U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-266/92023(DRP); 50-301/92023(DRP)

Docket No. 50-266; 50-301 License No. DPR-24; DPR-27

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

Facility Name: Point Beach Units 1 and 2

Inspection At: Two Rivers, Wisconsin

Dates: October 13 through November 22, 1992

Inspectors: K. R. Jury
J. Gadzala
G. F. O'Dwyer

Approved By: I. N. Jackiw, Chief — 12-8-92 Date
Reactor Projects Section 3A

Inspection Summary

Inspection from October 13 through November 22, 1992,
(Reports No. 50-266/92023(DRP); No. 50-301/92023(DRP)

Areas 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: One violation of NRC requirements was identified. An Executive Summary Follows.

Plant Operations

On October 14, the Unit 1 "white" instrument bus inverter failed and caused a plant transient due to loss of power to the reference temperature circuit (paragraph 3.a.).

Unit 2 completed a 52-day refueling outage (number 18) and was placed on line November 18. Due to the additional steam generator tube plugging performed during the outage, the unit is only able to achieve 98.7 percent power. At

the end of the report period, reactor power was being maintained at 95 percent due to reduced reactor coolant system flow rates (paragraph 3.b.).

A strength was identified in the pre-evolution briefings performed prior to mid-loop operations, steam generator crevice flushing, and Unit 2 startup (paragraphs 3.b.).

During Unit 2 refueling operations, effective communications were maintained between the control room, the refueling level in containment, and spent fuel pit personnel (paragraph 3.c.).

Maintenance/Surveillance

A violation was cited for a failure to follow a surveillance procedure during performance of a loss of voltage relay test on October 26, resulting in deenergization of 4160 VAC safeguards bus 2A06 and 480 VAC safeguards bus 2B04 (paragraph 4.b.).

The gas turbine overhaul was completed and post maintenance testing was conducted. The generator was load tested October 16, and post maintenance testing was completed October 24 at which time G05 was declared back in service. The temporary skid mounted diesel generator (G10) remains in place pending completion of G05 reliability testing (paragraph 4.a.).

Emergency Preparedness

An emergency preparedness medical exercise was conducted November 20 (paragraph 5.).

Engineering and Technical Support

On October 20, the plant identified that one breaker affected by the Unit 2 non-safeguards equipment electrical lockout relay for 480 VAC safeguards bus 2B04 did not open as required during testing (paragraph 6.a.).

Two unit specific non-safety related 60 cell station batteries, 1D-205 and 2D-205, were installed during the current outage to allow the plant to remove non-safety loads from safety related station batteries D-05 and D-06 (paragraph 4.b.).

Safety Assessment/Quality Verification

Outage risk assessment initiatives failed to recognize the potential impact of performing a surveillance during reduced inventory conditions (paragraph 7.a.).

On November 20 the Nuclear Power Department announced a reorganization of the corporate office (paragraph 7.b.).

DETAILS

1. Persons Contacted

G. J. Maxfield, Plant Manager
J. C. Reisenbuechler, Manager - Operations & Technical Support
T. J. Koehler, Manager - Maintenance & Engineering
N. L. Hoefert, Manager - Operations
*J. G. Schweitzer, Manager - Maintenance
W. B. Fromm, Sr. Project Engineer - Construction & Engineering
J. A. Palmer, Manager - Instrument & Controls
*W. J. Herrman, Manager - Technical Services
J. J. Bevelacqua, Manager - Health Physics
*J. F. Becka, Manager - Regulatory & Staff Services
*R. J. Chojnacki, Coordinator - Emergency Planning
*F. A. Flentje, Administrative Specialist

Other company employees were also contacted including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the personnel attending the management exit interview.

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

a. (Closed) Violation (301/92014-01): Excessive Cooldown of the Reactor Coolant System

On May 27, 1992, the technical specification cooldown rate of 100°F/hr (56°C/hr) was exceeded during performance of Refueling Procedure RP-6B, "Steam Generator Crevice Cleaning." The largest cooldown over a one hour period was 141°F (78° C). Additionally, the procedure did not prescribe adequate instructions to prevent exceeding the maximum heatup and cooldown rates. A civil penalty was imposed for these violations.

An analysis was performed by the reactor vessel's vendor to evaluate the effects of the cooldown transient. This analysis calculated that the ratio of the crack initiation toughness to the total stress intensity factor was 1.18. Since this ratio was greater than 1.00, it was concluded that the structural integrity of the vessel was assured and that acceptable margins of safety would be maintained during subsequent operations.

As corrective measures, the operators involved with this event were disciplined and Procedure RP-6B was rewritten to provide adequate guidance for conducting crevice cleaning. The changes implemented for this evolution included: lowering the temperature band at which steam generator cleaning is performed from 290-300°F (143-149°C) to 240-250°F (116-121°C); operating reactor coolant pumps throughout the boiling period to make up for heat losses; maintaining component cooling water temperatures at elevated

levels to minimize heat removal during the operation; assigning an additional licensed operator to plot heatup and cooldown rates and a third senior reactor operator to supervise the entire evolution; and precautions were added to the procedure to emphasize both the administrative and technical specification cooldown and heatup limits, and to clarify actions required if limits are exceeded. Additionally, the licensee effectively implemented applicable portions of procedure PBNP 3.4.19, "Infrequently Performed Tests or Evolutions" (see paragraph 3.b. for additional details).

The inspector reviewed the revised procedure and observed steam generator crevice cleaning performance utilizing the revised process on November 13, during the Unit 2 refueling outage. Plant management presence was noted during the evolution, reactor coolant system temperatures were maintained within administrative limits, and the evolution was strictly controlled. Further concerns were not identified and this item is closed.

b. (Closed) Violation (301/92014-02): Deprivation of Required Decay Heat Removal Capability

On November 10, 1991, all residual heat removal and reactor coolant loops were secured while fuel was in the core and reactor coolant temperature was between 140°F and 350°F, contrary to technical specification requirements. This violation occurred during steam generator crevice cleaning when the pumps were secured to prevent excessive cooldown of the reactor coolant system.

The corrective actions discussed in item 2a. encompass this violation as well as the violation discussed above. As such, this item is closed.

c. (Closed) Unresolved Item (266/92015-02): Instrument Cabinet Seismic Mounting Adequacy

On August 18, 1992, the plant discovered that Unit 1 analog instrumentation racks were not adequately seismically mounted. These racks were consequently declared inoperable, requiring entry into a three-hour limiting condition for operation (LCO) as the configuration was outside of the TS and plant design bases. The company requested and was granted a temporary waiver of compliance from this LCO for a period of 72 hours to effect repairs on the cabinets without requiring the unit to be subjected to a thermal transient by shutting it down.

These cabinets were installed during initial plant construction and their mounting configuration is not believed to have changed since that time. This condition was initially identified in late June 1992, as part of a formal plant initiative. Plant management's initial determination was that the existing hold down clips were adequate to restrain the cabinets in the event of a

safe shutdown earthquake (SSE). A detailed evaluation subsequently determined that the clips were inadequate to restrain the cabinets during an SSE.

The general adequacy of the licensee's seismic design was reviewed by an NRC contractor preoperationally as documented in Appendix D of the NRC's Safety Evaluation of the Point Beach Nuclear Plant, dated July 15, 1970. The review noted that some control room cabinets were not bolted to the floor but did not identify the seismic inadequacy of the design.

The plant's corrective action for the mounting inadequacy consisted of bolting angle irons to the base of the cabinets on the two long sides of each row. The angle irons were then bolted to the concrete floor using concrete expansion anchors. Work was completed within the 72 hours allowed by the temporary waiver. The inspectors monitored installation of the new mounting brackets and verified implementation of compensatory measures. Further concerns were not identified and this item is closed.

d. (Closed) Unresolved Item (266/92004-02): Loss of Normal Boration Flow Path

On January 20 and May 9, 1992, two similar blockages occurred in the normal boration flow paths for Unit 1 and Unit 2 respectively. Heat tracing circuits in a section of piping were controlling temperature below the normal setpoints and the boric acid in these sections crystallized. Heat lamps were used to return the boric acid to solution and the heat tracing thermostats were adjusted. Insulation was also improved on these sections of piping. The emergency boration flow path was verified to have remained operable in all cases.

To ensure that additional flow blockages do not go undetected, a weekly surveillance was added to require that boration flow paths be physically verified by a flow check. The inspector reviewed the plant's corrective actions and did not have additional concerns. This item is closed.

e. (Closed) Unresolved Item (266/92004-03): Control of Axial Flux Difference (AFD)

On August 16, 1990, and January 20, 1992, a turbine runback caused AFD to appear to transcend its control band. Operators were not able to return AFD to its control band within the required 15 minute interval based on plant process computer indication, even though control board indications showed AFD returning to its control band within 15 minutes. The reason for the disparity is the approximately two minute delay time inherent in the process computer indication due to its time weighted algorithm for this parameter.

To correct this problem, a modification was installed in September 1992 to update the computer software to increase the sample frequency for AFD so the computer indication will not substantially lag the actual AFD value. The revised calculation, instead of using a one-minute average of nuclear instrument readings and updating the display once per minute, now uses current nuclear instrument readings and updates the display once every four seconds. The technical specification basis regarding AFD was changed to reflect the updated operation of the process computer. The inspector reviewed these changes and did not have further concerns. This item is closed.

f. (Closed) Violation (266/92004-04): Inadequate Independent Verification

A Unit 1 turbine runback was caused on January 20, 1992, by an electrician inadvertently installing a jumper across two terminals in the wrong breaker cubicle. Activities to verify that the jumper installation conformed to procedural requirements were not adequately performed. The personnel involved were counselled regarding their actions and other maintenance electricians were informed of this event.

To prevent recurrence, the plant revised the Point Beach "Writer's Guide for Maintenance Procedures", to implement a concurrent verification system. Information concerning human factors issues was also expanded. Although the procedure used during this event was determined to have been accurate, it was deemed that additional information on the specific location of the terminals to be jumpered may have prevented the improper jumpering. Consequently, the Writer's Guide was also revised to require that a more detailed description of jumper locations be provided. The inspector reviewed the Writer's Guide changes and did not have further concerns. This item is closed.

3. Plant Operations (71707) (60710) (93702)

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), the inspectors reviewed shift logs, Operations' 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.

Plant tours and perimeter walkdowns were conducted to verify equipment operability, assess the general condition of plant equipment, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tag out procedures were properly implemented.

a. Unit 1 Operational Status

The unit continued to operate at full power with the exception of power being briefly reduced to 75 percent on October 24 as a precautionary measure during installation of the new swing battery into the DC distribution system.

On October 14, the "white" instrument bus inverter, 1DY03, failed. This initiated a plant transient due to loss of power to the reference temperature circuit, which caused control rods to drive in. Control operators promptly identified the cause of the transient and responded by taking manual control of control rods and shifting "white" instrument busses to the swing inverter, DYOC. Transferring the affected bus to the swing inverter restored instrument power and allowed operators to restore control systems to normal alignment. The plant is in the process of installing automatic bus transfer devices to prevent inverter failures from leading to major plant transients. The inspector discussed this event with plant personnel and did not have further concerns.

b. Unit 2 Operational Status

The unit completed a 52-day refueling outage (number 18), achieving criticality on November 16. It was placed on line November 18 and reached 98.7 percent power November 21. Due to the additional steam generator tube plugging performed during the outage the unit was only able to achieve 98.7 percent power with all four turbine governor valves fully opened and Tavg at the midpoint of the normal operating band. Equivalent tube plugging levels for the Unit 2 steam generators were 12.9 percent for the A steam generator and 13.0 percent for the B steam generator. The tube plugging also affected total reactor coolant system flow rate, which was determined to be 181,873 gpm at 95 percent power. This is only 73 gpm above the minimum flow allowed by technical specifications at rated power. Therefore power was maintained at to 95 percent pending completion of engineering testing and

analysis to verify flow rates and determine the minimum allowable flow rates and the corresponding operating power level.

A strength was identified in the pre-evolution briefings performed prior to mid-loop operations, steam generator crevice flushing, and Unit 2 startup. These briefings were performed as part of procedure PBNP 3.4.19, "Infrequently Performed Tests or Evolutions." The inspectors observed the pre-evolution briefings and noted that they were sufficiently thorough and effective in delineating the appropriate cautions, interfaces, expected plant response, and operator actions.

c. Refueling activities

Effective communications were maintained between the control room, the refueling level in containment, and spent fuel pit personnel whenever changes in core geometry were taking place. On the refueling floor, housekeeping was good and excellent control was maintained to prevent loose objects from falling into the reactor vessel.

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

a. Maintenance

The inspectors observed safety related maintenance activities on systems and components to ascertain that these activities were conducted in accordance with TS, approved procedures, and appropriate industry codes and standards. The inspectors determined that these activities did not violate LCOs and that required redundant components were operable. The inspectors verified that required administrative, material, testing, radiological and fire prevention controls were adhered to.

Specifically, the inspectors observed/reviewed the following maintenance activities:

- G05 gas turbine generator overhaul

  The gas turbine overhaul was completed and post maintenance testing was conducted. The generator was load tested October 16 and post maintenance testing completed October 24, at which time G05 was declared back in service. Reliability testing to meet the station blackout rule was then initiated, which includes twice per week starting and loading of G05 until attainment of 95 percent reliability can be demonstrated. The licensee's acceptance test program consists of completion of 20 tests with two or fewer failures as specified in Wisconsin Electric Company's letter to the NRC dated July 23, 1992. The test program is detailed in procedure PBNP 3.2.15, "Gas Turbine Generator

(G-05) Reliability Program". The temporary skid mounted diesel generator (G10) remains in place pending completion of G05 reliability testing. See Inspection Reports 50-266/92024; 50-301/92024 for additional details.

- G02 emergency diesel generator glycol heater replacement

  The plant coordinated removal of G02 from service with restoration of the G05 gas turbine generator and completion of reduced inventory operation on Unit 2.

- Unplanned Maintenance Work Request (UMWR) 1559, "Replace N11 terminal strips"

  Terminal N11 is associated with circuitry that ensures non-safety related loads are shed from the safeguards buses after a safety injection signal.

- MWR 925497, "Disassembly of Valve 2SI-825A"

  Valve 2SI-825A, the refueling water storage tank (RWST) outlet valve to the safety injection pumps, was disassembled to allow insertion of a camera to boroscopically inspect the Unit 2 common suction line between this valve and the RWST. During insertion or withdrawal, the camera and its cabling were not rotated to insure that all 360 degrees of the piping walls were being inspected. The inspectors discussed this concern with the licensee and they confirmed the boroscoping of this piping section was not adequate.

- RMP 153 (Revision 2), SI-853A Check Valve Inspection, Unit 2
  RMP 161 (Revision 2), SI-853C Check Valve Inspection, Unit 2

  This procedure was performed to identify and correct the cause of these Event-V valves failing leak testing. A mock-up was built to provide maintenance technicians with familiarity in valve internals repair. Repairs were coordinated and conducted well, resulting in all affected valves passing subsequent leak tests.

b. Surveillance

The inspectors observed certain safety related surveillance activities on systems and components to ascertain that these activities were conducted in accordance with license requirements. For the surveillance test procedures listed below, the inspectors determined that precautions and LCOs were adhered to, the required administrative approvals and tag-outs were obtained prior to test initiation, testing was accomplished by qualified personnel in accordance with an approved test procedure, test instrumentation was properly calibrated, the tests were completed at the required

frequency, and that the tests conformed to TS requirements. Upon test completion, the inspectors verified the recorded test data was complete, accurate, and met TS requirements; test discrepancies were properly documented and rectified; and that the systems were properly returned to service.

Specifically, the inspectors witnessed/reviewed selected portions of the following test activities:

- RMP 74 (Revision 4) B Train Degraded and Loss of Voltage Relay Test, Unit 2 (Monthly)

  During performance of this test on October 26, a maintenance electrician did not open an isolation knife switch as required by the procedure prior to depressing the relay test button. This caused an undervoltage signal to be transmitted to 4160 VAC safeguards bus 2A06 and consequent deenergization of that bus. The 480 VAC safeguards bus 2B04, which is powered by bus 2A06, was also deenergized. Emergency diesel generator G02 started as required and energized bus 2A06.

  RMP 74, step 3.2.1, directs that the knife switch cover be removed, the knife switch be opened, and a test point cover be remov . A caution statement preceding this step warns that testing with the knife switch closed will trip the associated bus power supply. Additionally, a similar warning is printed adjacent to the relay test push button. At this step, the electrician performing the test decided to assist his helper by removing one cover while the helper removed the other one. The electrician then initialed for completion of that step without realizing that the knife switch had not been opened. This is a violation of Technical Specification 15.6.8, which requires that the plant be operated and maintained in accordance with approved procedures (301/92023-01). Specific corrective actions regarding this violation had not been delineated by the end of this inspection.

  Unit 2 was in a reduced inventory condition at the time and the 2P10B residual heat removal (RHR) pump was supplying cooling water flow. Deenergization of bus 2B04 resulted in loss of power to this pump. Control operators responded by starting the 2P10A RHR pump and restoring cooling water flow within one minute. After determining the cause of the safeguards bus loss, operators restored the electrical line-up to normal and secured the emergency diesel. Additional details surrounding this event are described in LER 92007 and paragraph 7.a.

- RMP 203 (Revision 0) Station Battery 1(2)D-205 Performance Test

  Station batteries 1D-205 and 2D-205 are unit specific non-safety related 60 cell batteries that were installed during the current outage. This allowed the plant to remove non-safety loads such as the main turbine emergency lube oil pumps from safety related station batteries D-05 and D-06. Reducing the loading profile on D-05 and D-06 increases their design margin and thereby helps extend the life of the station batteries to 20 years per IEEE Standard 485-1983, "IEEE Recommended Practice for Sizing Large Lead Storage Batteries for Generating Stations and Substations". Reducing the loading profile on D-05 and D-06 is also expected to obviate the need for battery service testing. The plant's calculations show that performance discharge tests alone will completely envelope the worst case duty cycles for these batteries once the emergency lube oil pumps have been removed from them. IEEE Standard 450, section 5.2, allows a performance test to be used in lieu of a service test when the performance test envelopes the service test. Wisconsin Electric committed to install non-safety batteries by December 31, 1992, in their letter to the NRC dated September 11, 1992.

- Post modification stroke testing of Unit 2 main steam isolation valves per IWP MR 91-210*A

- ORT 3 (Revision 6) Safety Injection Actuation with Loss of Engineered Safeguards AC, Unit 2

- RMP 172 (Rev 0) Monitor Emergency Diesel Generator Fast Start Voltage and Breaker Closure

  This test was performed as a followup to ORT 3 (above) when it was discovered that the G-01 emergency diesel generator output breaker shut at a voltage of 2744 VAC. The minimum specified voltage was 3744 VAC. One of two parallel speed sensing relays in the output breaker closing circuit was found to be actuating at too low an engine speed on the diesel. The relay was adjusted and the test repeated satisfactorily. The plant intends to temporarily increase the periodicity of this annual test to evaluate any potential drift on the relay settings.

- TS-31 (Rev 13), High and Low Head Safety Injection Check Valve Leakage Test (Cold Shutdown), Unit 2

5. Emergency Preparedness (71707)

An emergency preparedness medical exercise was conducted November 20. The scenario involved a contaminated injured man requiring transport to an offsite hospital. The plant appropriately declared an Unusual Event classification for this situation. The inspectors observed drill conduct and significant concerns were not identified.

6. Engineering and Technical Support (71707) (37828) (71711)

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. Electrical Lockout Relay Incorrectly Wired

On October 20, the plant found that the Unit 2 non-safeguards equipment electrical lockout relay for 480 VAC bus 2B04 was in the tripped position. This relay is designed to strip nonessential equipment from its associated electrical bus upon receipt of a safety injection signal, to prevent overloading the emergency diesel generator. Since Unit 2 was in a refueling outage at the time, most of the equipment affected by this relay was already shutdown. The trip of the lockout relay was believed to have been caused by inadvertent bumping of relay 2-SI21X by plant personnel during as-built wire tracing of the safeguards relay racks. The plant notified the NRC of this event as required.

One breaker affected by this relay did not open as required. This breaker supplies motor control center MCC-B21. The plant's investigation of the failure of this breaker to open revealed that the actuation signal wire leads from the lockout relay to the MCC-B21 breaker were not connected. Therefore, the lockout relay was incapable of tripping the MCC-B21 breaker. Based on the condition of the electrical tape covering the wire lead terminations, the plant believes that these wires were never connected during original plant construction.

A review of wiring drawings and interviews with plant personnel familiar with original plant construction, determined that MCC-B21 had not always been powered from Unit 2 bus 2B04 (B train bus). During Unit 1 construction, it became necessary to energize MCC-B21 because it contained some minor loads required for Unit 1. Since bus 2B04 had not yet been built, MCC-B21 was connected to Unit 1 bus 1B01 (A train bus). Later, during March 1970, its power source was transferred to breaker "28C" in Unit 2 bus 2B04, where it remains to date.

However, initial plans were apparently to transfer MCC-B21 to breaker "35A" in Unit 2 bus 2B03 (A train bus). This was

evidenced by several terminals on the wiring being incorrectly identified with the "35A" breaker prefix. The lockout relay control switch terminal strip was labeled with the same "35A" breaker prefix, as were the wire leads attached to it. The plant theorizes that although the modification was subsequently changed to transfer MCC-B21 to bus 2B04 vice 2B03, the drawings and installation procedure were not adequately revised. Consequently, the wiring between the MCC-B21 breaker and its associated lockout relay was never connected.

This error was never discovered during testing for two reasons. First, the breaker supplying MCC-B21 is also designed to open on undervoltage. Second, an additional wiring error resulted in a lockout contact for load breakers in bus 2B03, being connected to the MCC-B21 control circuit. Thus, whenever loads were stripped from bus 2B03 on a safety injection signal, this additional wiring connection would cause MCC-B21 to strip from bus 2B04.

Testing of bus stripping functions was performed in two phases. In the first phase, a safety injection signal is actuated coincident with a loss of power to the safeguards busses. Since the breaker supplying MCC-B21 is also designed to open on undervoltage, this breaker opened during this phase of the test on the undervoltage signal, even though it did not receive the safety injection signal. Because the breaker opened, the test was considered successful. Another phase of the test is initiated by only inserting a safety injection signal. However, both safety injection train signals are inserted simultaneously. According to intended design, the A train signal strips loads from 2B03 while the B train signal strips 2B04. Although, unbeknownst to operators, the B train signal did not strip MCC-B21 from 2B04, actuation of the lockout relay for bus 2B03 by the A train safety injection signal, caused MCC-B21 to be shed from 2B04. The net result was that all required loads were stripped and the test appeared successful.

Since the purpose of the load stripping function is to protect the emergency diesel generators (EDGs) from being overloaded, an evaluation was performed on the safety significance of the existent wiring configurations. This evaluation determined that multiple coincident events would be required to overload an EDG. A postulated scenario that would create such a condition would require that the Unit 2 B train safeguards busses were initially being powered by their EDG without a prior loss of offsite power. This prerequisite ensures that MCC-B21 is not previously stripped on loss of offsite power due to its undervoltage relay actuating. If during such a condition, an actuation of safety injection occurred where only the B train safety injection signal functioned, MCC-B21 would not be stripped and the EDG could be overloaded (during normal operation, MCC-B21 draws between 150 and 200 amps). The diesel would subsequently restart and could then be manually loaded as necessary by the operator.

After this wiring discrepancy was identified, the plant removed the extraneous wire connecting the 2B03 lockout relay with the MCC-B21 control circuit. Wire terminations were then made up from the 2B04 lockout relay to the MCC-B21 breaker trip contact. A subsequent test of load stripping functions (ORT-3) was completed satisfactorily on October 31. The inspector discussed this event with plant management and observed testing of the load stripping functions. This is an unresolved item 266/92023 pending a review of the licensee's updated LER.

b. Installation and Testing of Modifications

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. Selected portions of the following modifications were reviewed:

- IWP 92-144*A, "CCW LW-63 and LW-64 Replacement to be Performed During U2R18, Unit 2"

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

a. Outage Risk Assessment

During the Unit 2 refueling outage the licensee performed an ongoing risk assessment of plant conditions (see IR 90018). As part of this assessment, the licensee reviews scheduled and emergent work's impact on the overall change of risk associated with existing plant conditions. Monthly surveillance test RMP 074 was scheduled for Unit 1 on October 26. Although this test is not required while shutdown, Unit 2's test was scheduled to coincide with Unit 1 test performance to keep the test schedule for both units in parallel. Unit 2 was in reduced inventory on that date, and this test involves testing the 4160 VAC and 480 VAC safeguards busses. Therefore, outage risk assessment would normally prohibit test performance in this plant configuration. Due to the Unit 2 test being scheduled on an emergent basis (i.e. not identified as a scheduled item in the initial Outage Safety Review), this surveillance was not recognized as having adverse risk impact. As discussed in paragraph 4.b., a personnel error during this test resulted in a loss of one train's safeguards busses normal power supply. The inspectors discussed this issue with management and concluded it was an isolated occurrence. Additionally, the licensee is reviewing emergent work controls for outage periods with respect to risk.

b. Licensee Event Report (LER) Review

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 LERs were reviewed and closed:

266/92-008-00 Reactor Trip Following Closure of Main Steam Isolation Valve 1MS-2018

This report discusses the reactor trip on October 5, 1992, caused by inadvertent closure of 1MS-2018, the Unit 1 A steam generator main steam isolation valve, during the performance of quarterly surveillance testing. Details are contained in Inspection Report 266/92018; 301/92018. The faulty solenoid valve was replaced and tested satisfactorily. Both MSIVs were then tested prior to startup. The inspector observed the solenoid valve replacement and selected corrective actions for the identified equipment anomalies.

301/92-002-00 Radioactive Waste Disposal System Component Cooling Water Isolation Valves Outside Design Basis

This report discusses the discovery of component cooling water system (CCW) isolation valves LW-63 and LW-64 in a condition outside of the plant's design basis. Valves LW-63 and LW-64 were discovered to not be capable of providing the appropriate interface between the Seismic Class I and Seismic Class III portions of the CCW system, as specified in the Point Beach Final Safety Analysis Report. This issue and the status of classification of the CCW system as safety related remain unresolved as stated in Inspection Report 266/92018; 301/92018. Corrective action will be tracked via the unresolved item.

301/92-003-00 One Train of Containment Spray Inoperable Due to Foreign Material
301/92-003-01 One Train of Containment Spray Inoperable Due to Foreign Material

This report describes an event which occurred on September 18 during performance of the containment spray system leakage test. The Unit 2 train A containment spray pump was rendered inoperable due to a foreign material exclusion plug blocking the containment spray pump suction. The plug had likely been left in the piping during installation of a full flow test line modification. Details are contained in Inspection Report 266/92018; 301/92018. An enforcement conference was held on this incident on November 6 and resolution of this item is pending the outcome of the enforcement action.

301/92-004-00 Manual Reactor Trip During Hot Control Rod Drop Testing

This report discusses a manual trip which was initiated during performance of Reactor Engineering Surveillance Procedure RESP 1.1, "Rod Control System: Rod Drop Testing." Details are contained in Inspection Report 266/92018; 301/92018. A lack of clear communication was the principal cause of this event. Plant management also recognized a procedural weakness and initiated a revision to the test procedure to insert a note alerting operators to expected equipment response during the test. The inspector interviewed personnel involved in this test, reviewed the test procedure, and did not have further concerns.

301/92-005-00 Steam Generator Tube Degradation

This report provides the results of the steam generator eddy current testing performed during the most recent Unit 2 outage. 36 degraded tubes were found in the A steam generator and 49 in the B steam generator. All of these tubes were subsequently plugged. Growth rate of tube indications averages 4-5 percent per year. The 800 psid leak test revealed four explosive plugs with excessive leakage. These four explosive plugs were removed and replaced with mechanical plugs. The inspection did not reveal other unusual conditions in either steam generator.

c. Manager's Supervisory Staff Meeting

The inspector observed several sessions of the Manager's Supervisory Staff. Issues discussed included operability testing of the emergency diesel generators, Quality Assurance audits of supervisory staff meetings, technical specification change requests, Licensee Event Reports, and safety related classification of the component cooling water system.

d. Corporate Management Reorganization

On November 20 the Nuclear Power Department announced a reorganization of the corporate office. In addition to the creation of an Assistant to the Vice President, the following sections in the corporate office have new managers effective November 20, 1992: Engineering; Regulatory Services; Planning, Systems and Support; and Quality Assurance. The inspectors discussed these changes with senior corporate management.

8. Exit Interview

A verbal summary of preliminary findings was provided to the Wisconsin Electric representatives denoted in Section 1 on November 23, at the conclusion of the inspection. Written inspection material was not 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.