U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/89023(DRSS); 50-301/89022(DRSS)

Docket Nos. 50-266; 50~301

Licenses No. DPR-24; DPR-27

Date Date

Licensee: Wisconsin Electric Power Company 231 West Michigan Mi Jaukee, WI 53201

Facility Name: Point Beach Nuclear Power Plant, Units 1 and 2 Inspection At: Point Beach Site, Two Creeks, Wisconsin

Inspection Conducted: July 10-14 and August 3, 1989

James E. Foster frontes

Inspector:

Approved By: William Snell, Chief

Radiological Controls and Emergency Preparedness Section

Inspection Summary

Inspection on July 10-14 and August 3, 1989, (Reports No. 50-266/89023(DRSS); 50-301/89022(DRSS))

Areas Inspected: Routine, announced inspection of the following areas of the Point Beach Nuclear Plant Emergency Preparedness program: Licensee action on previously-identified items (IP 92700); rollowup on actual emergency plan activations (IP 92701); operational status of the emergency preparedness program (IP 82701). Section 5 of this report contains the status of Emergency Preparedness related Safety Issues Management System (SIMS) items. This inspection involved one NRC inspector.

Results: No violations, deficiencies or deviations were identified. Routine maintenance of the emergency preparedness program appears well implemented, with the exception of those training related items carried from previous inspections as Open Items. the licensee has not completed action on several outstanding Open Items, but progress is being made towards resolution of these items.

DETAILS

1. Persons Contacted

- *J. Zach, Plant Manager
- *R. Bruno, Superintendent Training
- *G. Maxfield, General Superintendent Operations J. Knorr, Regulatory Engineer
- *D. Stevens, Emergency Preparedness Coordinator
- *R. Chojnacki, Quality Specialist EP *H. Gleason, Training Coordinator
- *F. Flentje, Administrative Specialist
- *E. Mercier, Engineer, Nuclear Plant Engineering
- M. Baumann, Engineer-II, Corporate

*Denotes those attending the exit interview on July 14, 1989.

The inspector also contacted other members of the licensee's staff during the course of the inspection.

2. Licensee Action on Previously Identified Items (IP 92701)

- (Closed) Open Item (No. 301/87900-01): Licensee action on NRC a. Information Notice IN-87-058 "Continuous Communications Following Emergency Notifications." This information notice reminds recipients that 10 CFR 50.72(c)(3) requires that licensees maintain continuous communications with the NRC when requested. The licensee has completed its review of the Information Notice, and concluded that no action is necessary. The basis for this conclusion is that EPIP 2.2 "NRC Notification" provides general guidance, and procedure DCS 2.1.1 "Requirements and Guidance for Immediate Notification to NRC of Significant Events at PBNP" specifically addresses continuous communications with the NRC upon request. A February, 1989 modification to Section 5.1 of EPIP 1.3 "Emergency Event - Immediate Actions" (Revision 15) clarified that additional Duty Technical Advisors "may be required for continuous manning of the NRC ENS telephone." This item is closed.
- b. (Open) Open Item (No. 266/88007-01): Licensee procedures did not assure annual Emergency Plan training for all personnel assigned duties in the Emergency Plan. The licensee revised their Emergency Plan on January 19, 1989 adding a requirement (Section 8.3.1.1b) for specialized annual training for key plant personnel and those individuals assigned specific duties associated with the Emergency Plan. The method of conducting this annual training is still under review, with an estimated completion timeframe of September, 1989. The area of EP training was the focus of a previous inspection (No. 50-266/89013; 50-301/890012, conducted in June 1989). Pending completion of licensee actions, this item will remain open.

- c. (Closed) Open Item (No. 266/88021-02): During the emergency preparedness exercise held on September 14, 1988, the individual in charge of the Emergency Operations Facility did not document his review and approval of hardcopy messages prior to transmittal offsite. During the emergency preparedness exercise held on March 15, 1989, documentation of such review and approval was complete and acceptable. This item is closed.
- d. <u>(Closed) Open Item (No. 266/88023-02)</u>: On the morning of October 20, 1988, a review of siren test printouts from the siren status feedback system indicated that a significant number of sirens were not operational. A "growl test" was conducted, which indicated that 8 of 14 sirens were not responding to Central Control Station signals. Prompt corrective action was taken, and over 90% of the sirens were functional by the end of the day. Some problems were identified in a new type of circuit board installed to allow a "remote reset" of a siren.

A number of sirer circuit boards have been replaced it the interim, and it has been found that the siren status feedback system is not entirely reliable. The licensee has been monitoring the accuracy of the siren status feedback system, but does not presently consider the system as in service (this is not a required system).

The licensee conducts siren tests at a frequency well over minimum NRC requirements, and has a system for rapidly determining the percentage of the Emergency Planning Zone population which would be affected by a siren's failure. There are provisions for compensatory notification measures should these be required. This item is closed.

- e. <u>(Closed) Open Item (No. 266/89008-01)</u>: During the last exercise, the licensee failed to adequately demonstrate the capability to coordinate the flow of information from the Control Room to offsite agencies and the proper use of EPIP I.1. Discussion with licensee personnel and review of information in a May 10, 1989 licensee letter responding to NRC exercise items indicated that this item was an "exercise artifact" caused by the use of a "Drill Control Room." A review of exercise events indicated that the observed problem would be unlikely to occur in an actual event involving the Control Room. This item is closed.
- f. (Open) Open Item (No. 266/89008-02): Exercise Weakness: During the last exercise, licensee personnel did not recognize and aggressively pursue the existence of the (scenario) containment release path. The licensee responded to this item via letter dated May 10, 1989, indicating that the Weakness was a performance problem, not a generic issue and no corrective action could be identified or implemented. Region III personnel did not accept this position, and the transmittal letter for NRC Inspection Report No. 50-266/89013(DRSS); 50-301/89012(DRSS) requested an additional response. This item will remain open.

- g. <u>(Open) Open Item (No. 266/89008-03)</u>: Operational Support (OSC) procedures should be modified to require activation of the OSC concurrently with the Technical Support Center (TSC), to provide augmented manpower to carry out any TSC directed initiatives. Licensee personnel committed to revise the Emergency Plan and Emergency Plan Implementing Procedures (EPIPs) to require concurrent activation of the TSC and OSC at the Alert declaration or higher. Discussion indicated that EPIP 1.3 (Revision 7) would have the OSC activate, at an Alert, up to the point of assuming OSC responsibilities for plant equipment function and maintenance. This is so that the normal maintenance organization can continue to function if OSC support is not required by the conditions of the Alert. Pending completion of licensee actions, this item will remain open.
- h. (Closed) Open Item (No. 266/89008-04): Emergency Plan Emergency Kit inventories should be revised to ensure adequate supplies are available to support multiple inplant teams. Supplies maintained under the Emergency Plan Maintenance Procedures (EPMPs) have been increased considerably for inplant team items. Review of the June, 1989 inventory checklist revision indicated that such supplies were adequate. This item is closed.
- i. <u>(Open) Open Item (No. 266/89008-05)</u>: During the previous exercise, sample handling techniques were poorly demonstrated by both field teams. Licensee personnel stated that a review of the present training program indicated that it was adequate in the area of Health Physics; additionally, the findings of the exercise inspection report were discussed with the Health Physics staff as training. The major concerns developed from the NRC findings were hand contamination and possible sample cross-contamination, as vehicle contamination was expected under the scenario conditions. The training department has been requested to complete a Training Needs Analysis for field sampling team members. Pending completion of licensee actions, this item will remain open.
- j. (Open) Open Item (No. 266/89008-06): Unresolved Item: During the previous emergency preparedness exercise (March 1989), the licensee was unable to obtain and analyze a containment atmosphere sample when containment air pressure exceeded 5 psig. The sampling procedure indicated that this maximum pressure was implemented because the sample pump seals would not be adequate for higher pressures. During the inspection, documentation was reviewed which indicated that the 5 psig limit was most likely based on the operating manual provided by the vendor of sample pump 707A.

A review of the Point Beach Final Safety Analysis Report, Section 14.3.4, "Containment Pressure Transients" indicated that peak containment pressure for a worst case accident was calculated to be between 52-53 psig. For the most conservation worst case analysis, resulting containment pressure could remain above 10 psig for over 2.75 hours, delaying utilization of the containment atmosphere sampling system. The NRC criterion for such sampling is that the sample be obtained and analyzed within three hours of the decision to sample.

Per an August 3, 1989 telephone discussion with the licensee's Emergency Preparedness Coordinator, the licensee has reviewed this information and concluded that the system is unacceptable with a 5 psig limitation.

Discussion indicated that the licensee has further reviewed the sampling system. The pump vendor advised the licensee that the pump seals are not at risk, but the pump motor can only tolerate a sample pressure of 15 psig in "continuous use" and 20 psig for "intermittent use" (no more than 15 minutes). The 5 psig limitation does apply to the seals at a radiation detector which is bypassed in the containment atmosphere sampling configuration, and is not a concern.

Design review did identify a drain trap upstream of the sampling pump, which has a glass collection bowl rated at 5 psig. Licensee personnel are pursuing either replacing the glass collection bowl with a metal bowl qualified to a higher pressure, or modifying the system to utilize a different trap mechanism. With an appropriate modifice in, the system would then have a 20 psig capability. A pressure lest of the modified system would then be performed to confirm its acceptability.

The licensee has performed a maximum sample time analysis, utilizing the containment atmospheric pressure transit data above, and conservatively assumed that the sample was requested at the time of transient initiation. Their analysis indicated that a 20 psig system will allow a containment atmosphere sample to be collected and analyzed within three hours, as containment pressure would decrease to the 20 psig point in an acceptable amount of time.

Licensee review of the sampling procedure has indicated that the present pre-sampling recirculation time of 15 minutes is unnecessary and could be significantly reduced. The above analysis of total sampling time was performed without reduction of the present 15 minute recirculation time.

This Unresolved Item is converted to an Open Item to track licensee corrective actions. Pending completion of licensee actions, this item will remain open.

k. (Open) Open Item (No. 256/89008-07): Unresolved Item: During the exercise it was noted that the licensee lacked a procedure for counting an air sample taken from the plant which had (scenario) elevated levels of radioactive iodine present. Discussion with licensee personnel indicated that this item was under active review. It appears that elevated plant air iodine measurement can be

conducted using a relatively short procedure and series of tables (related to reactor shutdown time) which would allow conversion of a sample dose rate into an airborne concentration. Predicted completion of this item was within three months. This Unresolved Item is converted to an Open Item to track licensee corrective actions. Pending completion of licensee actions, this item will remain open.

- 1. (Open) Open Item (No. 266/89013-01): More emphasis should be placed on the accurate documentation of Emergency Preparedness training. The licensee has formed a Emergency Preparedness training plan task force which has reviewed and updated training records, and is reviewing wno needs such training. A "punch list" of items in need of correction has resulted from this review. Pending completion of licensee actions, this item will remain open.
- m. (Open) Open Item (No. 266/89013-02): The licensee should assure that the training program is easily auditable and that the records of training provided are maintained in one area in order to verify the requirements of the training program are being met. The licensee has formed a Emergency Preparedness training plan task force which has reviewed and updated training records, and is reviewing who needs such training. A "punch list" of items in need of correction has resulted from this review. In addition, various tracking systems are being evaluated by the training group. Pending completion of licensee actions, this item will remain open.

3. Activations of the Licensee's Emergency Plan (IP 92700)

The following activation of the licensee's emergency plan was reviewed during the previous inspection. Further review took place during this inspection.

On March 29, 1989 at 0843 hours, Unit 2 experienced a main step-up transformer lockout main generator breaker trip and concurrent turbine and reactor trips. This was caused by a loss of (grid) load. The plant is designed to accept, without a reactor trip, a full loss of load while below 50% power, and a 50% loss of load while at 100% power. A loss of more than 50% load while at 100% power will normally cause a reactor trip.

Documentation relating to this event was reviewed and analyzed to determine if actions met those required by the Emergency Plan. All actions and notifications initiating and terminating this event were appropriately made and the event was properly classified as an Unusual Event per the Emergency Action Level (EAL) scheme. Category 6 of the EAL table (EPIP 1.2, Table 1.2-1, Page 9) "loss of electrical load" was utilized.

Guidance on EALs, contained in NUREG-0654, does not address loss of load incidents. Reactor trip events which do not involve other system

failures or perturbations (systems operate as designed) are not normally regarded as Unusual Events, although they may be reportable under the requirements of 10 CFR 50.72. Discussion with licensee personnel indicated that consideration will be given to deletion of this EAL during the next EAL review.

Based upon the above findings, this portion of the licenses's program was acceptable.

4. Operational Status of the Emergency Preparedness (EP) Program (IP 82701)

a. Emergency Plan and Implementing Procedures

By letter dated May 9, 1989, NRC Region III staff approved Revision 30 (dated April 12, 1989) to the Point Beach Nuclear Plant Emergency Plan.

A review of documentation associated with Revision 30 indicated that the changes had received internal review, comment and approval by appropriate management personnel.

Copies of the Emergency Plans and implementing procedures are considered as "uncontrolled copies," as they are not auditable by licensee personnel. The onsite staff distribute copies to State and local government agencies, while the corporate staff distribute copies to the NRC, whether to Region III or NRC Headquarters. Copies of documents sent to the NRC are provided to the plant staff. Distribution of documents is essentially done to all parties at the same time, and documents reviewed indicated that copies are promptly provided to the NRC.

Documentation indicated that during May 1989, a copy of EPIP 1.2 "Event Classification" was provided to State and local authorities for review and comment.

Based upon the above findings, this portion of the licensee's program was acceptable.

b. Emergency Response Facilities (ERFs), Equipment and Supplies

By letter of December 14, 1988, the licensee proposed relocation of the backup Emergency Operations Facility to the Corporate Emergency Center in the Wisconsin Electric corporate headquarters in Milwaukee, Wisconsin. This proposal is under review and additional information has been requested.

The Technical Support Center (TSC), Operations Support Center (OSC) and the Emergency Operations Facility (EOF) were toured by the inspector and verified to be in an adequate state of operational readiness. The TSC and EOF are presently dedicated facilities, while the OSC is normally utilized for training. A number of improvements were noted during facility tours. Additional space is available in the TSC/OSC area due to removal of vending machines near the turbine doorway area. Hardwired radio desksets are now positioned in the TSC/OSC facility, with units in the Health Physics area, chemistry area, TSC proper, and OSC proper. A passive radio antenna has also been installed to facilitate use of hand-held radios in the TSC/OSC area.

A new offsite dose projection program, MADCR has been reviewed, approved, proceduralized, and is in use in the TSC dose projection area.

NRC Emergency Notification System ("red phones") were tested in each area, including the office spaces assigned to the NRC, and were functional.

In the EOF, an autodialer has been connected to the telefax machine, and wire covers have been installed throughout the facility, reducing wire clutter and eliminating a trip hazard.

During the Control Room tour it was verified that the most recent revisions of the Emergency Plan, Emergency Plan Implementing Procedures and Emergency Plan related forms were available.

A review of inventory checks performed in accordance with Emergency Plan Maintenance Procedures (EPMPs) 1.1 and 1.2 was performed. This review indicated that a comprehensive and detailed maintenance, calibration and inventory program was in place for equipment associated with the Emergency Plan, including Health Physics equipment. Monthly, quarterly, semiannual and annual checks are made of various pieces of equipment. A large volume of documentation was reviewed. Licensee personnel indicated that, as of July 1, 1989, all of the various inventory checklists were revised to twelve monthly forms including affected equipment. This will greatly simplify the system and avoid any possible duplication of effort.

Based upon the above findings, this portion of the licensee's program was acceptable.

c. Organization and Management Control

The licensee emergency organization and procedures were largely unchanged from the last routine inspection. The onsite organization consists of an Emergency Planner who has the full time assistance of a Quality Specialist and part-time assistance of one individual at the corporate office. The Emergency Planner reports to the Regulatory Engineer, who reports to the General Superintendent, Operations.

Based upon the above findings, this portion of the licensee's program was acceptable.

d. Emergency Preparedness Training

Emergency Preparedness training was the focus of an inspection conducted during May 22-25, 1989 (Reports No. 50-266/89013; 50-301/89012). That inspection resulted in three open items and concerns regarding the overall effectiveness of the 'licensee's training program in the area of emergency preparedness. As licensee action had been initiated in response to the above inspection, but not completed, the overall training program for emergency preparedness was not assessed during this inspection.

Annual hospital training was provided on May 1, 1989, by Wisconsin Public Service Corporation (WPS) personnel. Through a cooperative agreement, WPS shares offsite training responsibilities with Wisconsin Electric Power Company.

Annual training for offsite Ambulance/rescue personnel was provided by WPS personnel on May 11, 1989.

Offsite emergency response training for State and county public information officers was conducted on April 25, 1989, and coordinated by WPS and NUTECH Engineers.

Emergency Preparedness training for offsite agencies was conducted on September 1, 7, and 8, 1988, with a total of 154 individuals attending. In addition, cross training was held with State of Wisconsin personnel on August 22, 1988, and with the Division of Emergency Government and the Department of Health and Safety on September 1, 1988.

Based upon the above findings, this portion of the licensee's program was acceptable.

e. Audits

The licensee normally performs two audits of emergency preparedness annually, one addressing the overall function of the program, and one addressing emergency preparedness training. This year, one audit was performed, addressing both areas, but with a primary focus in the area of emergency preparedness training. The audit was conducted during April 15-21, 1989.

Audit No. A-P-89-05 "PBNP Emergency Preparedness Program" was reviewed. The audit was performed by two QA engineers from the (corporate) Nuclear Quality Assurance Department. The audit resulted in six Audit Finding Reports (AFR). One AFR dealt with a documentation deficiency related to letters of agreement, and the others were related to emergency preparedness training. One AFR regarding controller/observer attendance at briefings was closed as not requiring corrective action. The audit concluded that the emergency preparedness program remains "well developed, adequately documented and sufficiently implemented to assure emergency preparedness except for the deficiencies noted." AFR documentation was reviewed and found to be accurate and complete. Items had been placed on a tracking system as AFKs A-P-05-012 through A-P-05-16. Responses to AFRs were provided via memo of June 15, 1989. Corrective actions were ongoing for several of the outstanding AFRs related to training.

As required by 10 CFR 50.54(t), a portion of the audit reviewed the adequacy of the interface with offsite authorities. 10 CFR 50.54(t) also requires that the portions of the annual audit dealing with the adequacy of offsite interfaces be made available to State and local government personnel. Documentation was available to indicate that personnel in the State of Wisconsin, Kewaunee and Manitowoc counties had been advised of the performance of the audit and the availability of a copy of the audit and recommendations for corrective action via letters dated May 1989.

Based upon the above findings, this portion of the licensee's program was acceptable.

5. TMI Safety Issues Management System (SIMS) Items

On October 31, 1980, the NRC issued NUREG-0737, which incorporated into one document all TMI-related items approved for implementation by the Commission at that time. On December 17, 1982, the NRC issued Supplement 1 to NUREG-0737 to provide additional clarification regarding Regulatory Guide 1.97 (Revision 2) - Application to Emergency Response Facilities, and Meteorological Data, as well as other areas. The status of the completion of these TMI SIMS items are internally tracked by the NRC.

The October 6, 1988 Inspection Report (No. 266/88021,301/88019) provided a status listing of the SIMS items related to emergency preparedness. The following listing provides an updated status of those SIMS items that remain open. All other emergency preparedness related SIMS items are closed (complete) or no longer applicable.

MPA-F-63 Current Status: Open

This item involves a review of the TSC during a future inspection.

MPA-F-65 Current Status: Open

This item involves a review of the EOF during a future inspection.

6. Exit Interview (IP 30703)

The inspector met with the licensee representatives denoted in Section 1 on July 14, 1989. The inspector summarized the scope and results of the inspection and discussed the likely content of the inspection report.

Routine maintenance of the emergency preparedness program appears well implemented, with the exception of those training related items carried from previous inspections as open items. The licensee indicated that none of the information disclosed during the inspection was considered proprietary in nature.

The inspector discussed the status of Unresolved Item No. 266/89008-06 in a subsequent telephone conversation with the Emergenc / Planning Coordinator on August 3, 1989.