

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CON'T

0	1
7	8

REPORT SOURCE

L	6	0	5	0	0	0	2	6	6	7	0	3	2	3	8	2	8	0	4	2	3	8	2	9
60	61	DOCKET NUMBER						68	69	EVENT DATE						74	75	REPORT DATE						80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During a March 23, 1982 inspection of operational containment pressure
0 3 transmitters installed as a TMI response modification, minor installa-
0 4 tion defects were noted on 4 of 6 inspected. These same type of defects
0 5 were also found in other operational in-containment transmitters. This
0 6 event was investigated and found not reportable under 10 CFR 21. This
0 7 event is reportable under T. S. 15.6.9.2.B.3. No reduction in public
0 8 health or safety was experienced as a result of this event.

09		SYSTEM CODE		CAUSE CODE		CAUSE SUBCODE		COMPONENT CODE						COMP. SUBCODE		VALVE SUBCODE	
7	8	I	B	B		C		Z	Z	Z	Z	Z	Z	Z	Z		
		9	10	11	12	13	14	15	16	17	18	19	20				
17		EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE		REPORT TYPE		REVISION NO.							
LER/RO REPORT NUMBER		8	2	008		03		L		0							
21		22	23	24		25	26	27	28	29	30						
ACTION TAKEN		FUTURE ACTION		EFFECT ON PLANT		SHUTDOWN METHOD		HOURS		ATTACHMENT SUBMITTED							
X	X	Z		Z		0000		V		NPRD-4 FORM SUB.							
18	19	20	21	22	23	24	25	26	27	28	29						
33	34	35	36	37	38	39	40	41	42	43	44						
PRIME COMP. SUPPLIER		COMPONENT MANUFACTURER															
Z		Z999															
43	44	45	46														

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this problem was breakdown of the quality control program
1 1 of the backfit contractor. Immediate corrective action included rein-
1 2 spection of all operational transmitters. Further corrective action
1 3 includes surveillance of other previously completed work as well as in-
1 4 creased licensee surveillance and quality assurance auditing.

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

FACILITY STATUS (28) E % POWER 0 8 7 (29) N/A OTHER STATUS (30) METHOD OF DISCOVERY (31) C DISCOVERY DESCRIPTION (32) Quality assurance inspection

ACTIVITY CONTENT
RELEASED OF RELEASE

1 6 2 33 34 N/A

AMOUNT OF ACTIVITY (35)

LOCATION OF RELEASE (36)

N/A

PERSONNEL EXPOSURES									
NUMBER			TYPE	DESCRIPTION					
1	7	0	0	0	(37)	2	(38)	N/A	(39)

PERSONNEL INJURIES		NUMBER		DESCRIPTION (41)	
1	8	0	0	0	(40) N/A

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31		32		33		34		35		36		37		38		39		40		41		42		43		44		45		46		47		48		49		50		51		52		53		54		55		56		57		58		59		60		61		62		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82		83		84		85		86		87		88		89		90		91		92		93		94		95		96		97		98		99		100	
1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31		32		33		34		35		36		37		38		39		40		41		42		43		44		45		46		47		48		49		50		51		52		53		54		55		56		57		58		59		60		61		62		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77		78		79		80		81		82		83		84		85		86		87		88		89		90		91		92		93		94		95		96		97		98		99		100	

ISSUED DESCRIPTION (45) 8204300435 NRC USE ONLY

ATTACHMENT TO LICENSEE EVENT REPORT NO. 82-008/03L-0

Wisconsin Electric Power Company
Point Beach Nuclear Plant, Unit 1
Docket No. 50-266

On March 19, a review of the construction of non-operational electrical conduit being installed as part of backfit modifications required by the NRC indicated that some of the installation features might not be in strict accordance with approved drawings and specifications. The scope of these inspections was increased and on March 23 it was discovered that four of six containment pressure transmitters currently in operation contained defects in these installation features. Further investigations indicated that these problems were confined to these specific areas:

1. Support of electrical conduit at right angle bends was not in strict accordance with the specification.
2. Some conduit is clamped closer than one inch from the Unistrut end. Clamping of conduit at least one inch from the Unistrut end is required for the type of clamps used for this purpose per the specification.
3. Some anchor nuts were not in strict accordance with the specification.

A reinspection program was initiated to cover the work performed during the period of time of greatest concern. Other work performed will be checked on a sampling program with increased surveillance possible based on findings.

Since only Unit 1 contained transmitters that were operational, it was decided that all transmitters outside containment would be inspected immediately and transmitters inside containment would be inspected during the steam generator inspection outage from March 26, 1982 through April 12, 1982. In addition, a reinspection program was instituted to cover the remainder of the work of this contractor using both contractor and licensee QA personnel.

Contributing causes for the discrepancies are summarized as follows:

1. Inadequate backfitting planning for the 1981 refueling outage.
2. Better training of the craft people performing the work was needed. Craft people had limited experience working with the specifications for this work activity.

3. Inadequate construction supervision.
4. Inadequate on-site quality control.
5. Infrequent QA monitoring or surveillance.

The corrective actions are summarized as follows:

1. Clarify and provide a broader, controlled distribution of specifications which govern the work to be accomplished.
2. Increase the training program for the construction craft people with respect to specifications and general nuclear work. Four training sessions have been completed including a special indoctrination session for those personnel reporting on site for the 1982 Unit 2 refueling outage.
3. Improve the performance and quality of the work force at all levels (craft, construction supervisory, quality control) by closer initial and continual scrutiny by the licensee. The licensee site supervisor will perform this function.
4. Contractor construction personnel will perform an inspection of 20% of the raceways separate from quality control or quality assurance activities.
5. Contractor quality control will perform an overall final field inspection against previous portional inspection reports related to a given raceway.
6. Licensee QA personnel will increase their surveillance and auditing of backfit work.
7. The licensee will prepare and distribute a project manual governing the backfit work.
8. Implement a reinspection program of work completed to date as needed.
9. Given systems associated with the backfit work will not be placed in service until the reinspection program has been completed and work has been accepted relative to a given system.

In all cases, the installations were equal to or better than original-installed equipment and resulted in no increase in the probability for the equipment to malfunction.

Since the problems discovered in the conduit and transmitter installation were of a minor nature, it was determined by the Nuclear Engineering Section Safety Review Committee that a substantial safety hazard as defined by 10 CFR 21 did not exist and, therefore, this event was not reportable under 10 CFR 21. An information letter to the Region was sent on the findings of the investigation. It was determined that reporting of this event should ensue under the Technical Specification 15.6.9.2.B.3, "Observed inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of degree of redundancy provided in reactor protection systems or engineering safety feature systems". Corrective action has been completed on the operational Unit 1 transmitters prior to their return to service on April 12.

The Resident Inspector has been notified.