flow rates on installed gauges. The failure to appropriately translate design basis requirements into required procedures was a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." This Severity Level IV violation is being treated as an NCV, consistent with Appendix C of the NRC Enforcement Policy (NCV 50-266/99009-02(DRS); 50-301/99009-02(DRS)). This issue was reported to the NRC in Licensee Event Report 50-266/98003.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
07/13/1999	1999009	Pri: ENG Sec: MAINT	NRC	POS	Pri: 2A Sec: 2B Ter: 4B	Facade freeze protection. The design, installation, and testing guidance for replacement components of the facade freeze protection system was consistent with industry recommendations and vendor documents.
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05/27/1999	1999008	Pri: ENG Sec:	NRC	MISC	Pri: 4B Sec: 4C Ter: 5B	Need to revise assessment of frozen safety injection line event. The inspectors identified two issues that required the licensee to revise the assessment of the frozen safety injection line event described in Inspection Report 50-266/99004(DRP) and Licensee Event Report 50-266/1999-001. Other than these issues, the licensee's assessments were complete and thorough.
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05/27/1999	1999008	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5C Ter:	Weak management of commitments to Generic Letter 89-13 on service water. The licensee's management of commitments of issues discussed in Generic Letter 89-13, "Service Water System Problems Affecting Safety-Related Equipment," had not been historically aggressive. The zebra mussel control program had not been fully effective as evidenced by the discovery of zebra mussel shells in heat exchangers for two safety-related components. Problems with these programs were identified by the licensee and other external organizations in 1998. At the end of the inspection period, the licensee had begun to address the programmatic deficiencies with the zebra mussel control program and the Generic Letter 89-13 commitment issues. However, these initiatives were still in the early stages of development and the full effectiveness could not be evaluated.
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05/12/1999	9905170258	Pri: ENG Sec: PLTSUP	NRC	LIC	Pri: 4C Sec: Ter:	Control room habitability. The technical content of the February 26, 1998, technical specification revision application submittal concerning the control room ventilation system was not complete and contained errors which necessitated numerous request-for-additional-information questions and phone calls between the NRC staff and the licensee's technical staff to clarify the application.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006	Pri: ENG Sec:	NRC	POS	Pri: 3A Sec: 4B Ter:	Reactor engineering improvement. The inspectors observed the performance of reactor engineering personnel supporting operations staff during the restart of the Unit 2 reactor. Routine reactor engineering tasks were also observed during control room monitoring by the inspectors. The inspectors noted improvement in the performance of reactor engineers during these activities.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-08	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Failure to properly check the adequacy of the design. The licensee identified that the circulating water pumphouse roof was not in accordance with the plant design basis. This issue was reported in Licensee Event Report 50-266/98023; 50-301/98023 and is being treated as a Non-Cited Violation, with a tracking number of 50-266/99006-08(DRP); 50-301/99006-08(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-09	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: 4C Ter:	Failure to maintain design basis. The licensee identified that operation of the control room smoke exhaust fan (W-13C) could prevent maintaining a positive pressure in the control room. That condition was outside the design basis of the control room ventilation system and was reported in Licensee Event Report 50-266/98025; 50-301/98025. This issue is being treated as a Non-Cited Violation with a tracking number of 50-266/99006-09(DRP); 50-301/99006-09(DRP).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/10/1999	1999006-10	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: Ter:	Failure to properly track corrective action. The licensee identified that operation of the control room smoke exhaust fan (W-13C) could prevent maintaining a positive pressure in the control room. That condition was outside the design basis of the control room ventilation system and was reported in Licensee Event Report 50-266/98025; 50-301/98025. This issue is being treated as a Non-Cited Violation with a tracking number of 50-266/99006-09(DRP); 50-301/99006-09(DRP). The licensee placed a temporary information tag on the W-13C control panel to prevent its operation except for its design purpose of smoke removal. The inspectors were unable to identify any open actions in the licensee's corrective action program associated with permanently resolving the reportable condition or eliminating the temporary information tag. The failure to have any open corrective action document to resolve a condition previously identified as being adverse to quality constituted a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action." This Severity Level IV violation is being treated as a Non-Cited Violation (NCV 50-266/99006-10(DRP); 50-301/99006-10(DRP)).
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03/12/1999	1999005	Pri: ENG Sec:	NRC	MISC	Pri: 4B Sec: Ter:	Operability determination process. Overall, the material condition and housekeeping of the systems reviewed were acceptable, and the ability of engineering personnel to identify material condition problems was good. The system engineers were knowledgeable about their system and familiar with their system's problem areas, backlogs, and modifications.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	Calculation control. The current calculation process was effective in ensuring calculation adequacy, control, and compliance with regulatory requirements. The methods used in performing and revising design calculations for recent modifications and design changes were found to be correct and appropriate.
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03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Design change control. The methods used to control design changes and modifications were effective. Modification packages were complete and of good technical quality. Plant changes were adequately designed and installed; and effective post-modification testing was specified and performed. Design configuration and configuration controls were maintained throughout the modification process. The licensee had effectively improved the procedures for design change control.
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03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	50.59s. In general, the 10 CFR 50.59 screenings and evaluations reviewed were appropriately prepared, of good quality, and were consistent with licensee procedures and regulatory requirements. The program ensured that trained and qualified personnel performed the necessary reviews and evaluations. Most evaluations adequately addressed the effects of the proposed changes on plant equipment and whether an unreviewed safety question existed.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Oversight of 50.59s. The additional oversight processes added to the safety review program demonstrated a rigorous effort and commitment to improve the thoroughness and consistency of 10 CFR 50.59 screenings and safety evaluations.
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03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 3B Ter:	System engineering. The system engineers interviewed appeared to be qualified and knowledgeable of their systems and system issues even though some system engineers were new to the system or the plant. The system notebooks were a good tool to keep relevant information for a system in one place, however, there was a wide variance of quality in the system notebooks.
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03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	Temporary modifications. The control of temporary modifications was good and the number of installed temporary modifications was not excessive. No concerns were identified with temporary modification designs or their associated 10 CFR 50.59 screenings and safety evaluations. Engineering personnel were adequately involved in the temporary modification process.
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03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: Ter:	Operating experience program. The Industry Operating Experience Review Program was effective, based on the demonstrated implementation of plant changes resulting from the thorough screenings and detailed analyses of industry information.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	Corrective action backlog. The corrective action program was effectively implemented. Issues were being properly identified, root cause evaluations were of good quality, and corrective actions were comprehensive. The large backlog of issues and timeliness of implementing corrective actions and issuance of root cause evaluations reports was a concern. However, recent management incentives for backlog items were expected to resolve these timeliness concerns.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	Quality assurance in engineering. The quality assurance audits and surveillances were being performed by qualified personnel. The results of the audits and surveillances were in-depth and identified a number of significant findings. The corrective actions for findings of the earlier audits resulted in program improvements.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	Plant review committees. The plant review organizations provided the technical expertise in the multiple areas required to review and evaluate the documents and activities that occur at the plant. Members of the groups were experienced and were aggressive in pursuing plant problems and issues. The minutes of the meetings indicated that probing questions were asked. The plant review organizations provided an effective and vigorous overview of plant activities related to safety.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
03/12/1999	1999005-02	Pri: ENG Sec:	NRC	NCV	Pri: 3A Sec: Ter:	Failure to implement adequate procedural guidance for performance of independent verification. In general, procedures used in the engineering process were acceptable. A non-cited violation was issued for failure to perform independent verification of lifting and restoring wires, contrary to 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The tracking number for this non-cited violation is 50-266/99005-02(DRS); 50-301/99005-02(DRS).
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03/12/1999	1999005	Pri: ENG Sec: MAINT	NRC	POS	Pri: 4B Sec: 2A Ter:	Engineering impact on material condition. Overall, the material condition and housekeeping of the systems reviewed were acceptable, and the ability of engineering personnel to identify material condition problems was good. The system engineers were knowledgeable about their system and familiar with their system's problem areas, backlogs, and modifications.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: ENG Sec:	NRC	NEG	Pri: 2A Sec: 4B Ter:	Lubrication program problems. The licensee was slow to recognize generic weaknesses in the programs for controlling the use of lubricants in safety-related applications. Examples of the problems included inconsistencies among various licensee documents, and poor follow-through by engineering staff or poor communications between engineering groups when addressing lubrication issues.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Thorough and well documented evaluation of cross-tying buses. The inspectors determined that the licensee's evaluation of cross-tying safety-related 480 volt buses was thorough and well documented. Equipment configuration restrictions specified in the evaluation were verified by the inspectors to have been properly implemented.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: ENG Sec:	NRC	MISC	Pri: 4A Sec: Ter:	No credit in licensing and design basis for boundary valve failure. The licensee concluded that the normal minimum flow path for the safety injection (SI) pumps was unavailable for an indeterminate period of time due to the frozen refueling water storage inlet line. Based on tests performed after this event, the licensee concluded that sufficient flow would have been established through failed low pressure boundary valves to have assured the safety-related function of the SI pumps during any previously analyzed accident scenario. However, the design and licensing basis does not credit the structural failure of low pressure system boundary valves to ensure that an emergency core cooling system function is operable.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: Ter:	Lack of controlled drawings. The common SI system minimum flow path was protected from freezing by a nonsafety-related heat trace circuit susceptible to a single failure. The licensee did not have controlled drawings or installation records for the facade freeze protection heat trace system. This made assessing the potential impact of faulty or failed heat trace elements difficult.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Technical evaluation in support of NOED. The licensee's technical evaluations which supported a Notice of Enforcement Discretion for continued operation of the facility with the frozen safety injection system line were thorough and accurate. One weakness was noted with the licensee's safety evaluation, but the validity of the evaluation's conclusion was not affected. All commitments associated with the requested discretion were satisfied.
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01/14/2000	2000002	Pri: PLTSUP Sec:	Self	MISC	Pri: 2A Sec: Ter:	Effectiveness of security radios. Records of security force-on-force drills, condition reports, and interviews with security force members showed operability problems with security radios. The licensee has initiated corrective action to address this problem.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
11/19/1999	1999020	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: Ter:	ALARA planning. The licensee effectively evaluated planned work activities and successfully integrated past performance to develop dose estimates and goals for the U1R25 refueling outage. ALARA plans were effective and included lessons learned from previous evolutions. Pre-job briefings were generally effective in providing radiological and other information resulting in workers that were knowledgeable of radiological conditions, hold points and special instructions.
Dockets Discussed: 05000266 Point Beach 1						
11/19/1999	1999020-01	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 3A Sec: Ter:	Failure to barricade and post a high radiation area in accordance with technical specifications. The failure to barricade and post a high radiation area outside the Unit 1 demineralizer cubicle during the hydrogen peroxide addition shutdown process resulted in a Non-Cited Violation. The tracking number for this NCV is 50-266/99020-01(DRS).
Dockets Discussed: 05000266 Point Beach 1						
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Effluent release program. The licensee implemented a technically sound effluent release program, and public doses due to radioactive effluent releases were well below regulatory limits.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	ISFSI. The Independent Spent Fuel Storage Installation (ISFSI) survey and environmental monitoring requirements were well implemented and indicated that exposure rates were well below regulatory requirements. Survey and monitoring results did not indicate any discernible environmental effects from the storage installation.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 2A Ter:	Effluent monitors. The proper calibration and effective tracking of instrument operability ensured that liquid and gaseous process and effluent radiation monitors accurately measured radioactivity in station effluents.
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By Primary Functional Area

Region III

POINT BEACH

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 2A Ter: 3B	Meteorological equipment. Meteorological tower instrumentation inspections and calibrations were appropriately performed, and personnel were knowledgeable regarding the monitoring equipment and the calibration process. The meteorological monitoring equipment was maintained in good material condition.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3B Ter:	REMP. The radiological environmental monitoring program (REMP) was well implemented by the radiation protection staff who was knowledgeable of the sampling procedure. Material condition of the air sampling equipment was good. Environmental sample results did not indicate any discernible environmental effects from plant operations.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5A Ter: 5B	PASS. The post-accident sampling system (PASS) was effectively maintained and, therefore, capable of obtaining required samples. A discrepancy between normally collected reactor coolant analysis and PASS collected reactor coolant analysis was identified by chemistry staff and appropriately evaluated.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011-01	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 3B Ter: 3A	Failure to control and post the shielded enclosure housing the spent resin transfer cask drain fitting. Radiation protection management's failure to ensure that experienced technicians were assigned to the movement of the spent resin transfer cask resulted in a Non-Cited Violation for the failure to post and control a high radiation area with dose rates greater than 1.0 rem per hour at 30 centimeters. The tracking number for the violation is 50-266/99011-01(DRS); 50-301/99011-01(DRS).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
05/21/1999	1999011-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 1C Sec: 3B Ter:	Failure to perform surveys of the Unit 2 seal water injection filter cubicle to evaluate the radiological hazard The radiation protection staff's lack of knowledge regarding the effects of placing the Unit 2 seal water injection filter system into operation and of the start up of Unit 2 on the radiation levels in the seal water filter cubicle resulted in a Non-Cited Violation for the failure to perform surveys to evaluate the radiological hazards present in the filter cubicle. The tracking number for the violation is 50-266/99011-02(DRS); 50-301/99011-02(DRS).
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Management support of the emergency preparedness program was strong. Overall, the emergency preparedness program had been maintained in an adequate state of operational readiness. Management support to the program was strong, and interviewed key emergency response personnel demonstrated a working knowledge of responsibilities and emergency procedures.
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Emergency preparedness facilities well-maintained. Emergency response facilities, equipment, and supplies were well-maintained. Demonstration of selected emergency response equipment verified that the equipment was operable. On-shift dose assessment capability was acceptable.
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04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Good administrative processes. The Nuclear Tracking System was an effective method to track and close emergency preparedness (EP) issues. Condition Reports were effectively utilized by the EP staff. Procedures were generally clear and easy to use with only minor problems identified in two procedures. The emergency information calendar was noted as a good public relations initiative.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Emergency preparedness training program. The emergency procedure training program was adequate. Training, drills, and exercises were properly critiqued. The interviewed Emergency Response Organization (ERO) personnel successfully demonstrated knowledge of their emergency roles. Documents to implement the training program for the revised ERO have not been fully developed.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Emergency preparedness management. The emergency preparedness (EP) Manager and Supervisor demonstrated in-depth knowledge of the licensee's EP program during discussions and had initiated appropriate corrective actions on several self-identified concerns.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
04/01/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5A Ter:	Emergency preparedness quality assurance. The licensee's 1998 and 1999 Quality Verification (quality assurance) audits of the emergency preparedness (EP) program were effective and satisfied the requirements of 10 Code of Federal Regulations 50.54(t) and properly followed licensee procedural guidance. The EP staff's ongoing responses to audit findings were appropriate and timely.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/22/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	Radiation protection activities. Throughout the inspection period, the inspectors observed radiological control postings and radiation protection technician performance during tours of the radiologically controlled area, including Unit 2 containment. Postings and surveys for radiological areas were appropriate and current. Technicians provided appropriate radiological oversight of work activities.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: Ter:	Laboratory and instrument quality control program. The laboratory and instrument quality control program was adequate, in that instrument verification initiatives were performed as required, and instruments generally performed within specified control limits.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1A Sec: Ter:	Good control of water chemistry. The staff's control of plant water chemistry continued to be good and was effective in reducing corrosive impurities in primary and secondary reactor water systems.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Chemistry sampling and analysis programs. The chemistry staff effectively implemented routine and emergency sampling and analysis programs. Technicians performed sampling and analysis activities in accordance with procedures and good chemistry practices. Technicians exhibited good radiation work practices during sample collection and surveillance activities.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Chemistry training program. The station's training program for chemistry personnel was effective in providing technicians with necessary skills, in that it was generally comprehensive and well structured. Improvements to the training curriculum permitted more formal, efficient qualification of chemistry personnel.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: 2A Ter:	Control room ventilation. Required surveillances and tests of the control room engineered safety feature filtration system were well implemented and performed in accordance with procedures. Test results indicated that the Final Safety Analysis Report and Technical Specification acceptance criteria were met. Material condition of the ventilation system was good.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 5C Sec: Ter:	Chemistry quality verification. The quality verification program was comprehensive and effective in identifying issues and tracking their resolution. Audits, surveillances, and work monitoring reports were thorough and of sufficient depth to identify deficiencies.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/19/1999	1999007-01	Pri: PLTSUP Sec:	NRC	IFI	Pri: 5C Sec: Ter:	Continuing weakness involving the lack of corrective action documentation in response to exceeding chemic A previously identified weakness continued regarding the lack of documentation for corrective actions taken in response to exceeding chemical parameter control limits, which could prohibit identification and correction of recurrent problems.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						
02/19/1999	1999007-02	Pri: PLTSUP Sec:	NRC	IFI	Pri: 1C Sec: Ter:	Analytical instrument quality control weakness involving not documenting corrective actions and not perform Weaknesses in the laboratory and instrument quality control program were identified for not assessing instrument quality control data for trends and biases or documenting corrective actions when quality control limits were exceeded, and for not performing the inter-laboratory cross check program. The effectiveness of the quality control program was reduced by not performing these activities.
Dockets Discussed: 05000266 Point Beach 1 05000301 Point Beach 2						

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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.