

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

REGION III

Report Nos. 50-266/81-11; 50-301/81-13

Docket Nos. 50-266; 50-301

License Nos. DPR-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 Rivers, WI

Inspectors: *J. D. Smith for*
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7-14-81

J. D. Smith for
R. L. Hague

7-14-81

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7-14-81

Inspection Summary

Inspection on June 1-30, 1981 (Report No. 50-266/81-11; 50-301/81-13)

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, Followup on Items of Noncompliance, Plant Trips, Review of Periodic and Special Reports, Independent Inspection Effort, Followup on TMI Action Plan Items. The inspection involved a total of 210 inspector-hours onsite by two inspectors including 45 inspectorhours on off-shifts.

Results: The licensee was found to be in compliance with NRC requirements within the 10 areas examined during this inspection except for the following four items: Improper control of a fire barrier door; improper valve lineup in the containment spray system; inadequate log reviews; and improper control of temporary procedure changes.

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 June, 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 auxillary building 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, by observation and by 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 month of June, 1981, the inspector walked down the accessible portions of the emergency diesel generating, auxillary feed, safety injection, and containment spray systems to verify operability. On June 21, 1981, the licensee, during a monthly safety system valve lineup check, discovered that the normally locked open manual outlet valve on the Unit 1 sodium hydroxide addition tank was locked shut. The valve was immediately opened and locked. Subsequent investigation by the licensee revealed that the valve was locked in the wrong position on June 17, 1981 during the performance of Technical Specification required surveillance testing on the chemical addition portion of the containment spray system. This test calls for shutting the sodium hydroxide tank manual outlet valve while cycling the downstream air operated valves. The procedure further calls for having a dedicated operator assigned to the valve and requires that the valve be opened and locked upon completion of the test. The

step calling for the valve to be locked open also calls for recording the serial number of the non-reusable locking device installed. A review of the test document associated with the June 17 test showed that the step requiring the valve to be locked open was initialled and the locking device number recorded. The recorded number for the locking device was the same as the number found on the locking device with the valve shut.

With the sodium hydroxide tank manual outlet valve shut, sodium hydroxide would not have been inducted into the containment spray system when called for, thereby degrading the ability of the containment spray system to scrub iodine from the containment atmosphere under accident conditions. This event is in violation of Technical Specification 15.3.3.B.2.c, which requires of the entire containment spray system, including the chemical addition portion, that "any valve required for the functioning of the system during accident conditions may be inoperable provided repairs are completed within 24 hours." The valve in question was shut for between 72 and 76 hours. In addition to repositioning the valve to its correct position, the licensee has conducted training for operations group personnel emphasizing the importance of establishing and maintaining proper valve lineups, attentiveness to watchstanding duties, and procedural compliance. The policies with respect to these matters were also published in Operations Memorandum Number 24. These actions are deemed sufficient to significantly reduce the probability of recurrence and this item of noncompliance is considered closed. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling.

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

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. Safety Related Pipe Hanger Modifications
- b. Annual Overhaul of 3D Diesel Generator
- c. Diesel Generator Room Ventilation Modification
- d. Installation of Fire Barrier Penetration Seals

While observing the maintenance work on the 3D Diesel, the inspector noted, on June 23, 1981, that the west fire barrier door between the 3D and 4D diesel rooms was propped open with no personnel present in either diesel room. The inspectors have noted similar situations in the past and brought them to the attention of the licensee. As a result of those previous occurrences the licensee has had the doors stenciled with large orange and white signs stating "Fire Door, Ensure Door is Fully Shut and Latched." The inspector considers the situation on the 23rd as more significant than the previous occurrences because in that case there were no personnel in the area, and with the dismantling of the 3D Diesel there existed a greater than normal fire hazard due to the presence of oily rags and other combustibles not normally in the diesel rooms.

This is an item of noncompliance.

The licensee has undertaken a plant wide training program to re-educate all personnel in fire protection requirements with emphasis on fire doors and their control. This corrective action is considered adequate to significantly reduce the probability of recurrence and the item of noncompliance is considered closed.

On June 25, 1981, the Unit 2 steam driven auxiliary feedwater pump trip valve was accidentally tripped by a contractor employee working in the auxiliary feed pump room. As the 3D diesel generator was out of service for annual overhaul at the time of the event, the number of auxiliary feedwater pumps available in the event of a loss of offsite power was reduced to two. This is one less than allowed by the technical specifications. The trip valve was immediately reset by a licensee employee in the area, restoring the pump to an operable status. The licensee subsequently suspended all contractor work in the auxiliary feed pump room pending the return of the 3D diesel generator to service.

Based on the short time period that the Unit 2 auxiliary feedwater pump was actually inoperable and the prompt, strong corrective action taken by the licensee, the inspector determined that issuance of a Notice of Violation is not warranted.

Following completion of maintenance on the 3D Diesel Generator and the Diesel Generator Room Ventillation Modification, the inspector verified that associated systems had been returned to service properly.

4. Monthly Surveillance Observation

The inspector observed the Unit 1 Quarterly Axial Offset Measurement and verified that the 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.

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>
50-266	81-004/03L-0	Containment Spray Valve Failure
50-266	81-002/03L-0	Inoperable Control Room Emergency Filtration System

6. IE Bulletin Followup

For the IE Bulletins listed below the inspector verified that the written response was within the time period stated in the bulletin, that the written response included the information required to be reported, that the written response included adequate corrective action commitments based on information in the bulletin and the licensee's response, that licensee management forwarded copies of the written response to the appropriate onsite management representatives, that information discussed in the licensee's written response was accurate, and that corrective action taken by the licensee was as described in the written response.

80-24	Prevention of Water Damage Due to Water Leakage Inside Containment
79-06	Revision 1 - Review of Operational Errors and System
79-06A	Misalignments Identified During the Three Mile Island Incident

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.

- 80-14 Radioactive Contamination of Plant Demineralized Water System and Resultant Internal Contamination of Personnel
- 81-04 The Role of Shift Technical Advisors and Importance of Reporting Operational Events
- 81-05 Self-Aligning Rod end Bushings for Pipe Supports
- 81-08 Foundation Materials

8. Plant Trips

Following the Unit 1 trip at 1315 hours on June 26, 1981, the inspector ascertained the status of the reactor and safety systems by observation of control room indicators and discussions with licensee personnel concerning plant parameters, emergency system status and reactor coolant chemistry. The inspector verified the establishment of proper communications and reviewed the corrective actions taken by the licensee.

All systems responded as expected, and the plant was returned to operation at 1615 hours on June 26, 1981. This trip was from 80% power and was caused by a contractor electrician accidentally opening the output breaker of the red instrument bus inverter while he was performing TMI related modifications.

Following the Unit 2 trip at 2213 hours on May 31, 1981, the inspector ascertained the status of the reactor and safety systems by observation of control room indicators and discussions with licensee personnel concerning plant parameters, emergency system status and reactor coolant chemistry. The inspector verified the establishment of proper communications and reviewed the corrective actions taken by the licensee.

All systems responded as expected, and the plant was returned to operation at 2254 hours on May 31, 1981. This trip occurred during zero power physics testing due to low level in the B stream generator.

9. Followup on Items of Noncompliance

Licensee actions in response to the item of noncompliance documented in the inspection report below were reviewed to ascertain that the actions were completed as committed and were in conformance with regulatory requirements.

50-301 79-15 (Closed) The licensee received new Technical Specifications concerning operation with inoperable control rods on May 4, 1981.

10. Review of Periodic and Special Reports

On May 27, 1981, the licensee forwarded a report on the results of inspections and tests on a tube removed from Unit 2 "A" steam generator and comparison of eddy current results past and present for Unit 2 steam generators to the Office of Nuclear Reactor Regulation. The report was filed in response to a request from that office.

The inspector reviewed the subject report to verify that:

- a. The report includes the information required by appropriate NRC requirements.
- b. Test results and supporting information discussed in the report are consistent with design predictions and performance specifications.
- c. Planned corrective action is adequate for resolution of identified problems.
- d. Information contained in the report need not be classified as an abnormal occurrence.

The following conclusions were reached:

- a. The report contains the information requested.
- b. The tube examination portion of the report transmits only results. It does not include any conclusions or inferences. The conclusions reached after comparison of past and present eddy current inspections are that penetration growth rates over the operating interval were 0.48%/EFPd for "A" steam generator and 0.43% for "B" steam generator. Because of the relatively small historical base, it is difficult to establish rate trends, but inference is made that the rates have not changed appreciably since 1974 based on photocomparison of eddy current traces from selected tubes.
- c. The licensee will continue to perform steam generator tube inspections and take corrective actions as required by Technical Specifications.
- d. Information contained in the report does not classify as an abnormal occurrence.

11. Independent Inspection Effort

- a. Inspection Reports 50-266/81-07 and 50-301/81-06 documented a concern on the part of the inspector that, at combined air sampling/environmental TLD stations, the TLD's might indicate excessive environmental radiation levels due to exposure to the accumulation of radionuclides on the filter in the air samplers. The licensee agreed to evaluate the situation at that time. The evaluation has been completed and the licensee is in the process of increasing the distance between the TLD's and air samplers.

- b. During the inspection period the inspectors reviewed log keeping practices to ascertain whether the requirements of 10 CFR 50 Appendix B, Section XVII were being adhered to. The review included all of the auxiliary building and turbine hall auxiliary operator's logs for the month of May, 1981. Based on the review it was determined that 28 out-of-specification readings had not been properly identified by either the operators or reviewers. One example concerned component cooling water flow to the excess letdown heat exchanger on Unit 2. On shift 1 of the May 11, 1981 auxiliary building log, the value recorded was 55 GPM. The minimum flow required by the log was 100 GPM. The out-of-specification condition was in no way identified nor did the remarks section of the log reference the condition.

It was further determined that in approximately 90% of the out-of-specification readings identified by the licensee, inadequate supporting information, as required by the licensee's procedures, was recorded in the log.

This is an item of noncompliance.

The licensee has conducted training with operations group personnel and has issued Operations Memorandum No. 24 addressing the area of log keeping. The inspectors have noted improvement in the logs. Based on this, this item of noncompliance is considered closed.

- c. During the inspection period the inspectors reviewed nuclear instrument calibrations completed during the Unit 2 refueling outages. The procedures reviewed included ICP 4.25, Intermediate Range Calibration, ICP 4.26, Power Range Calibration, and ICP 4.30, Refueling Source Range Drop-In Detector Calibration. The reviews were conducted to ascertain that acceptable results were obtained, that any out-of-specification values were identified, evaluated and corrected, and that any changes to these major procedures were appropriately approved.

For each of the procedures referenced above, it was determined that temporary changes were made in a manner not consistent with Technical Specification requirements. Technical Specification 15.6.8 requires, in part, that "For temporary changes to major

procedures under the jurisdiction of maintenance, instrumentation and control, reactor engineering, or chemistry and health physics which do not change the intent, changes may be made upon approval of the cognizant group head and a duty and call superintendent."

Contrary to the above requirement, Step 6.5.6 of ICP 4.25 performed on April 24, 1981, was changed. The change was approved that same day by the I&C engineer but was not approved by a Duty and Call Superintendent until May 1, 1981. The same inconsistencies were noted for steps 6.5.16 and 6.6.6 of ICP 4.26 performed on April 26, 1981 and step 6.6 of ICP 4.30 performed on April 28, 1981. This is an item of noncompliance.

With respect to the above cited procedures, subsequent manager's supervisory staff review confirmed the technical soundness of the changes.

The licensee has conducted training for group heads and Duty and Call Superintendents with respect to procedure changes. This action is deemed appropriate and this item of noncompliance is considered closed.

12. Followup on TMI Action Plan Items (TI 2515/52)

The inspectors reviewed licensee actions in accordance with temporary instruction 2515/52. The table below presents the current status of implementation of TMI Action Plan requirements called for by the referenced temporary instruction.

<u>Task</u>	<u>Subject</u>	<u>Status</u>
II.E.1.1	Auxiliary Feedwater System Evaluation	Licensee Responded to NRR Safety Evaluation Report on April 9, 1981.
II.E.4.1	Dedicated Hydrogen Penetrations	Complete. Original Plant Design.
II.K.1	IE Bulletins	Complete Per June 17, 1981 letter, R. A. Clark (NRC) to S. Burstein (WE).

13. 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.

The following items not addressed elsewhere in this inspection report were discussed with the licensee during the exit interview.

- a. RHR valve MOV-720 is the second isolation valve between the RCS and RHR system. As it serves as the transition point from high to low pressure piping in one portion of the RHR system, it falls into the event V check valve configuration. Because only a single check valve isolates MOV-720 from the RCS it is necessary to establish administrative controls on the valve to preclude inadvertent opening. Based on an April 20, 1981 order for licensee modification it could be inferred that the required administrative controls would consist of removing power from the valve operator.

In order to avoid having to remove power from MOV-720, the licensee proposed to rely on an existing, non-redundant interlock designed to prevent valve opening above 425 psi RCS pressure. They further contended that since MOV-720 is not part of the periodic valve cycling program, it was extremely unlikely that the valve would be inadvertently opened. This rationale was discussed with the Office of Nuclear Reactor Regulation. It was agreed that the proposed approach was acceptable provided the licensee periodically verifies the operability of the 425 psi interlock.

The inspector reviewed the licensee's calibration and surveillance procedures and determined that only the bistable portion of the interlock was tested. This was brought to the attention of licensee management during an exit interview on June 5, 1981. At that meeting the licensee committed to review and revise the calibration procedure to verify that the interlock was, in fact, functional, on at least a refueling interval.