

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-266/82-13(DPRP); 50-301/82-13(DPRP)

Docket No. 50-266; 50-301

License No. 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

Inspection Conducted: June 1-July 31, 1982

Inspectors: *P.R. Pelke*
R. L. Hague

8/24/82

for P.R. Pelke
B. E. Fitzpatrick

8/24/82

Approved By: *for P.R. Pelke*
J. E. Konklin

8/24/82

Inspection Summary

Inspection on June 1, 1982-July 31, 1982 (Report No. 50-266/82-13(DPRP); 50-301/82-13(DPRP))

Areas Inspected: Routine resident inspection of Operational Safety Verification; Monthly Maintenance Observation; Monthly Surveillance Observation; Followup on Licensee Event Reports; and Independent Inspection. The inspection involved a total of 282 inspector-hours onsite by two inspectors including 42 inspector-hours on offshifts.

Results: Of five areas inspected, no items of noncompliance were identified in four areas. One item of noncompliance was identified in one area (Shipment of liquid radwaste - Paragraph 6.b).

DETAILS

1. Persons Contacted

*G. A. Reed, Manager, Nuclear Operations
J. J. Zach, General Superintendent
T. J. Koehler, Operations Superintendent
J. C. Reisenbuechler, I & C Superintendent
W. J. Herrman, Maintenance & Construction Superintendent
R. S. Bredvad, Health Physicist
*R. E. Link, EQR Superintendent
*F. A. Zeman, Staff Services 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 months of June and July 1982. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the auxiliary building and both 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 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 months of June and July 1982, the inspector walked down the accessible portions of the safety injection, containment spray, auxiliary feedwater and diesel generating systems to verify operability. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and drumming.

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: annual maintenance on emergency diesel generator 3D and routine maintenance on the auxiliary feedwater and containment spray pumps.

Following completion of maintenance on the emergency diesel generator, auxiliary feedwater pumps, and containment spray pumps, the inspector verified that these systems had been returned to service properly.

On June 21, 1982, during annual maintenance on the 3D emergency diesel, it was discovered that the Unit 1 output breaker failed to close while on the test stand. Investigation revealed that the failure was caused by a broken latch check switch. The latch check switch was replaced and the breaker was successfully tested on June 21, 1982. Previous operational testing had revealed no difficulty in closing the breaker, therefore, it is suspected that the latch check switch was broken during breaker removal and transport to the test stand.

On July 27, 1982, while installing a hanger on the CVCS divert line, a pin hole leak was formed in an adjacent pipe weld. The procedure called for tack welding the hanger to the pipe within an inch of a welded pipe joint. While performing the tack welds the welded pipe joint began to leak a small (pin hole) stream of water. The leak was isolated within 10 minutes and the weld repaired later that day. Less than one quart leaked from the system. System pressure at the time of the leak was 2 to 3 psig. There was no detectable airborne activity and the highest smear was 500 dpm.

No items of noncompliance or deviations were identified.

4. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the 3D diesel generator and the Unit 2 reactor protection

system 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:

- IT-09 Inservice testing of the turbine driven auxiliary feed pump
- IT-06 Inservice testing of the containment spray pumps and eductor supply
- RHR valve 1-856-A operability verification prior to maintenance on 1-856-B

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.

- 81-010/01T-0 RHR core deluge valves
 1-853C and 1-853D
 were stuck open, Unit 1

6. Independent Inspection

On July 6, 1982, while returning the B cryogenic waste gas compressor to service after maintenance, the operators detected a leak on a discharge flange. The leak was isolated within five minutes of its discovery. The release was monitored by the auxiliary building stack detectors. The maximum 15 minute average release rate was .377% of the technical specification limit. The licensee made an ENS notification within 10 minutes of the release. No items of noncompliance or deviations were identified.

On July 13, 1982, the licensee shipped 9 drums of solidified liquid waste and other low level dry waste to Barnwell for burial. Barnwell notified the licensee on July 16, 1982, that on receipt inspection they found one drum with about 2 gallons of free liquid in it. On investigation the inspector found that the licensee had changed cement suppliers and was having some difficulties getting complete solidification with the new cement. They went back to using the cement they

had used previously and the problem cleared up. The drums with the solidification problems were held while continued attempts to get complete hardening were made by adding portions of good cement, re-rolling the drums, and finally adding a layer of good cement to the tops of the drums. The licensee believed complete solidification had been achieved prior to shipment of the drums. Upon receiving notification from Barnwell, the licensee informed them that 4 other drums in that shipment were from the suspect batch of cement. Barnwell inspected further and found one drum which had not completely hardened but found no further evidence of free liquid. The problem cement has been removed from the site. On July 30, 1982, the state of South Carolina informed the licensee that it was imposing a \$1,000 fine for the shipment of improperly packaged liquid waste. This is an item of noncompliance (266/82-13-01; 301/82-13-01).

7. 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 the findings.