U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report Nos. 50-266/94008(DRP); 50-301/94008(DRP)

Docket Nos. 50-266; 50-301 License No. DPR-24; 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: April 19 through May 26, 1994

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Reactor Projects Section 3A

Inspection Summary

Inspection from April 19 through May 26, 1994
(Reports No. 50-266/94008(DRP); No. 50-301/94008(DRP)

Areas Inspected: Routine, unannounced inspection by inspectors of plant operations, maintenance, engineering, plant support, and corrective actions on previous findings.

Results: No violations of NRC requirements and one unresolved item were identified. An Executive Summary follows.

Plant Operations

A decline in formality was noted in the conduct of control room operations during the Unit 1 refueling outage, indicating a weakness in management oversight of operations. A related issue concerning operations governed by a deficient special order remains unresolved. (Section 1)

Unit 1 safely completed a 28-day refueling outage. An inherent quadrant power tilt initially delayed full power operation. (Section 1.a)

On April 27, shutdown bank "A" control rods for Unit 1 were inadvertently tripped during testing. The unit was in refueling shutdown at the time. (Section 1.c)

Maintenance

Evaluation of a new maintenance prioritization tool, called the "Top 140" list, determined that it was moderately effective although not being utilized to its full potential. (Section 2.c)

Engineering

A followup inspection, regarding an improper bearing being found in a containment cooling fan, determined that the plant's commercial grade dedication process was not thorough in that material and part number changes by the manufacturer were not identified. (Section 3.a)

Installation of two new emergency diesel generators continued. (Section 3.b)

Wisconsin Electric's inspection of the Unit 1 reactor vessel head penetrations was evaluated as being appropriate. (Section 3.c)

Plant Support

Performance in this area remained consistent. No significant issues were noted. (Section 4)

Plant Improvement Initiatives

The expectations of the Manager's Supervisory Staff (MSS), the onsite safety review committee, for followup action were not always clearly conveyed to personnel presenting information for the staff's consideration. (Section 5.a)

DETAILS

1. Plant Operations (71707) (60710) (71715)

The inspectors evaluated selected 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.

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.

During facility tours, inspectors noticed few signs of leakage and that all equipment appeared to be in good operating condition. Overall, plant cleanliness has remained good.

Control Room Decorum

The inspectors observed control room operations, reviewed applicable logs and conducted discussions with Operations staff members. Early during the inspection period, the inspectors noted a decline in formality in the conduct of control room operations, indicating a weakness in management oversight of operations. Examples included cursory turnovers during short term watch relief, inconsistent response to annunciator alarms among shift crews, informal verbal communications, weak control over access to the reactor control board area, and numerous distracting public address system announcements. These conditions were predominately evident during the recent Unit 1 outage.

As discussed in previous inspection reports, the more significant aspects of this condition were the high volume of traffic in the control room and the overburdening of the shift superintendents with administrative duties during outages. Significant numbers of personnel, not otherwise required to be in the control room, entered to conduct administrative business with the superintendents. During outage periods, this created a significant distraction for control room operators. Although an additional senior reactor operator had recently been assigned to each operations crew, the amount of administrative work assigned during outage periods continued to overwhelm control room supervisors. During these periods, attention was diverted towards the outage unit to such a degree that the operating unit received little attention from other than the assigned reactor operator.

A meeting was held between the NRC and Wisconsin Electric management on May 13 to discuss this issue. Wisconsin Electric outlined measures they had recently undertaken to address these concerns. These included reassignment of several senior shift superintendents to monitor training

performance, operations performance, and provide feedback to bring about consistency of operations among the six operations crews. Additional emphasis will be placed on improving the effectiveness of the recently introduced work control center to reduce the administrative burden in the control room. Plant management also reiterated their expectations to plant staff regarding this area.

Following completion of the Unit 1 outage, the inspectors observed a notable improvement in control room formality. Operators appeared more diligent in observing their control panels, an increased sensitivity towards formal communications and alarm response was noted, control room traffic decreased significantly, and the administrative burden on senior reactor operators was nominal. Turnovers observed were thorough and professionally conducted. Reactor Operators monitored the back panels only for short periods and notified the senior reactor operators before leaving the control board area.

Management control over the May 14, Unit 1 downpower evolution showed significant improvement as discussed in section 1.a below. The inspectors will continue to monitor performance in this area.

Adequacy of an Operations Special Order Remains Unresolved

The inspector noted that Operations Special Order PBNP 93-03, "Potential 1B-03 Overcurrent Condition During Degraded Grid Voltage Conditions", directed operators to maintain a specific electrical distribution lineup in order to preclude undervoltage protection concerns. Operator aid tags on the Unit 1 coolant charging pumps conveyed information relating to this same issue. However, the requirements conveyed by the operator aid tags was not consistent with the special order. Additionally, both the operator aids and the special order specified 3953 volts as the minimum allowed voltage. A recent technical specification change set this value at 3959 $\pm$ ½% volts.

The purpose of both the tags and the special order was to prevent a potential overcurrent condition on 480 VAC safeguards bus 1B-03 during a postulated undervoltage condition and thereby prevent the resultant tripping of the bus' supply breaker. Additional information is contained in Inspection Report 266/93006.

Operators were not knowledgeable of the reason for the special order specifying the lower voltage or whether the specified voltage value remained correct in light of the technical specification change. The operator aid tags were revised on May 26 to clarify their requirements. This issue remains unresolved pending evaluation of the adequacy of the special order (266/94008-01).

a. Unit 1 Operational Status

The unit commenced this period in refueling outage 21. This 28-day outage was conducted with an appropriate emphasis on safety. The reactor was taken critical on April 28 and the main generator was placed on line April 30.

Reactor Core Reload Produced a Quadrant Power Tilt

98% power was achieved on May 5 but full power operation was initially prevented due to the existence of a 2.7% quadrant power tilt in the reactor core. This tilt was believed to have resulted from the core reload during the refueling outage.

Although incore flux mapping showed that the resultant power imbalance did not preclude full power operation based on hot channel factors, administrative controls required a 3.5° F margin between the highest indicated loop δT and the δT trip setpoint. The existent quadrant power tilt resulted in the "A" coolant loop δT being 2° F higher than that of the "B" loop. Consequently, the 3.5° F margin was reached on the "A" loop at 98% power.

As anticipated, the quadrant power tilt showed signs of slowly equalizing during the course of power operation. On May 13, the post refueling calculation of full power δT was performed. The calculation results required raising the δT trip setpoints. The δT trip setpoint increase was sufficient to enable raising reactor power to 100% without encroaching on the minimum required δT margin.

Downpower for Main Condenser Tube Leak Repair

Power was reduced from 100% to 58% on May 15 to identify the location of and repair a 60 gallon per day leak in the main condenser. One leaking tube was found and a heavily pitted tube was noted. Both tubes were plugged.

Operations management planned this power maneuver well and appeared to have adequately implemented short term corrective actions in response to oversight weaknesses noted during the February 6 Unit 1 power transient. Improved guidance was provided to onshift personnel for the downpower and subsequent return to full power. This direction included additional restrictions on allowed axial flux differential, xenon transient estimates, uppower ramp rate limit, quadrant tilt alarm guidance, and flux map guidance. The evolution was completed without incident and full power restored the same day.

The unit operated at full power for the remainder of this period with only requested load following power reductions.

b. Unit 2 Operational Status

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

c. Unit 1 Control Rods Inappropriately Inserted During Testing

On April 27, shutdown bank "A" control rods for Unit 1 were inadvertently tripped during testing. Unit 1 was in refueling shutdown at the time. The NRC was notified of this event as required.

Reactor protection analog testing was being performed as scheduled. Coincident with this evolution, the eight shutdown bank "A" control rods were withdrawn 20 steps for hot rod drop testing. Performance of reactor protection testing under the existent plant conditions generated an expected reactor trip signal. This trip signal caused the control rods to scram. Inadequate coordination of these two incompatible activities resulted in their being performed at the same time.

Both these activities had been discussed at a work planning meeting and attention was directed towards precluding the two tests from being performed concurrently due their incompatibility. The Duty Shift Superintendent was briefed on this concern; however, he did not pass along this information to the other operators in the control room. Instead, he authorized the two groups performing the respective tests to commence work, intending to personally coordinate the activities.

While portions of both activities were in progress, the Duty Shift Superintendent became preoccupied with an unrelated valve lineup issue. At the same time, engineers performing the rod drop testing completed the preliminary portion of their test and requested the Unit 1 operator to withdraw bank "A" control rods. As this was being done, a trip signal generated during the reactor protection test that was also in progress caused the rods to insert.

The Unit 1 operator was aware that reactor trip signals would be generated during that day's instrumentation testing. However, similar such testing had already been completed earlier during his shift and he had not been briefed to expect trip signals from the reactor protection test.

The Duty Shift Superintendent was counselled regarding his coordination of this issue and the lack of an adequate brief. The procedure governing the reactor protection test was found to lack appropriate initial plant conditions to preclude its performance with the reactor trip breakers shut. A revision to this procedure was initiated. A Licensee Event Report was also submitted on this condition.

2. Maintenance (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 technical specifications, approved procedures, and appropriate industry codes and standards. The inspectors determined that these activities did not exceed limiting conditions for operation and that required redundant components were operable. The inspectors verified that required administrative, material, testing, and radiological and fire prevention controls were adhered to.

Selected portions of the following maintenance activities were observed and reviewed:

- North service water supply inlet strainer inspection
- Cooling water chlorination system refurbishment

b. Surveillance

The inspectors observed certain safety related surveillance activities to ascertain that these activities were 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 limiting conditions for operation were met. Upon test completion, the inspectors verified the recorded test data was complete, accurate, and met technical specification requirements; test discrepancies were properly documented, reviewed and resolved by appropriate management personnel; and that the systems were properly returned to service.

Selected portions of the following test activities were observed and reviewed:

- ORT 3B (Revision 27), Safety Injection Actuation with Loss of Engineered Safeguards AC, Unit 1

  Good control was exercised during performance of this test. However, the inspector considered the steady stream of unrelated announcements over the plant wide addressing system to be an unnecessary distraction during the test.

- TS-39 (Revision 4), Main Steam Isolation Valve Operability Trip Test, Unit 1

- 1ICP-02-018-1 (Revision 0), Reactor Trip Breaker and Turbine Trip Circuit Trains A and B Shutdown Surveillance Test

- ICP 3.9 (Revision 4), RTD Time Response Check
- IT-02 (Revision 36), High Head Safety Injection Pumps and Valves (Monthly)
- ICP 10.11, Delta T Setpoint Calibration at Power

No discrepancies were noted during the observance of any of the above tests.

c. Evaluation of the Prioritized Maintenance List

In a continuing effort to improve prioritization of maintenance work, personnel in the engineering, operations and maintenance groups created a "Top 140" list of work orders considered the most urgent. It is generated by combining the top 20 items submitted by each of seven plant groups. The inspector reviewed this list and noted that it consisted of 65 work orders. Apparently at least 75 work orders had been completed and removed from the "Top 140" list since it was first generated on November 23, 1993. The inspector was informed that plant personnel did not keep statistics on the order of priority or rapidity that items on the "Top 140" list were being worked and therefore could not assess its effectiveness. Plans to monitor this performance were being formulated. On May 13, a new list was generated adding 63 work orders to bring the total to 128.

The inspector reviewed the approved weekly work plan for the week beginning May 8 and the tentative weekly work plan for the week beginning May 15 and found very few work orders from the "Top 140" scheduled. The explanation of plant personnel was that the maintenance workload during this period was dominated by post outage activities which took precedence over the items on this list. Additionally, many items on the "Top 140" list are done during "system weeks", when extensive maintenance work is scheduled on a specific system. The inspectors considered that the full potential of this prioritization tool was not being realized and will continue to monitor maintenance prioritization effectiveness.

3. Engineering (37551) (38703) (73753)

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. Commercial Grade Dedication of Bearings was not Thorough

A containment accident fan bearing with a nylon cage instead of a bronze cage was inadvertently installed in 1992. This bearing was

procured and dedicated as a commercial grade item (see discussion of LER 301/93-004, Inspection Report 301/93018). Although the bearing was originally manufactured using only bronze cages, one of the bearing manufacturers began using other materials, such as nylon, in 1982. A unique part number was then required for purchase of a bearing with a bronze cage.

The bearing had been purchased as part of a pillow block assembly and dedicated under Quality Assurance Record (QAR) 9547 using a generic evaluation, Technical Evaluation (TE) 91-039, revision 0. Although a bronze cage was specified in the purchase description, a bronze cage was not verified during the receipt inspection performed on April 16, 1992. The receipt inspection of the bearing consisted of ensuring that the bearing spun freely, verifying dimensions, visual inspection for configuration, part number verification, and the absence of any damage. The failure to check the cage material was partially due to the procurement of the bearing as part of a pillow block assembly in which no part number was specifically identified in the purchase description for the bearing.

The bearing dedication was not thorough in that the material and part number changes by the manufacturer were not identified. In addition to the failure to examine the cage material, the dedication of the bearing was weak because of excessive reliance upon visual inspection. Supplemental means of verifying quality of the item, such as commercial grade survey of the manufacturer and material testing, were not used. Similar dedication weaknesses were identified in three other procurement packages for bearings reviewed by the inspectors that used TE 91-39 (QARs 10622, 10653, and 10742). However, the other procurements were for bearings made by manufacturers that did not use nylon cages.

On May 4, 1992, Westinghouse informed the licensee of the part number change for the bearings in regard to another bearing purchase (QAR 9365). In response to this notification, Point Beach updated ordering and vendor manual information for the bearing. However, their response was weak in that bearings were not verified to have the correct cage material for existing stores or for orders still being processed. A more thorough evaluation could have identified the bearing with the incorrect cage material prior to installation.

The immediate corrective actions taken after discovery of the incorrect cage material were good. Corrective actions included the initiation of a condition report, CR 93-403, verification that the containment accident fan would have been operable under accident conditions, and verification that the other containment accident fans had bearings with the correct material.

As part of their long term corrective actions, Point Beach developed a technical evaluation, TE 93-113, specifically for the

containment accident fan bearings. The revised acceptance criteria specified by TE 93-113 was thorough in that it required several methods of verification during the receipt inspection process. They also performed a root cause evaluation of the event which concluded that the generic bearing technical evaluation had been inappropriately used for purchase of the containment accident fan bearings. The inspectors concurred with the evaluation's conclusion. Point Beach staff also planned to review a sample of older commercial grade dedications to determine whether similar problems exist.

For bearing purchases in general, Point Beach revised their generic bearing technical evaluation, TE 91-039, to require additional verifications for certain applications. A commercial grade survey of their preferred bearing manufacturer was also performed, which provides additional assurance.

Based on a review of QARs for items other than bearings, the inspectors concluded that the weaknesses associated with bearing purchases were not characteristic of purchases for other items. QARs reviewed were QAR 10897, for gate valves; QAR 10983, for pressure transmitters; and QAR 11099, for temperature switches. The dedications for these items were appropriate for their intended applications.

b. Construction of New Emergency Diesel Generator Building

Construction of the building to house two new emergency diesel generators (EDGs) and the new diesel fuel oil system began the week of June 7, 1993. Initial observations of this activity are discussed in Inspection Report 266/301/93011. During this inspection period, the following activities were inspected.

Cable installation was observed in the diesel building north and south switchgear rooms and in the plant electrical switchgear rooms. Fuel oil transfer pump motor terminations using Raychem termination kits and QC inspection activities relative to the terminations were observed to be adequate.

Start up activities were also observed including system pipe flushing, check out of cabinet and panel wiring, assembly and adjustment of circuit breakers, and EDG 4 radiator fan operation.

The inspector noted concrete cracks at embeds for missile shield anchorage on north side of the diesel building. The licensee's preliminary evaluation concluded that the cracks were caused by welding on the embeds during the installation of shims for alignment of bearing surfaces for the missile shields. To reduce the heat input to the imbeds and the concrete, the licensee shortened the welds to one inch lengths and changed weld deposition techniques to reduce temperatures in the embeds and transfer to the concrete. Inspection of subsequent welding on the

embeds did not indicate that damage to the concrete had resulted from the welding. The licensee issued non-conformance reports on the embeds with cracked concrete.

The inspectors will continue to monitor progress of this construction.

c. Control Rod Drive Mechanism (CRDM) Nozzle Weld Inspection

Background

In September 1991, a leak from a peripheral CRDM nozzle occurred during a 10-year hydro test at a French PWR. Visual examination revealed that the leaking crack had an axial orientation and was at the elevation corresponding to the lowest portion of the partial penetration weld attaching the nozzle to the inside surface of the vessel head. Additional inspection with eddy current, ultrasonic examination, and a dry penetrant test revealed several axial cracks on the inside surface. Destructive test of the damaged nozzle material revealed that the through wall crack was initiated on the inside surface at the counterbore The crack also penetrated the weld metal (alloy 182). Since the detection of the first cracking of the CRDM nozzle, approximately 1850 nozzles were examined at 37 overseas plants, and 59 nozzles were found to have cracks.

The nozzle wall beyond the attachment weld constitutes the primary pressure boundary. Any cracking in this pressure boundary or in the weld is a potential safety concern.

Actions Taken by Point Beach to Inspect CRDM Nozzles

As discussed in Inspection Report 266/94006, Point Beach Unit 1 was the first reactor in the United States to have its CRDM nozzles inspected. The examination consisted of a remote automated eddy current examination for detection of cracking and a remote automated ultrasonic examination to size the depth of the flaws. The examination process utilized was essentially the same as that used for the foreign reactor inspections.

The examination procedure and examiners were qualified by full performance demonstration on CRDM nozzle mockups with manufactured flaws deposited in the nozzles. The flaws were implanted and mapped by Electric Power Research Institute (EPRI). The qualification of the examination was performed at Westinghouse Waltz Mill facility where a full sized reactor vessel closure head was used to demonstrate the remote delivery tool and positioner capability. EPRI administered the CRDM nozzle mockup test for the examination qualification.

The examination tool was designed so that the CRDM nozzle thermal sleeves were not required to be removed. The EPRI mockups were

representative of the CRDM nozzle and reactor vessel head configuration. EPRI maintained the flaw locations and sizes confidential to evaluate the effectiveness of the performance demonstration examination. The examination procedure and examiners successfully demonstrated the ability to detect and size the flaws.

The examination was performed on the Unit 1 reactor vessel head CRDM nozzle penetrations. All 49 penetrations were examined using the eddy current detection procedure. The inspection surface area extended 2 inches above and below the penetration weld. Eight outer periphery CRDM nozzles were only partially (60-95%) examined due to the thermal sleeves not being concentrically aligned with the CRDM nozzle.

No indications were identified therefore the ultrasonic examination for sizing indications was not required.

NRC Evaluation Determined Inspection Activities were Appropriate

The NRC inspector observed the performance demonstration for the eddy current detection examination at the Westinghouse Waltz Mill facility and the examination of the Point Beach Unit 1 CRDM nozzle welds. The examination was performed utilizing a multi-frequency eddy current method in the absolute mode to detect any internal surface defect.

The NRC inspector verified the calibration of the ET inspection process, reviewed the inspection data and ET procedure, and interviewed the ET examiners and data analyst.

The ET examiners were knowledgeable of the inspection process and performed the examination in accordance with the procedure requirements.

Wisconsin Electric demonstrated a positive commitment to safety by voluntarily performing this inspection, as there was no requirement by the ASME Code Section XI, or the NRC, to examine these welds.

4. Plant Support (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 includes direct observation of the use of Radiation Work Permits; normal work practices inside contaminated barriers; maintenance of radiological barriers and signs; and health physics 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. When minor discrepancies were identified, the health physics staff quickly responded to correct any problems.

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.

The inspectors, by direct observation and interview, verified that portions of the physical security program were being implemented in accordance with the station security plan. This included checks that identification badges were properly displayed, vital areas were locked and alarmed, and personnel and packages entering the protected area were appropriately searched. The inspectors also monitored any compensatory measures that may have been enacted by the plant.

All activities were conducted in a satisfactory manner during this inspection period.

5. Plant Improvement Initiatives (40500)

Wisconsin Electric's quality assurance programs were inspected to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. Special consideration was given to issues which may be indicative of overall management involvement in quality matters such as self improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's attendance at technical and planning/scheduling meetings.

a. Manager's Supervisory Staff Meeting

The inspector observed sessions 94-06 and 94-07 of the Manager's Supervisory Staff. Issues discussed included Unit 2 feedwater flow measurement inaccuracies, installation of the two additional diesel generators, reliability trending, and upgrading of the component cooling water system.

The inspector observed that the Supervisory Staff's expectations of followup action were not always clearly conveyed to personnel presenting information for the staff's consideration. Following a presentation on reliability trending, the staff liberally discussed their desires regarding future trending reports. However, the inspector later determined that the presenter left the meeting with only an equivocal understanding of what was required of her.

All other activities were conducted in a satisfactory manner during this inspection period.

6. Corrective Action on Previous Inspection Findings and Licensee Event Reports (92901) (92902) (92903) (92904) [(92700) (90712)]

a. (Closed) Violation (301/92018-04): Inadequate Cleanliness Control Acceptance Criteria Causing Failure of a Containment Spray Pump

Inadequate acceptance criteria for foreign material exclusion allowed a foam disk to remain inside a section of containment spray recirculation piping installed during the 1991 refueling outage. On September 17, 1992, this disk was drawn into the suction of a containment spray pump, where it lodged, rendering the pump inoperable.

Initial corrective actions for this condition are discussed in Inspection Report 266/93009. Since that time, the inspector continued to observe the implementation of the plant's procedures regarding foreign material exclusion and control of contractor work activities in this area. The inspector determined that cleanliness procedures were being adhered to, contractors were familiar with the applicable requirements, and appropriate attention was directed towards exclusion of foreign material from plant systems during work activities.

Additional examples of the plant's foreign material control initiatives are discussed in Inspection Report 266/94006. One weakness was noted regarding operations testing of the containment sump recirculation suction valves, also discussed in Inspection Report 266/94006. This condition is being tracked separately via inspector followup item 266/94006-02.

b. (Closed) Violation (301/93014-03): Service Water Isolation Valve SW-LW-61 Inoperability

On September 10, 1993, service water isolation valve SW-LW-61 failed to shut as required during performance of periodic surveillance IT-72. This valve was the inlet isolation to a non-essential service water loads piping header. Per technical specifications, this valve may be out of service for a time not to exceed 48 hours. This valve was inoperable for a period of about 88 days.

As corrective action, the licensee performed a Human Performance Enhancement System (HPES) evaluation which determined that an inadequate work package combined with personnel error contributed to this event. A quality assurance audit was performed to determine whether this was an isolated case and if sufficient controls were in place for work packages and post maintenance testing. This audit determined maintenance work packages were of acceptable overall quality and were being properly closed out with

respect to post maintenance testing. The Operations Manager counseled the DSS involved in the review of the maintenance work package and the failure to perform the post maintenance testing of this valve. The licensee developed a lesson plan and trained appropriate personnel on the various aspects of this event.

The inspector reviewed the HPES evaluations, corrective actions and audit report and had no further concerns.

7. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. An unresolved item disclosed during the inspection is discussed in section 1.

8. Exit Interview (71707)

A verbal summary of preliminary findings was provided to the Wisconsin Electric representatives denoted in Section 1 on May 27, at the conclusion of the inspection. Information highlighted during the meeting is contained in the Executive Summary. No written inspection material was provided to company personnel during the inspection.

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

9. Persons Contacted (71707)

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

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.