UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

March 26, 1999

Mr. M. Reddemar
Site Vice President
Point Beach Nuclear Plant
6610 Nuclear Road
Two Rivers, WI 54241

SUBJECT: PLANT PERFORMANCE REVIEW - POINT BEACH

Dear Mr. Reddemann:

On February 3, 1999, the NRC staff completed a Plant Performance Review (PPR) of the Point Beach Nuclear Plant. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC's senior management meeting (SMM) reviews. PPRs examine information since the last assessment of licensee performance to evaluate long-term trends, but emphasize the last 6 months to ensure that the assessment reflects current performance. The PPR for Point Beach involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period November 29, 1997, through January 31, 1999. The NRC's most recent summary of licensee performance was provided in a letter of January 14, 1998, and was discussed in a public meeting with you on January 28, 1998.

As discussed in the NRC's Administrative Letter 98-07 of October 2, 1998, the PPR provides an assessment of licensee performance during an interim period that the NRC has suspended its Systematic Assessment of Licensee Performance (SALP) program. The NRC suspended its SALP program to complete a review of its processes for assessing performance at nuclear power plants. At the end of the review period, the NRC will decide whether to resume the SALP program or terminate it in favor of another process.

During this PPR assessment period, a partial loss of offsite power occurred when a Unit 1 transformer failed. Operators handled the event well and the Unit remained online. A refueling outage began in February 1998 and was completed in late June 1998. In September, Unit 1 reactor power was reduced to repair a vibration-induced fatigue crack on a pressure sensing line from the suction of the "A" steam generator feedwater pump and later to replace the rotating assembly of the "A" steam generator feedwater pump to reduce flow-induced system vibration. In November, Unit 1 power reductions occurred in response to a failed bearing on the "A" steam generator feedwater pump and to facilitate the repair of a high pressure turbine exhaust sensing line steam leak. On January 5, 1999, a shutdown commenced after discovery that the safety injection system pumps' common minimum recirculation flow line was frozen, and terminated when the NRC granted a Notice of Enforcement Discretion. Unit 1 was shut down on January 22 for several days to repair 4160-volt breakers. Unit 2 was conservatively shut down for several weeks in March 1998 while the operability of the component cooling water system was evaluated. Reactor power was reduced to 50 percent on September 28 to

repair an oil leak on the "B" steam generator feedwater pump speed controller sensing line. Subsequently, on October 23, Unit 2 was taken offline for several days because of explosive gas buildup in a 19/4.16-kilovolt auxiliary transformer. On October 30, Unit 2 began an end-of-core-life coastdown and on December 5 was taken offline to begin a refueling outage.

Overall, performance at Point Beach was acceptable, with some improvement noted in the area of self-assessment. For example, the use of industry peers for an assessment of operations was highly beneficial. However, secondary-side equipment material condition problems, including several involving the main feedwater system, and problems with the freeze protection system challenged routine reactor operations. Operator response to secondary-side equipment problems, including the sudden failure of a main feedwater pump bearing, was good. In contrast, problems with the freeze protection system, identified in December, were not properly assessed by operators resulting in the freezing of the safety injection minimum recirculation flow line. The material condition of safety systems appeared adequate, with some problems noted with zebra mussel blockage of containment fan cooler cooling water and the foaming of emergency diesel generator coolant. In addition, the material condition of some plant breakers was found minimally acceptable because of a poor breaker maintenance program. Senior management involvement has established a continuing goal to improve the plant's material condition and to ensure equipment was properly performance tested.

In the area of operations, performance was consistent. The safety focus and operating philosophy, demonstrated by operator response to operational events, was conservative. Routine reactor and refueling operations were conducted well; however, secondary-side and freeze protection system material condition problems have required additional attention from operators. Also, material condition issues continued to cause plant events and resulted in unplanned power changes. An improvement was noted with the quality of self-assessment and self-critical activities. The use of industry peers for an assessment of operations was highly effective. Personal errors were relatively infrequent and insignificant, but minor problems with procedure adherence continued from the previous assessment. Problems also continued with the management of the large quantity of corrective actions and improvement initiatives that have been initiated over the past several years. No inspection activities beyond the core inspection program are warranted; however, the inspection program will continue to provide additional emphasis on the corrective action program and material condition issues.

In the area of maintenance, performance was consistent. A 12-week work planning and scheduling program was initiated, an improvement over past practices. The conduct of maintenance and surveillance test activities was good, with notable exceptions including the ASME Section XI pressure test program, the program for maintaining medium- and low-voltage circuit breakers, and maintenance involving the "A" steam generator feedwater pump bearings. In the pressure test program, maintenance engineers failed to adequately follow up on several previously identified problems with the program. In the breaker maintenance program, several problems were identified, including poor control of breaker lubricants and the lack of design controls to verify that close and trip coil voltages were adequate. Except for several problems with balance-of-plant equipment and the freeze protection system, plant material condition was acceptable. The inspection program will continue to closely monitor material condition issues.

Beyond the core inspection program, inspection activities will include a review of your inservice testing program for pumps and valves as a follow-up to previously identified concerns in this area.

In the area of engineering, performance was consistent. An NRC inspection of the Generic Letter 96-01 program identified that safety-related logic circuits were being identified and properly tested. Engineering efforts to review plant design and increased emphasis on the use of the condition reporting system, combined with conservative decision-making, resulted in the resolution of several significant design issues. For example, the removal of the part-length control rod drive housings that were susceptible to cracking was considered a conservative action. System engineers, in general, continue to improve in their support to maintenance and operations. However, the material condition of some plant equipment appears to be declining and equipment testing deficiencies continue to occur. For example, comprehensive corrective action for inadequate surveillance testing of refueling equipment interlocks was not taken, and reactor engineering procedures contained deficiencies in the criticality estimation when using boron dilution to achieve criticality. Additional involvement appears necessary to ensure continuing equipment material condition and performance testing improvements. Inspection effort beyond the core is planned to evaluate the problem identification, resolution, and prevention program and the 10 CFR 50.59 safety evaluation process.

In the area of plant support, performance was consistent. Radiation protection and chemistry (RP&C) programs were effectively implemented; however, deficiencies in radiation survey instrument calibration and locked high radiation area key control programs were noted. Self-assessment and quality assurance audits were effective and identified procedure deficiencies in RP&C. The emergency preparedness program had been maintained in a state of operational readiness. Performance during the 1998 biennial emergency preparedness exercise was effective and post-exercise critiques were self-critical. The security force management organization was generally effective and consistent in the identification and resolution of security problems. However, on several occasions, lack of adequate oversight and ownership by security management resulted in extended compensatory measures and considerable staff overtime. No inspection activities beyond the core inspection program are warranted.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Wisconsin Electric. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that the NRC believes warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the Public Document Room as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the Point Beach PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact Roger Lanksbury at (630) 829-9631.

Sincerely,

/s/ G. E. Grant

Geoffrey E. Grant, Director
Division of Reactor Projects

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

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

See Attached Distributon

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DATE	03/26/99 MAK		03/26/99		03/30/99			

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POINT BEACH
INSPECTION / ACTIVITY PLAN

IP - Inspection Procedure
TI - Temporary Instruction
Core - Minimum NRC Inspection Program (mandatory all plants)
Regional Initiative - Discretionary Inspections

INSPECTION / ACTIVITY	TITLE / PROGRAM AREA	NUMBER OF NRC INSPECTORS/ INDIVIDUALS	PLANNED DATES	TYPE OF INSPECTION/ ACTIVITY- COMMENTS
IP37550 IP40500 IP37001	Engineering & Technical Support Problem Ident., Res., & Prevent. 50.59 Safety Evaluation Program	7	February 22 - March 12, 1999	Core & Regional Initiative ①
IP82701	Emergency Preparedness Program Maintenance	1	March 29 - April 1, 1999	Core
IP84750	Effluents, REMP, Met. Tower	1	May 17 - 21, 1999	Core
IP73756	Inservice Testing of Pumps and Valves	1	June 14 - 18, 1999	Regional Initiative ②
	Licensed Operator Examination	3	July 26 - 30, 1999	
IP 1001	Licensed Operator Requalification	2	August 16 - 20, 1999	Core
IP 60851 IP 60851 IP 60851 IP 60851	Spent Fuel Dry Cask Storage	1-2	TBD	Core

Notes
① Followup on previously identified weaknesses in Engineering
② Followup on previously identified concerns

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01/26/1999	1998-029-0	Pri: OPS Sec: MAINT	Licensee	LER	Pri: 1A Sec: 2A Ter:	While returning emergency diesel generator (EDG) G04 to service following performance of its monthly funtional test, the licensee discovered that the automatic start feature for the train "B" service water pumps and was not functional. This feature is designed to start the pumps upon closure of the EDG G04 output breakers. This feature failed to function because the power to the Unit 2 Train "B" safeguards relay rack, which provides power to this auto start function, was tagged out-of-service. The Unit 2 train "A" safeguards relay racks were also found to be tagged out-of-service. As a result, the automatic start signal for the train "A" service water pumps upon G01 or G02 output breaker closure to bus A205 was also not functional.
01/04/1999	1998021	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: 2B Ter:	The inspectors verified that the licensee had completed the cold weather preparation checklist; however, there was no checklist item or procedure for ensuring that ventilation systems used to protect safety-related equipment from cold weather were maintained in the proper configuration after performance of the checklist. Additionally, at the end of the inspection period, the licensee identified problems with maintaining the containment facade freeze protection equipment operational after the checklist was completed. In one instance, the Unit 1 minimum flow line for the safety injection pumps was frozen, rendering both trains of the safety injection system inoperable.
01/04/1999	1998021	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: Ter:	The inspectors' observations of the Unit 2 reactor vessel head lift indicated the continued need for licensee focus on conservative plant operation and proper procedure usage during major refueling activities. These observations and those documented in previous inspection reports reinforce the inspectors' concerns with some operators' understanding of procedure adherence requirements and with the unclear guidance contained in OM 1.4 regarding these requirements. Also, plant staff did not ensure adequate coordination of two procedures being used in parallel during the leak check inspection of the cavity-to-vessel seal ring during cavity flood-up.
01/04/1999	1998021	Pri: OPS Sec:	NRC	NEG	Pri: 5A Sec: 1A Ter:	The quality verification department did not identify any issues during Unit 2 shutdown observations, including those issues identified by the inspectors. This lack of issues called into question the effectiveness of the quality verification department's operations-related efforts.
01/04/1999	1998021	Pri: OPS Sec:	NRC	NEG	Pri: 5C Sec: Ter:	Deficiencies existed in the licensee's Nuclear Regulatory Commission commitment management program similar to problems identified by the inspectors in 1997.
01/04/1999	1998021	Pri: OPS Sec:	NRC	POS	Pri: 3A Sec: 1C Ter:	The inspectors found the licensee's receipt, inspection, and storage of new fuel assemblies to be well coordinated and properly implemented.
01/04/1999	1998021	Pri: OPS Sec:	NRC	WK	Pri: 1C Sec: Ter:	Overall, although the planning for the Unit 2 cycle 23 refueling outage improved from that of previous outages, the licensee did not meet its own pre-outage planning milestones, resulting in the potential for poor quality outage work documents and unnecessary worker radiation exposure. In addition, this pre-outage plan implementation problem reduced the time available to the licensee to perform risk and safety assessments of the scheduled outage work and to identify potential Technical Specification conflicts, instead placing those burdens on control room operators.

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01/04/1999	1998021	Pri: OPS Sec: MAINT	NRC	WK	Pri: 1A Sec: 2A Ter:	Operators safely shut down Unit 2 for the refueling outage. However, poor material condition, unresolved operator workarounds, and a lack of procedures resulted in a distraction to operators and required operator intervention during a critical and complex evolution.
11/20/1998	1998019	Pri: OPS Sec:	NRC	MISC	Pri: 3A Sec: 3B Ter:	The briefing conducted prior to a containment entry exhibited weaknesses including: a lack of clearly defined leadership roles, the radiation protection organization was not adequately prepared for the entry, no contingency plans were discussed, and no actions in the event of an emergency or evacuation alarm were discussed. However, the actual containment inspection was performed in a deliberate and thorough manner.
11/20/1998	1998019	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: 1A Ter:	The licensee's training plans were determined to be robust in terms of preparing control room operators for the transition to an 18-month operating cycle. In addition, the incorporation of applicable industry feedback and operating experience into the licensed operator requalification training development plans was considered a positive programmatic aspect.
11/20/1998	1998019-01	Pri: OPS Sec:	NRC	URI	Pri: 1C Sec: 3A Ter:	The inspectors will treat the procedure adherence issue as an Unresolved Item ((URI) 50-266/98019-01(DRP); 50-301/98019-01(DRP)) pending additional review by the Nuclear Regulatory Commission. Specifically, this review will consider the requirements for the reviewer of a procedure change, what level of changes involve changes of intent, what training level defines "skill of the craft," and the use of N/A for procedural steps.
11/20/1998	1998019	Pri: OPS Sec: MAINT	NRC	POS	Pri: 1A Sec: 2A Ter:	The inspectors concluded that safety systems in the Unit 2 containment were in good condition.
11/14/1998	1998021	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter:	Operators responded appropriately during the November 14, 1998, rapid reactor down power and removal from service of the Unit 1 "A" steam generator feedwater pump because of an outboard pump bearing failure.
10/05/1998	1998017	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 1A Ter:	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.
01/04/1999	1998021	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	The repairs of the Unit 1 "A" component cooling water pump were conducted in a manner commensurate with the safety significance of the job. Proper controls were used to minimize potential impact on the remaining operable Unit 1 "B" component cooling water pump.
01/04/1999	1998021	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	The licensee's use of a work-week coordinator facilitated the completion of the "B" motor-driven auxiliary feedwater pump outage; thereby, minimizing equipment out-of-service time. The maintenance activities were conducted in an acceptable manner, using the appropriate paperwork.

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01/04/1999	1998021	Pri: MAINT Sec: ENG	NRC	NEG	Pri: 2A Sec: 4A Ter:	The inspectors concluded that the long-standing component cooling water pump seal material condition/design issue had not yet been resolved, which had resulted in a failure of safety-related equipment and the continued existence of an operator workaround.
01/04/1999	1998021-26	Pri: MAINT Sec: ENG	NRC	VIO IV	Pri: 2B Sec: 5C Ter:	Violation issued as followup to item 50-266/98019-02; 50-301/98019-02, regarding past deficiencies in the licensee's American Society of Mechanical Engineers Code, Section XI pressure test program and the status of past corrective actions.
12/11/1998	1998-028-0	Pri: MAINT Sec: ENG	Licensee	LER	Pri: 2B Sec: 5C Ter:	On November 13, 1998, the licensee determined that five 40-month pressure tests required by the ASME Section XI Pressure Test Program had not been completed during the second period of the third inspection period interval. The results of the subsequent pressure test inspections for all five systems were satisfactory. The cause of this condition was failure to take timely action on and implement corrective actions for the ASME pressure test progam problems which were identified during a root cause evaluation of the program in April 1998 after a similar condition was identified in January 1998.
12/10/1998	1998022	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 5C Ter:	The licensee's corrective actions for the violations identified during the maintenance rule baseline inspection were acceptable, adequately documented, and properly implemented.
12/10/1998	1998022	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 5C Ter:	Follow-up items and weaknesses that were identified during the maintenance rule baseline inspection as needing additional attention by the licensee were properly completed.
11/20/1998	1998019	Pri: MAINT Sec: OPS	NRC	WK	Pri: 2A Sec: Ter:	Multiple and/or repetitive failures of nonsafety-related equipment caused planned and unplanned reactor power changes. Specific problematic equipment included instrument air compressors, a steam generator feed pump, and the Unit 2 auxiliary transformer. These failures created unnecessary challenges to control room operators, often resulted in significant impacts on the work scheduling process, and required maintenance personnel to re-allocate resources to address emergent work items.
11/20/1998	1998019-02	Pri: MAINT Sec: ENG	NRC	VIO IV	Pri: 2B Sec: 5C Ter:	The inspectors reviewed the past deficiencies in the licensee's American Society of Mechanical Engineers Code, Section XI pressure test program and the status of corrective actions. The review indicated that the licensee had identified numerous deficiencies in the pressure test program but had not effectively addressed many of them. Pending review by the inspectors of the corrective actions, this will remain open as an apparent violation. The failure to adequately complete the Code VT-2 visual examination of the Units 1 and 2 SFSP, may represent a violation of T/S 15.4.2.B.1 and will remain open as an example of an apparent violation for a reasonable time to allow the licensee to develop its corrective actions (EEI 50-266/98019-02a(DRP); 50-301/98019-02a(DRP)). The failure to perform the required tests, may represent a violation of T/S 15.4.2.B.1 which requires the systems be inspected as specified by the ASME Section XI Code and will remain open as an example of an apparent violation for a reasonable time to allow the licensee to develop its corrective actions (EEI 50-266/98019-02b(DRP)). In Inspection Report 50-266/98021(DRP); 50-301/98021(DRP), this item was dispositioned as a no-response, cited violation for failure to follow T/S 15.4.2.B.1. The tracking numbers for this violation are 50-266/98021-04a(DRP) and 50-266/98021-04b(DRP); 50-301/98021-04b(DRP).

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11/12/1998	1998-027-00	Pri: MAINT Sec:	Licensee	LER	Pri: 2B Sec: 5A Ter:	The licensee identified that the logic testing of the matrix circuit of the non-essential service water system isolation was potentially inadequate. With both Point Beach units operating at 100 percent power, a determination was made that this deficiency constituted a missed surveillance for Technical Specification Tables 15.4.1.-1 and 15.4.1-2. The causes of the testing deficiencies were 1) the failure of the existing test procedures to adequately consider all postulated failure modes of the contacts in the isolation matrix, and 2) the inadequate overlap between the breaker testing procedures which verified the auxiliary contacs and the service water isolation logic matrix testing.
10/05/1998	1998017	Pri: MAINT Sec:	NRC	POS	Pri: 3B Sec: 2B Ter:	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.
10/05/1998	1998017	Pri: MAINT Sec: OPS	NRC	NEG	Pri: 2A Sec: Ter:	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.
01/04/1999	1998021	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: Ter:	The inspectors identified the lack of controls to specifically limit the minimum component cooling water system operating temperature to within its design value.
01/04/1999	1998021	Pri: ENG Sec:	NRC	NEG	Pri: 5C Sec: Ter:	The licensee performed an assessment of the nuclear fuel function area relying on source documents and using offsite technical expertise. The inspectors concluded that the assessment of corrective action content appeared adequate but that the licensee failed to recognize that completing those actions in a timely manner was also important.
01/04/1999	1998021	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	Station management displayed conservative, risk-based decision-making regarding the approval and installation of a Unit 2 safety injection system modification. The modification was intended to address the long-standing need to use manual actions after an accident to align the safety injection system for the recirculation phase. The inspectors identified no concerns with the safety evaluation and installation work plans for the modification.
01/04/1999	1998021	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	The component cooling water system engineer's knowledge of assigned system fundamental characteristics was adequate, even though he was only recently given responsibility for the system.
01/04/1999	1998021-26	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	This item was described in Licensee Event Report (LER) 50-266/96013; 50-301/96013. The LER documented a condition under which design basis safety functions would not have been operable because of a common mode failure mechanism. This mechanism (a design flaw) involved the current limiting characteristics of the 120-volt alternating current static inverters in combination with the lack of physical separation of the nonsafety-related circuits that were powered from each inverter. This violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," is being treated as a Non-Cited Violation (50-266/98021-03(DRP); 50-301/98021-03(DRP)).

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01/04/1999	1998021-27	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	This issue was documented in Licensee Event Report (LER) 50-301/97002. The licensee identified that the Unit 2 reactor coolant system loop "B" resistance temperature detector branch connection could be stressed in excess of the design basis American Society of Mechanical Engineers Code allowable limits. The licensee determined that this resulted from an improperly performed design calculation associated with a 1987 piping support modification. The failure to perform adequate design calculations is being treated as a Non-Cited Violation (50-301/98021-05(DRP)) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control."
11/20/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 4B Ter: 1C	The licensee effectively implemented the recent Technical Specification change from a 12-month to an 18-month fuel cycle. The effects of the changes on the operational performance of the containment spray system and the new and spent fuel storage areas were appropriately considered by the licensee.
11/20/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: Ter:	The licensee effectively used the quality assurance surveillance process to evaluate the progress and readiness of the 18-month fuel cycle project. The surveillance identified weaknesses in the project requiring resolution to ensure timely and effective implementation of the extended 18-month fuel cycle.
11/20/1998	1998019-03	Pri: ENG Sec: OPS	NRC	NCV	Pri: 2A Sec: Ter:	On January 13, 1997, the licensee identified the potential for a particular common mode failure to occur in the vital direct current electrical system that could affect opposite trains of Unit 2 safeguards equipment. Further review by the licensee identified a similar common mode failure potential for Unit 1. This licensee-identified non-repetitive failure to maintain the respective Unit 1 and Unit 2 safeguards equipment free from common mode failures is being treated as an NCV (NCV 50-266/98019-03(DRP); 50-301/98019-03(DRP)) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," in accordance with Section VII.B.1 of the NRC Enforcement Policy. This issue was reported in LER 97004.
10/05/1998	1998017	Pri: ENG Sec:	NRC	MISC	Pri: 2A Sec: 5C Ter: 5A	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.
01/15/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The inspector concluded that management support for the ongoing security system replacement program was good. Close coordination and communication between security management and the security systems engineer were noted.
01/15/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The licensee's security implementing procedures and guidelines were generally adequate to perform the functions required by the security plan, and were consistent with regulations and security plan commitments. Guidance in the area of access authorization operating processes was deficient, a fact also identified by the licensee's quality assurance staff in their last annual security audit. The licensee was tracking corrective action for this issue through their condition report corrective action system.
01/15/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 1C Ter:	The most recent annual quality assurance (QA) audit of the security system was thorough and complete in terms of uncovering weaknesses in the security system, procedures and practices. The QA staff identified that the licensee granted unescorted access to an individual without completing the psychological assessment process. This is a non-cited violation of 10 CFR 73.56(b)(ii) and is asssigned a tracking number of 50-266/99003-01; 50-301/99003-01. The event has some safety significance because it had the potential to grant unescorted access to an individual who may be untrustworthy or unreliable.

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01/15/1999	1999003	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 5A Sec: 1C Ter:	Self-assessments conducted by the security organization were of high quality and were instrumental in identifying program weaknesses in procedures and practices.
01/15/1999	1999003	Pri: PLTSUP Sec: MAINT Ter:	NRC	POS	Pri: 1C Sec: 2A Ter:	The licensee's security system testing and maintenance programs ensured that security equipment met regulatory performance requirements and objectives. The security organization and the plant maintenance staff communicated well on matters affecting security system maintenance. The inspector identified that the licensee did not have a testing program in place to verify compliance with the security plan protected area lighting commitment. The inspector considered this a minor weakness which the licensee adequately addressed prior to the conclusion of the inspection.
01/08/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	Effective ALARA planning and controls were implemented for the Unit 2 outage. Overall, ALARA plans and radiation work permits were considered good. The licensee was reviewing a concern with overestimating dose goals. The licensee attributed the problem to poor task time estimates provided by the work groups and the use of electronic instead of self-reading dosimetry.
01/08/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The licensee had reasonably planned the core barrel bolt replacement work, given the limited station and industry experience. Licensee actions to mitigate problems with decreased job efficiency, increased work area dose rates and decreased water clarity were considered appropriate.
01/08/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: 3A Ter:	Radiation protection staff appropriately determined the outage goal for personnel contamination events and correctly documented and evaluated these events in accordance with station procedures. However, the number of events involving the head, face and/or neck of workers, indicated that radiaiton work practices may warrant improvement.
01/08/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: 3B Ter:	The training program for contract radiation protection technicians was sufficiently detailed and effectively implemented by the radiation protection and training staffs.
01/08/1999	1999001	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: 5B Ter:	The licensee's investigation of low level contamination found in the vicinity of the on-site retention pond was considered good. The inspectors concluded that the measured contamination levels in soil and groundwater did not pose a significant hazard to the public. The licensee planned to issue a final characterization report, which would discuss the environmental impact and recommendations for remediation. The inspectors planned to review this report after it was issued.
01/04/1999	1998021	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The licensee appropriately lowered the Unit 2 refueling outage 23 personnel exposure goal to better monitor and control radiation worker exposure.

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Region III
POINT BEACH

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
12/23/1998	1998-030-0	Pri: PLTSUP Sec: OPS	Licensee	LER	Pri: 1C Sec: 5A Ter:	While completing a re-verification and re-validation of the Fire Protection Evaluation Report fire scenarios, the licensee's Appendix R Rebaselining Project Team determined that the safety-related battery chargers should be reclassified as hot shutdown equipment. Plant procedures presently allow post-accident repairs of this equipment to bypass potential fire-induced electrical circuit damage. The Appendix R design basis does not allow for repairs of hot shutdown equipment needed to achieve or maintain hot safe shutdown; therefore, the plant was declared to be in a condition outside the design basis. A modification will be installed to provide manual switches that will permit bypassing the potential fire sensitive circuits and preclude the need to repair the battery chargers.
11/06/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5A Ter:	Self-critiques following termination of the 1998 Emergency Preparedness exercise were generally thorough, self-critical, and controllers effectively solicited verbal and written inputs from exercise participants.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 3A Ter: 3B	An inappropriate decision was made during the 1998 Emergency Preparedness exercise to tie a non-safety electrical bus to a safety-related electrical bus in order to enable providing reactor makeup water to Unit 2.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 3C Ter:	Field team sampling procedures and equipment for the 1998 Emergency Preparedness exercise needed enhancement.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Overall performance during the 1998 Emergency Preparedness exercise was effective and demonstrated that emergency plan implementation activities met regulatory requirements.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Exercise performance in the Control Room Simulator was exceptionally effective. Appropriate procedures, including abnormal operating procedures and emergency operating procedures were effectively used. "Repeat back" communications were consistently used by the crew. Close and effective command and control of the operators was consistently displayed by the Duty Operating Supervisor.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Overall, the Technical Support Center's staff's performance was adequate. Staff teamwork was apparent and communications with offsite authorities and between the emergency response facilities' staffs were effective.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Operations Support Center (OSC) staff performance was satisfactory. OSC teams were generally assembled, briefed and deployed in a timely manner. Returning teams were adequately debriefed.

United States Nuclear Regulatory Commission

Region III
POINT BEACH

PLANT ISSUE MATRIX

By Primary Functional Area

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	The Emergency Operations Facility (EOF) staff's overall performance was effective and in accordance with the Emergency Plan. The Emergency Director declared a Site Area Emergency and a General Emergency in a correct and timely manner as plant conditions worsened.
11/03/1998	1998020	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	A field monitoring team followed their procedures very well during the 1998 Emergency Preparedness exercise.
10/05/1998	1998017	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	Licensee performance during an emergency planning drill was improved compared to performance in a previous drill.

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved Item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

PLANT ISSUES MATRIX
Point Beach

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	9/30/1998	Positive	IR 98017(DRP)	NRC	Operations	1A	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.
2	9/14/1998	LER	LER 1998-026	NRC	Operations	1A	The licensee determined that the operation of the Potential Dilution in Progress alarm was not controlled in accordance with the intent of Technical Specifications. The specification requires that the operability of the alarm be verified prior to placing the plant in cold shutdown. Although the alarm was verified operable as required prior to placing the plant in cold shutdown, the licensee believes that the intent is also for the alarm to remain operable as long as the plant remains in cold shutdown, even though this is not stated in Technical Specifications.
3	8/17/1998	Positive	IR 98014(DRP)	NRC	Operations	1A	Auxiliary feedwater system material condition and housekeeping were generally acceptable. Procedures were adequate to ensure proper system operation under accident conditions.
4	8/17/1998	Positive	IR 98014(DRP)	NRC	Operations	1C	The licensee identified a condition where one train of the Unit 2 safety injection system and the opposite train of the Unit 2 residual heat removal system (low pressure safety injection) were inoperable simultaneously. Even though allowed by Technical Specifications, the licensee determined that the configuration was undesirable and established administrative controls and guidance on addressing unplanned configurations of this type in the future.
5	8/17/1998	Negative	IR 98014(DRP)	NRC	Operations	1C	Several minor inspector-identified discrepancies were brought to the licensee's attention and were corrected or placed into the station's corrective action program. Some problems were also noted by the inspectors with regard to controls for ensuring that changes to operator rounds logs did not invalidate NRC commitments and actions taken by the licensee in response to industry lessons-learned.
6	8/17/1998	Positive	IR 98014(DRP)	NRC	Operations	5B	Members of the Off-Site Safety Committee posed challenging and probing questions to station department managers during a recent meeting. This was a noted improvement in committee performance from that observed previously by the inspectors.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
7	7/17/1998	Negative	IR 98014(DRP)	NRC	Operations	1A	During plant walkdowns, the inspectors observed conditions with plant equipment, such as packing leaks and missing pipe insulation, that had not been documented via work order requests or condition reports, indicating that plant operators were not thorough in identifying equipment problems during their operator rounds.
8	7/14/1998	LER	LER 1998-022	Licensee	Operations	1C	Technical Specification Limiting Conditions for Operations permit having one component of the safety injection system out of service at the same time as one component from the opposite train of the residual heat removal system. Existing plant procedures were not written for cross train alignment of RHR discharge to the safety injection system for containment sump recirculation.
9	7/8/1998	LER	LER 1998-010-01	Licensee	Operations	3B	Circuit testing of the containment spray logic was potentially inadequate and constituted a missed Technical Specification surveillance for channel functional test. Subsequent testing proved continuity through the bistable test switch but continuity to both trains of core spray actuation logic through the safeguards logic test switches was not independently verified.
10	7/6/1998	Positive	IR 98011(DRP)	NRC	Operations	1A	Unit 1 fuel movements were performed in a careful and deliberate manner and distractions for fuel handling personnel from concurrent activities in the containment were kept to a minimum.
11	7/6/1998	Weakness	IR 98011(DRP)	NRC	Operations	1C	The licensee had not effectively implemented a recently developed defense-in-depth, system maintenance planning matrix. This did not constitute a violation of NRC requirements; however, it represented a deficiency within the production planning group.
12	6/27/1998	Strength	IR 98011(DRP)	NRC	Operations	1C	Control room operators and supervisors demonstrated a safety-focused and conservative approach to the Unit 1 reactor startup. Briefings for infrequently performed tests or evolutions were good to outstanding, and reactor operator performance during the approach to criticality was good with consistent three-way communications and constant control board monitoring and attentiveness evident.
13	6/27/1998	Negative	IR 98011(DRP)	NRC	Operations	2A	During startup of Unit 1, operators had to contend with unnecessary challenges from secondary system components which distracted their attention and complicated their efforts during the unit startup.

PLANT ISSUES MATRIX
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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
14	6/25/1998	Misc	IR 98301(DRS)	NRC	Operations	1A	The plant specific simulator accurately mimicked changing plant parameters during varied equipment malfunctions and plant conditions. However, a number of long standing software and hardware problems have the potential of impacting future simulator performance and licensed operator training, if not resolved.
15	6/25/1998	Weakness	IR 98301(DRS)	NRC	Operations	1A	While the licensee was meeting the requirements of the licensed operator requalification program, the licensee's decision to consider a scheduled refueling outage an "unforseen circumstance" for deletion of a scheduled simulator training session may not have been appropriate. As a result, two operating crews received 30% less simulator training than the other four operating crews and selected operators from the two crews had documented performance weaknesses during training which included one failure of the annual operating evaluation.
16	6/25/1998	Strength	IR 98301(DRS)	NRC	Operations	1C	The licensee provided a competent technical review and verification of the examination validity and provided positive feedback to the examiners when modification was required. The licensee maintained a high level of examination security.
17	6/25/1998	Positive	IR 98301(DRS)	NRC	Operations	1C	An appropriate level of attention to detail was observed during a main control room walkdown and parameter logging evolution. Control operator actions were consistent with licensee expectations as outlined in their administrative procedures.
18	6/25/1998	Negative	IR 98301(DRS)	NRC	Operations	3A	Operating procedures were generally accurate and complete for performing the task assigned. However, the examiners identified a procedural deficiency attributed to inadequate verification during the technical accuracy review process. The licensee was unable to determine whether the procedural error had been a technical or clerical mistake.
19	6/16/1998	NCV	IR 98011(DRP)	Self-Revealed	Operations	3A	A valve mispositioning event was the result of operator error in recalling the specific valve required to be closed. The licensee identified the error and aggressively took actions to evaluate and correct the problem. [Violation of 10 CFR 50, Appendix B, Criterion V].

PLANT ISSUES MATRIX
Point Beach

Search Sorted by Date (Desc and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
20	6/6/1998	Negative	IR 98011(DRP)	NRC	Operations	5A	The inspectors discussed with station management deficiencies with scheduling an emergency diesel generator post-maintenance test involving the potential inappropriate entry into limiting conditions for operation for the Unit 1 Train "A" residual heat removal system. Upon further review of this issue by station management, the testing was rescheduled to allow for correct plant conditions to be established for performing the test.
21	5/23/1998	NCV	IR 98009	Licensee	Operations	3A	A minor, non-cited violation of Technical Specifications occurred when a radioactive effluent discharge was made without first source checking an in-line radiation monitor. This failure could have been prevented by better control room command and control of shift activities, operator turnover, procedural adherence, and operator self-verification. The tracking number for this non-cited violation of Technical Specification 15.7.4 is No. 50-266/98009-02(DRP); 50-301/98009-02(DRP).
22	5/23/1998	Weakness	IR 98009	NRC	Operations	3C	The relatively high level of management attention which was required to ensure safe and effective completion of outage activities, coupled with the large backlog of corrective action and modification work, prevented resource allocation for necessary program improvement initiatives, effectively prevented immediate resolution of all degraded and nonconforming plant conditions, and diluted plant management's ability to drive committed improvements to completion. As a result, the licensee was evaluating a significant restructuring of commitment dates for program and hardware reviews and upgrades. Senior licensee management indicated that any change in docketed commitment dates would be formally submitted to the NRC in writing.
23	5/23/1998	Positive	IR 98009	NRC	Operations	3C	Senior plant and corporate management continued to demonstrate a strong commitment to improving performance. Examples of this commitment included increases in plant staffing, additional management changes, and extending the U1R24 outage to allow installation of many modifications. Significant progress was made during this outage in addressing main control board wire separation issues, electrical separation issues associated with safe shutdown equipment, removal of partial length control rod drive housings, and inspection and repair of service water system piping and pipe supports in containment.

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24	5/23/1998	Positive	IR 98009	NRC	Operations	5A	The licensee's root cause evaluation for a February 7, 1998, waterhammer event attributed the event to a poor operating procedure and poor decisions by the operating crew. The corrective actions were appropriate and thorough, with the exception that the licensee did not address a poor drain trap configuration associated with main steam piping on the 8-foot level of the turbine building. In addition, the inspectors identified a failed, nonsafety-related pipe support which licensee staff had overlooked during the event assessment and routine operator rounds.
25	5/23/1998	Positive	IR 98009	Licensee	Operations	5A	The licensee performed an effective self-assessment of the conduct of operations. The use of industry peers was highly beneficial. The need for improvement to bring the operations department up to current industry standards was identified. All self- assessment findings were consistent with the inspectors' observations.
26	5/13/1998	Positive	IR 98009	NRC	Operations	5A	The Manager's Supervisory Staff (MSS), which compose the station's onsite review committee, appropriately identified weaknesses with a proposed safety evaluation (SE) for a new fuel load. Because of the incomplete staff work associated with the SE, the MSS actively participated in development of the final product. Although no problems were identified with the SE reviewed by the inspectors, the practice of having MSS members provide so much input into SEs had the potential to affect the objectivity of the MSS.
27	5/12/1998	URI	IR 98009	NRC	Operations	2B	The inspectors determined that the containment spray system was aligned correctly during a safety system walkdown. The inspectors noted many discrepancies regarding the manner in which the containment spray system is tested. This issue is considered a URI pending a review by NRR. The tracking number for this issue is No. 50-266/98009-01(DRP); 50-301/98009-01(DRP)).
28	5/12/1998	Negative	IR 98009	NRC	Operations	3A	The Unit 2 licensed operator was not aware of a Unit 1 abnormal chemical and volume control system (CVCS) lineup and the impact this lineup had on the Unit 2 CVCS due to an incomplete turn-over and problems with control room activity coordination.
29	4/24/1998	LER	LER 1998-004 (Unit 2)	Licensee	Operations	1A	The licensee identified a condition that resulted in Unit 2 being operated on April 24, 1998, at an average power of 1519.1 megawatts-thermal, in excess of the maximum permitted reactor thermal output of 1518.5 megawatts-thermal.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
30	4/16/1998	LER	LER 1998-013	Licensee	Operations	1A	The licensee determined that the discharge pressure indicator root valves (1/2SI-848G and 1/2SI-848H) for the containment spray pumps were not shut as required to provide a closed system boundary for the spray system outside containment.
31	3/28/1998	Positive	IR 98006	NRC	Operations	1A	Operations personnel involved with the restart of the Unit 2 reactor exercised good control of reactivity changes. Clear, consistent communications were used by operators.
32	3/14/1998	VIO/SL-IV	IR 98006	NRC	Operations	1A	A reactor operator who was "at the controls" for a unit that was shut down and defueled, left the authorized surveillance area for a short period of time without being appropriately relieved by another reactor operator. This action was contrary to the requirements of the licensee procedure for the conduct of operations and was a violation of Criterion V, "Instructions, Procedures, and Drawings," of 10 CFR Part 50, Appendix B. The tracking number for this violation is No. 50-266/98006-01(DRP).
33	3/10/1998	Positive	IR 98006	NRC	Operations	1A 3A	Operators responded appropriately when the second stage seal of an idle reactor coolant pump partially opened. Planning of the pump restart and communications and procedure adherence during the restart were appropriate and effective.
34	3/2/1998	Negative	IR 98003	NRC	Operations	1A	Operators were observed using reactor engineering instructions (REIs), such as REI 11, "End of Life Coastdown," to change reactor power. The REIs provided specific operational guidance and steps which were more appropriate for operating procedures.
35	3/2/1998	Negative	IR 98003	NRC	Operations	1A	Operations personnel safely conducted and controlled fuel movements. However, containment work activities lacked coordination, and there was minimal management oversight of containment activities early in the refueling outage.
36	3/2/1998	Positive	IR 98003	NRC	Operations	3A	Personnel who inspected new fuel assemblies demonstrated appropriate attention-to-detail.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES			DESCRIPTION
37	3/2/1998	Negative	IR 98003	NRC	Operations	3A	1A		Operators were observed circumventing the licensee's work control process by verbally directing adjustments to nonsafety-related control valves during a unit startup. Operators performing informal troubleshooting caused an unplanned closure of the moisture separator reheater steam flow control valves during a unit shutdown, resulting in a four percent reactor power transient. The operator response to this minor transient was adequate, but the control room command and control roles were not consistent with the expectations in the procedure for conduct of operations.
38	3/2/1998	Negative	IR 98003	NRC	Operations	3B			A deficiency existed in auxiliary operator knowledge and understanding of the operation of oil reservoirs on safety-related pumps. Licensee management indicated that training enhancements would be made to address this deficiency.
39	3/2/1998	Positive	IR 98003	NRC	Operations	5A	4A		Plant staff, including design engineering personnel, continued to identify design basis issues. These issues were entered into the corrective action program in a prompt manner, and plant management evaluated and responded to each in an appropriate fashion.
40	2/7/1998	Positive	IR 98003	NRC	Operations	3A	1A	**	The Unit 2 startup on February 7, 1998, was conducted well; however, operators continued with unit startup without completely understanding the cause, or identifying all of the effects, of a waterhammer which occurred in the main steam piping during startup preparations. This was indicative of a lack of sensitivity to the potential consequences of waterhammer events. Licensee management initiated a high-level root cause evaluation of the event and the operator response.
41	2/2/1998	LER	LER 98001 (Unit 2)	Self-Revealed	Operations	1A			While Unit 2 was heating up following a maintenance outage, plant operators discovered a steam plume near the main steam vent lines. The steam was issuing from an open vent valve that had been inadvertently left open during outage because of an inadequate procedure.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
42	1/22/1998	NCV	IR 98003 LER 98006 50.72 No. 33576	Self-Revealed	Operations	2B 4B	Several non-essential loads of the service water system were isolated by an automatic actuation that was not anticipated. This partial actuation of an engineered safety feature (ESF) occurred during a special test of emergency diesel generator G-02. The systems to which the service water was isolated were not ESF systems and were not essential to accident mitigation or safe shutdown of the plant. The isolated service water supplies were restored within a matter of minutes, and the associated systems restored without incident. The event was caused by an inadequate test procedure. The tracking number for this Non-Cited Violation is No. 50-266/98003-05(DRP); 50-301/98003-05(DRP). Inadequate Procedure/Instruction
43	1/20/1998	Negative	IR 97026	NRC	Operations	2A	The licensee's use of the temporary information tag program was generally acceptable. However, the inspectors identified several instances where tags were left hanging on equipment longer than intended, and examples of the use of temporary information tags on abandoned in-place radioactive waste equipment instead of danger tags, which would have been more appropriate. Inadequate Oversight
44	1/20/1998	Positive	IR 97026	NRC	Operations	5C	Corrective actions for problems with several procedures and for the premature securing of cooling water to a reactor coolant pump were reviewed and found to be complete and thorough. Involved Management
45	1/8/1998	VIO/SL-IV	IR 97026 LER 98002	Self-Revealed	Operations	2A 1B 5A	The Unit 1 high voltage station auxiliary transformer failed on January 8, 1998. The operators responded well, and safety-related equipment worked as expected. The failure was caused by insulation degradation which was attributable to inoperable bus duct strip heaters. An automatic fast bus transfer did not occur as designed due to a design error. The licensee performed a thorough and insightful review of this event and identified a fundamental weakness in the use of some aspects of Technical Specifications (TSs) by licensed operators. The NRC review identified inappropriate procedural adherence standards regarding the use of emergency and abnormal operating procedures. One violation of Criterion V of 10 CFR Part 50, Appendix B, was identified for an inadequate procedure. The tracking number for this violation is No. 50-266/97026-01(DRP); 50-301/97026-01(DRP). Another violation was identified for the failure to prepare for a shutdown of the reactor as required by Technical Specification 15.3.0. The tracking number for this violation is No. 50-266/97026-02(DRP); 50-301/97026-01(DRP). Equipment Malfunction

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
46	12/15/1997	Positive	IR 97025	NRC	Operations	2B	3B	Operator knowledge was consistent with their responsibility for implementation of the maintenance rule. There was no indication that the maintenance rule detracted from the operators' ability to safely operate the plant. Teamwork/Skill Level
47	11/30/1997	Positive	IR 97021	NRC	Operations	1A	3A	Good command and control, deliberate conduct of operations, and good procedure adherence were observed during the shutdown of Unit 2 and the startup of Unit 1. Teamwork/Skill Level
48	11/30/1997	Positive	IR 97021	NRC	Operations	1A	3A	The facility was operated in a safe manner with a strong safety focus and generally conservative operational decisions. Two notable examples were the decision to promptly shut down Unit 2 when reactor protection instrumentation test problems could not be resolved within the allowed time and the decision to delay the startup of Unit 1 while a nuclear instrument detector was repaired. Conservative Decision
49	11/30/1997	Misc	IR 97021	NRC	Operations	1A	5A	Unit 2 was at full power and Unit 1 was in an extended outage at the start of the inspection period. Two-unit operation was precluded due to previously identified concerns with the auxiliary feedwater system. Unit 2 was shutdown on November 15, 1997, after the licensee identified that complete testing of reactor protection system instrumentation and control circuitry had not been completed as required by T/Ss. Unit 1 startup began November 21, 1997, and was completed November 30, 1997. **********
50	11/30/1997	VIO/SL-IV	IR 97021	NRC	Operations	1B		Most component cooling water (CCW) system normal, abnormal, and emergency operating procedures were considered appropriate, but the inspectors identified a weakness with the failure of the emergency operating procedure to provide positive isolation of nonsafety-related CCW flow paths during the containment sump recirculation phase of accident mitigation. This procedure weakness was considered one aspect of a test control violation (Criterion XI, 10 CFR Part 50, Appendix B). The tracking number for this violation is No. 50-266/97021-04(DRP); 50-301/97021-04(DRP). Inadequate Procedure/Instruction
51	11/30/1997	Negative	IR 97021	NRC	Operations	2A		Prior to unit restart, the inspectors determined that Unit 1 containment cleanliness was sufficient to prevent immediate safety concerns; however, the inspectors identified several items, including loose electrical tape, which should not have been present. Inadequate Oversight

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Point Beach

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SAL	SMM CODES	DESCRIPTION
52	11/30/1997	Positive	IR 97021	NRC	Operations	2B	The licensee had taken adequate measures to ensure those safety systems susceptible to freezing during the winter months were protected. Also, the licensee had taken acceptable actions in addressing concerns with the facade freeze protection system discussed in a previous inspection report. Involved Management
53	11/30/1997	Positive	IR 97021	NRC	Operations	3B	Operator knowledge of the CCW system and its operation was good. Reactor operators were familiar with the CCW system status and the cause for CCW system annunciators. Teamwork/Skill Level
54	11/30/1997	Positive	IR 97021	Licensee	Operations	5C 3A	The licensee identified and corrected three examples of the use of inappropriate procedures. The need for numerous other procedure changes was identified by operators prior to the use of inappropriate procedures. Despite these problems with procedure development and review, the inspectors considered the use of procedures in Operations to be good. This strong performance was based, in part, on Operations Department initiatives to ensure that all required procedures were performed as written, to ensure that activities requiring procedures were performed using procedures rather than work plans, and to provide mentors who reinforced the need for procedural control of activities affecting quality. The tracking number for the Non-Cited Violation regarding the inadequate procedures is No. 50-266/97021-01(DRP); 50-301/97021-01(DRP). Self-Critical

GENERAL DESCRIPTION OF PIM TABLE LABELS

#	A counter number used for NRC internal editing.
DATE	The date of the event or significant issue. For those items that have a clear date of occurrence use the actual date. If the actual date is not known, use the date the issue was identified. For issues that do not have an actual date or a date of identification, use the LER or inspection report date.
TYPE	The categorization of the issue - see the TYPE ITEM CODE table.
SOURCE	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
ID BY	Identification of who discovered the issue - see table.
SALP	SALP Functional Area Codes - Engineering, Maintenance, Operations, Plant Support and All/Multiple (i.e., more than one SALP area affected).
SMM CODES	Senior Manager Meeting Codes - see table.
DESCRIPTION	Details of the issue from the LER text or from the IR Executive Summaries.

TYPE ITEM CODE

DEV	Deviation from NRC Requirements
ED	Escalated Discretion - No Civil Penalty
EEI*	Escalated Enforcement Issue - Waiting Final NRC Action
LER	License Event Report to the NRC
Licensing	Licensing Issue from NRR
Misc	Miscellaneous (Emergency Preparedness Finding, etc.)
NCV	Non-Cited Violation
Negative	Individual Poor Licensee Performance
Positive	Individual Good Licensee Performance
Strength	Overall Strong Licensee Performance
URI**	Unresolved Inspection Item
VIO/SL-I	Notice of Violation - Severity Level I
VIO/SL-II	Notice of Violation - Severity Level II
VIO/SL-III	Notice of Violation - Severity Level III
VIO/SL-IV	Notice of Violation - Severity Level IV
Weakness	Overall Weak Licensee Performance

ID BY

Licensee	The licensed utility
NRC	The Nuclear Regulatory Commission
Self-Revealed	Identification by an event (e.g., equipment breakdown)
Other	Identification unknown

NOTES

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

SENIOR MANAGEMENT MEETING CODES

1	Operational Performance: A - Normal B - During Transients C - Programs and Processes
2	Material Condition: A - Equipment Condition B - Programs and Processes
3	Human Performance: A - Work Performance B - Knowledge, Skills, and Abilities C - Work Environment
4	Engineering/Design: A - Design B - Engineering Support C - Programs and Processes
5	Problem Identification and Resolution: A - Identification B - Analysis C - Resolution

PLANT ISSUES MATRIX
Point Beach

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Maintenance" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	9/30/1998	Negative	IR 98017(DRP)	NRC	Maintenance	2A	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.
2	9/29/1998	Positive	IR 98017(DRP)	NRC	Maintenance	3B 2B	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.
3	8/17/1998	Negative	IR 98014(DRP)	NRC	Maintenance	1C	Overall, plant operators performed a Technical Specification-required rod exercise test with an appropriate level of supervisory oversight and followed operating standards for the conduct of such tests. The inspectors identified that the test contained weak controls for ensuring that the operator selected the correct control rod bank prior to moving a rod bank, creating the potential for the incorrect rod bank to be moved.
4	8/17/1998	Positive	IR 98014(DRP)	NRC	Maintenance	2B	The licensee had effectively implemented a 12-week work planning and scheduling process, which was an improvement over past practices. Even though problems were encountered, no safety-related equipment remained out-of-service for an unacceptable duration as a result. The types of problems encountered were typical for a new program in the initial implementation stage. Many past program problems observed by the inspectors were not evident during this review.
5	8/17/1998	Positive	IR 98014(DRP)	NRC	Maintenance	3B	The maintenance organization effectively replaced the "C" service water pump in accordance with station procedures. The work was planned and scheduled appropriately and limiting conditions for operation durations were closely monitored throughout the evolution. Previous inspector-identified concerns with other service water pump work conducted earlier this year were not evident.

PLANT ISSUES MATRIX
Point Beach

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Maintenance" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
6	7/21/1998	LER	LER 1998-024 (Unit 1)	Self-Revealed	Maintenance	3B	During performance of post-maintenance testing on emergency diesel G01, technicians installed an electrical jumper wire that unexpectedly started the diesel. The jumper was installed by the work plan, but its installation was not expected to start the diesel. The licensee's investigation confirmed that installation of the jumper started the diesel as designed. The inspectors determined that the use of the inadequate work plan was a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," with a tracking number of 50-266/98017-01(DRP); 50-301/98017-01(DRP).
7	7/16/1998	Negative	IR 98013(DRS)	NRC	Maintenance	2A	The NRC inspection team reviewed the data concerning disassembly of six Westinghouse 4.16-kiloVolt type DH breakers and concluded that the condition of the lubricant and various moving parts was minimally acceptable. The results revealed indications of deteriorated lubrication on various breaker internal components which indicated poor maintenance practices.
8	7/16/1998	URI	IR 98013(DRS)	NRC	Maintenance	2A 5A	NRC Information Notice IN 97-53, "Circuit Breakers Left Racked Out in Non-Seismically Qualified Positions," issued on July 18, 1997, had not been adequately evaluated. The NRC inspection team identified some racked out breakers, without prior seismic evaluation, and considered this an unresolved item. The tracking number for this item is 50-266/98013-01(DRS); 50-301/98013-01(DRS).
9	7/16/1998	VIO/SL-IV	IR 98013(DRS)	NRC	Maintenance	2B	Failure to properly implement significant portions of the breaker maintenance requirements in maintenance procedures was not consistent with vendor recommendations and was not a proactive approach to good breaker maintenance. A no-response violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was cited, with tracking number 50-266/98013-02(DRS); 50-301/98013-02(DRS)
10	7/16/1998	VIO/SL-IV	IR 98013(DRS)	NRC	Maintenance	2B	The NRC inspection team determined that adequate measures were not established to ensure that only approved and authorized cleaning compounds and lubricants were used to clean/lubricate safety-related electrical breaker components. Consequently, unapproved and non-standard cleaners/lubricants were used. A no-response violation of 10 CFR Part 50, Appendix B, Criterion XV, "Nonconforming Materials, Parts, or Components," was cited, with tracking number 50-266/98013-03(DRS); 50-301/98013-03(DRS).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
11	7/16/1998	Weakness	IR 98013(DRS)	NRC	Maintenance	2B		The NRC inspection team concluded that adequate maintenance and failure history of breakers was not maintained. The plant engineers were not performing any root cause evaluations or trending of breaker failures. The team considered this a significant weakness.
12	7/16/1998	VIO/SL-IV	IR 98013(DRS)	NRC	Maintenance	2B		Adequate design controls were not in place to verify that the voltages available at the close and trip coils of medium and low-voltage circuit breakers would be adequate to safely operate the breakers in accident conditions. The NRC inspection team concluded that the original calculation of circuit breaker control voltage lacked the rigor normally seen in safety-related calculations. As a result, the breaker test procedures used a control voltage that was much higher than the vendor design data. A no-response violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was cited, with tracking number 50-266/98013-04(DRS); 50-301/98013-04(DRS).
13	7/16/1998	Negative	IR 98013(DRS)	NRC	Maintenance	3B		The NRC inspection team noted that adequate training was not provided to the technicians on correct lubrication practices. The team also noted a weakness that Point Beach did not provide training to the technicians on any revisions of the breaker maintenance procedures even when revisions were substantial.
14	7/16/1998	Negative	IR 98013(DRS)	NRC	Maintenance	5A		Previous self-assessments and quality verification audits did not identify the problems identified during this NRC inspection of medium- and low-voltage power circuit breakers.
15	7/16/1998	Positive	IR 98013(DRS)	NRC	Maintenance	5A	2B	The NRC inspection team concluded that Point Beach had participated in user groups relating to breakers. Point Beach had a number of technical personnel involved in the Westinghouse and Asea Brown Boveri User Groups that resulted in good access to vendor technical information.
16	6/26/1998	Positive	IR 98011(DRP)	NRC	Maintenance	3B		Engineering personnel provided good support to the maintenance personnel involved in the troubleshooting, repair, and testing of a Unit 1 "A" main steam line snubber. Maintenance personnel adhered to applicable procedures during the repair work. Appropriate controls existed for foreign material exclusion and use of replacement parts.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
17	6/15/1998	NCV	IR 98011(DRP)	Licensee	Maintenance	5C	The licensee identified and effectively corrected a problem regarding the failure to maintain the environmental qualification (EQ) status of the containment hydrogen monitors for both Units 1 and 2. A Non-Cited Violation [10 CFR 50, Appendix B, Criterion V] was identified involving the failure to provide an adequate procedure to maintain the EQ status of a safety-related component.
18	5/30/1998	Negative	IR 98011(DRP)	NRC	Maintenance	3B	The installation of the Unit 1 reactor vessel head was conducted in a safe manner. However, a job supervisor's understanding of the requirements of Nuclear Business Unit Procedure 1.1.4, "Procedure Use and Adherence," regarding procedural adherence was inaccurate.
19	5/28/1998	LER	LER 1998-018	Licensee	Maintenance	2B	The licensee identified that vent valves on certain electrical penetration assemblies were not subject to periodic local leak rate testing in accordance with 10 CFR 50, Appendix J testing commitments.
20	5/23/1998	Negative	IR 98009	Licensee	Maintenance	2A	Inadequate maintenance for containment upper personnel hatch latch and interlock mechanism components was determined to be the cause of repetitive surveillance test failures.
21	5/23/1998	Negative	IR 98009	NRC	Maintenance	2A	The inspectors identified that minor damage had occurred to instrument tubing and cables located near work areas within the Unit 1 reactor coolant system loop cubicles. The licensee initiated corrective actions for the specific damage and committed to review the process controls for preventing such damage. No other conduct of maintenance problems were identified in the refueling area during the inspection period.
22	5/23/1998	Positive	IR 98009	Licensee	Maintenance	4C	The licensee responded promptly to two 10 CFR Part 21 vendor notifications, resulting in the removal of defective or degraded components from the auxiliary feedwater system and the emergency diesel generators.
23	5/12/1998	LER	LER 1998-017 (Unit 1)	Licensee	Maintenance	2A	The licensee identified deficiencies in welds on a portion of a support for the "B" reactor coolant loop resistance temperature detector bypass piping.
24	5/7/1998	Negative	IR 98009	Self-Revealed	Maintenance	2A	Annunciator alarms for flow spiking of the seal water return from the reactor coolant pumps were a distraction to the operators. The alarms began when the gas stripper system was taken out-of-service to address material condition problems; however, the licensee was unsure of why the out-of-service gas stripper caused the spiking.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
25	5/5/1998	Positive	IR 98007	NRC	Maintenance	2B	Inservice Inspection procedures and data reviewed by the inspector complied with ASME Code, Section V and Section XI requirements.
26	5/5/1998	Positive	IR 98007	NRC	Maintenance	2B	State-of-the art equipment and procedures were utilized to perform the inservice inspections. Licensee and contractor audits and surveillance were adequate to assure compliance to procedures and the steam generator examination guidelines.
27	5/1/1998	Positive	IR 98009	NRC	Maintenance	3A	A senior reactor operator with no concurrent duties was assigned to directly supervise the reactor operators who performed the Unit 2 bi-weekly rod exercise test. The operators appropriately exercised self-checking techniques, independent verification, and three-way communications. The senior reactor operator maintained a good overview and ensured control room distractions were minimized. The operators utilized the surveillance procedure, and signed off each step as it was performed, consistent with licensee procedural controls.
28	4/27/1998	LER	LER 1998-016	Licensee	Maintenance	2B	Following an investigation and evaluation of a quality assurance condition report concerning the adequacy of testing of refueling system interlocks as required by Technical Specification Table 15.4.1-2, item 14, the licensee determined that refueling interlock testing conducted in accordance with plant procedure ORT-15, "Fuel Manipulator and Fuel Transfer System Checkout," was not adequate to verify each of the interlock and safety features described in Final Safety Analysis Report Section 9.5
29	4/17/1998	LER	LER 1998-014 (Unit 1)	Self-Revealed	Maintenance	2A	During the post-modificaiton testing of 1A52-60, the G01 emergency diesel generator output breaker to the Unit 1 4160-volt safeguards bus (1A05), two service water pumps started unexpectedly.
30	4/7/1998	LER	LER 1998-003 (Unit 2)	Licensee	Maintenance	2B	On April 7, 1998, the licensee determined that an increased frequency surveillance test for a Unit 2 reactor coolant drain tank vent valve (2WG-1787) should have been performed by March 30, 1998, as required by the Amercian Society of Mechanical Engineers Section XI Code, 1986 Edition, Subsection IWV, but was not. The valve stroke test was scheduled and successfully completed later that day on April 7, 1998
31	3/31/1998	Negative	IR 98006	NRC	Maintenance	2A	The use of tape to cover the bearing grease port of the residual heat removal pump motor reflected an acceptance of substandard conditions by auxiliary operators.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
32	3/31/1998	Positive	IR 98006	NRC	Maintenance	2B	Main control board wire separation work was conducted in a professional and thorough manner. All work observed was performed with the appropriate work order plan present and in active use.
33	3/31/1998	Negative	IR 98006	NRC	Maintenance	2B 5C	Many observed maintenance activities were completed in accordance with requirements specified in administrative and work control procedures. However, cases were noted where administrative requirements were not being implemented. Some of the corrective actions for these issues were narrowly focused, and the effort to address the inconsistencies in application of administrative requirements within the maintenance department was not an integrated effort.
34	3/30/1998	LER	LER 1998-012 (Units 1&2)	Licensee	Maintenance	2B	The licensee determined that 27 containment penetration pressure tests required by the American Society of Mechanical Engineers Section XI Code had not been conducted in accordance with the Code. The tests had been conducted in accordance with the licensee's 10 CFR Part 50, Appendix J program; however, the relief request to permit the Appendix J test had not been submitted to the NRC in a timely manner and had not yet been approved by the NRC. The failure to conduct the test in accordance with the Section XI Code is considered a non-cited violation of Technical Specification 15.4.2.B.1. The tracking number for this violation is No. 50-266/98009-05(DRP); 50-301/98009-05(DRP).
35	3/18/1998	**********	IR 98010	NRC	Maintenance	2B	The overall control of M&TE was acceptable. The licensee had made several changes to improve the control of M&TE by storing them in a locked room and requiring full-time attendants to dispense the instruments.
36	3/18/1998	Negative	IR 98010	NRC	Maintenance	2B	The measuring and test equipment (M&TE) procedures were weak. Three M&TE procedures contained conflicting information and did not contain adequate guidance for proper M&TE control. For example, the licensee was in the process of developing one procedure to control M&TE for operations, engineering, electrical/mechanical maintenance, and instrumentation and controls (I&C).
37	3/17/1998	Positive	IR 98006	NRC	Maintenance	3A	Maintenance and operations department freeze seal pre-evolution briefings held on March 17, 1998, were thorough and covered command and control responsibilities, expected communication standards, and contingencies. Teamwork between different disciplines was very evident and participants displayed a good questioning attitude.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
38	3/13/1998	Negative	LER 1998-002(U2) 50.72 No. 33897	Licensee	Maintenance	2A 5A	During radiography of the component cooling water (CCW) system, the licensee identified that the CCW containment return check valve, CC-745, was open with no flow in the pipe. The valve provides a redundant means for preventing loss of CCW fluid in the event of a failure of a CCW pipe inside containment.
39	3/13/1998	VIO/SL-IV	IR 98010	NRC	Maintenance	2B	Evaluations of some lost, damaged, or out-of-tolerance M&TE were not performed or inadequately performed. One violation of NRC requirements was identified. A violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified and assigned a tracking number of No. 50-266/98010-01(DRS); 50-301/98010-01(DRS).
40	3/4/1998	VIO/SL-IV	IR 98006	NRC	Maintenance	2B	Maintenance and health physics organizations were not effectively prepared to perform the lower internals lift based on planning meetings conducted 24 hours prior to the initiation of work. Early in the evolution, maintenance workers failed to follow procedures resulting in a violation of Technical Specification 15.6.8.1. Later in the evolution, the maintenance organization displayed better control of the activity, and the lower internals were moved without incident. The tracking number for this violation is No. 50-266/98006-02(DRP).
41	3/2/1998	Negative	IR 98003	NRC	Maintenance	2B	The licensee implemented improved work planning processes for on-line maintenance and refueling outages. Safety significant modifications were either completed or were scheduled for completion during upcoming outage periods. Notwithstanding these positive accomplishments, there was a large backlog of safety-related repairs and planned modifications, and some work activities were being deferred from their originally scheduled outage windows. The inspectors did not identify any examples of unsafe conditions created by the deferral of work items, but were concerned that the delays in implementing modifications would affect plant operations, such as the power transient described in Section O1.2 of Inspection Report No. 50-266/98003; 50-301/98003. The licensee provided the following backlog information: Open Corrective Maintenance Items - 2060 (212 identified as high priority); Open Condition Reports - 2424; Operations Workarounds - 36; Open Engineering Work Requests - 309; Open Modifications - 465.

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
42	3/2/1998	Negative	IR 98003	NRC	Maintenance	2B	3A	Maintenance staff performed lifts of the reactor vessel head and upper internals without incident. Procedures were followed; however, a lack of strong oversight, coordination, and control in containment was noted when foreign material entered the refueling cavity pool during the upper internals lift.
43	2/13/1998	LER	LER 98010	Licensee	Maintenance	5A	2B	As part of an ongoing review of NRC Generic Letter 96-01, "Testing of Safety-Related Logic Circuits," the licensee identified that circuit testing of the containment spray logic was potentially inadequate based on a potentially undetectable safety logic switch failure. Special testing of the containment spray actuation circuitry to verify proper continuity of the bistable trip switches was performed on February 14, 1998, and indicated that the switches were fully operable.
44	2/3/1998	LER	LER 98008	Licensee	Maintenance	2A	4C	After receiving a 10 CFR Part 21 notification from the vendor, the licensee identified that seven installed air start solenoid valves used in the emergency diesel generators did not meet the minimum direct current voltage requirements when inlet pressures below 200 pounds-per-square-inch-gauge were applied to the valves. Calculations were performed and indicated that only one of the diesels (G03) had sufficient post-accident voltage.
45	2/3/1998	LER	LER 98009	Licensee	Maintenance	5A	2B	The licensee identified that 12 480-volt alternating current undervoltage relay contacts for opposite Unit safeguards sequence circuitry were inadequately tested, contrary to Technical Specification surveillance requirements. The inadequate surveillance testing was discovered during the licensee's review of NRC Generic Letter 96-01, "Testing of Safety-Related Logic Circuits."
46	1/28/1998	VIO/SL-IV	IR 98003	NRC	Maintenance	2B		One violation was identified for a safety-related service water pump that was replaced with a work package which was inappropriate to the circumstances. An effective licensee follow-up assessment of material control concerns identified the need for some broad improvements in the control of nuclear grade parts and material. Programmatic corrective actions were planned at the end of the period; however, short term corrective actions did not receive the appropriate level of documentation and follow-up. The tracking number for this violation is No. 50-266/98003-06(DRP); 50-301/98003-06(DRP).

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47	1/23/1998	Positive	LER 98007	Licensee	Maintenance	2A	5A	In response to a 10 CFR Part 21 notification on potentially incomplete solder connections in a specific model of time delay relay, the licensee inspected the nine time delay relays onsite and identified that a relay installed in the 1P-29 turbine-driven auxiliary feedwater pump and two relays in the spare parts supply had the potentially incomplete solder. Other/NA
48	1/22/1998	NCV	IR 98003 LER 98006 50.72 No. 33576	Self-Revealed	Maintenance	2B		During first-time performance of a special test procedure to requalify the G02 emergency diesel generator, an unanticipated engineered safety feature actuation occurred which caused a partial service water system isolation. However, the isolation occurred as designed, but was unanticipated because the procedure did not recognize that one would occur. The tracking number for this Non-Cited Violation (of Criterion V of 10 CFR Part 50, Appendix B) is No. 50-266/98003-05(DRP); 50-301/98003-05(DRP). Inadequate Procedure/Instruction
49	1/22/1998	Positive	IR 98003	NRC	Maintenance	2B	3A	Operators performed well during a special test of an emergency diesel generator. Additional staff was provided for performance of the test and the test was effectively coordinated. Operators promptly identified and corrected an inadvertent service water isolation caused by an inadequate test procedure.
50	1/21/1998	NCV	IR 98003 LER 98005	Licensee	Maintenance	3A		The licensee identified that the control rod exercise test required by Technical Specifications had not been performed as required because of a data entry error in the computerized maintenance planning and scheduling system. The test is required to be performed at a two-week interval and was last performed on December 19, 1997. The tracking number for this Non-Cited Violation of Technical Specification Table 15.4.1-2, Item 10 is No. 50-266/98003-04(DRP). Personnel Performance Deficiency
51	1/20/1998	Negative	IR 97026	NRC	Maintenance	5C		Two completed corrective actions were reviewed in the maintenance area. One, for a foreign material exclusion issue, was determined to be narrowly focused, and the other was appropriate, but the corrective action was not accurately documented in the licensee's issue tracking database (NUTRK). The licensee indicated that a broad evaluation was being performed in the area of foreign material exclusion under a separate action from that reviewed by the inspectors. Inadequate Oversight

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52	1/2/1998	LER	LER 98001	Licensee	Maintenance	5A	2B	The licensee determined that five 40-month pressure tests (required by ASME Section XI) that were originally identified in September 1996 as not having been conducted were considered missed surveillances. Inadequate Procedure/Instruction
53	12/16/1997	LER	LER 97044 (Units 1&2)	Licensee	Maintenance	5A	2B	The licensee identified that certain inservice test procedures employed "dedicated operators" to replace the automatic containment spray additive function. As written, these procedures rendered inoperable the automatic function which injects sodium hydroxide to both trains of containment spray during a design basis accident. Inadequate Procedure/Instruction
54	12/15/1997	Negative	IR 97025	NRC	Maintenance	2A		In general, the material condition of the systems examined was acceptable. However, the maintenance department and the system engineer were not effectively monitoring battery electrolyte levels. Involved Management
55	12/15/1997	URI	IR 97025	NRC	Maintenance	2A	2B	The NRC inspectors questioned why leakage between the Unit 1 and Unit 2 component cooling water systems was not a functional failure under 10 CFR 50.65. NRC review of the license's evaluation of this issue is an Unresolved Item. The tracking number for this Unresolved Item is No. 50-266/97025-07(DRS); 50-301/97025-07(DRS).
56	12/15/1997	VIO/SL-IV	IR 97025	NRC	Maintenance	2B		In general, performance criteria were appropriately established to measure system performance. Performance criteria for one system did not adequately measure system performance. Established goals were generally conservative; however, two 10 CFR 50.65(a)(1) systems (the reactor coolant and residual heat removal systems) had inappropriate goals and a violation of 10 CFR 50.65(b) was identified. A weakness existed in the process for establishing and revising performance criteria in that new or revised criteria were not formally reviewed by an individual responsible for the maintenance rule program. A number of performance criteria documentation discrepancies were also identified. The tracking number for this violation is No. 50-266/97025-05(DRS); 50-301/97025-05(DRS). **********

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Search Sorted by Date (Descending) and SMM Codes (Ascending). Search Column = "SALP" ; SALP Area = "Maintenance" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
57	12/15/1997	Positive	IR 97025	NRC	Maintenance	2B	The approach to establishing the safety significance ranking for structures, systems, and components (SSCs) within the maintenance rule scope was adequate. The expert panel's safety determinations effectively compensated for the limitations of the probabilistic safety assessment applications. A weakness in the determination process was the use of a probabilistic safety assessment model that did not reflect plant configuration modifications and contained old plant-specific data. Conservative Decision
58	12/15/1997	Positive	IR 97025	NRC	Maintenance	2B	Processes for assessing plant risk resulting from taking equipment out of service during at-power and shutdown conditions were adequate. Plans for an on-line risk monitor, additional probabilistic safety assessment model insights in the matrix, and a shutdown probabilistic safety assessment model will strengthen the licensee's assessment processes. Conservative Decision
59	12/15/1997	Positive	IR 97025	NRC	Maintenance	2B	With the exception of inadvertently omitted performance monitoring criteria, the structure monitoring program was well-organized and comprehensive. Overall, with the exception of baseplate-to-structure hanger support gaps, the structures inspected were in good condition. The licensee noted that the hanger baseplate-to-structure inspection had not yet been performed, but was forthcoming. Involved Management
60	12/15/1997	Strength	IR 97025	NRC	Maintenance	2B	With the exception of the inappropriate goal for the residual heat removal system and the untimely identification of exceeding the component cooling water criteria, the maintenance rule was properly implemented for the systems the team examined. Classifying a number of systems (a)(1) [of 10 CFR 50.65(a)(1)] due to performance concerns, although no performance criteria had been exceeded, was considered a strength. Involved Management
61	12/15/1997	VIO/SL-IV	IR 97025	NRC	Maintenance	2B	A violation of 10 CFR 50.65(a)(2) was identified for the failure of the licensee to demonstrate that the performance or condition of the 120-volt alternating current electrical system and associated emergency lighting system had been effectively controlled by performing appropriate preventive maintenance. Specifically, the licensee failed to establish adequate measures to evaluate the effectiveness of the preventive maintenance on these systems. The tracking number for this violation is No. 50-266/97025-02a(DRS); 50-301/97025-02a(DRS). Inadequate Oversight

PLANT ISSUES MATRIX
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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
62	12/15/1997	Positive	IR 97025	NRC	Maintenance	2B	The process to balance availability and reliability appeared adequate. Adjustments had been made to preventive maintenance tasks on some systems as a result of these evaluations. Conservative Decision
63	5/1997	Positive	IR 97025	NRC	Maintenance	2B 5A	During implementation of the maintenance rule program, three audits and a Nuclear Energy Institute evaluation provided good observations and findings in several aspects of maintenance rule implementation. The most recent audit (May 1997) of the maintenance rule program was extremely thorough and was considered a strength. Corrective actions sampled by the team were appropriately implemented. Self-Critical
64	12/15/1997	Positive	IR 97025	NRC	Maintenance	2B 5A	The procedure for performing periodic assessments met the requirements of the maintenance rule and the intent of the Nuclear Management Resource Council implementing guidance. The yearly assessment, issued March 19, 1997, was acceptable. Conservative Decision
65	12/15/1997	VIO/SL-IV	IR 97025	NRC	Maintenance	2B 5A	In general, scoping of structures, systems, and components (SSCs) was considered adequate. Rescoping efforts in response to the May 1997, self-assessment findings appropriately placed additional SSCs in the maintenance rule program scope; however, two SSCs - the facade freeze protection system and the 345-kilovolt switchyard control building - were still inappropriately excluded. A violation of 10 CFR 50.65(b) was identified. The tracking number for this violation is No. 50-266/97025-01(DRS); 50-301/97025-01(DRS). Inadequate Procedure/Instruction
66	11/30/1997	Positive	IR 97021	NRC	Maintenance	2A	No problems were noted during observations of maintenance and surveillance activities involving the Unit 1 feedwater isolation feature and the auxiliary feedwater, safety injection, and residual heat removal systems. Involved Management
67	11/30/1997	Negative	IR 97021	NRC	Maintenance	2B	Maintenance supervision effectively responded to problems with maintenance procedures for the CCW pump and motor repairs. Inadequacies in the work scoping process and insufficient lead time following procedure development contributed to the procedure problems. **********

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VIO/SL-III	Notice of Violation - Severity Level III
VIO/SL-IV	Notice of Violation - Severity Level IV
Weakness	Overall Weak Licensee Performance

ID BY

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Other	Identification unknown

NOTES

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SENIOR MANAGEMENT MEETING CODES

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5	Problem Identification and Resolution: A - Identification B - Analysis C - Resolution

PLANT ISSUES MATRIX
Point Beach

3/23/99

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Engineering" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	9/30/1998	**********	IR 98017(DRP)	Licensee	Engineering	4B	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.
2	8/17/1998	Positive	IR 98014(DRP)	NRC	Engineering	3B	The initial training material for engineering support personnel appeared to be sufficient in depth and scope. The training instructors were knowledgeable, well prepared, and presented the material effectively.
3	8/17/1998	Positive	IR 98014(DRP)	NRC	Engineering	3B	During the review of the auxiliary feedwater system, the inspectors noted that the cognizant system engineer was knowledgeable of system operational concerns and outstanding maintenance work requests. The engineer displayed a clear sense of ownership for the system and was effectively involved in the work control process.
4	7/31/1998	LER	LER 1998-021	Licensee	Engineering	3B	Missed Technical Specification Surveillance. Inservice stroke test required by ASME Section XI had not been adequately performed on two low head safety injection core deluge isolation valves as scheduled during the recent refueling outage. During a subsequent review, the licensee identified two additional steam generator sample isolation valves had not been stroke tested within their required periodicity.
5	7/31/1998	LER	LER 1998-025, 50.72 No. 34593	Licensee	Engineering	4A	Operation of the control room smoke exhaust fan during control room ventilation operation in an emergency mode would prevent maintaining a positive pressure in the control room. Administrative controls were placed on this fan to prevent operation except for its design purpose of smoke removal.
6	7/31/1998	Positive	IR 98015(DRS)	NRC	Engineering	4C	The inspectors concluded that the licensee's reviews regarding the applicability of logic testing concerns described in NRC Information Notices were adequately addressed.
7	7/31/1998	Positive	IR 98015(DRS)	NRC	Engineering	4C	The inspectors concluded that the Technical Specifications related logic circuit functions reviewed during the inspection were tested in an acceptable manner.
8	7/31/1998	Positive	IR 98015(DRS)	NRC	Engineering	4C	The inspectors concluded that the licensee was identifying and controlling changes to systems containing logic circuits in an acceptable manner to ensure that required logic testing was being performed.

PLANT ISSUES MATRIX
Point Beach

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
9	7/31/1998	Strength	IR 98015(DRS)	NRC	Engineering	4C	The inspectors concluded that the licensee's logic testing program and supporting documentation was good and met the intent of Generic Letter 96-01 (all sections).
10	7/31/1998	Positive	IR 98015(DRS)	NRC	Engineering	5A	The inspectors concluded that the Quality Assurance (QA) organization effectively reviewed the Generic Letter 96-01 project resulting in positive changes to the project that led to improved management oversight and direction.
11	7/18/1998	LER	IR 98017(DRP) LER 1998-023	Licensee	Engineering	4A	The design basis wind loading analysis for the circulating water pumphouse did not address roof uplift caused by tornado winds. A preliminary evaluation indicated that the reinforcing steel at the edge of the roof slab would be above its allowable design stress and would thereby yield, though not break. Yielding of reinforcing steel is outside the design basis requirements for Class 1 structures at Point Beach. Operability of the service water system was not affected.
12	7/17/1998	LER	LER 1998-015-01	Licensee	Engineering	2A	Containment fan cooler test results outside acceptance criteria. Revision to LER identified source of blockage to "D" cooler due to presence of zebra mussel shells in the cooling water supply manifold.
13	7/14/1998	LER	LER 1998-019	Licensee	Engineering	2A	Protective coating applied to the hydrogen monitors electrical terminal strips (for environmental qualification requirements) needed to be replaced if the connections were ever disturbed. Maintenance and replacement of sensors internal to the monitors resulted in all four of the monitors' terminal strips being affected. These terminal strips had no intact coating that could be assured to withstand the harsh environment inside containment post accident.
14	7/6/1998	NCV	IR 98011(DRP)	Licensee	Engineering	2B	The licensee identified in September 1996, that six containment isolation valves associated with the containment heating steam system were inappropriately being tested in the reverse direction. The valves were subsequently removed via a modification. The heating supply line and condensate return line were cut and capped. This non-repetitive, licensee-identified and corrected violation of III.C.1 of Appendix J, was considered an NC V.

PLANT ISSUES MATRIX
Point Beach

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15	7/6/1998	Positive	IR 98011(DRP)	NRC	Engineering	5A	A recently completed quality assurance audit of design engineering activities contained additional examples of previously identified concerns with the design engineering organization. The inspectors concluded that, overall, the audit was probing and thorough and appropriately identified design engineering deficiencies.
16	6/27/1998	Weakness	IR 98011(DRP)	Licensee	Engineering	5A	The licensee's procedures used during reactor startups and the approach to criticality contained deficiencies which reflected a non-conservative approach to reactivity management since the procedures did not incorporate well-established industry guidance for criticality estimations when using boron dilution to achieve criticality.
17	5/29/1998	Positive	IR 98011(DRP)	Licensee	Engineering	5A	The licensee identified a calculational error in the service water system hydraulic flow model and subsequently implemented adequate interim administrative operational restrictions as corrective actions. Licensee management committed to submit a Technical Specification change request no later than July 31, 1998, to address the error in the long-term.
18	5/23/1998	Negative	IR 98009	NRC	Engineering	5A 4B	The corrective actions for a February 7, 1998, waterhammer event were appropriate and thorough, with the exception that the licensee did not address a poor drain trap configuration associated with main steam piping on the 8-foot level of the turbine building. In addition, the inspectors identified a failed, nonsafety-related pipe support which licensee staff had overlooked during the event assessment and routine operator rounds.
19	5/13/1998	Negative	IR 98009	Licensee	Engineering	4B	A draft SE, presented to the MSS for approval, for a slightly longer than normal operating cycle core load was conceptually adequate, but lacked appropriate reference to allowable plant conditions. The design engineers who developed the SE had not proposed appropriate administrative controls for ensuring that the plant conditions covered (allowed) by the proposed SE were maintained while the SE was in effect.
20	5/5/1998	Positive	IR 98007	NRC	Engineering	3A	The licensee's decision to remove the Unit 1 part length control rod drive housings in response to the leaking part length control rod drive housing at Prairie Island demonstrated a conservative decision based on safety. Observation and review of the work procedures confirmed that the modification was performed in accordance with applicable ASME Code and regulatory requirements.

PLANT ISSUES MATRIX
Point Beach

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
21	4/22/1998	VIO/SL-IV	IR 98009	NRC	Engineering	2B	The licensee engineering and regulatory affairs staff who responded to a licensee quality assurance finding of inadequate surveillance testing for refueling system interlocks failed to apply sufficient rigor in their assessment of the issue. Inspector intervention was required to ensure that the Technical Specification-required test was performed appropriately. One violation of Technical Specifications was identified.
22	4/20/1998	LER	LER 1998-015 (Unit 1)	Licensee	Engineering	2A	The licensee declared all the Unit 1 containment fan coolers inoperable after personnel questioned whether the total uncertainty identified in calculations for testing one of the coolers needed to be added to the calculated test results in order to determine the acceptability of the test. With the uncertainty added, the acceptance criterion of the test could not be met.
23	4/13/1998	Positive	IR 98009	Licensee	Engineering	5A	A licensee quality assurance report was effective in that it identified programmatic weaknesses in the licensee's response to Generic Letter 96-01, "Testing of Safety-Related Logic Circuits," specific concerns with the licensee's current position on some Generic Letter 96-01 issues, and a failure to perform some aspects of a required surveillance.
24	3/31/1998	VIO/SL-IV	IR 98006	NRC	Engineering	4A	The inspectors concluded that the 125-Volt direct current (Vdc) system was capable of meeting design basis functions. However, the failure to maintain an up-to-date battery loading calculation was considered a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." The tracking number for this violation is No. 50-266/98006-07(DRP); 50-301/98006-07(DRP).
25	3/31/1998	Negative	IR 98006	NRC	Engineering	4B	The practice of duty technical advisors (DTAs) serving two consecutive 24-hour watches was not consistent with the intent of program procedures and raised questions regarding the DTA's fitness-for-duty. Although, no specific performance issues were identified as a result of the DTA standing consecutive watches, licensee management immediately revised expectations regarding this practice to preclude potential fitness-for-duty issues.

PLANT ISSUES MATRIX
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26	3/31/1998	Negative	IR 98006	NRC	Engineering	4C	A ventilation control panel in an emergency diesel generator room was misclassified as nonsafety-related. The licensee's initial corrective actions did not include determining if operability of the system had been challenged while the component was incorrectly classified as being nonsafety-related. A non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified and assigned a tracking number of No. 50-301/98006-04(DRP).
27	3/31/1998	Negative	IR 98006	NRC	Engineering	4C	Offsite, corporate office-based engineering personnel working on a corrective action commitment initiative to assess the adequacy of a separation of seismically qualified and non-qualified piping systems were performing analyses and taking credit for components to function in a manner that may not have previously been considered in the design basis. The engineers had not evaluated whether such reliance might constitute a design basis change. Additionally, onsite licensee personnel performing concurrent and interrelated corrective action initiatives had not been informed of the potential design engineering activities that could have affected the results of these other initiatives.
28	3/31/1998	NCV	IR 98006	Licensee	Engineering	5A	The licensee identified and corrected two cases [illegible] valves between seismically qualified piping systems and non-qualified piping systems were not maintained in a closed position as required by the Final Safety Analysis Report. A non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified and assigned a tracking number of No. 50-266/98006-05(DRP); 50-301/98006-05(DRP).
29	3/28/1998	Negative	IR 98006	Licensee	Engineering	4B	The reactor engineering organization did not provide accurate critical rate position data to operations personnel during an initial attempt to start Unit 2. The problems revealed during the startup were considered additional examples of reactor engineering performance concerns which were the subject of a Notice of Violation from Inspection Report No. 50-266/98003(DRP); 50-301/98003(DRP).
30	3/2/1998	Negative	IR 98003	NRC	Engineering	4C 5C	Engineering evaluations were used to disposition failures of inservice test acceptance criteria. Engineering management responded promptly by issuing informal clarification of the expectation to use the condition report and operability determination system for such failures. After additional inspector involvement, the appropriate procedures were also modified to more clearly discuss this expectation.

PLANT ISSUES MATRIX
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Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "11/29/97" ; Ending Date = "9/30/98"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
31	2/6/1998	Negative	IR 98004	NRC	Plant Support	1C	The planning for the U1R24 refueling outage appropriately considered health physics requirements and radiological impediments associated with the outage. A weakness was identified where ALARA reviews did not always document how dose estimates were derived.
32	2/6/1998	Positive	IR 98004	NRC	Plant Support	3B	The health physics manager's qualifications indicated that he exceeded the position requirements in Technical Specification 15.6.3.2.
33	2/6/1998	Positive	IR 98004	NRC	Plant Support	3B 1C	The training program for contractor health physics technologists and radiation workers was sufficiently detailed and effectively implemented. The trainers conducted formal discussions, practical demonstations, and task performance evaluations to ensure an acceptable level of proficiency.
34	2/6/1998	Positive	IR 98004	NRC	Plant Support	5C 1C	Corrective actions for a failure to survey a tool before removing it from a contaminated area included a discussion of the event and the need to follow procedures with the health physics staff.
35	2/6/1998	Positive	IR 98004	NRC	Plant Support	5C 1C	Weaknesses in the protective clothing program were addressed by requiring that protective clothing be removed at contaminated area step-off pads, and that personal clothing/modesty garments worn under protective clothing not be removed or covered up before using the contamination monitors
36	2/6/1998	VIO/SL-IV	IR 98004	NRC	Plant Support	5C 1C	Corrective actions for the failure to calibrate emergency plan dosimeters were implemented except for issuing the administrative procedure outlining expectations that surveillances be performed and documented in a timely manner. The tracking number for this violation is No. 50-266/97018-01(DRS); 50-301/97018-01(DRS).
37	1/20/1998	VIO/SL-IV	IR 98002	NRC	Plant Support	3C 1C	The inspector observed a violation when an armed security response officer was posted to continuously monitor an outage of a protected area intrusion alarm zone. The significance of this finding was that licensee security management was aware of this routinely implemented practice, but did not recognize that this action was in violation of a security plan requirement which required the use of a non-response force security officer. Inadequate Oversight
38	1/20/1998	Positive	IR 97026	Licensee	Plant Support	5A 2A	Based on the results of a close-out inspection of the Unit 2 containment, the licensee identified the need to perform additional cleaning and improve future close-out cleanliness standards. Self-Critical

PLANT ISSUES MATRIX
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39	1/20/1998	Negative	IR 98002	NRC	Plant Support	5C	1C		The inspector observed a violation when a vehicle was inadequately searched. The violation was caused when a security officer's attention-to-detail in searching a vehicle was inadequate. Previous corrective actions for two similar violations were not totally effective to prevent recurrence. Each failure, although slightly different, involved weak attention to detail by the search officer. It appeared that previous corrective action had not been effectively focused on addressing the issue of attention-to-detail. Inadequate Oversight
40	1/20/1998	Positive	IR 97026	NRC	Plant Support	5C	1C		The inspectors determined that the health physics department was effective in addressing an adverse trend regarding workers failure to wear proper dosimeters. Involved Management
41	1/20/1998	Negative	IR 98002	NRC	Plant Support	5C	1C	3C	The licensee identified a violation regarding two failures to implement a specific compensatory measure. The events were caused when security supervisory personnel, because of a heavy workload in the alarm stations failed to implement on two occasions a specific compensatory measure. Contributing to this implementation failure was a lack of procedural guidance to address the specific compensatory measure required for the situation. Previous corrective actions for three similar events which included actions to improve alarm station effectiveness by reducing workload activities and improving procedural guidance were not totally effective. Although those actions have resulted in overall improved performance by alarm station personnel, they did not prevent the current events. Inadequate Oversight
42	1/14/1998	NCV	IR 98003 LER 98004 50.72 No. 33530	Licensee	Plant Support	5A			The licensee identified that the motor lube oil collection system for the Unit 2 "A" reactor pump may not comply with Section III.O of 10 CFR Part 50, Appendix R. Although the system was installed as designed and appeared to be in good condition, certain apparent deficiencies exisited, including potential leakage sites outside the system boundary and a potentially inadequate drain path between the oil deflector cone pan and leakoff trough. The tracking number for this Non-Cited Violation is No. 50-266/98003(DRP); 50-301/98003(DRP). Engineering/Design Deficiency
43	11/30/1997	Positive	IR 97021	NRC	Plant Support	2A			The radiological housekeeping within the Primary Auxiliary Building was good. Involved Management

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