U. S. NUCLEAR REGULATORY COMMISSION

REGION III

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Licensee: Wisconsin Electric Power Company
231 West Michigan - P379
Milwaukee, WI 53201

Facility Name: Point Beach Nuclear Plant, Units 1 and 2

Inspection At: Two Rivers, Wisconsin 54241

Inspection Conducted: January 6 through 10, 1992

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Inspection Summary

Inspection on January 6 through 10, 1992 (Report Nos. 50-266/92002; 50-301/92002)

Areas Inspected: Special Team Inspection to evaluate licensee performance in the areas of Plant Operations, Maintenance and Surveillance, Engineering and Technical Support, and Safety Assessment/Quality Verification. NRC Inspection Procedure 93802 was used as the primary guideline for conduct of the inspection.

Results: No violations were identified in any of the four areas inspected. See the Executive Summary (attached) for additional results.

## DETAILS

### 1.0 Inspection Scope and Objectives

The purpose of this inspection was to provide a view of licensee performance independent of that provided by the normal NRC line organization. Five inspectors performed the inspection, with inspection activity primarily at the Point Beach plant site, but with some activity at the licensee's corporate offices. Inspection effort had a duration of one week, January 6 through 10, 1992. Four major areas were covered by the inspection. These corresponded to the areas described in the NRC's Systematic Assessment of Licensee Performance (SALP) as Plant Operations, Maintenance, Engineering and Technical Support, and Safety Assessment/Quality Verification. The NRC inspection procedure for Operational Safety Team Inspections (OSTI), Procedure No. 93802, was used as a primary basis for the inspection. Only selected portions of the procedure were performed, however. There was some special focus on communications between and among management and staff concerning performance expectations and achievement, plant issues or problems and their resolution.

### 2.0 Plant Operations

#### 2.1. Conduct of Operations

An inspector observed the conduct of Operations personnel to assess operator professionalism, attentiveness, awareness of plant status, communications, conduct of plant evolutions, response to alarms or other abnormal indications, adequacy of training, and overall planning and control of plant and shift activities. During the inspection, both units were in routine power operation.

During these control room observations, an inspector noted that the conduct of operations and control room demeanor were consistently professional among crews. Distractions to the operators were kept at a minimum and response to annunciators and alarms was timely. The "black board" philosophy adopted by Operations appeared to be effective as evidenced by the low number of alarms received and the nonexistence of long-term annunciators lighted on the main control boards. Although auxiliary operators' (AO) performance outside the control room was not specifically observed, personnel interviews and review of the area shift logs indicated that AO performance parallels that of the professional performance within the control room. Communications were concise and appropriate within

Operations and with other departments. This included routine communications, as well as communications during performance of maintenance and testing activities.

During a review of the administrative controls for conducting plant operations, an inspector identified concerns with the licensee's "Night Order" process. The "Night Order" book is a non-controlled and non-proceduralized methodology for Operations management to convey informational material in a timely manner to the operating crews. The material contained in the book was diverse, ranging from congratulatory messages to plant configuration and operating controls. As the night orders were not administratively controlled, they did not receive formalized periodic reviews by the operating crews, nor were they removed or canceled when no longer applicable. As a result, several long-term operational instructions had not been proceduralized nor re-reviewed by the shifts. For example, a night order from January 25, 1991, discussed concerns with unreliable rod position indication for control rods C7 and K7. The night order discussed methods to determine if the position indications of these rods are inaccurate, and delineated applicable Technical Specification requirements and associated actions. While this night order is explicit in instructions to the crews, a long-term concern being addressed through a non-controlled process was considered inappropriate. Additionally, a night order from December 12, 1991, was utilized to change the Auxiliary Feedwater (AFW) system's operation and configuration. This night order detailed pump operation preferences during startups, shutdowns, and hot standby conditions. It also specified a change in the normal mode of operation for the motor driven pumps' discharge MOVs being changed from OPEN/AUTO to SHUT/AUTO. The inspector determined that applicable procedural, drawing, and checklist changes had been initiated and were in process during the inspection; however, there were no temporary procedure changes or drawing changes issued to provide interim AFW system operational guidance. As a result, AFW system operation and configuration were being controlled only through the night order process. The Operations Superintendent informed the inspector that the night orders and their utilization would be reviewed, with any process changes implemented as necessary to provide tighter administrative controls.

An inspector also evaluated the functions of the Duty Technical Advisor (DTA). The DTA does not have a highly interactive function with Operations and

normally performs collateral duties during the day. While the DTA's collateral duties are not normally Operations related, their specified Operations function is an advisory role which occurs only during transients or "off-normal" events. These non-Operations collateral duties could potentially inhibit the value of the DTA in his advisory role. The inspector concluded through interviews with on-shift personnel that the DTA is primarily used as a red phone communicator and for Critical Safety Function Procedure Status Tree monitoring, thus potentially minimizing his advisory role. Although the DTAs perform their segregated turnovers in the control room at the start of their 24 hour shift, an off-normal event could occur at the end of the shift when the DTA is least cognizant of plant status, lessening his effectiveness in accident assessment.

2.2 Shift Turnovers and Tours

A variety of shift turnovers were observed to assess the effectiveness of the process, including adequacy of time allotted, availability and utility of associated documentation, and quality of overall communications on plant and activity status. The shift turnover process consisted of individual position turnovers with no routine aggregate shift briefing. The inspector observed control operator, Duty Shift Supervisor (DSS), and Duty Operations Supervisor (DOS) turnovers. The turnovers were effective, with all pertinent information clearly communicated. The turnover checklists which are utilized appeared to help eliminate time consuming conveyance of non-critical and properly functioning equipment status. Although there is not an additional shift briefing, it did not appear necessary as all intra-crew communications were performed as necessary. A shift briefing could however, provide the DTAs and other ancillary positions (e.g. chemistry, rad waste, etc.) with a more detailed assessment of current plant status. The inspector was informed that shift briefings are more common during outages, when the amount of work being performed necessitates more interaction and coordination.

Tours of various plant areas were conducted to assess the adequacy of equipment condition, housekeeping, lighting, and labeling. This included an inspection for any potential fire or safety hazards. Overall, plant housekeeping and material condition were fair. While the housekeeping, lighting, and equipment condition in the Turbine building were good, the Auxiliary building conditions ranged from good to very

poor. There were numerous examples of non-secured "rolling" equipment which was warehoused near safety-related equipment, including a skid mounted compressor, a test rig, a fire bottle located next to SW piping and containment spray pump room cooling coils, and gas bottles by CCW piping. Additional housekeeping concerns included: excessive number of ladders and rolls of tape laying around throughout the building; cables and cords being draped over equipment; debris (tubing and a knife) inside an opening for a contaminated floor drain, and; the areas inside the containment facade were generally poorly maintained and dirty. Additionally, the inspector noted numerous instances where a floor marked (taped) as a contaminated area had material which crossed both the "clean" and contaminated boundary. There was an area in the main floor of the turbine building where the controlled area was extended for transferring material between the Auxiliary and Turbine buildings. On several occasions, material was observed to be resting on both sides of the taped demarcation line. With the possible exception of the loose stock/equipment, conditions were not observed which could affect equipment operation.

2.3 Support Activity Control

The effectiveness of Operations' appropriate influence or control over activities with potential to affect plant operating conditions was evaluated. Maintenance, trouble shooting, and testing activities were specifically addressed in this evaluation.

The Operations' planning staff initially prioritizes all maintenance activities which are identified to be performed. While the operations planning function was relatively new (less than a year), it has improved communication and coordination between Operations and Maintenance. Although there appeared to be some uncertainty among the Operations and Maintenance planners regarding responsibilities, the weekly planning meeting was well coordinated and performed. Diversions from the weekly schedule which occur as dictated by changing plant and equipment conditions, are well controlled and communicated. The DSS is responsible for ensuring proper work prioritization and performance during his shift, as well as coordinating emergent work activities. All evolutions observed were effectively controlled and coordinated.

The operating crews maintained proper oversight and control of maintenance and testing activities in

progress. This was evidenced during Charging Pump 2P-2C maintenance, testing, and subsequent unexpected troubleshooting. This troubleshooting was necessitated when the pump did not meet its required flow rate while attempting to return the pump to service. The post maintenance pump testing and troubleshooting activities were effectively controlled by the operating crew and involved coordination of maintenance and testing activities at several locations. All other plant activities with potential to affect plant operating conditions appeared to be adequately controlled from the control room.

2.5 Configuration Controls

Control of the removal from and return to service of the 2P-2C Charging Pump and its associated tag-out were evaluated. Additionally, the inspector reviewed and verified the tag-outs associated with the unit 1 and 2 purge valves (tag-outs 91-331 and 91-802, respectively). These tag-outs were performed to bypass air regulation for the purge valve seals due to leakage within the air regulation system which could have potentially caused a concern with the ability to maintain seal pressure. The inspector observed the tags were properly hung, the equipment placed in the proper configuration, and reviewed and evaluated associated documentation (including independent verification). No discrepancies were identified with this tag-out. With respect to the charging pump tag-out, independent verification of pump status changes and the adequacy of pump operability verification upon return to service were also assessed, (See paragraph 2.4 for discussion of Operations' coordination of this work). No discrepancies were identified with this evolution. It was noted during the review of tag-outs that there was no standardized methodology for determining tag-out alignments for repetitive work. While there are some standardized tag-outs for Repetitive Maintenance Procedures (RMPs) and some capability for "skeleton" tag-outs to be generated by computer, many tag-outs are frequently determined "ad hoc". Although there have been tag-out concerns identified in the Condition Report system, it did not appear any were due to not having standardized tag-outs. Additionally, the acceptability of equipment alignment determined by the tag-out initiator often receives additional Operations and Maintenance reviews. No inadequate tag-outs were identified.

Informal walkdowns of major valves and system flowpaths were performed to evaluate configuration controls and

any obvious system alignment concerns. This included portions of the CVC, AFW, CCW, and SI systems. While not extensive, these walkdowns did not identify any configuration control nor system alignment discrepancies. During plant tours, it was observed that plant equipment is well labelled and any significant discrepant conditions were identified and properly tagged. One potential area of concern was identified regarding configuration control. When a discrepant condition is identified, the normal process for repair is the Maintenance Work Request (MWR) process. Part of this process involves the hanging of MWR tags to identify the discrepant condition. While this is a standard process, there is no procedural guidance as to exactly where the MWR tag is to be placed, i.e. the procedure allows for placement on the component, in the control room, or both locations. While no concerns were identified with actual tag placements, the inspector determined through personnel interviews that tag placement methodology/philosophy is inconsistent among operating crews. This inconsistency could potentially result in inadvertent reliance on malfunctioning equipment, incorrect indication, etc.

No violations, deviations, unresolved or open items were identified in the area of plant operations.

## 3.0 Maintenance

### 3.1. Work Prioritization, Scheduling, and Backlog

The licensee's administrative control procedures on prioritization and scheduling of work were reviewed. The nature and extent of the licensee's corrective and preventive maintenance backlogs were evaluated by reviewing licensee data. Discussions were held with selected licensee representatives to assess how work is prioritized and scheduled. An inspector also attended the licensee weekly maintenance planning meeting.

The licensee is currently reviewing their planning process in an effort to formalize it. An operations planner position has also been added but their duties have not yet been clearly defined.

The review of the maintenance planning process showed that the various licensee organizations communicate well and ensure high priority work is completed in a timely manner. The weekly planning meeting initially schedules the maintenance work requests (MWR). The schedule is then adjusted daily as required although the published schedule is not updated.

The mechanical and electrical maintenance group had a three to six month backlog of MWRs with an increasing trend. This was a weakness. In an effort to reduce the backlog, the licensee has hired additional personnel who are currently in a training program. The instrument and control group does not have an MWR backlog problem.

3.2. Engineering Input and Reliability Monitoring

Licensee data on component failure and repair history were reviewed for equipment with high corrective maintenance frequencies. Licensee measures to address high maintenance components were discussed with responsible personnel. The licensee does not have a formal Reliability Centered Maintenance program.

The licensee's predictive maintenance program is still in development. Some analysis methods such as thermography, vibration analysis and oil sampling are used but the data has not yet been incorporated into a predictive maintenance program. The licensee's computer database has a large volume of maintenance information which the licensee plans to utilize for predictive maintenance when the system is upgraded. No date for the upgrade has been finalized.

Engineering input is limited to reactive work rather than proactive, as discussed further in Section 4.1. Future plans involve implementing a programmatic maintenance schedule based on both analysis methods and component data collected during equipment repairs.

3.3. Observation of Work and Review of Training

Corrective maintenance was inspected in progress to verify proper communication and coordination with operations, availability and use of procedures, independent quality verification activities, worker qualifications, and control of tools and parts used. Training procedures were reviewed and workers interviewed to assess the licensee's training program.

The maintenance staff was experienced and well trained. Workers were very knowledgeable of the components they serviced and thorough in their methods to determine the root cause of component failure. An example of this was evidenced in a worker performing a liquid penetrant test of the charging pump manifold to find seal leakage when not required by procedure. There was evidence of lack of training for foreign material exclusion (FME) from open systems. An inspector interviewed a worker

who was not aware of Maintenance Instruction 32.4 "Guidelines for Exclusion of Foreign Material from Plant Systems," nor of any licensee training other than that received on the job (i.e. formal training class).

The maintenance procedures lacked in providing specific work steps. Due to the experienced staff this was not observed to present a current problem. The licensee is in the early stages of developing updated and specific work procedures. Development is scheduled for completion in 1996.

3.4. Post-Maintenance Testing

Post-maintenance testing practices, to ensure proper return to service of equipment from maintenance status, were reviewed.

The licensee performs two types of post-maintenance testing. The first type is performed during maintenance to ensure the repairs to the equipment that are being performed are correcting the problem. This testing is specified in the MWR by the maintenance planner and is performed prior to turning the equipment over to operations for return to service. The planner uses database information and past experience to determine the types of tests, if any, that each component receives. The licensee is enhancing all post-maintenance testing information on specific components into a matrix form to aid planners in ensuring the correct tests for all equipment are performed.

The second post-maintenance test is determined by operations for return to service and does not affect the maintenance organization.

No violations, deviations, unresolved or open items were identified in the area of Maintenance and Surveillance.

4.0 Engineering and Technical Support

4.1. Interfaces

Communications interfaces among operations, maintenance, and engineering functions were evaluated by verifying that appropriate engineering guidance was being requested and used in the resolution of technical problems. The accuracy, completeness, and technical content of such guidance was assessed, as was its appropriate incorporation into corrective action planning.

Communication interfaces for the modification process were considered very good. Large modification projects were assigned to a team that usually consisted of engineers from corporate and the site and a representative from operations. The team concept was recently utilized, and considered successful, in modifications that added full flow test lines to the auxiliary feedwater and safety injection systems. The team concept appeared to facilitate good communication between all responsible departments.

Communication interfaces between engineering and the maintenance section were generally reactive as opposed to proactive. Although maintenance engineers were assigned responsibilities for certain components, their involvement in actual maintenance activities was dependent on the request from the maintenance department. Responsibilities of the maintenance engineer did not include tracking or trending equipment failures.

4.2. Technical Support

The effectiveness of the technical staff in supporting safe plant operations was evaluated by interviewing personnel and reviewing documents relating to operational performance monitoring and response. Plant, technical and design engineering functions were included.

Although the site engineering staff was relatively inexperienced, they appeared to provide good support to the plant when requested. Resolution of technical problems was left to management for assignment; however, interviews with maintenance engineers indicated that approximately 20% of their time was spent on Condition Report (CR) evaluations. Engineering at the site was organized on a component specialization basis rather than a system engineer basis. The number of engineers on the plant staff is on the increase.

Operational performance monitoring was performed at both the corporate office in Milwaukee and at the plant. Items monitored from corporate were: CRs, NPRDS, and limited equipment trending using a computer tracking system. Because CR trending was only recently implemented, the inspector could not assess the effectiveness of this trending. Other performance monitoring programs performed on site were thermography, vibration monitoring, and MOV diagnostic testing. Although data was being obtained, the data

was not used effectively as discussed above in Section 3.2.

4.3. Design Change Controls

The licensee's process for performing plant design changes was reviewed. This included both temporary modifications and permanent modifications to the facility. For temporary modifications, those currently in effect were reviewed to assess their impact on the approved plant design configuration.

The licensee's recently revised procedure for controlling temporary modifications, PBNP 3.1.10, "Temporary Modification," Revision 13, was reviewed. To improve the control and tracking of temporary modifications, the program was recently reassigned from the Operations Section to the Nuclear Engineering Section. This reassignment allowed temporary modifications to be controlled and tracked in the same manner as permanent modifications. Another attribute added was the assignment of a responsible engineer, which added a sense of ownership and accountability. The inspector reviewed the backlog (30) of existing temporary modifications and determined that none appeared to affect the safe operation of the plant or have an adverse effect on plant availability.

Through discussions with numerous site personnel, the team found that the modification process was well understood and controlled under QP 3-1, "Modification Requests," Revision 5. Engineers responsible for modifications were aware of their assignment backlog since monthly reports were issued to each responsible engineer. This monthly report was also given to the plant manager and corporate managers as well. This report was considered a positive attribute of the modification tracking and control program.

The licensee had approximately 440 outstanding modifications. An inspector reviewed this backlog and determined that approximately 20% were duplicate Modification Requests (MR) needed to complete modifications for both units. The review also determined that modifications were properly prioritized and none appeared to affect the safe operation of the plant or have an adverse effect on plant availability.

Many of the modifications were appropriately designated as "plant betterment".

An inspector reviewed the following five MR package in some detail:

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|---|---|
| MR 89-065 | Remove 150# flange on 1 SI-2 and 1 SI-13 drain line |
| MR 89-179A&B | Reorient U-2 RHR relief valve 861C discharge |
| MR 90-129 | Remove containment isolation check valve in the service air supply line |
| MR 90-152 | Single-failure proof MSIV isolation switch |
| MR 90-169 | Remove reactor vessel reference leg upper isolation valve 2RC-00500C |

All MRs were thorough and complete with all supporting data contained in the package. Evaluation summaries of 10 CFR 50.59 reviews were complete and adequately justified the conclusions made in the evaluation or screening.

4.4. Safety Evaluations

Safety evaluations performed pursuant to 10 CFR 50.59 were selectively reviewed and involvement by engineering personnel familiar with the plant design and licensing basis was assessed.

Screening and safety evaluations of 10 CFR 50.59 requirements were performed under QP 3-3, "Authorization of Changes, Tests and Experiments (10 CFR 50.59 Reviews)," Revision 4. The program required that applicability checks be performed for all permanent and temporary modifications, and for procedure changes and tests to determine if a safety evaluation was necessary. The majority of the screening and safety evaluations were performed by the responsible engineer in the modification group. The procedure had been recently revised with extensive training given to about 120 engineers and managers at the plant and at the corporate office in Milwaukee. This was considered a strength.

In an attempt to improve the quality of the reviews and evaluations, all recent 10 CFR 50.59 screening and safety evaluations were independently reviewed by the Safety Evaluation Group (SEG) in Milwaukee. The SEG used a Review Log to document common errors or weak

areas in the evaluation process. The SEG planned to issue a memo every six months to all department heads indicating the results of the reviews in an effort to correct problems or answer questions. If a reviewed evaluation was considered extremely weak immediate and direct feedback was provided to the engineer and documented in a Feedback Log.

Although the SEG reviews and feedback initiations were considered as having a positive impact on the quality of screening and evaluations performed, the majority of the reviews were completed after approval from the Managers Supervisory Staff Meeting (MSSM). Unless incorrect justifications were made, the screening or safety evaluation was not revised to improve the quality of the existing document. Although this was a potential weakness, the inspector could not identify an example of the post-approval review finding an improperly categorized 10 CFR 50.59 screening.

The inspector reviewed the 10 CFR 50.59 screening and associated safety evaluations for the MRs described in Section 4.3 and noted a definite improving trend in the quality of the engineering justifications of the screening and evaluations.

4.5. Nonconforming Conditions

Appropriate and timely evaluation of nonconforming conditions, and engineering based input to corrective action, to ensure identification and correction of the root cause of the condition, were assessed.

In April 1991, the licensee stopped implementing the Nonconformance Report (NCR) system and initiated a new Condition Report (CR) system under QP 15-3, "Condition Reporting System," Revision 0. The CR had a lower reporting threshold than the previous NCR system; however, the cover sheet for the CR was considerably less detailed than the NCR cover sheet. Because of the lack of specific detail, the inspectors had difficulty ascertaining the category and safety significance of the reported condition. The procedure directed that the CR be reviewed by Regulatory Services (RES) within three days. The inspectors did not consider that an appropriate time frame when an operability question was documented on the CR. However, when questioned about specific CRs with operability questions, the licensee

was able to show that appropriate personnel were notified immediately and appropriate actions were taken.

Review of selected CRs determined that they were not stand alone documents. Considerable effort was required by both the licensee and the inspectors to find all the documents relating to the status of the CR.

No violations, deviations, unresolved or open items were identified in the area of Engineering and Technical Support.

## 5.0 Safety Assessment and Quality Verification

### 5.1. Management Oversight

Management personnel were interviewed and activities such as status, planning and review meetings were observed to evaluate management's involvement in ensuring overall safe facility operations. Personnel at various plant levels were interviewed to assess communications effectiveness. Worker understanding of management goals and objectives, and of policies and directives, was evaluated. Management understanding of what activities were actually going on in the plant was evaluated.

Unlike most licensees Point Beach management does not formally meet each day to review plant status and activities. They typically meet once a week to go over the next weeks activities. Minutes to that meeting are published but activities may change without being reflected in revised minutes. Work seems to progress satisfactorily without the revised minutes but it leaves to individual communications (verbal) to assure conflicts are addressed. Senior plant management is in the control room on a daily basis to observe plant status and to review plant logs. Plant management was well represented in the site meetings attended by the inspectors.

Other than individual verbal communications there are few and infrequent mechanisms used to assure continuity of day-to-day work activities. There is very little progress reporting and feedback evident on a day-to-day basis. The communications between the site and corporate were examined and there were no problems found. The licensee has established the "sounding board" which allows for direct communications between Mr. Abdoo, Chairman and Chief Executive Officer, and selected plant staff at all levels on a monthly basis. The licensee had also developed the "Delta" (Developing Excellence Through Leadership, Teamwork and Accountability) process. Instruction was given to all Nuclear Department personnel where the emphasis was on

business behavior, feedback methods, communications and cooperation. This is seen as a strength.

Through interviews it is evident that communications had been improving. There seems to be a good working relationship not only between site groups but between the site and the office in Milwaukee. There is evidence that communication is quite open between all groups although much of it is verbal which is a potential weakness.

The licensee is involved in the 2-loop Westinghouse owners group as well as other industry organizations. Activity has also increased in the interface with their neighbor nuclear facility, Kewaunee, through periodic site management meetings and Kewaunee participation in the Point Beach MSIV investigation.

The plant manager holds an "all hands meeting" approximately every six (6) weeks to update the staff on all plant administrative issues as well as events and occurrences since the last meeting. The meeting, attended by an inspector, covered a patent received by two Point Beach employees for MOV inspections and a briefing of a plant emergency drill held in December 1991 and the INPO report covering that drill. The plant manager also covered some of his and corporate expectations but this was only verbal. This meeting was video taped so that those not attending, including the control room staff, could review it. The "all hands" meeting is considered a strength.

Through these initiatives both on-site and off-site the licensee is striving to improve their communications. Indications are that improvements are well along and continued effort in this area could produce positive results.

All employees were given the corporate "Business Plan" to review and give comments. This plan provided the corporate global expectations for 1992-1996. The Quality Assurance and Nuclear Technical Services sections developed well defined goals and objectives for 1992 to meet the intent of the Business Plan. Several groups within the various sections also developed a subset of these goals and objectives. This is seen as a strength. Goals and objectives to meet the plant managers expectations have not been well defined and developed. As mentioned above the plant manager does explain his expectations at the all hands meeting but it is only verbal. No staff commitment is solicited. Some of the groups under the direction of

the plant manager have either discussed group goals and objectives or are in the process of developing unique written goals and objectives.

The Management Supervisory Staff Meeting (MSSM) is held at least once per month and it acts as the Onsite Safety Review Committee. The meeting on January 7, 1992 was observed by inspectors. It was clear from the many questions raised by the members of MSSM that prior preparation and review of the materials before the meeting was accomplished. Several items were presented to the meeting that were for information versus approval which was consistent with the Point Beach procedure PBNP 1.7.1 Revision 10. However, two technical specification requests were presented to the committee (150 and 151) with many questions and comments, yet there was no direct guidance as to whether they were approved with changes or whether they needed to be returned to the MSSM for final approval. Procedure PBNP 1.7.1 alludes to voting rights of the members but there were no formal votes taken on the amendment change requests or other items at the meeting.

An inspector attended the Outage Critique meeting and determined that there were good questions and comments on the critique generated by the Outage Coordinator. The Outage Coordinator expressed many concerns dealing with the last plant outage on lack of support, schedule commitment and coordination among participating groups. Comments from the plant staff were solicited and presented in this report. Over one hundred issues were raised of which 4 will be followed in the new commitment tracking system (CMTRK) and the rest by the respective responsible groups. No formal tracking and closeout of these remaining issues were discussed. There was no apparent outage manager that was responsible for the total outage effort and the licensee did not use current outage planning and scheduling techniques that are presently used in the industry.

5.2. Self-Improvement Initiatives

A review was conducted and discussions were held for the purpose of evaluating the effectiveness of selected current licensee-initiated programs for improvement.

The licensee has established several self improvement initiatives. These include the maintenance procedure upgrade, design basis reconstitution and the as-built project. Because of the age of the plant many as-built

drawings were not completed during plant construction and much of the design basis documentation was not kept in residence by the licensee. These programs are projected to take up to seven years. Equipment performance monitoring and predictive maintenance efforts are still in their infancy. The initiation of operations planners to help coordinate operations workload with other plant work has been a positive step. Point Beach has also started a corrective action program to track open issues. This will be discussed later. The licensee has also established an action plan to address a Management Analysis Company (MAC) independent assessment of their Quality Assurance Program. They are also instituting a Nuclear Information Management System (NIMS) which will provide better access to plant related correspondence.

Also as discussed earlier the licensee is making improvements in areas such as staff teamwork and communications.

Overall staffing growth to 600 by late 1993 is projected. However, much of the work at the site is reactive because of the perceived need for resources. It will take time to bring new employees up to speed through classroom and on-the-job training. Also corporate knowledge is lost as employees leave through retirement. As mentioned above much of the communications is verbal. The combination of these items indicate that Point Beach will be in the reactive mode for some time.

5.3. Corrective Action Programs

The licensee's program for identifying, documenting and correcting problems was reviewed. Specific attention was directed in this review to mechanisms for rapidly raising significant deficiencies to an appropriate level of management attention.

The effectiveness of licensee corrective action programs, including root cause determinations, was evaluated by interviewing personnel, observing activities, and reviewing associated documentation, such as licensee event reports, audit reports, and root cause evaluations.

The licensee's Corrective Action Program includes a computer based commitment tracking system (CMTRK) that follows individual action items from initiation by a Condition Report to final completion. Priority and completion dates are established and tracked on this

system. Status reports are available to warn of impending completion dates and reports are elevated in management on missed commitments. CMTRK follows commitments such as INPO, NRC and other licensee commitments. Hardware changes to the plant for modifications,etc., are handled through the maintenance work request (MWR) program. This tracking system looks good based on a limited review. The Quality Assurance Section is a self-assessment focused organization and they have done "vertical slice" type audits and outside contractor reviews. Within the last six months the licensee has had an independent review of the Quality Assurance Section and they have established an action plan to address the issues raised by that review. This is seen as a strength.

A new Condition Report (CR) program, established in April 1991, is not being followed closely by management on a day-to-day basis. This program replaced the Non-Conformance Report (NCR) program. The Condition Report form lacks some of the details that were contained in the NCR forms. They don't contain sufficient information so that it can stand alone as a complete package. This program deals mostly with process versus equipment matters.

The Condition Report process deals loosely with immediate operability determinations. Plant procedure QP 15-3 highlights that the condition report initiator must raise the issue to the operations staff if it is an operability concern, but the condition report form does not specifically address the need to make this determination or whether it had been completed. Any employee may be an initiator, but few employees have the ability to judge operability issues.

Several CRs, audit reports, 50.59 evaluations, and Licensee Event Reports (LER) were reviewed and licensee personnel were interviewed to determine the effectiveness of the corrective action program. Personnel were aware of the CR program and that it allowed for anyone to initiate a condition report. However, the CRs reviewed did not thoroughly discuss root cause evaluations.

The licensee has a new trending activity using the guidelines of procedure QP 16-3, "Operating Experience Review Program," to identify trends and recurring events. A report is generated on a quarterly basis to the plant manager addressing these trends. This process allows for continued evaluation if there is not enough information available or a Plant Experience

Report may be initiated to evaluate and correct any recurring events or adverse trends.

A program to look at overall plant performance was not evident. Self-assessments were being accomplished for individual systems or equipment but not for overall plant performance in areas such as maintenance, operations, engineering and technical support, etc. It was determined through interviews that some plant personnel felt that plant performance had declined in several areas, yet they did not initiate or know of an assessment program to determine the cause of the perceived decline. If they did know the cause there was no corrective program evident. This is considered a plant weakness.

5.4. Safety Review

An inspector attended an onsite safety review committee meeting, designated "Management Supervisory Staff Meeting" (MSSM) at Point Beach plant, to evaluate member participation, preparation, and the approval process. Overall conduct of committee activities to enhance safe operation and ensure compliance to regulatory requirements was assessed.

Much of the work for the MSSM is handled by a subcommittee of the MSSM. Each member receives the material to be discussed several days before the meeting for review and serial review for approval is allowed. As mentioned in section 5.1 above, this meeting is informal and final approval was not clear for some items. Several previous meeting minutes were reviewed and they were adequate and complete. These minutes did state that the staff had accepted various items including technical specification change requests. Meeting minutes of the last two Offsite Safety Review Committee (OSRC) meetings and the OSRC charter were also reviewed and the OSRC Chairman was interviewed. The minutes were comprehensive and indicated good discussions and an independent review of issues were being accomplished. Most members were from key positions from other nuclear utilities and they met every six months. The Chairman reports to the President, Mr. Boston, and the only member from the Nuclear Power Department is Mr. Zach, Vice President Nuclear Power, as an ex officio member.

5.5. Generic Industry Issues

The licensee's program for review and appropriate disposition of industry notifications and operating

experience information, and for NRC Bulletins, Information Notices and Generic Letters was reviewed.

The dissemination of industry information seems to be adequate. The plant manager routes this information to his appropriate site groups for review. Also, the Operating Experience Review group in the Nuclear Technical Services section in Milwaukee does a formal evaluation of all appropriate industry information and sends it to those individuals that have a need for this information. If this evaluation produces actions to be followed up, the actions and commitments are placed into CMTRK for tracking purposes.

The licensee establishes a working group for each of the procedures in the Nuclear Power Department Quality Assurance Procedures Manual. These working groups include both Milwaukee and site personnel. They would be responsible for that procedure and whether training would be needed for select individuals on that procedure. This process is a strength. However, there has not been a training program developed for a new procedure issued October 11, 1991, on Justification for Continued Operation. The "training needs analysis," to be determined by the working group for that procedure was not located.

Through interviews it was det rmined that several individuals were unfamiliar with the Safety Policy (which includes nuclear safety) in their Nuclear Power Department General Policy Manual, GP 013, Revision 0, dated March 25, 1991. All employees do not have copies but do have access to this manual as well as the Nuclear Power Department Quality Assurance Procedures Manual. It was not clear as to whether new revisions or new policies for these manuals are routed for everyone's review or whether manual holders received the changes just for insertion into their manuals.

No violations, deviations, unresolved or open items were identified in the area of Safety Assessment and Quality Verification.

## 6.0 Management Interview

A management interview was conducted at the conclusion of the inspection on January 10,1992. The scope and findings of the inspection were discussed, as described in these "Details." In addition, the licensee was asked whether any documents or processes inspected were proprietary. None were identified.

# APPENDIX A

## ATTENDANCE SHEET

## EXIT MEETING - JANUARY 10, 1992

Wisconsin Electric Power Company (WEPCO)

G. Maxfield, Plant Manager
E. Lipke, Manager, Nuclear Technical Services
J. Palmer, Manager, Instruments and Controls
D. Johnson, Manager, Regulatory Affairs
M. Baumann, Project Engineer, Licensing
T. Koehler, Manager, Maintenance and Engineering
N. Hoefert, Manager, Operations
J. Reisenbuechler, Manager, Operations and Technical Support
G. Krieser, Manager, QA Section
J. Schweitzer, Manager, Maintenance
R. Seizert, Manager, Regulatory Services
B. McLean, Engineer, Regulatory Services
M. Reiff, Engineer, Construction
F. Flentje, Regulatory Services
M. Moseman, Health Physics

U. S. Nuclear Regulatory Commission (NRC)

R. Knop, Chief, Reactor Projects Branch 3
J. Gadzala, Acting Senior Resident Inspector

## EXECUTIVE SUMMARY

On January 6 through 10, 1992, a team of five NRC inspectors performed a limited scope Operational Safety Team Inspection (OSTI) at the Point Beach Nuclear Plant. The purpose of the inspection was to examine licensee performance independently from the NRC line organization normally overseeing these matters. The inspection focused on the areas of Operations, Maintenance, Engineering and Technical Support, and Safety Assessment/Quality Verification. Focus was directed to the communication of expectations from management to staff, the monitoring of performance to meet those expectations, and the communication from staff to management on plant issues or problems.

In the area of Operations, strengths were noted in control room professionalism, in communications among staff (particularly for shift turnover) in alarm response, and in the degree of specificity and detail in turnover sheets and "rounds" sheets. Operations staff were knowledgeable and experienced. Weaknesses were noted in the practice of using Standing Orders or Night Orders as long-term mechanisms to control system configuration, implement tests, or respond to chronic problems involving rod position indication during power changes. Plant equipment was in excellent condition and minor discrepancies were all identified and tagged. Lighting, labeling, and housekeeping were good in well-traveled areas, but ranged all the way down to very poor in out-of-the-way areas. Routine use of the Duty Technical Advisor position in support of Operations was minimal.

In the area of Maintenance, staff skill, experience and training were considered strengths. Personnel were inquisitive, communicated and coordinated well among work groups, and were kept selectively informed of pertinent industry experience. Post maintenance testing appeared to be performed in depth. A high workload with limited resources had caused or contributed to a large and increasing work backlog and to a reactive versus proactive engineering presence. These were considered weaknesses. Predictive and Reliability Centered Maintenance (RCM) activities or programs were not well developed. Procedures were relatively few, relatively brief, and were not heavily relied upon. Initiatives to improve procedures, move to predictive techniques, become proactive in equipment trending and root cause analyses, and reduce the backlog were all underway, but schedules were either prolonged or no fixed objectives had been set.

In the area of Engineering and Technical Support, modifications interfaces and personnel knowledge about the process were good. A new corporate group to independently review 50.59 issues was considered a strength. Design changes were not excessively backlogged (this had previously been considered a problem) nor were the in-place temporary modifications problematical, either

individually or cumulatively. The engineering staff was growing but lacked experience compared to some other disciplines. Resolution of technical problems usually involved engineering reactively, not proactively. New trending initiatives appeared to have potential, but networking among experienced managers remained the primary technique for highlighting issues, applying resources, and resolving problems.

In the area of Safety Assessment/Quality Verification, strengths were noted in the identification and support of several self-improvement initiatives across a broad spectrum of performance areas. Implementation schedules were prolonged, however. Self-assessment appeared effective, with both broad area reviews and ve. .cal slice techniques in use. Applicable requirements were being met in onsite safety review, commitment tracking, and auditing. Many practices, including communication of management expectations, progress reporting and feedback, onsite committee discussions, and sharing industry information, lacked formality. The corrective action program was not closely monitored by senior management and lacked emphasis on immediate operability determinations for discrepant equipment conditions or behavior. This was considered a weakness. Senior management was, however, highly accessible and, by informal techniques, stayed knowledgeable of the details of issues and problems.

Conclusions:

The team determined that the licensee was utilizing a combination of highly experienced personnel across various disciplines, with familiar but generally informal communications and monitoring techniques, to achieve its objectives; to identify, attack and resolve problems; and to pass along selected information on success and failure. Reliance on personnel, in lieu of programs or procedures, was high. These techniques had historically provided adequate safety. Self-identified improvement initiatives were underway in various areas which had the potential to shift reliance to a more formal set of control processes.