

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Reports No. 50-266/89020(DRP); 50-301/89019(DRP)

Docket Nos. 50-266; 50-301

Licensed 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 Creeks, Wisconsin

Inspection Conducted: June 1 through July 15, 1989

Inspectors: C. L. Vanderniet

R. J. Leemon

J. Gadzala

Approved By: Robert W. DeFayette, Chief
Reactor Projects Section 3A

7/25/89
Date

Inspection Summary

Inspection from June 1 through July 15, 1989 (Reports No. 50-266/89020(DRP),
No. 50-301/89019(DRP))

Areas Inspected: A routine, unannounced inspection by resident inspectors of previous inspection findings; operational safety verification; radiological controls; maintenance and surveillance; emergency preparedness; security; engineering and technical support; safety assessment/quality verification; and temporary instruction followup.

Results: During this inspection period, both units operated at full power with only requested load following power reductions. Issues addressed in this inspection report include: steam generator blowdown sample isolation valve failure to close (Paragraph 3.d); steam generator blowdown tank monitor calibration (Paragraph 5); and corporate management position changes (Paragraph 9). New issues which remain unresolved include: diesel generator turbocharger holddown bolts (Paragraph 3.c); station battery D05 (Paragraph 3.c); Unit 2 safety injection accumulator (Paragraph 3.e); and RHR piping support (Paragraph 8).

DETAILS

1. Persons Contacted

- *J. J. Zach, Plant Manager
- T. J. Koehler, General Superintendent, Maintenance
- *G. J. Maxfield, General Superintendent, Operations
- J. C. Reisenbuechler, Superintendent, Operations
- W. J. Herrman, Superintendent, Maintenance
- N. L. Hoefert, Superintendent, Instrument and Controls
- R. J. Bruno, Superintendent, Training
- T. L. Fredrichs, Superintendent, Chemistry
- D. F. Johnson, Superintendent, Health Physics
- R. C. Zyduck, Superintendent, Technical Services
- *J. E. Knorr, Regulatory Engineer
- *F. A. Flentje, Administrative Specialist

The inspectors also contacted other licensee employees including members of the technical and engineering staffs, and reactor and auxiliary operators.

*Denotes the licensee representatives attending the management exit interviews.

2. Licensee Action on Previous Inspection Findings (92701)

- a. (Closed) Open Item (266/89002-01): Tubing Support Clamps Missing - Unlabeled Instrument Penetration - Charging Pump 1P2A (Three Items).

During a walkdown of the auxiliary building, the inspector identified the following three problems: tubing supports missing from lines to the Hot Leg Sample Valve and 2MS-2083; cuts in an unlabeled instrument penetration; and one nut of approximately half the normal height on 1P2A charging pump.

The licensee has written a Maintenance Work Request (MWR) for the replacement of the missing tubing supports; replaced the half height nut on charging pump 1P2A; and explained that the cuts had been made on the instrument penetration to compensate for expansion. In light of the aforementioned actions, this open item is closed.

- b. (Closed) Open Item (266/89002-02 and 301/89002-02): Procedure Inadequate for Use of Vibration Instruments and Instructions on the Proper Scale to be Used.

During the performance of IT-05 (Revision 15), Inservice Testing of Containment Spray Pumps and Eductor Supply Check Valves 847A and B, problems were encountered in obtaining the required vibration readings. The inspector questioned whether the procedure was

inadequate in its instructions or if the operator taking the readings had been inadequately trained in the use of the vibration instrument.

The licensee stated that the problem was due to the inexperience of the operator in taking the vibration readings. To correct the problem, the licensee retrained the operator. Proper readings were then obtained and the test was satisfactorily completed. Based on the training given and the satisfactory completion of the test, this item is closed.

- c. (Closed) Unresolved Item (266/89006-03 and 301/89006-03): Corrective Actions - Possible Addition of Precautions or Cautions to Equipment Train Related Testing.

During the performance of IT-05 (Revision 16), Inservice Testing of Containment Spray Pumps and Eductor Supply Check Valves and Sodium Hydroxide Addition Valves, it was discovered that both trains of containment spray were placed in an inoperative condition. No Technical Specifications were violated due to the short time this condition existed, however, questions concerning the prevention of future similar events were asked of the licensee.

The licensee informed all operations personnel to be more aware of the condition of opposite train equipment during train related testing. The licensee is also considering the addition of precautions or cautions requesting the validation of the operability of opposite train equipment. In light of the above action and, because no technical specifications were violated, this item is closed.

3. Operational Safety Verification and Engineered Safety Features System Walkdown (71707, 71710, (64704)

- a. Control Room Observation

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the inspection period. During these discussions and observations, the inspectors ascertained that the operators were alert, cognizant of current plant conditions, attentive to changes in those conditions and took prompt action when appropriate. The inspectors noted that a high degree of professionalism attended all facets of control room operation and that the Unit 2 control boards were generally in a "black board" condition (no non-testing annunciators in alarm condition). Several shift turnovers were also observed and in all cases the turnovers appeared to be handled in a thorough manner.

The inspectors performed walkdowns of the control boards to verify the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components.

b. Facility Tours

Tours of the Auxiliary, Turbine, Service Water Buildings, and Unit 1 Containment were conducted to observe plant equipment conditions, including plant housekeeping/cleanliness conditions, status of fire protection equipment, fluid leaks and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance.

During the facility tours, inspectors noticed very few signs of leakage and that all equipment appears to be in good operating condition. Overall the plant cleanliness has remained good.

c. Safety System Walkdowns

During this inspection period, the inspectors walked down accessible portions of the Auxiliary Feedwater, Vital and DC Electrical, Diesel Generating, Component Cooling, Safety Injection, and Containment Spray systems to verify operability.

During a walkdown of the Emergency Diesel Generator (EDG) G01 on July 7, 1989, the inspectors noticed that one of the recently replaced bolts on the EDG turbocharger had become loose. This was brought to the immediate attention of the maintenance department. The licensee retightened the bolt and commenced a monitoring period to evaluate bolt loosening on the EDG turbochargers. The inspector expressed his concern over this matter especially since problems with these same bolts were identified earlier this year and remain unresolved (266/89006-02; 301/89006-02). The licensee indicated that a change to the annual diesel inspection procedure is forthcoming to specifically address inspection of these bolts. This additional issue will be added to the original Unresolved Item pending issuance of the procedure change.

During a walkdown of the A station battery (D05), the inspector noted that the spare cell (No. 60) was connected to its own battery charger, resulting in an arrangement that is inconsistent with Figure 8.2-10 (Revision 3) of the FSAR. Since this cell shares a common housing with cell 59 of the main battery, the inspector questioned whether a safety evaluation of connecting cell 60 to its own charger had been performed. The inspectors also noticed that three cells from an old battery were sitting on the floor of the battery room in an unsecured condition. The licensee was informed of this condition and is evaluating it. This issue remains unresolved pending licensee evaluation and subsequent NRC review (266/89020-01; 301/89019-01).

d. Unit 1 Operational Status

The unit continued to operate at full power during this period with only requested load following power reductions. A short power reduction to about 50% power was initiated by the licensee to repair

a nipple of a suction relief valve on one of the main feed water pumps. This was a proactive action due to the relatively minor leakage coming from the nipple.

On June 1, 1989, during testing of the closure of IMS-2083 (steam generator blowdown sample isolation valve), the valve failed to close on a simulated high radiation signal. The licensee identified that the failure was due to a faulty solenoid valve. The licensee closed the valve by failing control air to the valve and later replaced the faulty solenoid valve. Licensee Event Report (LER) 266/89003 has been issued concerning this matter.

e. Unit 2 Operational Status

The unit continued to operate at full power during this period with only requested load following power reductions.

Point Beach Unit 2 has two safety injection accumulators, each with two water level indicators. One of the level indicators on the B accumulator was previously known to be inoperative and had been labeled as such. On June 12, 1989, the other B accumulator level indicator was indicating near the low end of the operating band and was generating intermittent low level alarms. Believing the tank was low, the operators began adding water. When this was done, the B accumulator pressure increased but the water level indication on the operable level instrument remained constant indicating the instrument was not working properly. The operators ceased adding water to analyze the situation.

Subsequently, after performing a safety evaluation, the licensee cross connected the nitrogen and water sides of the A and B accumulators which would equalize the two levels and allow using the A accumulator level instruments for both accumulators. When this was done, the water level in the A accumulator began to increase as noted on 1 of the 2 A accumulator level instruments; the other A instrument did not respond, indicating it was inoperative thereby giving a situation where three of the four accumulator level instruments were inoperative. Furthermore, the water level in the A accumulator (as measured by the only operable level instrument) began to approach the upper Technical Specification limit, forcing operators to drain the excess water. This indicates that the initial addition of water to the B accumulator increased its level above the Technical Specification limit, and this excess water was flowing to the A accumulator as the two water levels equalized.

Shortly afterwards, LE-935 on the B accumulator was restored to service and the accumulator lineup was returned to normal with one level indication per accumulator. The inspector observed the licensee's response to this event in the control room, reviewed the safety evaluation for operating with the accumulators cross connected, reviewed the maintenance actions taken to restore the detector to service and discussed the event with the licensee. The

inspector was satisfied with the actions taken to assure safe operation and maintain the plant within the requirements of the Technical Specifications.

The multiple failure of level detectors remains a concern along with the length of time that operation continued without level indication or possibly excessively high level in the B accumulator. The NRC will also evaluate all data and information to assure that all Technical Specifications were met. The licensee is investigating this event and this item will remain unresolved pending the results of that investigation and subsequent NRC evaluation (266/89020-02; 301/89019-02).

These reviews and observations were conducted to verify that facility operations were in conformance with the requirements established under technical specifications, 10 CFR, and administrative procedures.

4. Radiological Controls (71709)

The inspectors routinely observed the licensee's radiological controls and practices during normal plant tours and the inspection of work activities. Inspection in this area includes direct observation of the use of Radiation Work Permits (RWPs); normal work practices inside contaminated barriers; maintenance of radiological barriers and signs; and health physics (HP) activities regarding monitoring, sampling, and surveying. The inspector also observed portions of the radioactive waste system controls associated with radwaste processing.

From a radiological standpoint the plant is in good condition which allows access to most portions of the facility. During tours of the facility, the inspectors noted that barriers and signs also were in good condition. When minor discrepancies were identified, the HP staff quickly responded to correct any problems.

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

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

a. Maintenance

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

The following items were considered during this review: the limiting conditions for operation were met while components or systems were removed from service; approvals were obtained prior to initiating the work; activities were accomplished using approved procedures and were inspected as applicable; functional testing and/or calibrations were performed prior to returning components or systems to service;

quality control records were maintained; activities were accomplished by qualified personnel; parts and materials used were properly certified; radiological controls were implemented; and fire prevention controls were implemented.

Work requests were reviewed to determine status of outstanding jobs and to assure that priority is assigned to safety-related equipment maintenance which may affect system performance.

Portions of the following maintenance activities were observed/reviewed:

- Replacement of the "A" Station Battery (D05)

This replacement was observed by the resident inspectors and no problems with the installation of the new battery cells were identified.

- Repair of the 1B Main Feedwater Pump leaking suction relief nipple.

This was a proactive repair that was completed by the licensee and no problems were identified.

- Repair of level element LE-935 in the B Safety Injection Accumulator.

- Oil change and coupling greasing of the 1A Closed Cooling Water pump.

The technician performing this work appeared knowledgeable and professional. The inspector questioned him about the types of lubricants being added to the equipment and determined that the required lubricants were being used.

b. Surveillance

The inspector observed surveillance testing and verified that testing was performed in accordance with adequate procedures; that test instrumentation was calibrated; that limiting conditions for operation were met; that removal and restoration of the affected components were accomplished; that test results conformed with technical specifications and procedure requirements and were reviewed by personnel other than the individual directing the test; and that any deficiencies identified during the testing were properly reviewed and resolved by appropriate management personnel.

The inspector witnessed and reviewed the following test activities:

- PT-R.5 (Revision 4) No. 1 Station Battery (D05) Service Test

- TS 2 (Revision 25) Emergency Diesel Generator G02
- HPCAL 3.13 (Rev 5) Steam Generator Blowdown Tank Monitor Calibration Check

The monitor's detector response fell slightly outside the acceptance criteria provided in the test procedure. The HP supervisor was called to evaluate the data and determined it was acceptable. A Temporary Change Notification was then processed to change the acceptance criteria. The HP Supervisor explained to the inspector that this procedure was recently revised, the detector configuration changed and that the detector response in this configuration is still being evaluated to determine new acceptance criteria.

No discrepancies were noted during the observance of any of the above tests.

6. Emergency Preparedness (82301)

An inspection of emergency preparedness activities was performed to assess the licensee's implementation of the site emergency plan and implementing procedures. The inspection included monthly review and tour of emergency facilities and equipment, discussions with licensee staff, and a review of selected procedures.

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

7. Security (71881)

The inspectors, by direct observation and interview, verified that portions of the physical security plan were being implemented in accordance with the station security plan. The inspectors also continued to monitor compensatory measures that have been enacted by the licensee.

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

8. Engineering and Technical Support (37701)

The inspector evaluated licensee 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.

The licensee identified a possible design error in a piping support on the primary side return line from the LHX-11A Residual Heat Removal (RHR) cooler. Apparently, the maximum temperature used for the design basis was 128 deg F., the steady state design limit, whereas in practice the actual coolant temperatures in the piping can reach 350 deg F. during

system startup. This raised the possibility that the piping is being exposed to thermal expansion beyond the capability of the pipe support. The licensee is evaluating this condition and this item will remain unresolved pending the results of that evaluation and subsequent NRC review (266/89020-03; 301/89-019-03).

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

9. Safety Assessment/Quality Verification (35701, (35502)

An inspection of the licensee's quality assurance programs was performed to assess the implementation and effectiveness of programs associated with management control, verification, and oversight activities. The inspection considered issues which may be indicative of overall management involvement in quality matters such as self improvement programs, response to regulatory and industry initiatives, the frequency of management plant tours and control room observations, and management personnel's attendance at technical and planning/scheduling meetings.

During this inspection period, the licensee implemented a minor management restructuring in the corporate office. This restructuring was primarily confined to title changes which included the former President and Chief Operating Officer being elevated to the title of Chairman and Chief Executive Officer, Wisconsin Electric Company. The Nuclear Department, which had previously reported to the President, now reports to the Chairman. Hence, the number of reporting levels for the Nuclear Department did not change. Regional management has been informed of the changes and has discussed them with the licensee.

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

10. Unresolved Items

Unresolved items are matters about which more information is required in order to ascertain whether they are acceptable items, items of noncompliance, or deviations. Unresolved items disclosed during the inspection are discussed in Paragraphs 3.c, 3.e, and 8.

11. Exit Interview

The inspectors met with the licensee representatives denoted in Section 1 on July 17, 1989, after conclusion of the inspection and discussed the purpose of the inspection and the findings.

The inspectors also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspectors during the inspection. The licensee did not identify any documents/processes as proprietary.