

U.S. NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT

REGION III

Report No. 50-266/81-07; 50-301/81-06

Docket No. 50-266; 50-301

License No. DRP-24; DPR-27

Licensee: Wisconsin Electric Power Company
231 West Michigan
Milwaukee, WI 53203

Facility Name: Point Beach Nuclear Power Plant Units 1 and 2

Inspection At: Point Beach Site
Two Creeks, Wisconsin

Inspection Conducted: April 1-3, 6-10, 13-17, 20-24, 27-30, 1981

Inspectors:

J. E. Konklin
for
W. D. Guldemond

5/28/81

J. E. Konklin
for
R. L. Hagde

5/28/81

Approved By: *J. E. Konklin*
J. E. Konklin, Acting Chief
Reactor Projects Section 2A

5/28/81.

Inspection Summary

Inspection on April 1-3, 6-10, 13-17, 20-24, 27-30, 1981 (Report No. 50-266/81-07; 50-301/81-06)

Areas Inspected: Routine resident inspection of Operational Safety Verification, Monthly Maintenance Observation, Monthly Surveillance Observation, Followup on Licensee Event Reports, IE Bulletin and Circular Followup, Review of Plant Observations, Independent Inspection Effort, Spent Fuel Storage Racks Modification, Review and Audit, Implementation, Audit Program, Procurement. The inspection involved a total of 216 inspector-hours onsite by two NRC inspectors including 40 inspector-hours onsite during offshifts.

Results: No items of noncompliance or deviations were identified.

8106150604

DETAILS

1. Persons Contacted

- *G. A. Reed, Manager, Nuclear Power Division
- J. J. Zach, Superintendent Technical Services
- T. J. Koehler, Operations Superintendent
- J. C. Reisenbuechler, I&C Engineer
- W. J. Herrman, Maintenance Superintendent
- R. S. Bredvad, Health Physicist
- *R. E. Link, Assistant to the Manager
- *F. A. Zeman, Office Supervisor

The inspectors also talked with and interviewed members of the Operations, Maintenance, Health Physics, and Instrument and Control sections.

*Denotes personnel attending exit interviews.

2. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the month of April, 1981. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the Unit 2 reactor building and both auxiliary and turbine buildings were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance. The inspector noted on April 23, 1981, that the service water D/P gage for the 4D diesel was reading well below zero with no maintenance request initiated. This was brought to the attention of the licensee who committed to initiate a maintenance request. During the routine tour of the Emergency Diesel Generator rooms on April 9, 1981, the inspector found the fire doors between the two rooms blocked open by a contractor welding machine power cable. No personnel were in the area. The situation was brought to the attention of the Fire Protection Supervisor and immediately corrected. The power cable was rerouted to an outlet in the same room. Because of the recurrent nature of this problem, it was discussed with licensee management in an exit interview on April 15, 1981. The licensee committed to follow this and similar matters more closely. The inspector by observation and direct interview verified that the physical security plan was being implemented in accordance with the station security plan.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the inspection period the inspectors noted a small decline in cleanliness conditions due to the number of contractor personnel on site. The licensee agreed with this evaluation and reaffirmed his commitment to high housekeeping/cleanliness

standards. During the month of April, 1981, the inspector walked down the accessible portions of the safety injection, containment spray, auxiliary feed, emergency diesel generating systems to verify operability. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling. Verification of shipping activities included spot checking package labeling, reviewing shipping papers, monitoring the loading operation, spot checking the vehicle radiation survey, and monitoring the briefing of the vehicle driver.

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

No items of noncompliance or deviations were identified.

3. Monthly Maintenance Observation

Station maintenance activities of safety related systems and components listed below were observed/reviewed to ascertain that they were conducted in accordance with approved procedures, regulatory guides and industry codes or standards and in conformance with technical specifications.

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service; quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and, fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety related equipment maintenance which may affect system performance.

The following maintenance activities were observed/reviewed:

- a. Alarm relay replacement on the 3D Diesel Generator
- b. Relief valve replacement on service water to the 3D Diesel Generator
- c. Fuel oil strainer leak repair on the 3D Diesel Generator
- d. Replace bearings in 851 "B" MOV motor RHR suction valve
- e. Removal of Unit 2 "A" S/G safety valves for calibration
- f. Seal replacement on Unit 2 "B" reactor coolant pump

Following completion of maintenance on the 3D diesel generator 851B MOV RHR suction valve, the inspector verified that these systems had been returned to service properly.

No items of noncompliance or deviations were identified.

4. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the Unit 1 containment sump isolation valve, Unit 1 reactor protection system logic testing and Unit 2 EOL xenon follow and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector also witnessed portions of the following test activities: biweekly test of 4D diesel generator, NIS power range testing, and calibration of Unit 2 power range channel N-43.

No items of noncompliance or deviations were identified.

5. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

<u>Docket No.</u>	<u>LER No.</u>	<u>Title</u>
50-301	81-001/03L-0	Setpoint Drift on Loop "A" S/G Safeguards Actuation
50-266	81-003/-03L-0	Failure of Diesel Generator Relay

No items of noncompliance or deviations were identified.

6. IE Bulletin Followup

The inspector reviewed all outstanding Bulletins and determined that none could be closed out at this time.

7. IE Circular Followup

For the IE Circulars listed below, the inspector verified that the Circular was received by the licensee management, that a review for applicability was performed, and that if the circular were applicable to the facility, appropriate corrective actions were taken or were scheduled to be taken.

- 81-02 Performance of NRC Licensed Individuals While on Duty
- 81-01 Design Problems Involving Indicating Pushbutton Switches
Manufactured by Honeywell Incorporated

No items of noncompliance or deviations were identified.

8. Review of Plant Operations

During the month of April, 1981 the inspector reviewed the following activities.

a. Environmental Protection

The inspector verified the installation and operability of four air sampling stations and five environmental TLD's and associated equipment and reviewed records for completeness and accuracy. In addition, the inspector observed eight vegetation samples, eight soil samples, four shoreline silt samples, and four lake water samples. The inspector also reviewed the licensee's Technical Specification required Semi-annual Monitoring Report for completeness and accuracy. The inspector noted that at combined air sampling/environmental TLD stations, the TLD's are located immediately next to the air samplers. This was pointed out to the licensee who agreed to investigate the possibility that, under accident conditions, the TLD's might indicate excessive radiation levels due to exposure from the accumulation of radionuclides by the filter in the air samplers.

No items of noncompliance or deviations were noted.

b. Emergency Preparedness

The inspector reviewed the status of emergency preparedness including the following: coordination with offsite agencies, facilities and equipment, means for monitoring release of radioactivity, and medical arrangements. The following items were noted.

The inspector verified that the Kewaunee Nuclear Plant and the Two Rivers Community Hospital are familiar with their roles in the Point Beach Nuclear Plant Emergency Plan. However, problems have been encountered in conducting training for other outside organizations. The Point Beach Nuclear Plant Emergency Manual, Section 8.2, states in part that "The company will annually provide the opportunity for training for offsite organizations and agencies as specified in respective agreements and understandings," and, "The opportunity for annual training for hospital personnel, ambulance/rescue personnel, police, and fire departments will be provided...." A review of the letters of agreement with offsite agencies contained in Appendix D of the Emergency Plan showed that the only letter making reference to any training was that of the Two Rivers Community Hospital. When

queried, the licensee stated that no training had been scheduled for offsite agencies. It was further stated that past attempts to conduct such training were of marginal benefit as offsite agency participation was minimal.

The inspector toured the emergency facilities described in the Point Beach Nuclear Plant Emergency Plan and spot checked the availability of emergency equipment/monitors. The following monitors were not yet active in the Technical Support Center: Units 1 and 2 containment sump levels, Unit 1 and 2 containment high range radiation monitors, Unit 2 auxiliary feedwater flow, wind speed, and wind direction. Each of the inactive monitors is awaiting completion of a plant modification required by the TMI Action Plan or IE Bulletin 79-01B. The licensee has established commitment dates for modification completion in response to these documents.

Except as noted above, the plant equipment for monitoring the release of radioactivity was verified to be operable. This included effluent monitors, survey team instrumentation, meteorological equipment, and decisional aids. Onsite medical capabilities as described in the Emergency Plan were observed to exist.

No items of noncompliance or deviations were identified.

c. Independent Inspection Effort

The inspectors reviewed the status of the determination of the adequacy of station electric distribution systems voltages/evaluation of the analysis and testing of vital bus transformers with the following results.

An August 8, 1979 letter to the licensee from W. P. Gammill of the NRC requested the licensee to: (1) review the electric power systems at each of their nuclear plants to determine analytically whether, assuming all onsite sources of power are not available, the offsite power system and the onsite distribution system is of sufficient capacity and capability to automatically start as well as operate all required safety loads; (2) verify the analysis of the adequacy of the onsite distribution of power from the offsite circuits by test; and (3) review the electric power systems of the nuclear station to determine if there are any events or conditions which could result in the simultaneous or consequential loss of both required circuits to the offsite network, to determine if any potential exists for a violation of GDC-17.

Items 1 and 2 were addressed in an October 12, 1979 letter from C. W. Fay (WE) to H. R. Denton (NRC). This letter contained an analysis of the Unit 2 distribution system concluding that it is adequate under the defined conditions and committed the licensee to perform tests not only on the distribution system as a whole,

but also on safety related motor starters to demonstrate that the latter would pull in and hold in under worst case degraded voltage conditions. Also referenced in this letter were two Technical Specification change requests dated June 2, 1977 and August 4, 1979 to change the settings of the undervoltage relays which are used to detect degraded voltage conditions and provide additional time delay and tolerance information for these relays respectively. Item 3 was addressed in a licensee letter dated September 17, 1976 to B. C. Rusche (NRC).

The tests committed to in the licensee letter of October 12, 1979 were completed on November 7, 1979. The information on motor starters was submitted via a January 17, 1981 letter. The grid test results, though complete, have yet to be submitted.

That the October 12, 1979 submittal was incomplete was indicated by a September 8, 1980 request for additional information from R. A. Clark (NRC) to S. Burstein (WE). This request was responded to in a January 21, 1981 letter from C. W. Fay (WE) to H. R. Denton (NRC). However, it also was incomplete based on a request for additional information from R. A. Clark dated March 26, 1981.

On April 6 and 7, 1981, the inspector attended portions of the Off-Site Review Committee Technical Specification Meeting. During this meeting open items from previous meetings and significant operating abnormalities or deviations from normal and expected performance of plant equipment that affect nuclear safety were discussed. The inspector verified that the committee composition was in accordance with the Technical Specifications that a quorum was present, and that all items required by the Technical Specifications were addressed.

No items of noncompliance were identified.

d. Spent Fuel Storage Racks Modification

High density spent fuel storage rack installation was completed on April 7, 1981 with the placement of racks in the south half of the spent fuel pool. The north-half racks were installed in December, 1979. Procurement and receipt installation documentation was reviewed for all racks, including licensee QA audits of the vendor. All documentation was in order.

The inspector observed the installation of racks in the south half of the pool and verified adequacy and compliance with approved procedures. There was no need to drill vent holes in the poison channels because they were not sealed at the top and bottom as in other designs. Thirty corrosion test specimens were installed in the north half of the pool in December of 1979 and thirty more will be installed in the south half. These specimens are always kept next to the most recently removed fuel

to receive maximum irradiation. An inspection schedule for examining the specimens has been established and is being adhered to.

No items of noncompliance were identified.

e. Review and Audits Including Site Review Committee

This inspection requirement, which requires attendance at Manager's Supervisory Staff Meetings and followup on the decisions reached as documented in the minutes, was completed in January, 1981 as part of the inspection for Review of Plant Operations. Its completion was documented in Inspection Reports 50-266/81-01 and 50-301/81-01.

No items of noncompliance were identified.

f. Implementation, Audit Program

This inspection requirement, which requires participation in a QA audit conducted by licensee personnel and followup on audit results, was completed in January, 1981 as part of the inspection for Review of Plant Operations. Its completion was documented in Inspection Reports 50-266/81-01 and 50-301/81-01.

No items of noncompliance were identified.

g. Procurement

The inspectors reviewed the licensee's material procurement activities to ascertain whether the storage of components, materials, and supplies was in conformance with the licensee's Quality Assurance Program and implementing procedures. Included in this inspection were reviews of Sections 3.25 and 6.1.1 of the Operating Point Beach Nuclear Plant Administrative Control Policies and Procedures Manual and Sections 7, 8, 13, and 15 of the Materials, Repairs and Modifications Quality Assurance Manual, and a tour of the licensee's storage areas.

During the tour the following was noted. Several lengths of small diameter pipe did not have the ends covered as recommended in Appendix "B" to Section 3.25 of the PBNP Administrative Control Policies and Procedures Manual. The licensee representative accompanying the tour committed to have covers installed. Several complete Quality Assurance Release tags, used to document that a part has been accepted for Quality Assurance purposes, were found lying on the floor in the storerooms. These tags were collected and removed from the area by the licensee representative accompanying the tour. Seventeen "O" rings were discovered in the storeroom which has passed their published shelf life. Followup on this item revealed that the licensee has no means for tracking limited shelf life items to ensure that they are neither issued nor used. The problem is compounded by the fact that the licensee routinely removes items, such as "O" rings, from the vendor's

packaging and places them in his own packaging labelled only with the part number. Shelf life information is not transcribed either onto the package or into the inventory system. This item remains open pending satisfactory resolution by the licensee.

None of the above items are considered noncompliances at this time.

9. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection period and summarized the scope and findings of the inspection activities. The licensee acknowledged these findings.