

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-266/82-24(DPRP); 50-301/82-22(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

Inspection Conducted: December 1, 1982 - January 31, 1983

Inspectors: *[Signature]*  
R. L. Hague

3/3/83

*[Signature]*  
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3/3/83

Approved By: *[Signature]*  
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Projects Section 2B

3/3/83

Inspection Summary

Inspection on December 1, 1982 - January 31, 1983 (Report No. 50-266/82-24 (DPRP); 50-301/82-22(DPRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of licensee action on previous inspection findings; operational safety; maintenance; surveillance; Licensee Event Reports; IE Bulletins; independent inspection of NFB relays failures; and plant trips. The inspection involved a total of 370 inspector-hours onsite by two inspectors including 60 inspector-hours on offshifts.

Results: No items of noncompliance or deviations were identified.

## DETAILS

### 1. Persons Contacted

- \*J. J. Zach, Manager, PBNP
- \*T. J. Koehler, General Superintendent
  - G. J. Maxfield, Operations Superintendent
  - J. C. Reisenbuechler, I & C Superintendent
  - W. J. Herrman, Maintenance & Construction Superintendent
  - R. S. Bredvad, Health Physicist
  - R. Krukowski, Security Supervisor
- \*R. E. Link, EQR Superintendent
- \*F. A. Flentje, Staff Services Supervisor

The inspectors also interviewed members of the Operations, Maintenance, Health Physics, and Instrument Controls Sections.

\*Denotes personnel attending exit interviews.

### 2. Action On Previous Inspection Findings

- a. (Closed) Noncompliance (266/82-10-01(DPRP)): Failure to maintain fire door between diesel generator rooms closed. The licensee has initiated higher fire door awareness among contractors and employees and has highlighted vital area fire doors by painting them red.
- b. (Closed) Noncompliance (301/82-01-03(DPRP)): Failure to follow PBNP 4.13 "Equipment Isolation Procedure". The licensee has revised PBNP 4.13 and standing order PBNP 4.12.4 to clarify responsibility for returning systems to normal after maintenance. Also, a new chemistry procedure, CAMP-1000, has been issued requiring post maintenance valve line-up checks prior to sampling.
- c. (Closed) Open Items (266/82-01-02(DPRP) and 301/82-01-01(DPRP)): Resolution of steam pressure sensing line freezing problem. As of December 23, 1982, the modified heat tracing system was operational and on January 14, 1983, the final insulation modification was complete.
- d. (Closed) Open Items (266/82-01-03(DPRP) and 301/82-01-02(DPRP)): Failure to promptly reset R-11 alarms. Better communications between chemistry and operations as to when sampling is completed has alleviated this problem.
- e. (Closed) Open Item (266/82-01-06(DPRP)): Elevated R-11 readings after shutdown. During the last Unit 1 refueling, which ended December 9, 1982, the licensee found a body to bonnet leak on valve 559 B, "B" loop RTD bypass manifold isolation valve, Ref. LER 82-019. Repair of this leak has resulted in normal R-11

readings since the unit was restarted and appears to have been the cause of the previous elevated readings.

- f. (Closed) Unresolved Item (301/82-18-01(DPRP)): Instrumentation for "C" BAST found to be jumpered to an interruptable power supply. After an extensive investigation and document search by both the inspectors and the licensee, it was determined that the subject miswiring could have been performed prior to the licensee receiving their operating license. This coupled with the fact that the licensee was not required to verify as-built wiring diagrams led to the decision to exclude this unresolved item as a possible item of noncompliance.

### 3. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the months of December 1982 and January 1983. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of Unit 1 containment, auxiliary 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 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 December 1982 and January 1983, the inspector walked down the accessible portions of the service water, safety injection, and containment spray systems to verify operability. The inspector also witnessed portions of the radioactive waste system controls associated with radwaste shipments and barreling.

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.

On December 28, 1982, a small unplanned release occurred over a one-hour period beginning at about 0935. While shifting mixed bed demineralizers, an operational error caused about 280 gallons of primary coolant system water to overflow from the sump drain tank onto the -19 foot level of the auxiliary building. The water was collected for treatment in the radioactive waste water treatment system. No water was released from the plant, however, the water degassed and caused a gaseous release from the auxiliary building ventilation system.

The vent path is continuously monitored and the release rate was about 1.0 percent of the technical specification 15 minute limit. About 43 curies of noble gas (primarily Xenon) were released. The licensee

made a red phone notification at 1041, December 28, 1982. The inspector was in the control room for the duration of the release.

Further investigation disclosed an apparent lack of communication between operations and I & C personnel which resulted in operations draining water to a tank that I & C was given permission to do level instrumentation calibrations on. This in-turn resulted in a lack of concern over the sump drain tank high level alarm which apparently each thought was generated by the other. The licensee has done its own investigation which indicates a need for better communications and a possible procedural change to prevent recurrence.

4. 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:

Source and Intermediate Range Detection Replacement  
Oil Change Auxiliary Feedwater Pumps  
Oil Change Safety Injection Pumps

Following completion of maintenance on the auxiliary feedwater system and the safety injection system, the inspector verified that these systems had been returned to service properly.

5. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the rod control system and the radiation monitoring 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 restora-

tion 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:

Unit 1 Flux Mapping  
Unit 2 Safeguards Logic  
Unit 1 Reactor Coolant System Flow Tests

6. 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.

Unit 1

- 50-266/81-019/01T-0 - Misaligned Steam Flow Transmitters
- 50-266/81-020/03L-0 - Frozen Steam Pressure Sensing Line
- 50-266/82-001/03L-0 - Frozen Steam Pressure Sensing Lines
- 50-266/82-004/03L-0 - Differential Pressure Instrument 4007  
Found Isolated
- 50-266/82-015/03L-0 - Unit 1 Gas Stripper Flange Leak
- 50-266/82-016/01T-0 - R-11 and R-12 Suction Valve Failed  
To Close
- 50-266/82-017/01T-0 - Eddy Current Examination Results
- 50-266/82-017/01T-1 - Eddy Current Examination Results (Update)
- 50-266/82-017/01X-2 - Eddy Current Examination Results (Update)
- 50-266/82-018/01T-0 - Loss of Yellow Instrument Bus
- 50-266/82-019/01T-0 - RTD Bypass Manifold Isolation Valve Body  
to Bonnet Studs Found Degraded
- 50-266/82-020/01T-0 - Containment Isolation Valve Leakage
- 50-266/82-020/01X-1 - Containment Isolation Valve Leakage (Update)



- 50-266/82-021/03L-0 - Old Fire Detection System Deenergized Prior to Testing New System
- 50-266/82-024/03L-0 - Steam Flow Transmitter Out of Calibration
- 50-266/82-025/03L-0 - Undervoltage Relay Out of Time Specification
- 50-266/82-028/03L-0 - Fire Detector System Out of Service
- 50-266/82-029/03L-0 - Control Rod Alignment Alarm Out of Service
- 50-266/82-030-03L-0 - Snubber Shaft Seal Failure

Unit 2

- 50-301/82-005/03L-0 - 4KV Undervoltage Relays Outside Limits
- 50-301/82-005/01T-0 - "C" Boric Acid Storage Tank Instruments Improperly Wired
- 50-301/82-007/03L-0 - Pressurizer PORV Found Inoperable
- 50-301/82-008/03L-0 - Steam Line Pressure Instrument Out of Calibration
- 50-301/82-009/01T-0 - Flux Difference Alarm Out of Service
- 50-301/82-010/03L-0 - Boric Acid Heat Tracing Out of Service
- 50-301/82-011/03L-0 - Steam Generator Pressure Transmitter Sensing Line Frozen

7. IE Bulletin Followup

For the IE Bulletins listed below the inspector verified that the Bulletin was received by licensee management and reviewed for its applicability to the facility. If the Bulletin was applicable 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 presented in the Bulletin and the licensee's response, that the 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.

- 82-03      Stress Corrosion Cracking in Thick-Wall, Large-Diameter, Stainless Steel, Recirculation System Piping at BWR Plants
- 82-04      Deficiencies in Primary Containment Electrical Penetration Assemblies

8. Plant Trips

Following the Unit 1 plant trip at 1013, December 9, 1982, 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 1724, December 9, 1982.

The plant trip was caused by low low level in "A" steam generator while controlling levels on the bypasses during low power physics testing. The operator had previously received a high level alarm which fails the bypass valves shut. The valves can be reset by depressing buttons on the control panel once the high level condition has cleared. Due to the low power level it took quite some time for the high level alarm to clear and the operator forgot to reset the valves. As the low level was approached and the operator tried to increase feed he thought the bypass valves were malfunctioning.

The reactor tripped on low low level before the operator realized he had forgotten to reset the valves.

9. Independent Inspection

Due to an increasing rate of failure (coil burnout) of NBF D relays the licensee, at the manufacturers suggestion, began replacing these coils with a later model. Early in 1982 Westinghouse sent to the licensee approximately 60 new relay units and another 60 replacement coils. The new relays were installed in Unit 2 during the spring 1982 refueling. The relays removed from Unit 2 were rebuilt using the new coils supplied by Westinghouse. On testing the rebuilt relays prior to Unit 1 start-up one relay was found to have an excessive dropout time. Further testing, including the all new relays installed in Unit 2, indicated one additional relay in Unit 1 with excessive drop-out time. Inspection of the failed coils disclosed that coil filler epoxy had leaked into the plunger cavity thereby inhibiting plunger drop-out on deenergization. Discussions with the manufacturer on December 6, 1982, indicate that there may be a batch problem in that the epoxy was not properly cured. No specific batch identification is made for these relay coils, however, both failed coils have identifications of 8203 indicating manufacture in March 1982. These coils are type 1293 C51 G01. After a safety evaluation, the licensee decided to replace the newly rebuilt relays in Unit 1 with the old style coil which fails in the conservative rather than non-conservative mode. This has been accomplished as of December 7, 1982. Further investigation by the licensee and Westinghouse is in progress.

10. 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.