U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-266; 50-301
License Nos:	DPR-24; DPR-27
Report No:	50-266/98017(DRP); 50-301/98017(DRP)
Licensee:	Wisconsin Electric Power Company
Facility:	Point Beach Nuclear Plant, Units 1 and 2
Location:	6610 Nuclear Road Two Rivers, WI 54241-9516
Dates:	August 18, 1998, through October 5, 1998
Inspectors:	F. Brown, Senior Resident Inspector P. Louden, Resident Inspector P. Simpson, Resident Inspector R. Walton, Resident Inspector, Quad Cities Station
Approved by:	M. A. Kunowski, Acting Chief Reactor Projects Branch 7

EXECUTIVE SUMMARY

Point Beach Nuclear Plant, Units 1 and 2
NRC Inspection Report 50-266/98017(DRP); 50-301/98017(DRP)

This inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 7-week inspection period by the resident inspectors.

Operations

- The plant was operated safely during the report period. Minor problems were noted in the areas of equipment status control, command and control in the control room, controls for operator manipulation of equipment, and auxiliary operator performance of rounds. Each of these issues was entered into the licensee's corrective action program. (Sections O2, O3, and O4)

Maintenance

- The licensee conducted a good pre-job briefing for the Unit 1 "A" steam generator feedwater pump repair work. The repair work was completed in a timely manner, consistent with planned estimates. (Section M1.1)

- Plant operators were challenged by some material condition problems in the secondary systems. Licensee response to individual problems was generally good; however, the inspectors were concerned by the potential for long-term degradation of plant systems from high vibration or high pressure transient loadings. No immediate safety concerns were identified by the inspectors, and the licensee indicated an awareness and appreciation of the potential long-term degradation. (Section M2.1)

Engineering

- The licensee identified inadequacies with the original design calculations for the effects of a tornado on the circulating water pumphouse. The pumphouse was subsequently determined to be operable but degraded. (Section E1.1)

- The licensee identified an unexpected foaming of the coolant for the two Train "B" emergency diesel generators. Licensee management and system engineers displayed conservative decision-making in response to the foaming; however, the initial efforts to correct the condition were hampered by the absence of effective oversight. Performance improved after a project manager was appointed. (Section E2.1)

Plant Support

- Licensee performance during an emergency planning drill was improved compared to performance in a previous drill. (Section P1)

Report Details

Summary of Plant Status

Both units were operating at 100 percent rated thermal power at the beginning of the inspection period. On September 1, 1998, Unit 1 power was reduced to approximately 52 percent while a vibration-induced fatigue crack on a pressure sensing line from the suction of the "A" steam generator feedwater pump was repaired. Unit 1 was returned to 100 percent power on September 3, 1998. On September 12, 1998, another vibration-induced fatigue failure caused an oil leak on the Unit 2 "B" steam generator feedwater pump speed controller sensing line. Power for Unit 2 was reduced to 50 percent for several hours while the sensing line was repaired. Unit 2 was returned to 100 percent power later the same day. On September 28, 1998, Unit 1 power was reduced to 50 percent to replace the rotating assembly of the "A" steam generator feedwater pump. This replacement was required to reduce flow-induced vibration in the Unit 1 feedwater system. Following this work, Unit 1 was returned to 100 percent power on October 2, 1998. Both Units remained at 100 percent power through the end of the inspection period on October 5, 1998.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (Inspection Procedures (IPs) 71707, 60855)

The inspectors conducted frequent reviews of ongoing plant operations, including Unit 1 and Unit 2 control room shift turnovers and daily control room operations. No major problems were identified.

The inspectors also observed portions of the spent fuel operations associated with loading the site's third dry storage cask. Again, no major problems were identified. Observations of cask loading operations will be documented in Inspection Report (IR) 72-005/98018(DNMS).

O2 Operational Status of Facilities and Equipment

O2.1 Equipment Status Control (IP 71707)

The inspectors observed that a normally open manual isolation valve for one of the eight Unit 1 condenser steam dump valves was closed. In addition, the valve was not tagged or otherwise marked to specify the abnormal position. The inspectors asked the unit reactor operator and the duty operating supervisor (DOS), a senior reactor operator, whether they were aware of the position of this manual valve. The operator and DOS were aware that the valve was closed.

The inspectors then asked how the valve's abnormal position was being tracked. The DOS stated that an equipment out-of-service entry for the associated condenser steam dump valve was the method for tracking the abnormal valve position. The inspectors

discussed with senior plant management the lack of specificity associated with this method and with other indirect methods of monitoring equipment status. Control of equipment status has been an area of concern to plant management and the NRC for some time. The managers indicated that this weakness had been independently identified, and that actions to restrict the number of allowed methods for tracking equipment status were planned. The inspectors had no further concerns at this time.

O2.2 Command and Control in the Control Room (IP 71707)

During a review of routine control room activities, the inspectors observed two separate occasions when the command and control function appeared to be handled different from that described in Operations Manual (OM) 1.1, "Conduct of Operations," Revision 0. The inspectors considered both cases to have been nonsafety significant, and passed the specific observations to plant management for resolution. These occurrences were indicative of a continuing need for the licensee to ensure that OM 1.1 accurately reflected management's expectations and to reinforce the expected compliance with the requirements of OM 1.1.

O3 Operations Procedures and Documentation

O3.1 Procedural Controls for Equipment Manipulations (IP 71707)

A minor water hammer event occurred in the Unit 1 heater drain tank high level dump line to the condenser on September 29, 1998. The licensee followed up on this event in accordance with the procedure for assessing the potential consequences of water hammer events. The licensee concluded that the water hammer was an expected result of dumping hot water from the heater drain tank to the condenser, and that the dump line was designed to handle the water hammer pressure transient. The inspectors had no concern with the licensee's conclusions.

In reviewing the circumstances of the event, the licensee identified that an auxiliary operator had manipulated the position control switch for the Unit 1 condensate pump minimum recirculation flow line control valve. This action was orally directed by the DOS, who believed that the valve was not in the optimum position. The manipulation of the switch led to cycling (from open to closed to open) of the valve. This cycling caused a minor condensate system flow transient; however, the transient had no effect on the Unit 1 feedwater system or steam generator level.

Plant management was concerned that operators had manipulated a control system in a manner outside of the system's intended design. The inspectors concluded, based upon discussion with licensed operators, that plant operators generally considered operations such as manipulation of the switch to be within the "skill-of-the-craft," and thus not subject to procedural controls. The operations department manager initiated training and procedural changes to address the divergence between management's expectations and the operators' practices. The licensee wrote Condition Reports (CRs) 98-3526 and 98-3557 to document the problem and initiated an assessment of, and corrective actions for, this issue.

The inspectors shared plant management's concern that operators had taken an action, which had the potential to impact normal feedwater flow to the steam generators, without the review and evaluations associated with procedural controls. However, the inspectors concluded that regulatory requirements and the Point Beach licensing basis did not mandate the use of procedures for the type of operation performed by the operator. Notwithstanding this conclusion, the inspectors considered the operators' tolerance of equipment which did not operate as expected and the operators' willingness to take compensatory actions outside of procedural controls to be performance issues with the potential to impact the normal operation of the reactors. A similar performance issue was discussed in Section O1.2 of IR 50-266/98003(DRP); 50-301/98003(DRP).

In addition to the issues discussed above, the inspectors noted that OM 1.4, "Use of Operations Group Procedures and Work Plans," Revision 0, contained guidance on partial performance of procedures and performing work without procedures, which appeared to be less restrictive than the upper tier guidance contained in Nuclear Power Business Unit Procedures Manual (NP) 1.1.2, "Procedure and Administrative Controls," Revision 2. Because the inspectors identified this concern near the end of the inspection period, there was not sufficient time to completely assess whether the operations department (or other departments) had adopted procedural adherence standards which were less restrictive than the plant's upper tier requirements. The inspectors will track the evaluation of this concern under an existing Inspection Follow-up Item ((IFI) 50-266/97020-02(DRP); 50-301/97020-02(DRP)). A similar issue was addressed in Section O1.2 of IR 50-266/97026(DRP); 50-301/97026(DRP).

O4 Operator Knowledge and Performance (IP 71707)

During routine walkdowns of risk-significant safety systems, the inspectors observed oil and boric acid buildup on the Unit 1 "B" and Unit 2 "A" safety injection pump pedestals. The amount and size of the buildup indicated that the condition had existed for at least several days. The inspectors had previously observed this condition and documented the observation in Section O4 of IR 50-266/98014(DRP); 50-301/98014(DRP). At that time, the inspectors also discussed with station management the poor performance of auxiliary operators in meeting management expectations for general housekeeping and monitoring equipment leakage. Operations management subsequently issued a "night order" instruction re-emphasizing the expectation for equipment cleanliness. However, the inspectors' recent observations indicated that the night order had not been effective. The licensee agreed and concluded that additional supervisory presence in the auxiliary building was necessary to ensure that expectations were being met by auxiliary operators.

O8 Miscellaneous Operations Issues (IP 92901)

O8.1 (Closed) IFI 50-266/96018-04(DRP); 50-301/96018-04(DRP): "Revise Technical Specification (T/S) Bases on Accumulator Cross-Connect." The inspectors verified that the licensee planned to include a revision to these T/S bases as part of the improved T/S upgrade initiative which was underway.

O8.2 (Closed) Violation (VIO) 50-266/96018-05a, b, and c(DRP); 50-301/96018-05a, b, and c(DRP): "Examples of Appendix B, Criterion V, Procedure Problems." Three examples of inadequate procedures were identified. The inspectors verified that the inadequacies had been addressed through procedure revisions.

O8.3 (Closed) VIO 50-266/96019-01a(DRP); 50-301/96019-01a(DRP): "Valve Mispositioned by Operator." The licensee changed OM 1.1, "Conduct of Operations," to clarify management's expectations for procedure adherence. The inspectors verified completion of the corrective action commitments associated with this violation. The inspectors will continue to track procedural adherence issues as described in the last paragraph of Section O3 of this report.

O8.4 (Closed) VIO 50-266/96019-01b(DRP); 50-301/96019-01b(DRP): "Failure to Document Deficient Conditions on Condition Reports." The inspectors had identified several instances of deficient conditions not being entered into the corrective action program. Since that time, the licensee has demonstrated better performance in the identification of problems. The inspectors continue to monitor the status of the licensee's corrective action program as part of the routine core inspection program.

O8.5 (Closed) VIO 50-266/97009-01a(DRP); 50-301/97009-01a(DRP): "Failure to Take Adequate Corrective Actions for Previous Valve Mispositioning Events." Recurring valve mispositioning events prompted the licensee to perform a root cause evaluation. Based on the results of the evaluation, the licensee concluded that the events were due to lack of management expectations, and/or vague or unclear expectations. The inspectors determined that appropriate corrective actions were taken by the licensee.

O8.6 (Closed) Licensee Event Report (LER) 50-266/97019-00 and Escalated Enforcement Item (EEI) 50-266(301)/96018-08: "Residual Heat Removal (RHR) Not Aligned In Accordance With T/S." The licensee rendered both trains of RHR inoperable during testing of certain RHR and safety injection valves. The inspectors reviewed the licensee's corrective actions as stated in the LER and in response to EA 97-075. All actions were complete.

O8.7 (Closed) VIO 50-266/97026-01(DRP); 50-301/97026-01(DRP): "Inappropriate Procedure Adherence Guidance." During a loss of a station transformer event, the inspectors identified that a blanket authorization to perform steps out-of-sequence was inconsistent with a licensee upper tier procedure. The licensee implemented procedure changes that rectified the inconsistencies. The inspectors will continue to track procedural adequacy issues as described in the last paragraph of Section O3 of this report.

O8.8 (Closed) LER 50-266/98-024; 50-301/98-024: "Inadvertent Emergency Safety Features Actuation During Emergency Diesel Generator (EDG) Testing." On July 21, 1998, during post-maintenance testing of the Unit 1 Train "A" EDG, technicians installed an electrical jumper wire which unexpectedly actuated "fast start" relays and started the EDG. The root cause of the event was an inadequate procedure which instructed the technician to jumper a contact for the start failure auxiliary relays but failed to identify that the fast start relays would also be affected. Installation Work Plan 97-040, "Removal of Start Failure Auxiliary Alarm," was revised to include the appropriate relays

to be jumpered for testing and the personnel responsible for the inadequate procedure were counseled on the need for self-checking. The inadequacies in Work Plan 97-040 were considered a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," which requires, in part, that activities affecting quality, such as the testing of the EDG, be prescribed by documented instructions, procedures or drawings appropriate to the circumstances. However, this non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation ((NCV) 50-266/98017-01(DRP); 50-301/98017-01(DRP)) consistent with Section VII.B.1 of the NRC Enforcement Policy.

II. Maintenance

M1 Conduct of Maintenance

M1.1 Repairs on the Unit 1 "A" Steam Generator Feedwater Pump

a. Inspection Scope (IP 61707)

The inspectors reviewed documentation and observed licensee repair activities involving the replacement of the pump impeller for the Unit 1 "A" steam generator feedwater pump. Documents reviewed during this inspection activity included the following:

- Maintenance Work Plan 110, "Steam Generator Feed Pump Overhaul," Revision 1,
- Unit 1 Work Order 9815630, "Steam Generator Feed Pump 1P-28A," and
- NP 8.4.10, "Exclusion of Foreign Material From Plant Components and Systems," Revision 6.

b. Observations and Findings

The inspectors attended the licensee's pre-job briefing on September 29, 1998, for the replacement of the impeller for the Unit 1 "A" steam generator feedwater pump. The briefing was attended by all workers involved in the around-the-clock job, which was scheduled for 5 days. The designated maintenance project leader provided the work overview and identified key individuals for the evolution. Many good clarifying questions were asked and contingency plans were discussed during the briefing. The inspectors determined that the pre-job briefing was good as evidenced by attendance of all workers involved with the job, the detailed review of the planned work review, and a good discussion between workers following the overview.

The inspectors observed work activities frequently during the job. Early in the work evolution, the inspectors noted that workers seemed to increase their attention to administrative type requirements, such as foreign material controls and procedural adherence, when they were aware of the inspectors' presence in the area. Performance appeared to be consistently good later in the work evolution.

The Unit 1 "A" steam generator feedwater pump was returned to service on October 2, 1998, close to the planned outage time scheduled for the repairs. The planning and scheduling aspect of this work was well controlled by work-week managers, indicating that the effectiveness of the licensee's work control and planning group continued to improve from that noted during earlier observations of that group by the inspectors.

c. Conclusions

The licensee conducted a good pre-job briefing for the Unit 1 "A" steam generator feedwater pump repair work. The repair work was completed in a timely manner, consistent with planned estimates.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Material Condition (IP 71707, IP 62707)

The inspectors observed continued improvement in the planning and executing of planned and emergent maintenance activities. Licensee staff were effective in ensuring that appropriate plant conditions were established for maintenance activities, and that applicable T/S limitations were observed. However, the need remained for continued efforts by the licensee to ensure that all site organizations were effectively working together to ensure that equipment outage times were minimized and that emergent equipment problems did not challenge operators. The licensee was aware of this issue, and continued to focus on improving performance in this area.

As indicated in the "Summary of Plant Status" section of this report, each unit was forced into a rapid power reduction in response to fatigue-induced failures of small diameter piping associated with the steam generator feedwater pumps. Repair of the rotating element in the Unit 1 "A" steam generator feedwater pump resulted in significant reductions in the vibration in the feedwater system pipes; however, the high vibration condition existed for several months during the summer of 1998 without corrective action being taken. Point Beach Inspection Reports for 1997 and 1998 document high transient loadings, such as water hammer occurrences, in other plant systems (both safety- and nonsafety-related). Additionally, the inspectors had observed occasions when operators "worked-around" equipment which did not function as expected or intended (see Section O3.1 of this report). In assessing these issues, the inspectors considered licensee management's strong emphasis on eliminating operator work-arounds and on making conservative operability determinations to be strengths. On the other hand, the reactive nature of the response to these issues concerned the inspectors. For instance, the licensee was increasing the use of fatigue analysis to assess conditions of high vibration, but did not have a comprehensive program for assessing areas of historically high fatigue loading in the plant (no regulatory requirement exists for such a program). The inspectors discussed with licensee management the possible impact of these issues on potential power uprate and life-extension projects. Licensee management acknowledged these issues, and indicated that plant staff had already been directed to consider such possible impacts.

M8 Miscellaneous Maintenance Issues (IP 92902)

M8.1 (Closed) VIO 50-266/96015-01a and -01b(DRP); 50-301/96015-01a and -01b(DRP): "Title 10 CFR Part 50, Appendix B, Criterion V, Procedure Violation." The licensee completed the corrective actions to this violation. The inspectors verified that the licensee had addressed the procedure compliance concerns discussed in the violation involving inadequacies in work packages and work control processes. The inspectors continue to monitor the quality of maintenance activities and work control process improvements as part of the routine core inspection program.

M8.2 (Closed) VIO 50-266/96019-01c(DRP); 50-301/96019-01c(DRP): "Safety Injection Pump Repaired Without Appropriate Instructions." Administrative inadequacies in the licensee's equipment repair/replacement program was determined to be the root cause of the identified violation. The inspectors verified that the identified inadequacies had been effectively addressed.

M8.3 (Closed) IFI 50-266/97009-03(DRP); 50-301/97009-03(DRP): "Inspectors Identified Procedures Which Did Not Contain Required Post-Maintenance Testing." The inspectors verified that the licensee performed a thorough review of procedures and corrected any identified post-maintenance testing inadequacies.

III. Engineering

E1 Conduct of Engineering

E1.1 Circulating Water Pumphouse Design Inadequacies (IP 37551)

During this inspection period, licensee engineering personnel identified that the original design and as-built condition of the circulating water pumphouse may not have been in accordance with the original design bases for tornado loadings on the structure. Licensee Event Report 50-266/98023; 50-301/98023 was written to document the problem. The pumphouse was subsequently determined by the licensee to be operable but degraded. At the completion of the inspection, this issue was forwarded to the NRC Office of Enforcement for evaluation and proper resolution in accordance with the NRC Enforcement Policy. This matter will be closed in the next routine inspection report.

E2 Engineering Support of Facilities and Equipment

E2.1 Operability Determination for EDGs (IP 71707, IP 37551)

During routine surveillance testing of the Unit 1 train "B" EDG (G-03), the licensee identified that a small portion of the glycol engine coolant had overflowed out of the coolant expansion tank. Subsequent licensee reviews of the surveillance test data identified that the coolant was foaming during engine operation. A similar condition was also identified with the coolant in the Unit 2 train "B" EDG (G-04). The licensee declared both train "B" EDGs inoperable.

The inspectors observed that the initial licensee response to the foaming condition was hampered by a lack of knowledge about the probable causes and potential consequences of the foaming condition. System engineers were conservative in that they did not assume the foaming condition was acceptable simply because it may have existed in the past. After some delay, licensee management recognized that assignment of a project manager was necessary to have a single point of contact and to maintain oversight of the troubleshooting activities. Performance improved after the assignment of a project manager.

Overall, with the exception of the early difficulties in efforts to assess and correct the foaming problem, licensee management was conservative in declaring the two Train "B" EDGs inoperable until the condition could be evaluated and addressed.

E2.2 Testing of Feedwater Check Valves (IP 37551)

As described in Section M2.1 of this report, the Unit 1 feedwater system experienced excessive flow-induced vibration during this reporting period. The inspectors reviewed the licensee's testing of the feedwater check valves (1CS-466AA, -466BB, -476AA, and -476BB). The purpose of the testing was to ensure that adequate flow from the auxiliary feedwater system would be directed to the steam generators in the event of a main feedwater pipe failure.

The inspectors were initially concerned with the test methodology and acceptance criteria as contained in the applicable test procedures. After discussions with the licensee, regional inspectors, and the Office of Nuclear Reactor Regulation, the inspectors concluded that the licensee's test program for these valves satisfied the plant licensing basis requirements. The inspectors also identified several human factors issues with the test procedures. These issues had not affected the most recent test performance, so they were communicated to the responsible engineers as areas for potential procedure improvement.

E8 Miscellaneous Engineering Issues (IP 92903)

E8.1 (Closed) LER 50-266/97005: "Core Deluge Valve 1SI-852A Not Tested In Accordance With Technical Specifications." The issue was the subject of a violation discussed and closed in Section E8.2 of this report.

E8.2 (Closed) VIO 50-266/96019-03(DRP); 50-301/96019-03(DRP): "Core Deluge Valve 1SI-852A Not Tested In Accordance With T/Ss." The root cause of this violation was determined to be a failure to appropriately ensure that inservice testing procedures identified all valves subject to the test requirements. As part of its corrective actions, the licensee verified that surveillance testing frequency requirements for all applicable components had been adequately incorporated in procedures. In addition, the licensee was revising the entire inservice testing program at the station.

E8.3 (Closed) IFI 50-266/97009-02(DRP); 50-301/97009-02(DRP): "Multiple Instances of Loss of Control Room Annunciators Due to Replacement of Blown Indicator Bulbs." The licensee was addressing the issue by replacing the incandescent bulbs with light

emitting diodes. The replacement project was scheduled to be completed in March 1999.

E8.4 (Closed) VIO 50-266/97026-05(DRP); 50-301/97026-05(DRP): "Inadequate Testing of Containment Accident Fan Coolers." The licensee identified that nonconservative values had been used for service water temperature, flow rate, and piping fouling factors. The resulting calculation determined that the fan coolers could not meet design heat removal rates. The licensee later determined that the system was operable and confirmed that determination with a test.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls

R1.1 General Comments

The inspectors did not note any performance issues in the radiological protection area during routine tours of the radiologically controlled area or during observation of work activities. Health physics technicians were typically present at job sites and provided adequate oversight of activities.

R8 Miscellaneous RP&C Issues (IP 92904)

R8.1 (Closed) VIO 50-266/97009-01b(DRP); 50-301/97009-01b(DRP): "Failure to Take Adequate Corrective Actions for Previous Valve Mispositioning Events." The licensee's root cause evaluation of this event identified a need to reinforce procedural adherence with workers and provide additional administrative controls. Several chemistry procedures were reclassified as "continuous use" which required personnel to read each procedure step prior to performing the task. The inspectors determined that the actions taken adequately addressed the original concern.

P1 Conduct of Emergency Planning Activities (IP 71750)

The inspectors observed portions of an emergency planning drill conducted on September 30, 1998, and concluded that the emergency response organization's performance was markedly improved compared to its performance during a previous drill described in IR 50-266/98014(DRP); 50-301/98014(DRP).

F8 Miscellaneous Fire Protection Issues (IP 92904)

F8.1 (Closed) IFI 50-266/97009-05(DRP); 50-301/97009-05(DRP): "Inadequate Lighting of Fire Protection Areas." This IFI is being closed to Apparent Violation 50-266/97010-07(DRS); 50-301/97010-07(DRS) of 10 CFR Part 50, Appendix R, Section III.J. "Emergency Lighting."

F8.2 (Closed) LER 50-266/97020-00 and 50-266/97020-01; 50-301/97020-00 and 50-301/97020-01: "Conditions Outside 10 CFR Part 50 Appendix R Safe Shutdown Analysis." A fire protection inspection reviewed these conditions and documented these conditions in IR 50-266/97010(DRS); 50-301/97010(DRS). The issues were dispositioned in Enforcement Action 97-347. This LER and its revision are being closed to the following apparent violations:

- 50-266/97010-04(DRS); 50-301/97010-04(DRS) - 10 CFR Part 50, Appendix R, Section III.G.2,
- 50-266/97010-05(DRS); 50-301/97010-05(DRS) - 10 CFR Part 50, Appendix R, Section III.L.1,
- 50-266/97010-06(DRS); 50-301/97010-06(DRS) - 10 CFR Part 50, Appendix B. Criteria V.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management, after the conclusion of the inspection, on October 7, 1998. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

Wisconsin Electric Power Company

M. E. Reddemann, Site Vice President
R. G. Mende, Plant Manager
J. R. Anderson, Operations Manager
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J. G. Schweitzer, System and Component Engineering Manager
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V. M. Kaminskas, Regulatory Services and Licensing Manager

INSPECTION PROCEDURES USED

IP 37551:	Onsite Engineering
IP 40500:	Effectiveness of Licensee Controls in Identifying, Resolving, and Preventing Problems
IP 60855:	Operation of an ISFSI [Independent Spent Fuel Storage Installation]
IP 61726:	Surveillance Observations
IP 62707:	Maintenance Observation
IP 71707:	Plant Operations
IP 71750:	Plant Support Activities
IP 92901:	Followup - Operations
IP 92902:	Followup - Maintenance
IP 92903:	Followup - Engineering
IP 92904:	Followup - Plant Support

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-266/98017-01(DRP) 50-301/98017-01(DRP)	NCV	Inadvertent Emergency Safety Features Actuation During EDG Testing

Closed

50-266/96018-04(DRP) 50-301/96018-04(DRP)	IFI	Revise T/S Bases on Accumulator
50-266/96018-05a,b,c(DRP) 50-301/96018-05a,b,c(DRP)	VIO	Examples of 10 CFR Part 50, Appendix B, Criterion V, Procedure Violations
50-266/96019-01a(DRP) 50-301/96019-01a(DRP)	VIO	Valve Mispositioned by Operator
50-266/96019-01b(DRP) 50-301/96019-01b(DRP)	VIO	Failure to Document Deficient Conditions on CRs
50-266/97009-01a(DRP) 50-301/97009-01a(DRP)	VIO	Failure to Take Adequate Corrective Actions for Previous Valve Mispositioning Events
50-266/97019	LER	RHR Not Aligned in Accordance with T/Ss
50-266/96018-08(DRP) 50-301/96018-08(DRP)	EEI	RHR Not Aligned in Accordance with T/Ss
50-266/97026-01(DRP) 50-301/97026-01(DRP)	VIO	Inappropriate Procedure Adherence Guidance

50-266/98024 50-301/98024	LER	Inadvertent Emergency Safety Features Actuation During EDG Testing
50-266/98017-01(DRP) 50-301/98017-01(DRP)	NCV	Inadvertent Emergency Safety Features Actuation During EDG Testing
50-266/96015-01a,b(DRP) 50-301/96015-01a,b(DRP)	VIO	Title 10 CFR Part 50, Appendix B, Criterion V, Procedure Problems
50-266/96019-01c(DRP) 50-301/96019-01c(DRP)	VIO	Safety Injection Pump Repaired Without Appropriate Instructions
50-266/97009-03(DRP) 50- 301/97009-03(DRP)	IFI	Inspectors Identified Procedures Which Did Not Contain Required Post-Maintenance Testing
50-266/97005	LER	Core Deluge Valve 1SI-852A Not Tested in Accordance With Technical Specifications
50-266/96019-03(DRP) 50-301/96019-03(DRP)	VIO	Core Deluge Valve 1SI-852A Not Tested in Accordance With T/Ss
50-266/97009-02(DRP) 50-301/97009-02(DRP)	IFI	Multiple Instances of Loss Of Control Room Annunciators Due to Replacement of Blown Indicator Bulbs
50-266/97026-05(DRP) 50-301/97026-05(DRP)	VIO	Inadequate Testing of Containment Accident Fan Coolers
50-266/97009-01b(DRP) 50-301/97009-01b(DRP)	VIO	Failure to Take Adequate Corrective Actions for Previous Valve Mispositioning Events
50-266/97009-05(DRP) 50-301/97009-05(DRP)	IFI	Inadequate Lighting of Fire Protection Areas
50-266/97020-00,01 50-301/97020-00,01	LER	Conditions Outside 10 CFR Part 50 Appendix R Safe Shutdown Analysis

Discussed

50-266/97020-02(DRP) 50-301/97020-02(DRP)	IFI	Assess Procedural Controls

LIST OF ACRONYMS USED IN POINT BEACH REPORTS

AC	Alternating Current
AFW	Auxiliary Feedwater
ASME	American Society of Mechanical Engineers
CFR	Code of Federal Regulations
CR	Condition Report
DNMS	Division of Nuclear Materials Safety
DOS	Duty Operating Supervisor
DRP	Division of Reactor Projects
DSS	Duty Shift Superintendent
EA	Enforcement Action
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
EEI	Escalated Enforcement Action
ESF	Engineered Safety Feature
EP	Emergency Planning
IFI	Inspection Follow-up Item
IP	Inspection Procedure
IPE	Individual Plant Evaluation
IR	Inspection Report
ISFSI	Independent Spent Fuel Storage Installation
LCO	Limiting Condition for Operation
LER	Licensee Event Report
NCV	Non-Cited Violation
NP	Nuclear Business Unit Procedure
NRC	Nuclear Regulatory Commission
OI	Operating Instruction
OM	Operations Manual
OSTI	Operation Safety Team Inspection
PASS	Post-accident Sampling System
QA	Quality Assurance
RCS	Reactor Coolant System
RHR	Residual Heat Removal
RMP	Routine Maintenance Procedure
RP	Radiation Protection
RP&C	Radiological Protection and Chemistry
RWST	Refueling Water Storage Tank
SER	Safety Evaluation Report
SFP	Spent Fuel Pool
SI	Safety Injection
SW	Service Water
T/S	Technical Specification
TS	Technical Specification Test
URI	Unresolved Item
VIO	Violation