December 6, 2000

Mr. M. Reddemann Site Vice President Kewaunee and Point Beach Nuclear Plants Wisconsin Electric Power Company 6610 Nuclear Road Two Rivers, WI 54241

# SUBJECT: POINT BEACH NUCLEAR PLANT INSPECTION REPORT 50-266/00-14(DRP); 50-301/00-14(DRP)

Dear Mr. Reddemann:

On November 9, 2000, the NRC completed a baseline inspection at your Point Beach Nuclear Plant. The results of this inspection were discussed with you and members of your staff on November 9. The enclosed report presents the results of that inspection.

Based on the results of this inspection, two issues of very low safety significance (Green) were identified. These issues were determined to involve violations of NRC requirements. However, because of their very low safety significance and because they have been entered into your corrective action program, the NRC is treating these issues as Non-Cited Violations, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny these Non-Cited Violations, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Point Beach facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response, if you chose to provide one, will be available <u>electronically</u> for public inspection in the NRC Public Document Room <u>or</u> from the *Publicly Available Records System (PARS)* component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <u>http://www.nrc.gov/NRC/ADAMS/index.html</u> (the Public Electronic Reading Room).

M. Reddemann

We will gladly discuss any questions you may have concerning this inspection.

Sincerely,

# /RA/

Roger D. Lanksbury, Chief Reactor Projects Branch 5

Docket Nos. 50-266; 50-301 License Nos. DPR-24; DPR-27

- Enclosures: Inspection Report 50-266/00-14(DRP); 50-301/00-14(DRP)
- cc w/encl: R. Grigg, President and Chief Operating Officer, WEPCo M. Wadley, Chief Nuclear Officer, NMC J. Gadzala, Licensing Manager D. Weaver, Nuclear Asset Manager F. Cayia, Plant Manager J. O'Neill, Jr., Shaw, Pittman,

Potts & Trowbridge K. Duveneck, Town Chairman Town of Two Creeks B. Burks, P.E., Director Bureau of Field Operations A. Bie, Chairperson, Wisconsin Public Service Commission S. Jenkins, Electric Division Wisconsin Public Service Commission State Liaison Officer

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# M. Reddemann

R. Grigg, President and Chief cc w/encl: Operating Officer, WEPCo M. Wadley, Chief Nuclear Officer, NMC J. Gadzala, Licensing Manager D. Weaver, Nuclear Asset Manager F. Cayia, Plant Manager J. O'Neill, Jr., Shaw, Pittman, Potts & Trowbridge K. Duveneck, Town Chairman Town of Two Creeks B. Burks, P.E., Director **Bureau of Field Operations** A. Bie, Chairperson, Wisconsin Public Service Commission S. Jenkins, Electric Division Wisconsin Public Service Commission State Liaison Officer ADAMS Distribution: CMC1

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# U.S. NUCLEAR REGULATORY COMMISSION

# **REGION III**

Docket Nos: License Nos:	50-266; 50-301 DPR-24; DPR-27
Report No:	50-266/00-14(DRP); 50-301/00-14(DRP)
Licensee:	Nuclear Management Company, LLC
Facility:	Point Beach Nuclear Plant, Units 1 & 2
Location:	6610 Nuclear Road Two Rivers, WI 54241
Dates:	October 1 through November 9, 2000
Inspectors:	J. Lara, Senior Resident Inspector, Kewaunee R. Powell, Resident Inspector D. Chyu, Regional Inspector M. Kunowski, Regional Inspector
Approved by:	Roger D. Lanksbury, Chief Reactor Projects Branch 5 Division of Reactor Projects

# NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

#### Reactor Safety

#### Radiation Safety

#### **Safequards**

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Public
- Occupational
  Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW, or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

# SUMMARY OF FINDINGS

IR 50-266/00-14, IR 50-301/00-14, on 10/1-11/9/2000, Nuclear Management Company, LLC, Point Beach Nuclear Plant, Units 1 & 2. Surveillance testing.

The inspection was conducted by resident inspectors and two regional inspectors. The inspection identified one Green finding which was a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation.

# A. <u>Inspector-Identified Findings</u>

### Cornerstone: Mitigating Systems

Green. On October 11, 2000, the inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for an inadequate procedure that did not require verification of appropriate automatic overpressure protection on hydrostatic pressure test equipment during valve seat leakage testing on Train "B" of the Unit 2 residual heat removal system.

This finding was of very low safety significance because procedurally required manual overpressure protection was available during testing and Train "A" of the Unit 2 residual heat removal system was operable. (Section 1R22.1).

#### B. Licensee-Identified Violations

One violation of very low safety significance was identified by the licensee and was reviewed by the inspectors. Corrective actions taken or planned by the licensee appear reasonable. This violation is listed in Section 4OA7 of this report.

# **Report Details**

<u>Summary of Plant Status</u>: Unit 1 operated at or near 100 percent power throughout the inspection period except from October 6-14, 2000, when power was reduced to 90 percent because of repairs to an offsite power line, from October 22-23 because of routine condenser cleaning, and from October 27-30 after the reactor was shutdown due to operator concern for a diver in the Unit 2 circulating water forebay. Unit 2 operated at or near 100 percent power until October 13 when the Cycle 24 refueling outage began.

# 1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

### 1R04 Equipment Alignment

- .1 Emergency Diesel Generator (EDG) G-04 Partial System Walkdown
- a. Inspection Scope

The inspectors performed a partial system walkdown of G-04 to verify system operability. The G-04 system was selected due to its safety significance and because recent major maintenance outage activities had been conducted on G-04. The inspectors used Checklist (CL) 11A G-04, "G-04 Diesel Generator Checklist," Revision 5, and system drawings to accomplish the inspection.

The inspectors verified the correct position of control switches, breakers, and valves associated with G-04 and G-04 support systems, such as the starting air and glycol cooling systems, using system diagrams and CLs. The inspectors also observed instrumentation valve configurations and appropriate meter indications. Appropriate control room switch positions were also verified by the inspectors. Finally, the inspectors evaluated other elements such as material condition, housekeeping, and component labeling.

b. Findings

No findings of significance were identified.

- .2 Service Water (SW) System Walkdown
- a. Inspection Scope

The inspectors performed a partial walkdown of the SW system to verify that valves were in the proper position to perform their safety-related function. The inspectors also verified that system parameters were within appropriate limits by direct observation of installed plant instrumentation and evaluated other conditions such as component material condition, adequacy of housekeeping, and proper component labeling. This system was selected based upon its high risk significance and substantial system modification activities. The inspectors used system drawings and CL 10B, "Service Water Safeguards Lineup," Revision 44, to accomplish the inspection.

b. <u>Findings</u>

No findings of significance were identified.

- 1R05 Fire Protection
- a. Inspection Scope

The inspectors walked down the following areas to assess the overall readiness of fire protection equipment and barriers:

- Auxiliary Feed Pump Room, Fire Zone 304
- Unit 1 Facade, Fire Zone 524
- Unit 2 Facade, Fire Zone 596

Emphasis was placed on the control of transient combustibles and ignition sources, the material condition of fire protection equipment, and the material condition and operational status of fire barriers used to prevent fire damage or propagation. Area conditions/configurations were evaluated based on information provided in the licensee's "Fire Protection Evaluation Report," August 1999.

The inspectors verified that fire hoses and portable fire extinguishers were installed at their designated locations, were in satisfactory physical condition, and were unobstructed. The inspectors verified the physical location and condition of fire detection devices. Additionally, passive features such as fire doors, fire dampers, and mechanical and electrical penetration seals were verified to be located per Fire Protection Evaluation Report requirements and to be in good physical condition.

Additionally, the inspectors reviewed the following documents:

- Design Basis Document (DBD) T-40, Fire Protection/Appendix R, Section 9.0, "Special Extinguishing Systems," Revision 0
- Fire Emergency Plan 4.12, "Auxiliary Feedwater Pump and Vital Switchgear Area," Revision 4
- Technical Specification Test (TS) 78, "Semiannual Halon 1301 Fire Suppression System Surveillance Test," Revision 12
- Periodic Check (PC) 21, Part 4, "Miscellaneous Data," Revision 7

# b. <u>Findings</u>

No findings of significance were identified.

#### 1R12 Maintenance Rule Implementation

#### a. <u>Inspection Scope</u>

The inspectors reviewed the licensee's implementation of the maintenance rule requirements to ensure that component and equipment failures were identified, entered, and scoped within the maintenance rule and that select structures, systems, or components (SSCs) were properly categorized and classified as (a)(1) or (a)(2) in accordance with 10 CFR 50.65. Additionally, the inspectors verified licensee changes to performance criteria were reflected in the licensee's probabilistic risk assessment. Specific systems reviewed were:

- Safety Injection system
- Residual Heat Removal (RHR) system
- Component Cooling Water system

Additionally, the inspectors reviewed the following documents:

- Calculation 98-0169, "PRA Assessment of MR APC and RPC," Revision 1 [Probabilistic risk assessment of maintenance rule availability performance criteria and reliability performance criteria]
- "1999 Annual Report for the Maintenance Rule," dated March 30, 2000.
- Nuclear Power Business Unit Procedure Manual (NP) 7.7.4, "Scope and Risk Significant Determination for the Maintenance Rule," Revision 6
- Nuclear Procedure NP 7.7.5, "Determining, Monitoring and Evaluating Performance Criteria for the Maintenance Rule," Revision 6
- b. Findings

No findings of significance were identified.

# 1R13 Maintenance Risk Assessment and Emergent Work Evaluation

a. Inspection Scope

The inspectors reviewed the licensee's evaluation of plant risk, scheduling, configuration control, and performance of maintenance associated with planned and emergent work activities and verified that scheduled and emergent work activities were adequately managed. In particular, the inspectors reviewed the licensee's program for

conducting maintenance risk safety assessments and verified that the licensee's planning, risk management tools, and the assessment and management of shutdown risk were adequate. The inspectors also verified that licensee actions to address increased shutdown risk during periods when equipment was out-of-service for maintenance, such as establishing compensatory actions, minimizing the duration of the activity, obtaining appropriate management approval, and informing appropriate plant staff, were accomplished when shutdown risk was increased due to maintenance on risk-significant SSCs. The following specific activities were reviewed:

- the maintenance risk assessment for work planned for the week of October 23, 2000, including work associated with the Unit 2 core offload.
- the maintenance risk assessment for work planned for the week of November 5, 2000, including work associated with the Unit 2 safeguards busses and core reload.

Additionally, the inspectors reviewed the following documents:

- NP 10.3.6, "Outage Safety Review and Safety Assessment," Revision 5
- NP 10.2.1, "Outage Planning, Scheduling, and Maintenance," Revision 10
- b. <u>Findings</u>

No findings of significance were identified.

- 1R14 Personnel Performance During Non-Routine Plant Evolutions
- a. Inspection Scope

On November 4, 2000, the inspectors reviewed the licensee's performance following a manual reactor trip of Unit 1 after reactor operators became concerned about the safety of a diver who had been working in the Unit 2 forebay. As a result of these concerns, control room operators secured the circulating water pumps and closed the main steam isolation valves. These actions necessitated the need to use the atmospheric dump valves to remove decay heat. The inspectors also evaluated the performance and interactions among the reactor operators, control room supervisor, and shift supervisor. Additionally, the inspectors evaluated adherence to the licensee's communications and alarm response operations standards, and use and adherence to abnormal, alarm response and emergency operating procedures (EOPs). The inspectors reviewed the following documents:

- EOP 0, "Reactor Trip or Safety Injection," Revision 34
- EOP 0.1, "Reactor Trip Response," Revision 23
- NP 5.3.3, "Incident Investigation and Post-Trip Review," Revision 1, Attachment A, "Transient and Post-Trip Review" and Attachment B, "Incident Investigation Checklist"

The inspectors also verified that plant equipment operated as designed following the reactor trip.

b. Findings

No findings of significance were identified.

# 1R15 Operability Evaluations

### a. Inspection Scope

The inspectors verified that the subject operability evaluations addressed the applicable current licensing basis requirements and commitments, and provided an adequate basis for justifying operability. Independent reviews included a discussion with licensee personnel and reviews of design and licensing basis documentation. The inspectors reviewed the following operability evaluations:

- Condition Report (CR) 00-3121, "CVCS [chemical and volume control system] Valve 2RC-427 Failure"
- CR 00-2981, "RCS [reactor coolant system] depressurization following SGTR [steam generator tube rupture]"
- b. Findings

No findings of significance were identified.

- 1R17 Permanent Plant Modifications
- a. Inspection Scope

The inspectors reviewed a permanent plant modification that was being installed over an extended period of time. The modification affected the SW system. Documents reviewed included the following:

- Installation Work Plan (IWP) 98-024\*B-03, "Modification of the pipe for the 'Original' Service Water supply and return for the Spent Fuel Pool (SFP) Heat Exchangers (HX) 13A & 13B"
- DCN [drawing change notice] 2000-1945 associated with system Drawing M-207, Sheet 3
- Point Beach Final Safety Analysis Report (FSAR), Section 9.9, "Spent Fuel Cooling," dated June 2000
- Point Beach FSAR, Section 9.6, "Service Water System," dated June 2000
- CL 10B, "Service Water Safeguards Lineup," Revision 44

 Abnormal Operating Procedure 8F, "Loss of Spent Fuel Pool Cooling," Revision 7

The inspectors compared the modification work to the SW design and licensing requirements, specifically the FSAR system and functional descriptions. The inspectors verified that the modification package contained a safety evaluation and that the IWP conformed to the safety evaluation. The inspectors reviewed the system procedures to verify that the modification was appropriately reflected in the procedures.

b. Findings

No findings of significance were identified.

- 1R19 Post-Maintenance Testing
- .1 P38-A Minimum Flow Recirculation Line
- a. Inspection Scope

The inspectors reviewed and observed portions of post-maintenance testing activities following installation of pressure reducing orifice RO-04008 in the motor driven auxiliary feedwater pump P38A minimum flow recirculation line. The inspectors verified that the testing was adequate for the scope of maintenance work that had been performed and that the testing acceptance criteria were clear and demonstrated operational readiness consistent with design and licensing basis documents. Specifically, the inspectors reviewed the following documents:

- Point Beach FSAR, Section 10.2, "Auxiliary Feedwater System," dated June 2000
- Design Basis Document DBD-01, "Auxiliary Feedwater System," Revision 1
- Installation Work Plan 99-029\*A, "Aux Feed Water Pump P-38A Minimum Flow Recirc Line Orifice"
- b. <u>Findings</u>

No findings of significance were identified.

- .2 Containment Spray Valve 2SI-870A
- a. Inspection Scope

The inspectors reviewed and observed portions of post-maintenance testing activities following planned maintenance on containment spray valve 2SI-870A. The inspectors verified that the testing was adequate for the scope of maintenance work that had been performed and that the testing acceptance criteria was clear and demonstrated

operational readiness consistent with design and licensing basis documents. Specifically, the inspectors reviewed the following documents:

- Point Beach FSAR, Section 6.4, "Containment Spray System," dated June 2000
- Routine Maintenance Procedure 9376-2, "Limitorque MOV [motor-operated valve] Removal, Installation, and Adjustment for Gate and Globe Valves," Revision 5
- Work Order 9924886, "SI-870A MOV Post Rebuild Checkout"
- b. Findings

No findings of significance were identified.

- 1R20 Refueling and Outage Activities
- a. Inspection Scope

The inspectors observed work activities associated with the Unit 2 refueling outage which began on October 13, 2000. The inspectors assessed the adequacy of operations activities during the plant cooldown, and other outage-related activities such as configuration management, clearances and tagouts, and RCS reduced inventory operations. Additionally, the inspectors also reviewed refueling operations for implementation of risk management, conformance to approved site procedures, and compliance with TSs. The following major activities were observed:

- outage planning meetings
- unit shutdown
- transition to shutdown cooling using RHR
- draining the RCS for reduced inventory operations
- filling and venting Train "A" of RHR
- fuel handling activities
- other general outage activities, including foreign material exclusion controls and safety shutdown assessments

The following documents were reviewed:

- Operating Procedure (OP) 3A, "Normal Power Operation to Low Power Operation," Revision 52
- OP 3B, "Reactor Shutdown," Revision 31

- OP 3C, "Hot Shutdown to Cold Shutdown," Revision 81
- OP 4D, Part 3 "Draining the Reactor Cavity and Reactor Coolant System," Revision 10
- Operating Instruction (OI) 136A, "Fill and Vent Train A RHR System Unit 2," Revision 0
- b. Findings

No findings of significance were identified.

- 1R22 <u>Surveillance Testing</u>
- .1 Leakage Reduction and Preventive Maintenance Program Seat Leakage Test
- a. Inspection Scope

The inspectors reviewed and observed leakage reduction and preventive maintenance program seat leakage testing of Train "B" of the Unit 2 RHR system. Additionally, the inspectors reviewed the following documents:

- IT 535B, "Leakage Reduction and Preventive Maintenance Program Seat Leakage Test of the Train B RHR System, Unit 2," Revision 8
- "Containment Leakage Rate Testing Program Basis Document," Revision 3
- OI 65, "Post-Maintenance Pressure Testing," Revision 19

The inspectors reviewed the test procedures for appropriateness, observed significant parts of the performance of the test, and verified that work practices and procedure adherence were consistent with regulatory requirements and standards. The inspectors also verified that all testing prerequisites were satisfied and that test data were complete and appropriately verified. Following completion of the test, the inspectors verified that the test equipment was removed and that the equipment was returned to a condition in which it could perform its safety-related function.

The following Condition Reports were initiated during this inspection activity, and were reviewed as part of the inspection scope:

- CR 00-3036, "Excessive Leakage on Unit 2 RHR System"
- CR 00-3071, "Improper Regulator on Hydro Rig"

### b. <u>Findings</u>

The inspectors identified that a procedure for hydrostatic testing of the RHR system lacked verification of automatic overpressure protection. The inspectors observed performance of seat leakage testing of the Unit 2 Train "B" of RHR on October 11, 2000. Testing was suspended when maintenance personnel were unable to achieve the test pressure of 350-375 pounds per square inch - gauge (psig). Subsequent auxiliary operator investigation identified that an incorrect pressure regulator (rated for 30-300 psig), which served as the automatic overpressure protection for the system, was installed on the hydrostatic pressure test rig. The inspectors reviewed licensee procedures, discussed the event with operators and operations management, and determined the following:

- Procedures OI 65 did not require verification of appropriate automatic overpressure protection on hydrostatic pressure test equipment prior to use.
- An identical seat leakage test of Train "A" of RHR had been conducted on October 10. The Senior Reactor Operator serving as test coordinator and the auxiliary operator conducting the test both stated to the inspectors that the same test rig had been used the previous day and that test pressure was reached.

The inspectors discussed the sequence of events with the operations manager on October 13. The inspectors questioned how a pressure relief device could have achieved test pressure 50-75 psig greater than its maximum rating on October 10 and then function properly to limit test pressure to within its rated value on October 11.

Subsequently, on October 13, CR 00-3071 was submitted to document the use of the incorrect automatic overpressure relief device during the October 11 test. The CR stated that the pressure regulator may have been damaged, thus allowing test pressure of 350-375 psig to be reached during the October 10 test. The CR was reviewed by plant management in accordance with administrative procedures; however, corrective actions did not address the use of a failed pressure regulator during the October 11 test nor did management question how the regulator would have achieved a test pressure 50-75 psig greater than its maximum rating on October 10 and then function properly to limit test pressure to within its rated value on October 11.

On November 9, the inspector discussed these shortcomings with the licensee, who subsequently initiated a review of the potentially discrepant data and sequence of events. The licensee assigned additional corrective actions to CR 00-3071 to review the discrepancy.

The inspectors concluded that procedure OI 65 was inadequate in that it did not require verification of appropriate automatic overpressure protection on hydrostatic pressure test equipment prior to use. This finding had a credible impact on safety in its potential effect on the operability and availability of a train in a mitigating system; however, since manual overpressure protection was available and Train "A" of RHR was operable, the finding is considered to be of very low safety significance (Green). The inadequacy of

the operating procedure constituted a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." However, because of the very low safety significance of the item and because the licensee has included this item in their corrective action program (CR 2000-3071), this procedure violation is being treated as a Non-Cited Violation (NCV 50-301/00-14-01)

### .2 Main Turbine Mechanical Overspeed Trip Device

#### a. <u>Inspection Scope</u>

The inspectors reviewed and observed testing of the Unit 2 main turbine mechanical overspeed trip device. Additionally, the inspectors reviewed the following documents:

- Operations Refueling Test (ORT) 4, "Main Turbine Mechanical Overspeed Trip Device, Unit 2," Revision 13
- Point Beach FSAR, Appendix T, "Turbine Overspeed Protection," dated June 2000
- NP 1.2.6, "Infrequently Performed Tests or Evolutions (IPTEs)," Revision 7

The inspectors reviewed the test procedures for appropriateness, observed significant parts of the performance of the test, and verified that work practices and procedure adherence were consistent with regulatory requirements and standards. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing, that all testing prerequisites were satisfied, and that test data were complete and appropriately verified. Following completion of the test, the inspectors verified that the test equipment was removed and that the equipment was returned to a condition in which it could perform its safety-related function.

b. <u>Findings</u>

No findings of significance were identified.

- .3 Containment Spray Pump and Valve Testing
- a. Inspection Scope

The inspectors reviewed and observed testing of the Unit 1 containment spray pumps and valves to meet in-service testing requirements. The inspectors reviewed the following documents:

- Inservice Test Procedure (IT)-05, "Containment Spray Pumps and Valves (Quarterly) Unit," Revision 42.
- Point Beach FSAR, Chapter 6, "Engineered Safety Features"

The inspectors reviewed the test procedures for appropriateness, observed significant parts of the performance of the test including pump starts, vibration measurements, and valve stroke timing. The inspectors also verified that all testing prerequisites were satisfied and test data were acceptable. Following completion of the test, the inspectors verified that the test equipment was removed and that the equipment was returned to a condition in which it could perform its safety-related function.

b. Findings

No findings of significance were identified.

- .4 Safety Injection with Loss of Safeguards Power Test
- a. Inspection Scope

The inspectors reviewed and observed testing of plant equipment in response to a safety injection with a loss of safeguards power for Unit 2. The inspectors reviewed the following documents:

- Operations Refueling Test (ORT) 3A, "Safety Injection Actuation With a Loss of Engineered Safeguards AC (Train A) Unit 2," Revision 32
- Point Beach FSAR, Chapters 6, 7, and 8
- NP 1.2.6, "Infrequently Performed Tests or Evolutions (IPTEs)," Revision 7

The inspectors reviewed the test procedures for appropriateness, attended the IPTE briefing, observed significant parts of the performance of the test, and verified that procedure adherence were consistent with regulatory requirements and standards. The inspectors also verified that the impact of the testing had been properly characterized during the pre-job briefing; that all testing prerequisites were satisfied; and that test data were complete and appropriately verified. Following completion of the test, the inspectors verified that equipment was returned to a condition in which it could perform its safety-related function.

b. <u>Findings</u>

No findings of significance were identified.

- 1R23 Temporary Plant Modifications
- a. Inspection Scope

The inspectors reviewed the licensee's approved temporary modification (TM) 00-039, "Install Blank Flange on Purge Exhaust System Duct." The scope of this TM was to remove a section of duct associated with the containment purge and exhaust system to facilitate replacement of the "B" reactor coolant pump motor. The TM required the installation of a flange on the purge duct to maintain system operability. The inspectors reviewed the TM safety evaluation, performed a walkdown of the purge and exhaust system, reviewed the associated Technical Specification requirements for the system as well as the facility's FSAR. The inspectors verified that the system design function would be maintained with the TM installed when system operability was required.

b. Findings

No findings of significance were identified.

# 4. OTHER ACTIVITIES

#### 4OA3 Event Follow-up

- .1 (Closed) Licensee Event Report (LER) 50-266/2000-006, Revisions 0 and 1: Inadequate Procedural Guidance to Restore Equipment Necessary To Maintain Hot Safe Shutdown as Required by Appendix R Design Basis. The licensee identified that abnormal operating procedure, AOP 10B, "Safe Shutdown to Cold Shutdown in Local Control," did not have sufficient guidance to restore ventilation to the auxiliary building battery and inverter rooms to prevent the inverter room temperature from exceeding the equipment qualification temperature limits. The licensee subsequently performed a heat-up test of the room and reviewed the procedure which revealed that certain loads were tripped early in the post-fire conditions. Therefore, it would take greater than 22 hours for the room to heat-up to the equipment qualification limits. In addition, the licensee determined that the batteries supplying the required vital inverters would last greater than 72 hours, allowing the Units to achieve cold shutdown prior to the need to restore a battery charger. The inspectors considered that there would be sufficient time to reach the procedural step directing the operators to restore ventilation to the rooms before the temperature limit was reached. Therefore, there was no safety significance and there was no violation of regulatory requirements associated with this LER.
- .2 (Closed) LER 50-266/2000-009-00; 50-301/2000-009-00: Initial Conditions Do Not Match Shielding Configuration. This LER described a licensee-identified inadequacy in emergency operating procedures which did not require the prompt placement of portable shielding in front of control room windows to limit dose to operators during certain accident scenarios to less than NRC limits. This finding did have a credible impact on safety in its effect on the integrity of the control room envelope; however, since it affected only the barrier integrity cornerstone, the finding is considered to be of very low safety significance (Green). The inadequacy of the emergency operating procedures constituted a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." However, because of the very low safety significance of the item and because the licensee had included this item in their corrective action program (CR 2000-2937), this procedure violation is being treated as a Non-Cited Violation (NCV 50-266/00-14-02; 50-301/00-14-02).

#### 4OA6 Meetings, including Exit

On November 9, 2000, the inspectors presented the inspection results to Mr. M. Reddemann and other members of licensee management. 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.

### 4OA7 Licensee-Identified Violation

The following finding of very low safety significance was identified by the licensee and is a violation of NRC requirements which met the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as a Non-Cited Violation (NCV).

NCV Tracking Number	Requirement Licensee Failed to Meet
NCV 301/00-14-03	Criterion V, "Instructions, Procedures, and Drawings," of Appendix B of 10 CFR Part 50, requires that activities affecting quality be prescribed by documented instructions, procedures, or drawings. As described in the CR 2000-2937, an operating procedure did not provide for timely placement of portable shielding in front of control room windows to ensure accident doses to operator would remain below NRC limits.

# PARTIAL LIST OF PERSONS CONTACTED

### <u>Licensee</u>

- F. Cayia, Plant Manager
- J. Gadzala, Licensing Manager
- V. M. Kaminskas, Maintenance Manager
- R.G. Mende, Director of Engineering
- B. J. O'Grady, Operations Manager
- M. E. Reddemann, Site Vice President
- D. D. Schoon, System Engineering Manager
- S. J. Thomas, Radiation Protection Manager

# <u>NRC</u>

B. A. Wetzel, Point Beach Project Manager, NRR

# ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed During this Inspection		
50-301/00-14-01	NCV	Inadequate Procedure for Pressure Test of RHR (1R22.1)
50-266/00-14-02 50-301/00-14-02	NCV	Inadequate Procedure for Shielding Placement in Front of Control Room Windows (40A3.1)
<u>Closed</u>		
50-266/2000-009-00 50-301/2000-009-00	LER	Initial Conditions Do Not Match Shielding Configuration (4OA3.2)
50-266/2000-006-00,01 50-301/2000-006-00,01	LER	Inadequate Procedural Guidance To Restore Equipment Necessary To Maintain Hot Safe Shutdown As Required By Appendix R Design Basis (4OA3.1)

# **Discussed**

None

# LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

Inspection Procedure			Report		
Num	ber	Title	- Section		
7111	1.01	Adverse Weather	R01		
7111 <i>′</i>	1.04	Equipment Alignments			
7111 <i>°</i>	1.05	Fire Protection			
7111 <i>°</i>	1.06	Flood Protection Measures			
7111 <i>°</i>	1.07	Heat Sink Performance			
7111 <i>°</i>	1.11	Licensed Operator Requalification			
71111	1.12	Maintenance Rule Implementation	R12		
7111 <i>°</i>	1.13	Maintenance Risk Assessment and Emergent Work Evaluation	R13		
7111 <i>°</i>	1.14	Personnel Performance During Non-routine Plant Evolution	R14		
71111	1.15	Operability Evaluations	R15		
7111 <i>°</i>	1.16	Operator Work-Arounds	R16		
7111 <sup>-</sup>	1.17	Permanent Plant Modifications	R17		
7111 <i>°</i>	1.19	Post Maintenance Testing	R19		
7111 <i>°</i>	1.20	Refueling and Outage Activities	R20		
7111 <i>°</i>	1.22	Surveillance Testing	R22		
7111 <i>°</i>	1.23	Temporary Plant Modifications	R23		
71114	4.01	Exercise Evaluation	EP1		
71114	4.06	Drill Evaluation	EP6		
711	51	Performance Indicator Verification	OA1		
711	52	Identification and Resolution of Problems	OA2		
711	53	Event Follow-up	OA3		
		Cross-cutting Issues	OA4		
		Other	OA5		
		Meetings, Including Exit	OA6		

# LIST OF ACRONYMS USED

CFR CL	Code of Federal Regulations Checklist
	Division of Reactor Projects
FDG	Emergency Diesel Generator
FSAR	Final Safety Analysis Report
IT	Inservice Test
LER	Licensee Event Report
NCV	Non-Cited Violation
NP	Nuclear Power Business Unit Procedures Manual
NRC	Nuclear Regulatory Commission
OI	Operating Instruction
OP	Operating Procedure
PC	Periodic Check
psig	pounds per square inch - gauge
RCS	Reactor Coolant System
RHR	Residual Heat Removal
SW	Service Water
ТМ	Temporary Modification
TS	Technical Specification Test