

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/92009(DRP); 50-301/92009(DRP)

Docket Nos. 50-266; 50-301

Licenses No. DPR-24; DPR-27

Licensee: Wisconsin Electric Company
231 West Michigan
Milwaukee, W' 53201


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

Inspection At: Two Rivers, Wisconsin

Dates: March 16 through May 3, 1992

Inspectors: K. R. Jury
J. Gadzala

Approved By:


I. N. Jackiw, Chief
Reactor Projects Section 3A

5-15-92
Date

Inspection Summary:

Inspection from March 16 through May 3, 1992, (Reports No. 50-266/92009(DRP); 50-301/92009(DRP))

As Inspected: Routine, unannounced inspection by resident inspectors of corrective actions on previous findings; plant operations; radiological controls; maintenance and surveillance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

Results: Two violations of NRC requirements were identified, one of which was not cited. An Executive Summary Follows.

Plant Operations

Unit 1 was shut down for a scheduled 42 day refueling outage on April 11. Startup was scheduled for May 23.

On April 28, maintenance activities caused the loss of power to one of the 4160 VAC safeguards busses on Unit 1. The other safeguards bus train had been tagged out for work during the outage. Safeguards electrical power to Unit 1 was restored when the GO1 emergency diesel automatically started, and loaded onto the bus as designed. The reactor was completely defueled at the time and one train of spent fuel pool cooling remained operable throughout the event.

During a gas turbine generator inspection, the plant disclosed significant internal component degradation and wear. The gas turbine was declared out of service and attempts were initiated to obtain replacement parts.

Radiological Control

The radiological barriers around the auxiliary building controlled zone were changed to encompass the exit point whole body monitors. Since most areas in the controlled zone were free of contamination, used but clean shoe covers were previously being needlessly discarded as contaminated waste. With the monitors inside the controlled zone, shoe covers can be verified clean and discarded as regular waste. During the current outage, this process reduced the amount of contaminated waste volume generated by about one drum per day.

Maintenance/Surveillance

Extensive preventative maintenance was conducted on safeguards busses and a temporary DC distribution panel was installed. Good management oversight was noted during the conduct of these activities. However, a maintenance technician inadvertently opened the cover of the wrong safeguards bus potential transformer, causing the bus to deenergize. This was cited as an example of inadequate work control.

Emergency Preparedness (EP)

The annual EP exercise was conducted on March 17 and performance was good with no significant weaknesses being identified.

Security

A demonstration was held April 26 near the plant boundary by a small group opposed to nuclear power. Appropriate compensatory measures were taken and no untoward events occurred.

Engineering and Technical Support

During the Unit 1 refueling outage, extensive preventive maintenance was performed on two Electrical Distribution System (EDS) safeguards busses, low voltage station auxiliary transformer 1X04, and high voltage station auxiliary transformer 1X03. This required that the EDS be lined up in abnormal and unique configurations, some of which required entry into technical specification limiting conditions for operation. In each case, the plant performed a safety evaluation and engineering analysis of the EDS line up for safety considerations associated with design basis accidents on Unit 1 and Unit 2. Additionally, numerous precautions, clarifications, and contingency actions were specified in each maintenance procedure to address appropriate operator action in the event that an abnormal condition occurred during maintenance. The work was completed safely.

The 125 volt DC distribution bus D-01 was replaced. Extensive planning and preparations were involved with this modification including safety reviews and building and training on a mockup of the panel. Work was performed while the

Unit 1 reactor core was defueled to minimize potential safety concerns. A decision was also made to reduce Unit 2 power to 55 percent during the most sensitive part of the procedure to minimize the affect of any plant transient had DC power been inadvertently interrupted during the evolution.

While testing a portion of the Residual Heat Removal (RHR) system on April 29, approximately 160 gallons of primary plant coolant water spilled into the containment spray pump room due to a vent valve being left open on the section of piping being tested. The valve had recently been installed in the system via an engineering change request (ECR). The ECR process did not require revisions to be made to engineering drawings to show the existence of this new valve. Operators used a controlled engineering drawing that had not been updated for lining up the system. Consequently, the valve was left open. This was one example of the violation cited for inadequate work control.

Safety Assessment/Quality Verification

Recent initiatives during the Unit 1 refueling outage were the Outage Safety Review and the presentation of a risk analysis briefing at the conclusion of each daily refueling status meeting. The risk assessment briefings provided an additional level of awareness to group heads regarding specific activities and were considered beneficial to the conduct of safe operations. Both initiatives were indicative of proactive shutdown risk assessment.

DETAILS

1. Persons Contacted (71707) (30702)

- *G. J. Maxfield, Plant Manager
- J. C. Reisenbuechler, Manager - Operations & Technical Support
- *T. J. Koehler, Manager - Maintenance & Engineering
- N. L. Hoefert, Manager - Operations
- J. C. Schweitzer, Manager - Maintenance
- J. A. Palmer, Manager - Instrument & Controls
- W. J. Herrman, Manager - Technical Services
- T. L. Fredrichs, Manager - Chemistry
- J. J. Bevelacqua, Manager - Health Physics
- R. D. Seizert, Manager - Training
- *J. F. Becka, Manager - Regulatory & Staff Services
- J. M. Mann, Project Engineer - Nuclear Regulation
- J. M. Stje, Administrative Specialist

Many employees were also contacted including members of the maintenance and engineering staffs, and reactor and auxiliary operators.

The personnel attending the management exit interview for the purpose of preliminary findings.

2. Corrective Action on Previous Inspection Findings (92701) (92702)

a. (Closed) Violation (266/91008-01): Inadequate Procedure Review.

Several procedures had received inadequate final review after completion of word processing, resulting in missing or transposed information in the procedure steps. Two of these occurrences had led to plant events. As corrective action, the plant revised PBNP 2.1.1, "Classification, Review, and Approval of Procedures", to define the level and detail of reviews to be performed on a procedure. Depth of review for word processing checks was added to the procedure, as was the requirement that final approval not occur until the procedure is in its final form. Additionally, "self checking" measures were initiated to encompass the entire life cycle of a procedure. These measures were started with the Instrument & Controls group and are primarily an awareness education program to sensitize operators and technicians to the need for objectively reviewing each procedure before performing it. This item is closed.

b. (Closed) Unresolved Item (266/90018-03; 301/90018-03): Undocumented Upgrade of Fuel Oil System to Quality Assurance (QA) Status.

An electrical distribution system functional inspection performed by the NRC identified that several modification packages for the fuel oil system had not been classified as QA. These

modifications were intended to upgrade the fuel oil system to a QA status but were implemented prior to the plant developing a formal upgrade procedure. The company subsequently completed a formal evaluation of the system for upgrading to QA status. Several items were identified and scheduled for resolution including system testing, material history reviews and support reviews.

NRC Region III management has reviewed this item and determined that it will be closed administratively due to its safety significance relative to emerging priority issues and to the age of the item. Wisconsin Electric is reminded that commitments directly relating to this item are the responsibility of the company and should be met as committed. NRC Region III will review corrective actions by periodically sampling administratively closed items.

- c. (Closed) Unresolved Item (301/92007-03): Improper Calibration of One Channel of Over-Temperature Delta-Temperature (OTDT).

On February 17, 1992, one channel of OTDT protection was rendered inoperable during the performance of a calibration procedure. A reactor engineer entered the wrong calibration current data into the procedure. This was discovered during the calibration process and was subsequently corrected. Corrective actions were implemented to provide for double verification of future entries of calibration current data into the procedure. Additional details appear in the evaluation of the licensee event report describing this incident in Paragraph 9.a. This item is closed.

- d. (Closed) Open Item (266/91025-06; 301/91025-06): Technical Specification 15.4.7 Required Revision.

Technical specification 15.4.7 required that main steam isolation valve closures be timed from the closure signal until the disk is stopped by the valve operator dashpot. However, the dashpot had long since been deliberately rendered non-functional under a plant modification. The company has since formally submitted a technical specification amendment request to the NRC to correct this discrepancy. Additional technical specification upgrades are being tracked via open item 92007-02. This item is closed.

3. Plant Operations (71707) (93702)

- a. Control Room Observation (71707)

The inspectors evaluated licensee 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.

To verify equipment operability and compliance with technical specifications (TS), inspectors reviewed shift logs, operation's records, data sheets, instrument traces, and records of equipment malfunctions. Through work observations and discussions with Operations staff members, the inspectors verified the staff was knowledgeable of plant conditions, responded promptly and properly to alarms, adhered to procedures and applicable administrative controls, was cognizant of in-progress surveillance and maintenance activities, and was aware of inoperable equipment status. The inspectors performed channel verifications and reviewed component status and safety-related parameters to verify conformance with TS. Shift changes were observed, verifying that system status continuity was maintained and that proper control room staffing existed. Access to the control room was restricted and operations personnel carried out their assigned duties in an effective manner. The inspectors noted professionalism in most facets of control room operation and that both unit control boards were generally in a 'black board' condition (no non-testing annunciators in alarm condition). The Plant Manager was observed making periodic control room and plant tours.

b. Facility Tours (71707)

Facility tours and perimeter walkdowns were conducted to verify equipment operability and conditions, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tagging procedures were properly implemented. During these tours few signs of leakage were evident and most equipment appeared to be in good operating condition. Although Unit 1 was in a refueling outage, plant housekeeping has been generally good.

c. Unit 1 Operational Status (93702)

The unit operated at full power until April 11, when it was shut down for a scheduled 42 day refueling outage number 19. Unit 1 main steam isolation valves were tested satisfactorily during the shutdown evolution. Major activities planned for this outage included a complete core off load, steam generator eddy current testing, residual heat removal system tie-in work for the safety injection full flow test line modification, B reactor coolant pump seal maintenance and motor work, main turbine generator refurbishment, safeguards electrical bus work, and instrument bus inverter replacement. Startup is scheduled for May 23.

The inspectors verified that the plant had reviewed their controls for reduced inventory operations and that applicable administrative procedures were in place prior to the unit's reactor vessel being placed into a partially drained condition.

d. Unit 2 Operational Status (93702)

The unit operated at full power during this period with the exception of requested load-following power reductions and the following:

On March 21, power was reduced to about 5 percent for testing the main steam isolation valves (MSIVs). The main turbine was taken off line and the MSIVs tested satisfactorily. The unit was placed back on line March 22 and returned to full power the following day.

On April 25, power was reduced to about 55 percent while rerouting DC power cables to a temporary distribution panel. Power was reduced to minimize the affect of any plant transient had DC power been inadvertently interrupted during the evolution. The cable rerouting was completed satisfactorily and the plant was returned to full power later that day.

e. Loss of Unit 1 Safeguards AC Busses (93702)

On April 28 the plant notified the NRC via the emergency notification system of an engineered safeguards feature actuation due to the G01 emergency diesel fast starting. While 4160 VAC safeguards bus 1A06 was deenergized for maintenance (see paragraph 5.a.), power was lost to the other 4160 VAC safeguards bus, 1A05. Since bus 1A05 was supplying both trains of 480 VAC safeguards busses at the time, power to these was also lost. The G01 diesel sensed the loss of power, started, and loaded onto bus 1A05 as designed. This restored safeguards electrical power to Unit 1. The reactor was completely defueled at the time and one train of spent fuel pool cooling remained operable throughout the event.

The cause of the event was due to maintenance technicians inadvertently opening the cover of the 1A05 potential transformer. The technicians had apparently intended to open only the cover for the 1A06 potential transformer. These covers are interlocked with their respective bus undervoltage relays such that opening the cover causes the undervoltage relay to sense an undervoltage condition, thereby opening the bus supply breaker and deenergizing the bus.

The potential transformers for both bus 1A05 and 1A06 are located in the same cubicle (1A00-62). Inside this cubicle, each bus' potential transformer is located behind its own panel which is identified by a small label. The maintenance personnel thought that the entire cubicle contained only bus 1A06 components, which he knew to be deenergized. The potential transformers for both bus 1A05 and 1A06 are located behind their respective panels inside a 1A06 bus cubicle. The technician thought both panels covered bus 1A06 components and inadvertently opened the panel for the 1A05 bus potential transformer. An interlock in the panel

caused the 1A05 bus to sense an undervoltage condition, which opened its supply breaker and started the G01 emergency diesel generator. Although the individual panels were labeled the procedure controlling this activity did not contain adequate cautions alerting the technician to the presence of both sets of potential transformers within the one cubicle. This is an example of inadequate work control and is the second example of violation 92009-01 (paragraph 8.c.).

Unit 1 safeguards AC was lost for only the few seconds required for the diesel generator to start and load onto the bus. Operators promptly responded to the event and restored the electrical lineup within about 10 minutes. The diesel was secured and returned to standby mode. The inspectors responded to the control room and monitored operator actions. Two of the six service water pumps and one of the two auxiliary feedwater pumps lost power briefly during the event. Power was also lost to the standby spent fuel cooling pump. Other Unit 1 loads were not required to be in service due to the defueled condition of the reactor.

Plant management supervised recovery actions and held a post event critique. Large red placards were subsequently fabricated and placed on each potential transformer cover warning that opening the cover will deenergize the respective bus. The inspectors considered these initial corrective actions appropriate.

f. Gas Turbine Generator Deficiencies (71707)

During an inspection of the gas turbine generator, the licensee discovered significant internal component degradation and wear. This degradation included, but was not limited to: combustor baskets had eroded and cracked to the point that pieces had fallen into the compressor blading; fuel nozzles were found partially blocked, and; turbine vanes and blading were cracked. The gas turbine was declared out of service and attempts were initiated to obtain replacement parts. In addition to its role as alternate AC source under the station blackout rule, the gas turbine is also the backup source of power for the alternate shutdown panel. As compensatory measures, the licensee commenced twice per shift fire rounds of the cable spreading room and vital switchgear room.

Wisconsin Electric management convened a review panel to evaluate corrective action options. A decision was made to perform a major overhaul based on the information obtained. This overhaul is scheduled to commence during mid June, and is expected to last approximately eight weeks. The company has performed similar gas turbine overhauls at its fossil fuel plants and plans to involve maintenance personnel from those plants in this overhaul. Compensatory measures during the overhaul's duration had not been finalized. A commitment exists to establish 95 percent reliability on the gas turbine generator to comply with the

station blackout rule.

g. Reactor Thermal Output Exceeding 100 Percent Power (71707)

On April 1, 1992, at approximately 1:40 a.m., Unit 1 exceeded 102 percent indicated reactor thermal output (RTO) due to 'B' steam generator (S/G) controlling feed flow channel failing low. The licensee reported this situation as a non-emergency report as required by 10 CFR 50.72. Upon investigation, it was determined that during the transient, the actual power increase was less than 1 percent and that the analyzed limit of 102 percent was not exceeded. This determination was based on the plant process computer (which calculates RTO) utilizing feed flow in its calculation but not steam flow. In effect, the calculation assumes that all feed flow is converted to steam flow. During this incident however, most of the increased feed flow resulted in an increase in S/G level as the feedwater regulating valve went full open when the controlling channel failed low. The change in steam flow was not as appreciable and as such resulted in a falsely high RTO indication. The power range nuclear instrumentation detectors exhibited little change as a decrease in average temperature (Tavg) masked the power increase. The change in delta temperature, which provides the best indication of power change, showed that the actual power change was less than 1 percent, not the 2.1 percent indicated. The inspectors reviewed the transient graphs and interviewed the cognizant Reactor Engineer and concur with the licensee's determination that 102 percent RTO was not actually exceeded.

These reviews and observations were conducted to verify that facility operations were conducted safely and in conformance with requirements established under technical specifications, federal regulations, and administrative procedures.

One violation and no deviations were identified.

4. Radiological Controls (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 (RWPs); normal work practices inside controlled barriers; maintenance of radiological barriers and signs; and health physics (HP) 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 HP staff quickly responded to correct any problems.

The radiological barriers around the auxiliary building controlled zone were changed to encompass the exit point whole body monitors. Plant routine had previously been to require removal of shoe covers at the exit of the controlled zone and then perform a whole body frisk. The shoe covers were discarded as contaminated waste. However, most areas in the controlled zone are free of contamination. Areas that are contaminated require additional protective clothing including a second set of shoe covers. As a result, the inner set of shoe covers worn in the controlled zone were nearly always free of contamination, but were nevertheless treated as contaminated waste. This increased the amount of material disposed of as contaminated.

Under the new procedures, personnel preparing to exit the controlled side enter the whole body monitor wearing their shoe covers. If contamination is not detected, the person exits the area and the shoe covers may be discarded as clean waste. During the current outage, this process has reduced the amount of contaminated waste volume generated by about one drum per day. Out of the thousands of personnel exits from the controlled area, fewer than ten incidents of contaminated shoe covers have occurred in the first month of this new program.

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

No violations or deviation were identified.

5. Maintenance/Surveillance Observation (62703) (61726)

a. Maintenance (62703)

Station maintenance activities of safety-related systems and components listed below were observed/reviewed to ascertain that they were conducted in conformance with technical specifications and in accordance with approved procedures, regulatory guides, industry codes, and standards.

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.

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

- Repair of Unit 1 feedwater flow wiring harness
- Transfer of DC power cables to temporary distribution panel TD-01
- Inspection of potential transformers inside safeguards bus 1A06

Paragraph 3.e. contains an example of violation 92-009-01, which occurred during the potential transformer inspection.

- Service water piping flow reducer replacement
- Auxiliary feedwater flow transmitter 1FT-4036 scale change

Paragraph 8.b. discusses strengths identified within maintenance activities conducted. All other activities were conducted in a satisfactory manner during this inspection period.

b. Surveillance (61726)

The inspectors observed surveillance testing 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.

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

- ICP 2.1 (Revision 11), Surveillance Test Procedure, Production and Safeguards Analog
- TS 40 (Revision 1), Main Steam Isolation Valve Operability Trip Test, Unit 2
- IT-03A (Revision 5), RHR Pump and Valve Tests, Unit 1
- IT-750 (Revision 0), RHR Pump RWST Suction Check Valve Test (Refueling), Unit 1

No violations or deviations were identified.

6. Emergency Preparedness (71707)

An inspection of emergency preparedness (EP) 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 annual EP exercise was conducted on March 17 and performance was good with no significant weaknesses being identified. Details are contained in inspection report 266/301/92003.

A minor concern arose during the exercise regarding unit operation with inadequate core cooling. Procedure CSP-C.1, "Response to Inadequate Core Cooling", contained a step directing that reactor coolant pumps be secured. However, the step did not require verification of sufficiently low core exit thermocouple temperatures prior to securing the pumps. The event scenario during this exercise caused some confusion among operators at this step. It appeared that if coolant pumps were secured at this point, they would have to later be restarted because core exit thermocouple temperatures would be too high. The plant has since reviewed this procedure step and initiated a procedure revision. The revised procedure step will include a note to verify core exit thermocouple temperatures as one of the criteria for securing coolant pumps.

No violation or deviations were identified.

7. Security (71707)

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.

A demonstration was held April 26 near the plant boundary by a small group (approximately 80 people) opposed to nuclear power. The plant increased their security presence onsite during this event and obtained assistance from local and state law enforcement agencies as a precautionary measure. The inspectors evaluated the licensee's preparation for and response to, these activities. The security measures taken were proactive and appropriate. No civil disobedience occurred during this demonstration, which was monitored by the inspectors.

No violations or deviations were identified.

8. Engineering and Technical Support (71707) (37828)

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. Engineering Support for Electrical System Maintenance (71707)

During the Unit 1 refueling outage, the plant performed preventive maintenance on two Electrical Distribution System (EDS) safeguards buses (1A05 and 1A06), low voltage station auxiliary transformer 1X04, high voltage station auxiliary transformer 1X03, and associated breakers.

To provide for adequate isolation of each section of the EDS identified above for personnel safety and to maintain essential Unit 1 and 2 electrical loads, it was necessary to line up the EDS in an abnormal and unique configuration for each maintenance activity. As required over the course of this maintenance, two safeguards divisions on Unit 1 (1B03 and 1B04) were cross connected, auxiliary feedwater pump P38A was placed out of service (requiring entry into a seven day limiting condition for operation on Unit 2), and one service water pump was electrically lined up to its alternate AC source to allow it to remain powered.

In each case, the plant performed a safety evaluation and engineering analysis of the EDS line up for safety considerations associated with design basis accidents on Unit 1 and Unit 2. Additionally, numerous precautions, clarifications, and contingency actions were specified in each maintenance procedure to address appropriate operator action in the event that an abnormal condition occurred during maintenance. Included in these compensatory measures were administrative restrictions placed on the fuel oil transfer pumps and the spent fuel pool cooling system. The work was completed safely and no concerns were noted.

b. Installation and Testing of Modifications (37828)

The inspectors observed onsite activities and hardware associated with the installation of selected plant modifications to ascertain that modification activities are in conformance with requirements. This inspection included but was not limited to, verification of the following items:

- Verification by direct observation that work is being performed by qualified workers and in accordance with approved procedures.
- Verification that the installation conforms to the as-built drawings.
- Confirmation that the equipment and material being used is

correct.

Selected portions of the following modification was reviewed:

-- Mod 90-134*D, 125 Volt DC Distribution Bus D-01 Replacement

Extensive planning and preparations were involved with this modification. An extensive safety review was performed prior to implementation. The modification was performed while the Unit 1 reactor core was defueled to minimize potential safety concerns. A decision was also made to reduce Unit 2 power to 55% during the most sensitive part of the procedure to minimize the affect of any plant transient had DC power been inadvertently interrupted during the evolution. A mockup was built and used to train the technicians that would be performing the work on the intricacies involved. This further minimized the probability of an error being made during the actual installation. Plant management was observed providing extensive and direct coverage of this activity. The extensive planning and preparations of this modification, the service water piping replacement, and the EDS work discussed above, was demonstrative of a strength within the Engineering groups.

No unacceptable conditions were identified.

c. Residual Heat Removal (RHR) Piping Hydrostatic Test (71707)

During the current refueling outage, modifications were made to the RHR system piping that necessitated hydrostatic testing. While testing a portion of the system on April 29, approximately 160 gallons of primary plant coolant water spilled into the containment spray pump room due to vent valve RH-V19 being left open on the section of piping being tested. Although two personnel were splashed by this water, no skin contamination resulted.

A review of the event revealed that vent valve RH-V19 had recently been installed into the system via an engineering change request (ECR). The ECR process did not require revisions to be made to engineering drawings to show the existence of this new valve. Although a temporary revision was made to the engineering drawing in the control room, other controlled drawings located elsewhere in the plant were not modified to include this valve.

Operators lining up the system for the hydrostatic test were not provided with a valve lineup sheet. They were supplied with a "hydro sheet", which was a hand drawn sketch defining the extent of the pressure test. Procedure PBNP 3.2.5, "Pressure Test Program", intends this drawing only to document the extent of the pressure test. As such, this hydro sheet did not show all valves within the portion being tested. A separate verification is required, and was performed, to assure system integrity. This

verification identified vent valve RH-V19 as needing closure, but this information was not adequately conveyed to the operators performing the system lineup.

The operators used the controlled engineering drawing located in the auxiliary building as their primary guide for lining up the system. This drawing had not been updated to include vent valve RH-V19. Although one of the operators had been verbally informed of and shown vent valve RH-V19, he did not recall this information while performing the lineup. Consequently, this valve was left open. This process violated 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings", which requires that activities be controlled by instructions or drawings of a type appropriate to the circumstances (266/92009-01). Another example of this violation is described in paragraph 3.e.

The pressure test was suspended and a written valve lineup sheet was developed to isolate the system. The test was then completed without further incident. The plant initiated a requirement that all pressure testing lineups be performed using a written valve lineup sheet. Additionally, an evaluation was initiated to determine changes needed to the ECR process regarding control of drawings. Additional corrective action will be addressed in a future report.

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

One violation and no deviations were identified.

9. Safety Assessment/Quality Verification (40500) (90712) (92700)

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.

Prior to the Unit 1 refueling outage, an Outage Safety Review was performed. This review, performed by the combination of the Safety Evaluation group and the plant, was based on experience gained from previous outages and industry initiatives and experiences. The licensee is also performing a review of the guidelines contained in NUMARC 91-06, "Guidelines for Industry Actions to Assess Shutdown Management". This review is scheduled for completion by the end of 1992. This effort is indicative of proactiveness in assessing shutdown risk management. During the refueling outage, daily status meetings were held to ensure responsible personnel were aware of current outage activities. A recent initiative was the presentation of a risk analysis briefing at the

conclusion of each meeting. The inspector observed that these risk assessment briefings provided an additional level of awareness to group heads regarding specific activities and were considered to have been beneficial to the conduct of safe operations.

a. Licensee Event Report (LER) Review (90712)

The inspectors reviewed LERs submitted to the NRC to verify that the details were clearly reported, including accuracy of the description and corrective action taken. The inspector determined whether further information was required, whether generic implications were indicated, and whether the event warranted onsite follow up. The following LER was reviewed and closed:

*301/92-001 Improper Calibration of One Channel of Over-Temperature Delta-Temperature, Resulting in a Technical Specification Violation

This report describes the improper calibration of one channel of over-temperature δT , which resulted in a violation of the minimum operable channels and minimum degree of redundancy. The calibration data for 100 percent power was inadvertently entered into the procedure being used to calibrate the instruments. This particular procedure, however, requires the data for 105 percent power. Two of the four channels were simultaneously rendered out of service as a result. Such a condition is contrary to the requirements of technical specification table 15.3.5-2, that at least three of the four detectors be operable. This licensee identified violation is not being cited because the criteria specified in Section V.G. of the Enforcement Policy were satisfied.

The technician questioned the values in the procedure and the erroneous data was consequently recognized. The correct inputs were then entered and the calibration completed without further incident. Actions to preclude a recurrence of this event were implemented to provide for double verification of future entries of calibration current data into the procedure.

b. LER Follow Up (92700)

The LER denoted by asterisk above was selected for additional follow up. The inspectors verified that appropriate corrective action was taken or responsibility was assigned and that continued operation of the facility was conducted in accordance with Technical Specifications and did not constitute an unreviewed safety question as defined in 10 CFR 50.59. Report accuracy, compliance with current reporting requirements and applicability to other site systems and components were also reviewed.

c. Manager's Supervisory Staff Meeting (40500)

The inspector observed a session of the Manager's Supervisory Staff reviewing the technical specification upgrade project items. Staff members discussed the list of changes being proposed to technical specifications which are intended to ensure that all equipment needed for safe operation as stated in the Final Safety Analysis Report is also addressed in technical specifications.

No violations or deviations were identified.

10. Management Meetings (30702)

A Meeting was held between NRC Region III management and plant management on March 24, to discuss items of interest and foster improved communications between Wisconsin Electric and the NRC. Items of discussion included plant initiatives regarding shutdown risk, the upcoming Unit 1 refueling outage, operation at rated thermal power, maintenance procedure upgrades, and plant management goals.

11. Exit Interview (71707)

A verbal summary of preliminary findings was provided to the Wisconsin Electric representatives denoted in Section 1 on May 6, at the conclusion of the inspection. 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.