

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/93013(DRP); No. 50-301/93013(DRP)

Docket Nos. 50-266; 50-301

Licenses No. DPR-24; No. DPR-27

Licensee: Wisconsin Electric Company
231 West Michigan
Milwaukee, WI 53201

Facility Name: Point Beach Units 1 and 2

Inspection At: Two Rivers, Wisconsin

Dates: July 15 through September 6, 1993

Inspectors: K. R. Jury
J. Gadzala
J. H. Neisler

Accompanying Personnel: K. K. Bristow

Approved By: J. A. Gavula
J. A. Gavula, Acting Chief
Reactor Projects Section 3A

9/24/93
Date

Inspection Summary

Inspection from July 15 through September 6, 1993
(Reports No. 50-266/93013(DRP); No. 50-301/93013(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of plant operations; radiological controls; maintenance and surveillance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

Results: No violations or deviations were identified. While a number of individual weaknesses were identified during this inspection period, overall licensee performance does not appear to have declined.

Plant Operations

An Engineered Safeguards Feature (ESF) actuation occurred due to a personnel error by a maintenance technician.

A security system power supply inverter failed, causing extensive smoke and fire brigade activation.

Radiological Control

Housekeeping and equipment stowage weaknesses were noted in high and locked high radiation areas.

Maintenance/Surveillance

Poor communications between Maintenance and Operations resulted in extended limiting condition for operations (LCO) entries on two occasions.

A weak maintenance work plan resulted in an additional test of the emergency diesel generator.

A personnel error resulted in an ESF actuation.

Emergency Preparedness

An emergency drill was conducted on August 18 with acceptable results. Weaknesses included failure to promptly recognize and declare a general emergency and inter-facility communications. Drill planning was considered a strength.

Engineering and Technical Support

Strong engineering involvement and coordination was evident during several maintenance activities.

Safety Assessment/Quality Verification

A Manager's Supervisory Staff Meeting did not properly focus on the safety/risk perspective while discussing the timing of two work activities.

The Offsite Review Committee meeting was considered effective.

Plant housekeeping has gradually deteriorated and the spent fuel pool material control procedure does not address material in the pool's vicinity.

DETAILS

1. Persons Contacted (71707) [(30702)]

*G. J. Maxfield, Plant Manager
T. J. Koehler, Site Engineering Manager
R. D. Seizert, Training Manager
*M. F. Baumann, Manager - Licensing and Radiological Engineering
*J. F. Becka, Regulatory Services Manager
*J. G. Schweitzer, Maintenance Manager
J. C. Reisenbuechler, Manager - Operations
N. L. Hoefert, Manager - Production Planning
J. J. Bevelacqua, Manager - Health Physics
F. P. Hennessy, Manager - Chemistry
J. A. Palmer, Manager - Maintenance
G. R. Sherwood, Manager - Instrument & Controls
W. B. Fromm, Sr. Project Engineer - Plant Engineering
T. G. Staskal, Sr. Project Engineer - Performance Engineering
W. J. Herrman, Sr. Project Engineer - Construction Engineering
*F. A. Flentje, Administrative Specialist

Other company employees were also contacted including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the personnel attending the management exit interview for summation of preliminary findings.

2. Plant Operations (71707) [(71710) (93702)]

The inspectors evaluated licensee activities to confirm that the facility was being operated safely and in conformance with regulatory requirements. These activities were confirmed by direct observation, facility tours, interviews and discussions with licensee personnel and management, verification of safety system status, and review of facility records.

To verify equipment operability and compliance with technical specifications (TS), the inspectors reviewed shift logs, Operations' records, data sheets, instrument traces, and records of equipment malfunctions. Through work observations and discussions with Operations staff members, the inspectors verified the staff was knowledgeable of plant conditions, responded promptly and properly to alarms, adhered to procedures and applicable administrative controls, was cognizant of in progress surveillance and maintenance activities, and was aware of inoperable equipment status. The inspectors performed channel verifications and reviewed component status and safety related parameters to verify conformance with TS. Shift changes were observed, verifying that system status continuity was maintained and that proper control room staffing existed. Access to the control room was restricted and operations personnel carried out their assigned duties in

an effective manner. The inspectors noted professionalism in most facets of control room operation.

Plant tours and perimeter walkdowns were conducted to verify equipment operability, assess the general condition of plant equipment, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tag out procedures were properly implemented.

The inspectors accompanied two auxiliary operators (AOs) as they performed equipment rounds to ascertain their knowledge and comprehension of pump lubricating oil bubblers. The AOs were aware of the function of the bubblers and the purpose for checking oil levels. Any bubbler requiring oil would be noted on the rounds sheet and formally documented under the maintenance work request process immediately following completion of the rounds.

The licensee's use and control of overtime was reviewed. Currently, overtime is controlled by PBNP 3.4.4, "Work Duration Restrictions," Revision 9. This policy applies to all Wisconsin Electric (WE) employees participating in safety related work during normal operation and outages. Contractor personnel are exempt from the restrictions. However, the WE liaison engineer is made aware of contractor work practices and stated that an evaluation would be initiated if excessive contractor overtime was noted.

a. Unit 1 Operational Status

The unit continued to operate at full power during this period with only dispatcher requested load reductions. A loss of the 1A06 electrical safeguards bus occurred during performance of maintenance but did not result in a plant transient. Details appear in paragraph 4.c. below.

b. Unit 2 Operational Status

The unit continued to operate at full power during this period with only dispatcher requested load reductions.

c. Security System Power Supply Inverter Failure

On September 1, an electrical fire occurred in a security system power supply inverter. All affected personnel were immediately evacuated and the necessary compensatory measures were implemented. Although flames were not observed, smoke was exhausted from the area promptly and fire brigade activities were suspended within ten minutes. No impact on operations resulted from the event and a root cause for the inverter's failure was determined.

Onsite NRC representatives responded to the area and evaluated the licensee's response. Following the event, a debrief was held with

all personnel that responded in order to obtain important information that may improve emergency response in the future.

3. Radiological Controls (71707)

The inspectors routinely observed the plant's radiological controls and practices during normal plant tours and the inspection of work activities. Inspection in this area included direct observation of the use of Radiation Work Permits (RWPs); normal work practices inside contaminated barriers; maintenance of radiological barriers and signs; and health physics (HP) activities regarding monitoring, sampling, and surveying. The inspectors also observed portions of the radioactive waste system controls associated with radwaste processing.

From a radiological standpoint the plant is in good condition, allowing access to most sections of the facility. During tours of the facility, the inspectors noted that barriers and signs also were in good condition. During a tour of high and locked high radiation areas, the inspectors noted that housekeeping in infrequently entered areas was poor and that most areas had at least one unsecured ladder in the area. These concerns were communicated to an HP supervisor who was accompanying the inspector. He subsequently documented the concerns on a zone inspection report for correction.

4. Maintenance/Surveillance Observation (62703) (61726)

a. Maintenance

The inspectors observed safety related maintenance activities on systems and components to ascertain that these activities were conducted in accordance with TS, approved procedures, and appropriate industry codes and standards. The inspectors determined that these activities did not violate LCOs and that required redundant components were operable. The inspectors verified that required administrative, material, testing, and radiological and fire prevention controls were adhered to.

Specifically, the inspectors observed/reviewed the following maintenance activities:

- ICI-6 (Revision 1), Rod Control System Maintenance
- MWRs 933381, 933488, and 933790, Rod Control System Troubleshooting/Circuit Card Replacement

These activities were well coordinated and controlled by the system engineer. The technicians involved in trouble shooting and repair were knowledgeable of the system and conducted their work in a professional manner.

- MWR 933630, Replacement of D05 station battery.

- IWP 93-030-02 (Revision 0), Replacement of HX-12B Outlet 4" SW Piping
- IWP 93-030-03 (Revision 0), Replacement of HX-12C Outlet 4" SW Piping
- Replacement of G01 diesel generator high fuel level switch

This level switch was believed responsible for intermittent stopping of the day tank to engine sump fuel transfer pumps during manual operation. Additional details are contained in Inspection Reports 50-266/93011; 50-301/93011. Following replacement of the switch on August 4, routine surveillance test TS-1 was performed to verify diesel generator operability. However, TS-1 does not normally result in cycling of the high fuel level switch. As a result, the high level pump cut-off function was not tested. Although this is not a safety related function of the switch and is redundant to the normal level control switch, the responsible engineer felt that it was prudent to test this function. As a result of not testing the switch during the first diesel test, the diesel was tested a second time using a modified TS-1 to raise fuel sump tank level sufficiently to fully test the level switch operation. The modified return to service test was satisfactorily completed without further incident.

During review of the circumstances surrounding the failure to test the switch during the first diesel test, the maintenance planner stated that it was his intention that both of the switch's functions be tested during TS-1. This was not clearly stated on the MWR work plan, consequently resulting in the second test of the diesel. The concern of a lack of specific instructions in the work plan resulting in an additional diesel test was discussed with the Maintenance Manager.

- G05 gas turbine load fuel scheduler repair

This activity was also well coordinated and controlled by the system engineer. The technicians involved in trouble shooting and repair were knowledgeable of the system and conducted their work in a professional manner.

b. Surveillance

The inspectors observed certain safety related surveillance activities on systems and components to ascertain that these activities were conducted in accordance with license requirements. For the surveillance test procedures listed below, the inspectors determined that precautions and LCOs were adhered to, the required administrative approvals and tag-outs were obtained prior to test

initiation, testing was accomplished by qualified personnel in accordance with an approved test procedure, test instrumentation was properly calibrated, the tests were completed at the required frequency, and that the tests conformed to TS requirements. Upon test completion, the inspectors verified the recorded test data was complete, accurate, and met TS requirements; test discrepancies were properly documented and rectified; and that the systems were properly returned to service.

Specifically, the inspectors witnessed/reviewed selected portions of the following test activities:

- TS-5 (Revision 14), Biweekly Rod Exercise Test, Unit 1

The plant had increased the performance frequency of this test from twice monthly to twice weekly following replacement of a faulty circuit card on Unit 1. Details appear in Inspection Report 266/93011. On July 22, Unit 1 testing frequency was returned to its normal periodicity after no further abnormal operation of the rod control system occurred. Unit 2 testing frequency was then increased to twice weekly to verify normal operation in that unit's rod control circuitry.

- IT-06 (Revision 31), Containment Spray Pumps and Valves (Quarterly), Unit 2

The inspector noted that the lighting in #3 pipeway (upper) was inadequate to allow operators to properly identify containment spray header discharge valves 2SI-868A/B and header vent valves 2SI-869A/B without using a flashlight. The plant was informed of this condition for correction. Of positive note, operators consciously minimized the time that spray pumps were out of service by performing the test in a manner that allowed for uninterrupted progression from start to finish.

- TS-1 (Revision 37), Emergency Diesel Generator G-01 Biweekly
- 2ICP02.003A-1, Reactor Protection System Logic Train A (Monthly)

c. Inadvertent Loss of Vital Bus 1A06 and Emergency Diesel Start

During performance of meter calibration on July 27, a technician caused a short circuit that resulted in loss of the 1A06 electrical bus. Loss of normal power to this 4160 VAC safeguards bus caused the emergency diesel generator (EDG) to start as designed and supply emergency power to it. Bus 1A06 provides B train safeguards power for Unit 1.

A maintenance technician had been calibrating a control room voltmeter. The procedure requires that a slider (manual disconnect device) first be opened to remove the meter from the circuit. The technician operated the slider but not sufficiently to open it. As a result, when he connected his calibration instrument to the metering circuit, a grounding path developed which caused one of two supply fuses for the circuit to blow and deenergize the circuit. The affected circuit also supplies power to the undervoltage protection relays for bus 1A06. When the circuit was deenergized, these relays sensed the loss of voltage and caused the supply breaker for bus 1A06 to open as designed. The emergency diesel started automatically as required and promptly reenergized the bus.

Station battery charger D-108, which is powered from bus 1A06, was stripped from the bus on the undervoltage signal as designed. This occurrence placed the plant in a condition prohibited by Technical Specifications. Loss of this battery charger necessitated station battery D106 to power its associated 125 VDC distribution bus, D04. Since battery chargers do not reset automatically upon restoration of power, DC bus D04 continued to be powered by battery D106 for about 22 minutes until operators manually reset the battery charger. Wisconsin Electric documented this incident in Licensee Event Report (LER) 266/301/93-007.

Operators responded to the event and ensured that the plant remained stable. No reactor power transient occurred as a result of this event. The inspectors were onsite at the time of the event and responded to the control room and the vital switchgear room. Troubleshooting and repair activities were well controlled and directed by the engineering staff. After initial determination of the cause, an independent evaluation was made by another engineer to verify the initial conclusion prior to initiating corrective action.

Following repair of the affected circuit, operators restored normal power to bus 1A06 and secured the emergency diesel. As initial corrective action, the plant changed the meter calibrating procedure to verify a slider is open by use of a portable voltmeter to check for the no voltage condition.

On July 30, an analogous event occurred on the 2Y103 inverter circuit during meter calibration. The same technician involved in the above event was using a voltmeter for slider position verification and a signal generator for the calibration procedure. After opening the slider to disconnect a meter in the inverter circuit, the technician attempted to verify the open circuit with the portable voltmeter as required. However, he inadvertently reached for and used the wrong set of leads, thereby connecting the signal generator instead of the voltmeter to the circuit. The resultant short circuit caused a minor electrical perturbation on the inverter bus but did not result in a loss of the bus nor a

plant transient. Testing was suspended at that point until completion of a human performance evaluation to determine appropriate corrective actions. Corrective action adequacy for both events will be tracked and reviewed during LER closeout.

d. Loss of Boric Acid Heat Trace Circuitry

On the evening of July 28, during performance of surveillance test TS-11 on boric acid heat trace circuit HTCP-49 controller, a fault was found in the test switch which prevented testing the circuit. This test is required to be performed monthly but is normally scheduled and performed at two week intervals. The shift supervisor declared the circuit inoperable based on the inability to test and appropriately commenced a 48 hour LCO. The Duty and Call Superintendent was notified, who decided to wait until the following morning to initiate repair activities. The switch was replaced the following day but additional problems were then found in the circuit controller. The ensuing troubleshooting activities were unable to correct the fault. No spare controller existed in stock, requiring fabrication of a new one. At this point, it was the end of the work day and due to miscommunication between Operations and Maintenance groups, maintenance personnel believed they had ample time to complete the work the next day. Therefore, no work was scheduled or performed on this system after the normal day shift crew left for the day. The next morning, with about 10 hours remaining in the 48 hour LCO, a new controller was fabricated, installed and tested, and the system returned to service.

The inspectors discussed the importance of minimizing time spent in a LCO with plant management. The plant manager stated that entry into the LCO was believed to have been a conservative decision based on the assumption that this condition was only due to a test switch that prevented testing the circuit and did not actually affect operation of the system. Consequently, he decided to postpone initiation of maintenance activities that evening until the next morning. The maintenance and operations managers acknowledged that miscommunication regarding the time of entry into the LCO was a principle factor in not addressing this issue with the priority it warranted.

e. Emergency Diesel Generator Redundant Start Testing

An additional example of miscommunications between Maintenance and Operations occurred during redundant start testing of the emergency diesel generators. This miscommunication resulted in Operations taking the diesel out of service for approximately four hours before maintenance began the actual testing. Due to problems encountered during the test, additional daily surveillance tests of the other diesel were required. If the miscommunication between the two groups had not occurred initially, one of the required diesel test runs could have

possibly been avoided. The inspectors discussed these two examples of poor communication with management. A policy memo was subsequently promulgated by the maintenance manager discussing performance of maintenance on systems that are responsible for the plant being in a LCO.

5. Emergency Preparedness (71707)

An inspection of emergency preparedness activities was performed to assess the plant's implementation of the site emergency plan and implementing procedures. The inspection included monthly review and tour of emergency facilities and equipment, discussions with company staff, and a review of selected procedures.

Point Beach performed an emergency plan drill on August 18 involving declaration of several emergency classification levels; activation of the technical support center, operations support center and emergency operations facility; plant accountability exercising; and offsite response team exercising. The drill scenario consisted of a fire in the cable spreading room causing loss of one train of safeguards equipment, and a Unit 1 loss of coolant accident in containment followed by a seal leak in a residual heat removal pump leading to an offsite release. The control room simulator was used to provide realism and enhance effectiveness of the drill.

Excellent preparations for the conduct of the drill were evident. The scenario and its timing were well planned and carried out. Effective drill control was evident throughout the scenario, thereby maximizing its training effectiveness.

Overall drill performance was acceptable. Emergency classification levels, with the exception of a general emergency, were appropriately declared and notifications were made within specified time requirements. A significant weakness was the length of time required to identify the containment breach and offsite release. About 35 minutes elapsed from the start of the release until this fact was recognized. Although simulation weaknesses were partly to blame, significant items of information such as alarming area radiation monitors, a distinct upward trend in exhaust stack activity levels, and an identified loss of primary inventory were known to drill participants but not adequately relayed to the Technical Support Center (TSC) director for evaluation. This resulted in the failure to recognize and declare a general emergency.

Control room personnel responded well to the scenario and a second control operator was assigned to assist the Unit 1 operator. Communications were occasionally weak among the control room, technical support center, and operations support center. This resulted in degraded coordination of activities and some confusion regarding status of these response facilities' responsibility for specific corrective actions.

Operations teams were well briefed on the specific job they were to perform. However, they received minimal briefing on current plant status. This factor, coupled with the plant's practice of providing minimal status announcements over the plant wide announcing system, resulted in some confusion among operators as to the reason for some of the actions they were directed to perform. This caused some delays in implementation of actions as operators attempted to obtain information amongst themselves before performing certain evolutions.

A critique was held shortly after the drill to provide feedback to the participants. Many of the weaknesses noted by the controllers were also identified by the inspectors. The licensee recognized that lack of communication continues to be a concern as evidenced by the poor turnover between the TSC and the emergency operations facility, the excessive time required to assess the damage in the cable spreading room, and the amount of time that was allowed to elapse before the offsite release was recognized. The licensee plans to correct the identified weaknesses by performing extensive training in the areas of concern.

6. Engineering and Technical Support (71707) (45053) [(37828)]

The inspectors evaluated engineering and technical support activities to determine their involvement and support of facility operations. This was accomplished during the course of routine evaluation of facility events and concerns, through direct observation of activities, and discussions with engineering personnel.

a. Replacement of Station Battery D05

On July 19, replacement of station battery D05 commenced. Replacement of battery D06 is scheduled for November 1993. These batteries, which were last replaced in 1989, are expected to have a life of about 20 years. However, they have shown visible signs indicating excessive sulfation, and the manufacturer is replacing them under warranty. Other than the precipitate which has built up on the cell bottoms, there has been no measurable deterioration in battery performance such as capacity or individual cell voltages. The inspector monitored replacement of the battery, the ensuing battery tests, and had no concerns.

b. Construction of New Emergency Diesel Generator Building

Construction of the building to house two new emergency diesel generators and the new diesel fuel oil system began the week of June 7. Initial observations of this activity are discussed in Inspection Report 266/93011; 301/93011. During this inspection period, concrete pours continued for the fuel oil tank walls and the main building support walls. The two fuel oil storage tanks were set in place and back-filled. Electrical conduit was placed in the below ground section of the building between the fuel oil storage tanks and back-filled with fill concrete. Trenches were

excavated for the power cables from the new diesel generator building to the existing safeguards busses. Electrical conduit was laid in these trenches and back-filled with concrete. Because both the new diesels will be designated as B train, their output power supply conduits were run in the same concrete filled trench.

The inspectors monitored excavation and grading activities, concrete placement activities including installation of reinforcement (rebar), laying of conduit, batch plant operation, concrete transport and pumping, testing, form removal and post pour inspection. Discussions were held with craft workers and supervisors to evaluate their knowledge of the job requirements. The inspectors will continue to monitor progress of this construction.

The inspectors noted that during early pours, the workability of the fresh concrete was causing some placement problems. The licensee corrected the problems by reducing the fly ash content and adjusting the amount of plasticizer in the mix. These modifications to the mix design produced a more easily worked concrete that should reduce the amount of voids or honeycombs in the finished structure.

The inspectors observed onsite testing of fresh concrete by the licensee's test contractor. Tests required by job specifications were slump tests, air entrainment tests, and concrete strength tests, all were to be from samples taken at the pour site. Slump tests and air content test results were inconsistent during the early pours but were returned to specified limits by the above modifications to the mix design.

The inspectors noted that the concrete testing contractor's procedures were dated February 1990 and referenced the appropriate codes and standards. However, project specifications referenced codes and standards issued in 1990, 1991 and 1992. The licensee's quality assurance department initiated immediate corrective action to update the procedures to reflect project requirements for concrete testing.

Quality control inspectors were present during rebar placement, form erection and at each concrete pour. Post pour inspections were performed immediately after form removal. Voids or honeycomb areas were being identified and categorized as minor or major deficiencies. Major honeycombs are defined as any void or honeycomb that exposes the rebar when the unsatisfactory concrete is removed. A nonconformance report (NCR) is issued for each major deficiency. Each NCR is reviewed by the licensee's engineering staff and quality assurance. A copy of the NCR, including repair instructions, is provided to the craft supervisor before repairs commence. Six major honeycombs have been identified in the building walls that warranted NCRs and specific repair instructions.

The inspectors reviewed licensee quality assurance audit reports of the concrete testing contractor's facilities. Three audit findings relative to the contractor's quality assurance program were identified in the report. The contractor responded to each of the findings with their proposed corrective action. Followup of the audit findings had not been performed at the time of the inspection. Licensee quality assurance personnel routinely performed surveillances of construction and inspection activities at the construction site. These surveillances are documented in an activity monitoring report used to effect immediate corrective action.

7. Safety Assessment/Quality Verification (40500) (90712) (92700)

a. Licensee Event Report Review

The inspectors reviewed LERs submitted to the NRC to verify that the details were clearly reported, including accuracy of the description and corrective action taken. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite follow up. The inspector also verified that appropriate corrective action was taken or responsibility was assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. The following LER was reviewed and closed:

(Closed) LER 266/301/91-001 Minimum Auxiliary Feedwater (AFW) Flow During Automatic Actuation

This report documents discovery of a potential design inadequacy involving the actuation of simultaneous AFW flow to both units coincident with a failure of one of the turbine driven AFW pumps. Under the circumstances of a loss of off site power to both units, resulting in a loss of normal feedwater, coincident with the failure of the turbine driven AFW pump in one unit, the AFW system may be incapable of providing automatic feedwater flow to one of the units without operator intervention. This case would require that the steam pressure in the unit with the failed turbine driven AFW pump also be at a higher pressure than in the other unit. Under such conditions, the feedwater would be preferentially diverted to the unit with the lower steam generator pressure.

Several discussions were held between the licensee and the NRC regarding the acceptability of the response actions to be taken during the scenario. Additional information to evaluate the acceptability of this condition was provided by Wisconsin Electric in their letter dated August 24, 1993. The information delineated in the discussions and the letter were evaluated and determined to be acceptable. The licensee has procedures in place to assure that appropriate actions are taken in the event of this condition.

The flow split condition is expected to be corrected by operators within five minutes of the loss of feedwater. This situation is analogous to the operator action required to line up the qualified AFW suction source (service water) in the event of loss of the non-qualified condensate storage tanks. This latter situation is addressed in the Final Safety Analysis Report (FSAR) and is considered acceptable. Both conditions are correctable by operators from the control room within the five minutes determined in section 14.1.10 of the FSAR, wherein the inventory in the steam generators does not go below the minimum inventory determined for the loss of feedwater accident. Additionally, the May 3, 1982, Technical Evaluation Report (TER) for NUREG-0737 item 11.E.1.2 discusses the acceptability of manual operator actions under certain accident conditions. Based upon the apparently more limiting scenario described in the FSAR and the acknowledgement of required operator action in the TER, this item is closed.

b. Manager's Supervisory Staff Meeting

The inspector observed sessions 93-14 and 93-15 of the Manager's Supervisory Staff. Issues discussed included proposed containment system technical specification changes, license renewal activities, status of rod control system troubleshooting, design basis documentation activities, diesel generator turbo exhaust modification, and service water valve maintenance. The inspectors raised a concern with management regarding the diesel exhaust modification and service water maintenance discussions, in that, these discussions did not address optimal timing based upon a safety/risk perspective. Apparently, the service water system maintenance's timing was considered prior to the staff meeting; however, this safety consideration was performed at the working level and was not well understood during the staff meeting. After the inspectors discussed the diesel modification work's timing with management, the acting Chairman postponed the decision until a future meeting. This was done to allow further analysis of optimal timing from a safety perspective.

c. Off Site Review Committee Meeting

The inspector observed meeting 50 of the Off Site Review Committee (OSRC). The required quorum was maintained throughout the meeting and was periodically supplemented by additional persons. Committee members were experienced in various aspects of the nuclear industry and possessed diverse backgrounds extending outside of NRC Region III. Much of the meeting was held onsite and included tours of the plant and one on one interviews with selected individuals by committee members.

The committee reviewed items required by their charter which included pertinent safety issues such as 10 CFR 50.59 safety evaluation reports and technical specification change requests.

The committee's discussions were candid and constructive and not dominated by the plant staff. The meeting was well documented and action items clearly identified and tracked. Overall, the inspector considered OSRC's reviews to be effective.

d. Facility Housekeeping

During routine tours of the facility, the inspectors noted a gradual deterioration in the general cleanliness/housekeeping of portions of the plant. The eight foot elevation of the primary auxiliary building and the area around the spent fuel pool were the principle areas of concern. The inspector discussed this with plant management.

Reactor Engineering Instruction (REI) 24.0, "Spent Fuel Pit", provides a checklist to verify that items stored in the vicinity of the spent fuel pool are prevented from inadvertent entry into the pool. The inspector discussed the REI with the spent fuel pool administrator and found that although the instruction is being adequately followed, it fails to address the control of material in close proximity to the pool such as in the contaminated storage area. The inspectors will continue to monitor this area in future inspections.

8. Temporary Instructions (TI)

a. (Closed) TI 2500/028 Employee Concerns Programs

Using the TI for guidance, the inspectors evaluated the characteristics of the company's employee concerns program. The inspectors also reviewed General Policy 013, "Safety Policy," and PBNP 3.5.2, "Injuries, Accident Reporting, OSHA Form 200 Requirements, and Industrial Safety," to verify the company's conformance with the TI (See Attachment "A").

The inspection determined that no formal employee concern program pertaining to nuclear safety issues exists at this time. All employees are expected to bring safety concerns to the attention of their respective supervisor. In cases where the employee believes that the safety concern was not properly addressed by his/her supervisor, the employee should convey the concern to any manager or department head until the issue is resolved.

A program is in place for employees to express concerns that pertain to industrial safety. Concerns are communicated through the use of safety improvement suggestion forms which are located in a central area of the plant. The forms are reviewed by the Division Safety Committee and general recommendations to resolve the concern are made to the Plant Manager. The final corrective actions are approved by the Plant Manager and communicated to the employee. This TI is closed.

9. Exit Interview (71707)

A verbal summary of preliminary findings was provided to the licensee representatives denoted in paragraph 1 above on September 14, at the conclusion of the inspection. Information highlighted during the meeting is contained in the Executive Summary. The licensee agreed with the assessment of the inspection findings and dissenting comments were not received. No written inspection material was provided to the licensee during the inspection.

The likely informational content of the inspection report with regard to documents or processes reviewed during the inspection was also discussed. Licensee management did not identify any documents or processes that were reported on as proprietary.

Attachment A

EMPLOYEE CONCERNS PROGRAMS

PLANT NAME: Point Beach Nuclear Plant LICENSEE: WEPCo. DOCKET #: 50-266/50-301

A. PROGRAM:

1. Does the licensee have an employee concerns program?
(No, employees are expected to communicate nuclear safety concerns to their respective supervisors. A formal program exists for industrial safety concerns.
2. Has NRC inspected the program? Report # 93013

B. SCOPE: (Circle all that apply) Note: All answers in parts B - I pertain to the industrial safety program only.

1. Is it for:
 - a. Technical? (No)
 - b. Administrative? (No)
 - c. Personnel issues? (No)
2. Does it cover safety as well as non-safety issues?
(No, only covers industrial safety issues.)
3. Is it designed for:
 - a. Nuclear safety? (No)
 - b. Personal safety? (Yes)
 - c. Personnel issues - including union grievances?
(No, union grievances are handled using a four step process. In step one, the employee, his/her supervisor, and a union representative discuss the issue and the corresponding group manager issues a resolution document. If the union is not satisfied with this resolution, they can appeal the resolution to the plant manager for another decision. The union has the option of appealing the plant manager's decision to the WEPCo Employee Relations Manager. If the issue remains unresolved, it goes to final and binding arbitration.
4. Does the program apply to all licensee employees?
(Yes)

Employee Concerns Programs

5. Contractors?
(Yes, the program applies to contractors when they are working on projects in conjunction with WEPCo employees. Contractors performing independent of WEPCo are not required to follow the program.)
6. Does the licensee require its contractors and their subs to have a similar program?
(No, WEPCo expects contractors to have a program but the program is not evaluated.)
7. Does the licensee conduct an exit interview upon terminating employees asking if they have any safety concerns?
(No)

C. INDEPENDENCE:

1. What is the title of the person in charge?
Fire Protection and Safety Coordinator
2. Who do they report to?
Site Services Manager
3. Are they independent of line management?
No
4. Does the ECP use third party consultants?
No
5. How is a concern about a manager or vice president followed up?
Industrial Safety Program does not address concerns pertaining to management.

D. RESOURCES:

1. What is the size of staff devoted to this program?
One Fire Protection and Safety Coordinator, five Division Safety Committee members, and the Plant Manager. All duties are collateral.
2. What are ECP staff qualifications (technical training, interviewing training, investigator training, other)?
None

E. REFERRALS:

1. Who has followup on concerns (ECP staff, line management, other)?
The Division Safety Committee and the Plant Manager.

Employee Concerns Programs

F. CONFIDENTIALITY:

1. Are the reports confidential?
(No)
2. Who is the identity of the alleged made known to (senior management, ECP staff, line management, other)?
To the Division Safety Committee who recommends actions to resolve the concern, and the Plant Manager who is responsible for providing feedback to the alleged.
3. Can employees be:
 - a. Anonymous? (Yes)
 - b. Report by phone? (Yes)

G. FEEDBACK:

1. Is feedback given to the alleged upon completion of the followup? (Yes, results are communicated through the Plant Manager.)
2. Does program reward good ideas?
No
3. Who, or at what level, makes the final decision of resolution?
The Plant Manager
4. Are the resolutions of anonymous concerns disseminated?
Yes
5. Are resolutions of valid concerns publicized (newsletter, bulletin board, all hands meeting, other)?
Yes, through the Division Safety Committee meeting minutes which are posted on plant bulletin boards.

H. EFFECTIVENESS:

1. How does the licensee measure the effectiveness of the program?
By the low number of serious injuries that occur at the plant.
2. Are concerns:
 - a. Trended? (No)
Only the injury and accident rate is trended.
 - b. Used? (Yes)

Employee Concerns Programs

3. In the last three years how many concerns were raised? 151
Closed? 97 What percentage were substantiated? 91%
4. How are followup techniques used to measure effectiveness (random survey, interviews, other)?
The Industrial Safety Program does not use any types of followup techniques at this time to measure the effectiveness of the program. As stated earlier, the effectiveness of the program is measured by the low number of injuries.
5. How frequently are internal audits of the ECP conducted and by whom?
The Industrial Safety Program is randomly audited by the onsite quality assurance group (last audit 4/93) and the corporate Industrial Health and Safety Group (last audit 4/92)

I. ADMINISTRATION/TRAINING:

1. Is ECP prescribed by a procedure? (Yes)
2. How are employees, as well as contractors, made aware of this program (training, newsletter, bulletin board, other)?
Safety improvement suggestion forms are located in a central area on the plant.

ADDITIONAL COMMENTS: (Including characteristics which make the program especially effective or ineffective.)

The expectations of the licensee's safety policy are as follows:

1. No manager or management employee may impede proper consideration of a safety concern brought to his or her attention.
2. No employee of the Nuclear Power Department is permitted to waive an accepted safety requirement in the conduct of his/her job.
3. All employees are encourage to bring safety concerns to the attention of their respective supervisor. However, any employee who believes a safety concern was not properly addressed or understood by his/her supervisor or who is reluctant for any reason to discuss that concern with his/her supervisor is free to convey that concern to any section head or directly to the department head.
4. No supervisor may penalize an employee in any way for expressing a safety concern outside the normal chain of command.

Employee Concerns Programs

5. Communication of a safety concern may be made by writing, by telephone, or in person.

The person completing this form please provide the following information to the Regional Office Allegations Coordinator and fax it to Richard Rosano at 301-504-3431.

NAME:	TITLE:	PHONE #:	DATE COMPLETED:
Karla Bristow	Reactor Eng. Intern	414-755-2309	09-07-93