Enclosure 1

SALP 8

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FINAL SALP REPORT

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE

Inspection Report Nos. 50-266/90001; 50-301/90001

Wisconsin Electric Power Company

Point Beach Nuclear Plant

April 1, 1989 through August 31, 1990

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Enclosure 1

Point Beach Nuclear Plant

Α.

Summary of Meeting with Wisconsin Electric Power Company on November 19, 1990

The findings and conclusions of the SALP Board are documented in Report Nos. 50-266/90001; 50/301/90001 and were discussed with the licensee on November 19, 1990, at the Point Beach Energy Center.

While the meeting was primarily a discussion between the licensee and NRC, it was open to members of the public as observers.

The following licensee and NRC personnel were in attendance, as well as the noted observers.

Wisconsin Electric Power Company

R. A. Abdoo, Chairman and Chief Executive Officer
J. W. Boston, President and Chief Operating Officer
C. W. Fay, Vice President, Nuclear Power
J. J. Zach, Senior Manager, Nuclear Engineering
G. J. Maxfield, Plant Manager
R. A. Newton, Manager, Nuclear System Engineering and Analysis
E. J. Lipke, Manager, Nuclear Plant Engineering
Nuclear Regulatory Commission

A. B. Davis, Regional Administrator
H. J. Miller, Director, Division of Reactor Projects (DRP)
R. C. Knop, Chief, DRP Branch 3
C. L. Vanderniet, Senior Resident Inspector, Point Beach
P. Castleman, Senior Resident Inspector, Kewaunee
A. Dunlop, Project Engineer, DRP
J. Gadzala, Resident Inspector, Point Beach
R. B. Samworth, Project Manager, Office of Nuclear Reactor Regulation

B. Comments Received from Licensee

Wisconsin Electric Power Company response to the Point Beach Nuclear Plant Initial SALP 8 Report dated December 18, 1990, included several comments that have resulted in a minor revision to the Initial SALP Report. These changes are listed in Enclosure 2 and the revised pages are included as Enclosure 3.

The affected pages of the Initial SALP Report should be replaced with the corrected pages included in Enclosure 3.

C. Regional Administrator's Conclusions Based on Consideration of Licensee Comments

I have concluded that the overall ratings in the affected areas have not changed.

Enclosure 2

REVISION SHEET

PAGE	LINE	NOW READS	SHOULD READ
11	15-16	" lack of attention to detail on the part of instrumentation & control (I&C) technicians performing surveillances."	" lack of attention to detail during the performance of instrumentation & control (1&C) related surveillances."

Basis: The personnel errors should not have been attributed to only the I&C technicians in the performance of surveillances. The NRC believes that the lack of attention to detail does characterize the root cause of these events.

16	4	"The licensee also	"The licensee is
		committed to a major"	planning a major"

Basis: The licensee is making plans to perform this hardware upgrade program, however, a formal commitment has not been made to the NRC.



Maintenance/Surveillance

1. Analysis

C .

Evaluation of this functional area was based on the results of 1 special and 11 routine inspections performed by resident and regional respectors.

Enforcement istant in this functional area was excellent during this assessment orriod, with no areas of significant regulatory concern being itentified.

There were numerous incidents requiring the submittal of LERs attributable to thi functional area. Five incidents were caused by personnel error. This is a notable increase over the previous assessment period and appears to be primarily attributable to a lack frattention to detail on the part of instrumentation & control (ind) technicians performing surveil ances. Two incidents resulted from procedural inadequaties, which are being addressed by a new procedure correction program. The remaining eight incidents were caused by equipment failure or malfunction. The majority of these resulted from age degradation problems. None were of any major safety significance. Safety and value and corrective actions were adequately addressed in the LERs. There induces indicate a potential inadequacy in identification of broad scope root cause and corrective actions

Management involvement in ensuring quality in this functional area remained a strength. Senior personnel pere involved in the conduct of maintenance and surveillance at the facility and routinely visited job sites. Refueling attages performed during this assessment period were well manager, and all three outages were completed close to the original estimated completion date. A special maintenance outage on Unit 1 to repair two leaks in the reactor coolant system (ACS) was properly planned and corrected in an appropriate menner despite complications that arose while performing the work. The licensee also initiated a pilot reliability centered maintenance program at the end of this period; this is an important initiative given the age related problems that are being observed.

3. Recommendations

None.

C. Maintenance/Surveillance

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There were numerous incidents requiring the submittal of LERs attributable to this functional area. Five incidents were caused by personnel error. This is a notable increase over the previous assessment period and appears to be primarily attributable to a lack of attention to detail during the performance of instrumentation & control (I&C) related surveillances. Two incidents resulted from procedural inadequacies, which are being addressed by a new procedure correction program. The remaining eight incidents were caused by equipment failure or malfunction. The majority of these resulted from age degradation problems. None were of any major safety significance. Safety analysis and corrective actions were adequately addressed in the LERs. However, the repeat occurrences of personnel errors during surveillances indicate a potential inadequacy in identification of broad scope root cause and corrective actions.

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Site and corporate security management have kept NRC regional personnel fully informed of security issues involving the site. However, early in the assessment period the corporate security office failed to notify site personnel of NRC's acceptance of a significant security plan change. This change required the posting of security personnel at the entrance to containment during outage activity. Consequently, the site failed to implement this provision of the plan, resulting in a violation.

during outage activities. Consequently, the site failed to implement this provision of the plan, resulting in a violation. The licensee's approach to the identification and resolution of technical security issues was good, as evidenced by the comprehensive action plan to resolve problems associated with the intrusion detection system. The licensee hired a contractor to conduct a technical resider of the system. The subsequent equipment upgrades significantly reduced system downtime and the high alarm rate.

The licensee's program for reporting security events was adequate. Required reports were generally accornte and timely, except for a 1-hour report that was late because of a misunderstanding on the part of the on-duty security stift upervisor. There were seven 1-hour event reports made during this assessment period. Three of the events related to failure of the alarm station operators to adequately implement compensatory measures for failed intrusion alarm zones. The last event occurred in the closing month of the current assessment period and related to a degraded VA barrier.

The licensee's security organization was adequitely staffed. Positions and responsibilities within the organization were defined, and overtime was adequately monitored and controlled. During the current assessment period, the licensee permanently filled the security supervisor's position with an individual whose sole responsibility related to security. The contract security force experienced a 20% turnover rate for the assessment period, which was considered high. The exterience level of non-supervisory personnel was consequently low. The high turnover rate has negatively affected the morate of security force members because of the frustration of continually training new personnel on the job. The licensee was reviewing this issue and was seeking ways to reduce the current turnover rate. communications. Management has taken a proactive security posture, increasing staff attention to security matters. The licensee made progress in increasing the security consciousness of all plant employees. The licensee is planning a major security hardware upgrade program to be completed over the next 3 years.

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VPNPD-90-494 NRC-90- 124

December 18, 1990

Mr. A. Bert Davis, Regional Administrator U.S. NUCLEAR REGULATORY COMMISSION Region III 799 Roosevelt Road Glenn Ellyn, Illinois 60137

Dear Mr. Davis:

DOCKET NUMBERS 50-266 AND 50-301 RESPONSE TO INSPECTION REPORT NOE, 50-266/90001 AND 50-301/90001 SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE POINT BEACH NUCLEAR PLANT

Your letter dated October 30, 1990, transmitted your Systematic Assessment of Licensee Performance (SALP) for our Point Beach Suclear Flant for the period April 1, 1989, through August 31, 1990. We appreciated the opportunity to discuss your assessment of our performance at our November 19, 1990, meeting. We thank you for the positive and constructive comments made regarding our performance as summarized in the SALP report and as discussed during the November 19 meeting. We agree with your assessment of our performance.

Your assessment acknowledged high performance ratings in the Plant Operations and Maintenace/Surveillence categories. These high ratings were in part attributable to our strong, knowledgeable, and professional operations staff. Our operations staff continues to maintain good awareness of plant conditions. Professional atmosphere and "black board" conditions are maintained in the control room. As you identified, our high capacity factors and very low forced outage rates are achieved by the diligence of our operations staff, the quality of work performed by our employees, and the effectiveness of our maintenance and surveillance programs. We remain very proud of these accomplishments and the performance results achieved in these areas.

Recurring high radiation area control and unplanned extremity exposure events, which occurred early in the assessment period, contributed to a lower performance rating in the area of Radiological Controls. We believe that training and management enhancements have corrected the weaknesses which contributed to the

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Mr. A. Bert Davis December 18, 1990 Page 2

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occurrence of these events. Efforts which have been initiated to enhance our ALARA program are expected to additionally improve performance in the Radiological Controls functional area.

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As was discussed at the November 19 meeting, we have a number of actions ongoing and specific programs in place or planned which are intended to continue to improve overall plant performance. As you noted during the November 19 meeting, we believe these actions have resulted in positive performance trends in all of the assessed functional areas. Your report specifically identified our efforts to increase our staff resources, improve our corrective action program, continue our safety system functional inspection program, and to initiate a design reconstitution program. We expect that these and other initiatives will be effective in contributing to improved plant performance and safety.

The following comments are provided on two specific statements included in the SALP report. Section IV.E.1, which summarizes Security, states "the licenses also committed to a major security hardware upgrade program to be completed over the next 3 years." It should be understood that although we are making plans to perform this hardware upgrade program, a formal commitment to complete this work has not been made to the NRC. Section IV.C.1, which summarizes Maintenance/Surveillance, discussed incidents requiring LERs and identified five LERs which were caused by personnel errors. Although, we concur that personnel error likely contributed to these incidents, we believe the report improperly attributes all of these events to surveillance work performed by instrument and control technicians. Also we believe that the statement "a lack of attention to detail on part of the instrument and control technicians" improperly characterizes the root cause of these events.

We are particularly pleased that the SALP report noted a significant improvement has been made in our communications with and responsiveness to the NRC. Continued improvement in communications remains one of our principal objectives.

Very truly yours,

...

C. W. Fay Vice President Nuclear Power

Copies to NRC Document Control Desk NRC Resident Inspector