

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/84-07(DRP); 50-301/84-05(DRP)

Docket Nos. 50-266; 50-301

Licenses No. DPR-24; DRP-27

Licensee: Wisconsin Electric Power Company
231 West Michigan
Milwaukee, WI 53203

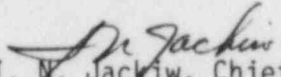
Facility Name: Point Beach Nuclear Power Plant, Units 1 and 2

Inspection At: Point Beach Site

Inspection Conducted: June 1 - July 31, 1984

Inspectors: R. L. Hague

B. E. Fitzpatrick

Approved By: 
I. W. Jackiw, Chief
Projects Section 2B

8-9-84
Date

Inspection Summary

Inspection on June 1 through July 31, 1984 (Report No. 50-266/84-07(DRP);
50-301/84-05(DRP))

Areas Inspected: Routine, unannounced inspection by resident inspectors of operational safety; maintenance; surveillance; independent inspection and plant trips. The inspection involved a total of 231 inspector-hours onsite by two inspectors including 31 inspector-hours on off-shifts.

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, Superintendent - Operations
- J. C. Reisenbuechler, Superintendent - Technical Service
- W. J. Herman, Superintendent - Maintenance & Construction
- *R. E. Link, Superintendent - EQR
- R. S. Bredvad, Health Physicist
- R. Krukowski, Security Supervisor
- *F. A. Flentje, Staff Services Supervisor

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

*Denotes personnel attending exit interviews.

2. Operational Safety Verification

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the months of June and July 1984. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the auxiliary building and turbine buildings were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance. The inspector by observation and direct interview verified that the physical security plan was being implemented in accordance with the station security plan.

The inspector observed plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls. During the months of June and July 1984, the inspector walked down the accessible portions of the auxiliary feedwater, RHR, and diesel generating 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.

At 1:28 p.m. on July 31, 1984, a Delta T alert annunciator was received on Unit 1. The operator reviewed his indications and found reactor power was at about 102% with turbine power at 100%. The operator took manual turbine control and reduced reactor power to 94%. An investigation into the cause

disclosed that contractors removing the door and steel wall sections at the south end of the control room had plugged an electric grinder into an outlet supplied at a 10 amp instrument bus breaker. The breaker normally supplies the rack mounted meteorological strip charts and the feedwater heater bypass valve pressure switch. The function of this valve is to ensure net positive suction head to the feed pumps in the event of a valving error or other normal flowpath blockage. Deenergizing the pressure switch caused the 12 inch bypass valve to fail open bypassing the first four stages of feedwater heaters. The breaker was reset, the valve closed, and power was returned to 100%. An extension cord was run to an outlet in the turbine hall which is not fed from the instrument busses. The control room outlet was tagged requiring shift superintendent's permission for use.

2. 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:

- 3D diesel oil change
- Auxiliary feed discharge valve modification
- Auxiliary feed pump cooling from fire main modification.

Following completion of maintenance on the diesel generator and auxiliary feed, the inspector verified that these systems had been returned to service properly.

The auxiliary feedwater discharge valve modification was completed the last week in June. This modification now provides automatic auxiliary feedwater addition to the affected unit without operator action. All four discharge valves will remain open during two unit operation, if auxiliary feedwater is called for to one unit the discharge valves to the other unit will automatically shut. There is a manual override to the automatic function, if required.

3. Monthly Surveillance Observation

The inspector observed technical specifications required surveillance testing on the 3 and 4D diesel generators, Unit 1, quarterly axial flux mapping, and Unit 2 reactor protection system logic and verified that testing was performed in accordance with adequate procedures, that test instrumentation was calibrated, that limiting conditions for operation were met, that removal and restoration of the affected components were accomplished, that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test, and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector also witnessed portions of the following test activities:

Containment Tendon Surveillance.

4. Plant Trips

Following the Unit 1 plant trips on July 21, 1984, 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 on the same day.

At 8:00 p.m. on July 20, 1984, Unit 1 commenced a shutdown to clean flux mapping thimble tubes. The unit was off-line at 2:23 a.m. on July 21, 1984 and the reactor shutdown at 4:07 a.m. on July 21, 1984. At 4:17 a.m. while energizing source range monitors, SR 32 indicated two decades high initiating a source range high flux trip. I&C determined the problem to be with the detector and the SR 32 channel was bypassed. At 4:42 a.m. on July 21, 1984, the shutdown banks were again withdrawn. At 11:30 a.m. on July 21, 1984, another reactor trip occurred when placing turbine first stage pressure in test. A spike on indicated first stage pressure of about 100# instituted P-7, the at power trips. Pressurizer pressure was being maintained at 700# so a low pressurizer pressure trip occurred. I&C unblocked 12 of 19 thimble tubes and Unit 1 was made critical at 7:23 p.m. on July 21, 1984. The unit was placed on line at 11:54 p.m. July 21, 1984 and was at fully power at 10:50 a.m. on July 22, 1984.

5. Independent Inspection

During the inspection period the inspectors have been observing the preparations for the installation of the auxiliary safety instrumentation panels (ASIP). The Unit 2 ASIP arrived on site July 2. This is about 18 months past the original delivery date. The Unit 1 ASIP should be arriving some time in August. These panels contain the instrumentation for providing the monitoring of the 0737 II.F.1 items in the control room as well as the breaker controls for the new batteries and chargers.

The licensee reviewed Anker-Holth's Part 21 report on steam generator snubbers. Based on a Bechtel load analysis for a main steam line rupture the licensee determined that the installed snubbers could withstand the loading even at the reduced load rating. The licensee intends to replace the Torrington bearings during the next scheduled outage for both units.

The Westinghouse Part 21 report on possible component cooling water system over pressurization, although not directed to Point Beach, is applicable. The licensee has completed a modification which removes the automatic closure feature of the expansion tank vent valve.

While undergoing an extensive review of the possible reportability of the runback which occurred on May 7, 1984 (see Inspection Report 50-255/84-06; 50-301/84-04), the licensee has sent a request to their corporate nuclear engineering group for further review on the possible filing of a Part 21 report. The runback in question was caused by a down spike on one of the nuclear instrumentation power channels which was seen by the reactor protection system as a possible rod drop. Another input to the rod drop runback is the rod bottom bystables. A Westinghouse analysis indicates that although the runback does not provide core protection the associated rod withdrawal block does. The concern that a possible Part 21 report may be involved stems from the fact that although the nuclear instrumentation channels have always been maintained as safety related equipment the rod bottom circuitry and equipment has not. It has been maintained as equipment used for control functions only.

6. 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.

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