



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION III
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LISLE, IL 60532-4352

September 1, 2011

Mr. Larry Meyer
Site Vice President
NextEra Energy Point Beach, LLC
6610 Nuclear Road
Two Rivers, WI 54241

SUBJECT: POINT BEACH NUCLEAR POWER PLANT, UNITS 1 AND 2,
PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000266/2011008; 05000301/2011008

Dear Mr. Meyer:

On July 21, 2011, the U.S. Nuclear Regulatory Commission (NRC) completed a Problem Identification and Resolution (PI&R) team inspection at the Point Beach Nuclear Plant. The enclosed report documents the inspection results, which were discussed on July 21 with Mr. T. Vehec and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the samples selected for review, there were no findings identified during this inspection. The team concluded that your staff was effective at identifying problems and incorporating them into the corrective action program. In general, issues were appropriately prioritized, evaluated, and corrected, audits and self-assessments were thorough and probing, and operating experience was appropriately screened and disseminated. Your staff was aware of the importance of having a strong safety-conscious work environment and expressed a willingness to raise safety issues.

However, the inspection did identify weaknesses in the identification of trends and performance deficiencies pertaining to the initiation and quality of operability determinations and reportability evaluations. Additionally, the inspection identified that extensive changes made to plant systems and structures for the power uprate modifications should be considered for their effect on previous issues and corrective actions identified in the corrective action program.

L. Meyer

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Sincerely,

/RA/

Michael A Kunowski, Chief
Branch 5
Division of Reactor Projects

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

Enclosure: Inspection Report 05000266/2011008; 05000301/2011008
w/Attachment: Supplemental Information

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report No: 05000266/2011008; 05000301/2011008

Licensee: NextEra Energy Point Beach, LLC

Facility: Point Beach Nuclear Plant, Unit 1 and Unit 2

Location: Two Rivers, Wisconsin

Dates: June 27 – July 21, 2011

Inspectors: J. Jandovitz, Project Engineer, Team Leader
M. Thorpe-Kavanaugh, Resident Inspector, Point Beach
S. Sheldon, Senior Reactor Inspector
M. Munir, Reactor Inspector

Approved by: Michael A. Kunowski, Chief
Branch 5
Division of Reactor Projects

Enclosure

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SUMMARY OF FINDINGS

IR 05000266/2011008; 05000301/2011008; NextEra Energy Point Beach, LLC; on 06/27/2011 - 07/21/2011; Point Beach Nuclear Plant, Unit 1 and Unit 2; Problem Identification and Resolution biennial inspection.

This report covers a 2-week, baseline inspection of problem identification and resolution (Inspection Procedures 71152 and 71004). This inspection was conducted by three regional inspectors and the Point Beach resident inspector. Based on the results of this inspection, there were no findings or violations identified during this inspection.

Identification and Resolution of Problems

The inspection generally concluded that implementation of the corrective action program (CAP) was adequate to identify, evaluate, and correct issues. A sufficiently low threshold for identifying issues and entering them in the CAP existed. The plant's safety culture is generally healthy and workers at the site expressed willingness to raise safety concerns. Operating experience was entered into the CAP and appropriately evaluated. Self-assessments are being conducted at appropriate frequencies for all departments and resulting deficiencies and enhancements included in the CAP. Quality assurance (Nuclear Oversight (NOS)) oversight of the CAP and work performance was considered good.

The inspection did identify weaknesses in the plant programs for trending long-standing and repetitious issues. Adverse trends in reject rates for Apparent Cause Evaluations and with equipment problems associated with radiation monitors and services water valves were not identified by the respective trend programs.

Additional deficiencies were identified with the conduct and quality of operability determinations and reportability evaluations. Similar issues had been previously identified by NRC resident staff and NOS and represented a weakness of the CAP to improve this area and CAP oversight groups, such as the Issue Screening Team (IST) and the Management Review Committee (MRC), to monitor and enforce adequate standards.

A. NRC-Identified and Self-Revealed Findings

No findings were identified.

B. Licensee-Identified Violations

No violations were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution (71152B)

The activities documented in Sections .1 through .4 constituted one biennial sample of Problem Identification and Resolution (PI&R) as defined in Inspection Procedure (IP) 71152.

.1 Assessment of the Corrective Action Program (CAP) Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's CAP implementing procedures and attended selected CAP program meetings to assess the implementation of the CAP by site personnel.

The inspectors reviewed risk and safety-significant issues in the licensee's CAP since the last NRC PI&R inspection in April 2009. The items selected ensured an adequate review of issues across the NRC cornerstones. The inspectors used issues identified through NRC generic communications, department self-assessments, licensee audits, operating experience reports, and NRC-documented findings as sources to select issues. Additionally, the inspectors reviewed CAP items generated that had resulted from performance of daily plant activities. The inspectors also reviewed CAP items and a selection of completed investigations from the licensee's various investigation methods, including root, apparent, and common cause evaluations.

The inspectors performed a more extensive review of the safety-related component cooling water (CCW) system. This review consisted of a five-year search of related issues identified in the CAP and discussions with appropriate licensee staff to assess the licensee's efforts in addressing identified concerns. The inspectors reviewed licensee's CAP and work management system procedures that provided guidance for trending. The inspectors selected the radiation monitoring and the service water systems as vertical slice samples based on input from the resident staff semi-annual trend review. The inspectors reviewed corrective action documents for the past two years, interviewed the system engineers, and performed a walk-down of these systems.

The inspectors reviewed issues related to the extended power uprate (EPU) project, since this involved large, construction-oriented organizations (such as Bechtel) performing significant modifications to the plant over the last several years. Specifically, Bechtel's use of the licensee's CAP was reviewed.

The inspectors attended meetings of the Issue Screening Team (IST) and Management Review Committee (MRC) to observe how issues were being screened and evaluated and to obtain insights into the licensee's oversight of the CAP program.

The inspectors reviewed the timeliness and effectiveness of corrective actions for selected issue reports, completed investigations, and NRC findings, including non-cited violations (NCVs).

During the reviews, the inspectors evaluated whether the licensee's actions were in compliance with the facility's CAP and with 10 CFR Part 50, Appendix B requirements. Specifically, the inspectors evaluated if licensee personnel were identifying plant issues at the proper threshold, entering the issues into the CAP in a timely manner, and assigning the appropriate prioritization for resolution of the issues. The inspectors also assessed whether the licensee staff assigned the appropriate investigation method to ensure the proper determination of root, apparent, and contributing causes.

b. Assessment

(1) Effectiveness of Problem Identification

Issues were generally being identified at a low threshold, evaluated appropriately, and corrected in the CAP. Workers were familiar with the CAP and felt comfortable raising concerns. A large number of CAP items were generated annually; which were reasonably distributed across the various departments. A relatively new computer program was instituted that personnel interviewed described as easier to enter issues and also did automatic generation of a CAP issue when completing a work request. Although, it was also noted the system no longer had the capability to specifically identify which issues were initiated due to NRC concerns.

In 2009, a NOS (Nuclear Oversight—quality assurance) surveillance, PBN 10-003, "2009 4th Quarter Site Quarter Priority DQS Roll-up," (PBNP-QA-10-01), was conducted of the Bechtel CAP and concluded the Bechtel QA [Quality Assurance] Program for the EPU project during the Unit 2 refueling outage 30 was inadequate and did not prevent significant performance deficiencies from occurring and recurring. Resulting corrective actions included training, lowering the threshold for Bechtel personnel entering issues into the CAP, encouraging personnel to enter issues into CAP, thorough and timely resolution of CAP issues, and the use of the Point Beach CAP for all issues or events related to equipment problems within the scope of the Bechtel contract. Improvements were noted for Bechtel's use of the CAP but the licensee has continued to monitor and ensure the Point Beach CAP standards were met. Another NOS surveillance, PDN 11-04, was scheduled to assess the effectiveness of the corrective actions.

The inspectors noted that causal evaluations, in particular apparent cause evaluations (ACEs), were of good quality. Although as noted in the following sections, ACEs were found to have a significant reject rate by the corrective action review board (CARB), which was considered a contributing factor in achieving the quality noted.

There were instances found where issues were not put into the CAP because the issue had already been identified and entered. The inspectors noted, however, that the plant conditions had been modified significantly due to the EPU, and that issues previously identified (and prioritized or resolved) may now have different conditions warranting a new entry into the CAP. For instance:

A clogged drain in the turbine-driven auxiliary feedwater pump room resulted in water spilling on the floor and was previously entered into the CAP. As a result of EPU, a new electrical panel was installed above the drain. During a system walkdown with a licensee individual, the drain was found clogged and the inspectors noted the individual had not planned to enter the issue into the CAP

since it had been previously entered, even though newly installed equipment may have affected the corrective actions or priority of the initial issue. This issue was captured in the CAP as Action Request (AR) 01670042.

The inspection also revealed a weakness in identifying trends in human performance and equipment issues. Procedure PI-AA-207, "Trend Coding and Analysis," was used for human performance trends and defined a potential trend as a change in frequency of occurrence of a given parameter or a change in the level of performance of a particular group, process, program, or procedure. It also defined an adverse trend as a negative change in performance that knowledge, experience, and judgment indicated an adverse impact on safety or reliability, or because a relative large number of performance problems pointed to more significant future problems. The team identified that from January through June 2011, there was a negative trend regarding ACE rejection rate that was not identified by the licensee. This issue was captured in the CAP as AR 01670053.

Additionally, procedure ER-AA-201-2001, "System and Program Health Reporting," was used to identify equipment trends and stated that "system health reporting is the sum of activities that enables the early identification of system or equipment failures and to determine actions required to ensure reliable equipment performance and the process shall monitor indirect measure and trends of system and component performance of critical equipment." Through the inspectors' interviews with staff, it was identified that upon the implementation of the system health reporting system nearly two years ago, certain systems were identified and given a higher priority to establish the direct system reporting system. The inspectors identified the following two examples of equipment trends that were not captured by the licensee's trending program.

One of the systems that had direct system monitoring was the service water (SW) system. The inspectors reviewed condition reports for the past 2 years and found 12 condition reports documenting the repetitive position indication and isolation issues for the SW North Header to South Header Crossconnect Valve, SW-2890. The inspectors reviewed the system health reports for SW and found that two trends were identified for pump operating life and increasing vibrations and for increasing numbers of mussels found in the system. However, the inspectors found no trend identified relative to the SW isolation valve issues. Based on the above described definitions, the inspectors observed that the repetitive issue met the definition of a trend. In response, the licensee initiated AR 1670071.

One system that utilized indirect system monitoring was the radiation monitoring system. The inspectors reviewed condition reports for the past 2 years (60 conditions reports) related to radiation monitoring equipment issues. The inspectors noted that a number of these conditions reports had been written for the clogging of flow indicators by lake grass and unknown mystery alarms which led to increasing out-of-service times for the equipment. Many of the ARs were closed to action taken without looking into the underlying cause that inspectors concluded represented a trend. In response, the licensee initiated AR 1670071 to evaluate the observation.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors found that issue resolutions established and monitored through the IST and the MRC were correctly assigned significance and priority in accordance with station procedures. However, vulnerabilities were identified in the licensee's prioritization of conditions, the licensee's evaluation of operability, and the licensee's implementation of interim barriers.

Modifications completed for the EPU resulted in many safety systems changing their risk profiles. Most notable, the addition of new auxiliary feedwater pumps (AFW) significantly reduced the risk ranking of the AFW system and components. Conversely, the standby gas turbine electrical, G-05, was now the most risk significant component in the plant's probabilistic risk assessment (PRA). Therefore, the inspectors noted that open corrective actions from previous issues with these and other systems and components whose risk changed, should be evaluated for changes to priority and completion dates.

The licensee entered this issue into the CAP as CR01668982 and took action prior to the inspection exit. The licensee determined that the risk rankings for several systems increased (such as CCW, the chemical and volume control, safety injection, residual heat removal, and emergency diesel generator ventilation) and several decreased (125-Volt direct current and AFW). For systems that increased, there were 44 open actions, of which 36 required ranking revisions. For systems that decreased, there were 35 open actions, of which 23 required ranking revisions. All ranking changes were made and the owners of the action items were notified to adjust the current priority and due dates if needed.

The inspectors also identified a number of deficiencies with operability and reportability determinations. Integrated inspection report 2011003 included an NCV for a failure to perform an operability determination in accordance with a procedure when a leak on the secondary side of the steam generator was identified in late 2010. The inspectors found a number of examples where operability determinations did not address the degraded or non-conforming condition described in the AR when concluding operability. Some of these examples included:

- AR 01653799 – Pitting and Corrosion on SW piping between SW-833 and SW-364 – The operability section stated that “EH [Electro-Hydraulic] system is not in service but this issue needs resolution prior to relying upon EH system.” The operability section did not address the pitting and corrosion of SW piping. It was not known why operations addressed the EH system.
- AR 01653323 – HELB Door 193 Held Open – The operability section stated that per the STA [shift technical advisor] walkdown the door is functional as a HELB [high energy line break] and fire door from both the auxiliary building and the fan room. The operability section did not address the door being held open, which impacted the operability of the door as a HELB and fire barrier.
- AR 01652446 – Unexpected D-08 Battery Charger Ground Fault Alarm – The operability section stated “No Tech Spec, EPlan, reportability, or TRM threshold exceeded. Operability is N/A.” The operability section did not address the degraded or non-conforming condition of the ground fault.

- AR 01652104 – D-08 and D-07 Battery Charger Trouble Alarms – The operability section stated, “The ground alarms cleared prior to identification of ground location. All battery parameters with the exception of the ground alarms remained normal. The 125VDC system is operable and capable of satisfying its safety function.” The non-conforming condition was the existence of the ground and was not addressed in the operability section.
- AR 01653792 – AFW Pump Room Drain Plugged – The operability section stated, “No Tech Spec, EPlan, reportability, or TRM threshold exceeded. Operability is N/A.” The operability section did not address the operability of the AFW pumps due to internal flooding from the clogged drain. Also, the source of the water was not addressed.

These issues were entered into the CAP as AR 01666221 and the operability bases were revised for each condition noted by the NRC. With the new information added and all deficient aspects addressed in the operability determination, the inspectors agreed that in all the cases the equipment remained operable.

The conduct of reportability evaluations was also found to be weak. In one case, water seals were missing on the electrical conduit entering the electrical panel for the G-1 and G-02 emergency diesel generators. The basis of the technical assessment for reportability (TAR) contradicted the Final Safety Analysis Report (FSAR). The FSAR credited the seals for flood protection, while the engineering walkdown for the TAR concluded the flooding scenario discussed in the FSAR would not occur. Based on the inspectors’ questions, the TAR was revised to delete the contradiction with the FSAR. The inspectors also noted that in some instances reportability evaluations were not conducted until the NRC raised questions. One issue involved a non-seismic block wall that could fall on and rupture the nearby condensate storage tanks with a potential to for flooding safety-related components. Another issue described non-seismic water storage tanks in the auxiliary building that could fail during a seismic event causing flooding of the residual heat removal pumps. Several of these reportability evaluations were still being evaluated by the NRC.

The inspectors noted that similar observations had been made by the resident staff. Inspection Report (IR) 2011003 issued August 5, 2011, discussed an NCV associated with the failure to perform an immediate operability assessment for a Unit 1 secondary side leak in containment. The inspectors also noted that Nuclear Oversight had identified four instances where operability determinations were not prompt or initial determinations did not invoke more timely and rigorous documentation of the conditions and concluded that the quality of some of the operability notes could be improved and that training was being performed to address the issue. These observations were documented in AR 01652090.

The inspectors reviewed the licensee’s CAP and noted weaknesses in implementation of interim barriers. Procedure PI-AA-204 was reviewed and the inspectors found that it defined “an interim corrective action as an action taken to temporarily prevent the effects of a condition or make an event less likely to recur during the period when the condition is being evaluated and until final corrective actions are completed.” Also, the inspectors noted that procedure PI-AA-205 further clarified that “compensatory/interim actions are classified as interim actions designed to arrest or minimize recurrence until the corrective action to prevent recurrence or corrective action has been implemented.”

However, neither of these procedures discussed when and who should evaluate and implement interim or compensatory corrective actions and hence they may not be done. The most significant example of where better interim actions could have precluded a more significant issue is described below.

The inspectors found an issue concerning inappropriate breaching of HELB doors during plant modifications that was entered into the CAP in February 2010. Several interim corrective actions were established for the Operations department while the causal evaluation was conducted. In June 2010, the NRC identified that the control room door, a HELB barrier, was blocked open by maintenance, a violation of HELB requirements. This occurrence resulted in a licensee event report (LER) and several NCVs. More widespread interim corrective actions could have prevented the control room door issue.

(3) Effectiveness of Corrective Actions

The inspectors concluded that the corrective action program was generally effective in addressing identified issues. A licensee emphasis on corrective action due dates has resulted in no overdue CAP actions for over 550 days.

Corrective actions were generally appropriate for the identified issues. One exception is discussed below.

AR 01661717, Incorrect Noun Name on Instrument Face, was initiated on June 17, 2011, by Operations. The AR discusses "old" AFW pump instrumentation on the C01 main control room board still labeled AFW instead of its new system description as the "Standby Steam Generator Pumps." The AR actions did not try to determine why the labels were not corrected as part of the recent modification or determine the extent of condition. Instead, it assigned actions to fix the labels with a due data in October. As a result of inspectors' questions, AR 01668861 was initiated to perform a causal analysis and extent of condition. Through subsequent discussions with the modification engineer, the inspectors determined the labels had not been corrected yet since the modification was partially accepted and modification activities were still in progress to correct the labels. In effect, the issues in the CAP could have been addressed with no actions required by reference to the modification.

The inspectors noted that the licensee has self-identified many instances where corrective actions were closed inappropriately. The inspectors verified that plant staff do get feedback, or feedback was available to them, on how their issues were addressed. However, the area that most personnel interviewed would like to see more improvement was to have more input for their issues that were dispositioned as closed to actions taken to ensure the issue was properly understood and addressed. For instance:

A licensee individual initiated AR 01654217 when the small article monitor (SAM) was found out-of-service due to high background. Subsequent investigation found that some high activity smears were thrown in the nearby trash, causing the high background. Further, the smears were there because they had been used in the iSOLO instrument, which was considered by the individual inappropriate for this high level of activity. The corrective action desired was to

prevent radiation protection (RP) personnel from using the iSOLO for that high contamination level. The AR was closed to action taken which was to remove the swipes from the trash and returning the SAM to service. The AR initiator was not consulted or satisfied with this closure.

The inspectors found that additional actions were completed but not documented in the AR, including discussions with RP personnel on use of the iSOLO and putting new equipment in service to use for the high contamination smears. The AR initiator would probably have been satisfied closing the AR to these actions.

c. Findings

No findings were identified.

.2 Assessment of the Use of Operating Experience (OE)

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the facility's OE program. Specifically, the inspectors reviewed OE program implementing procedures, observed meetings for the use of OE information, and reviewed completed evaluations of OE issues and events. The intent was to determine if the licensee was effectively integrating OE experience into the performance of daily activities, whether evaluations of issues were proper and conducted by qualified personnel, whether the licensee's program was sufficient to prevent future occurrences of previous industry events, and whether the licensee effectively used the information in developing departmental assessments and facility audits. The inspectors also assessed if corrective actions, as a result of OE experience, were identified and implemented effectively and in a timely manner.

b. Assessment

In general, OE was effectively used at the station. The inspectors observed that OE was discussed as part of the daily station and pre-job briefings. Industry OE was effectively disseminated across the various plant departments and no issues were identified during the inspectors' review of licensee OE evaluations. However, during the review of corrective actions associated with an NCV, the following instance was found where operating experience was not incorporated into site guidance and, if it had been, the event may have been prevented.

The inspectors reviewed the corrective actions related to NCV 2010005-03, "Failure to Submit LER related to breach of HELB Barrier," including the licensee's root cause evaluation (RCE) 01616620, "4Q10 Potential NCV on Failure to Submit LER on HELB Issues." The licensee's RCE concluded that the root cause was inadequate evaluation of NRC RIS 2001-009, "Control of Hazard Barriers." The inspectors noted that even though the initial event occurred in 2001, the licensee's evaluation limited the scope of revalidation to 10 regulatory information summaries, all from 2010. The inspectors considered this a missed opportunity to use operating experience from the same timeframe as the initial

issue. The licensee acknowledged that a more rigorous review was needed based on this example.

c. Findings

No findings were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors assessed the licensee staff's ability to identify and enter issues into the CAP program, prioritize and evaluate issues, and implement effective corrective actions through efforts from departmental assessments and audits. The inspectors reviewed recent self-assessments of the CAP, all self-assessments from operations and emergency planning, and assessments of Bechtel engineering and maintenance and audits conducted by NOS.

b. Assessment

The inspectors concluded that, overall, the licensee's use of self-assessments and audits was appropriate for the identification, evaluation, and correction of issues. The programs for self-assessments and audits were scheduled at an appropriate frequency and included a broad cross-section of performance areas. For the audits and assessments reviewed, observations were documented and ARs written for deficiencies as well as enhancements. NOS assessments and observations were found to be thorough and challenging as evidenced by conclusions and insights related to reviews performed on Bechtel work practices and programs discussed in other sections of this report. Overall, self-assessments were adequately performed.

c. Findings

No findings were identified.

.4 Assessment of Safety-Conscious Work Environment (SCWE)

a. Inspection Scope

The inspectors assessed the licensee's SCWE through reviews of safety culture surveys and assessments conducted in 2010 and of the employee concerns program (ECP) implementing procedures, discussions with the corporate ECP manager, and reviews of issue reports. Approximately 19 personnel were interviewed (including Bechtel personnel): 6 supervisors and 13 workers.

The inspectors reviewed a sample of ECP case files involving potential cases of harassment and intimidation for raising safety issues or discrimination concerns.

b. Assessment

The inspectors found that personnel interviewed had a reasonable knowledge of the basic definition of a safety-conscious work environment and what it meant to them.

Most have received some training, either in annual site access or initial site access, and were aware of general discussions on the subject by the management. All personnel expressed a strong willingness to raise safety issues, without fear. No one knew of any retaliation against an individual for raising a concern.

The inspectors reviewed the results of licensee quick hit assessment report, PBS_PBNP_10_02, "Aggregate Review of 2010 Safety Culture Learnings." This assessment provided a summary and assessment of the results and corrective actions for all the safety culture surveys conducted in 2010. Surveys included in the assessment were the Fleet Safety Culture Survey conducted in June 2010, the Fleet Engagement Survey conducted in spring 2010, the Fleet NEM survey in July 2010, and the Safety Culture Improvement Team (SCIT) results. The inspectors considered the number of surveys and assessments conducted were higher than normal for a year and would provide the licensee plentiful data to formulate effective corrective actions for weaknesses and enhancements identified for safety culture sustainability and improvements.

Although many surveys were conducted, results evaluated for various levels and groups, and actions developed, most personnel interviewed could not provide any details on the safety culture assessments in their specific departments or actions to address department weaknesses. Additionally, most individuals were not aware of the purpose, actions or results of the site's SCIT. This team was initiated by the site prior to the last NRC PI&R inspection (March 2009) and evaluated department safety culture through discussions with plant staff on a periodic basis and reports the results to management. The NRC team noted that additional feedback to plant personnel on safety culture efforts and results, including department results and corrective actions, may enhance the effectiveness of the SCIT.

The inspectors noted that one of the weaknesses identified in the above assessments was communications around decision-making processes and more effectively sharing information with the workforce. During discussions with the plant personnel, there were examples of good communications provided, such as the decision to take the generator off-line in July 2010 to fix a hydrogen leak. Also, more written communications and video messages by the plant manager on plant issues were apparent. However, during the interviews, the inspectors noted that most of the individuals, especially those not associated with operations, were not aware of the existing steam leak on the secondary side of the Unit 1 'A' steam generator or plant management's basis to conclude it was acceptable to continue to operate the Unit rather than shutdown to fix the leak. In response to the inspectors' observation, a Point Beach Newsflash was issued on July 14, 2010, describing the steam generator leakage and operating basis.

The inspectors reviewed 2011 Daily Quality Summary reports for observations determined by the NOS evaluator to be unsatisfactory. Included in the daily reports were insights of possible reasons the evaluator concluded the activity was unsatisfactory. In five observations from March 7 through April 27, 2011, NOS insights included a production-over-safety theme, including schedule pressure. Some of these issues were put into the CAP and resolved as procedure interpretation differences. However, the inspectors noted that the licensee had not performed an overall evaluation of these insights, and any other inputs received from the CAP or ECP regarding possible safety culture concerns, to ensure safety culture degradation was not occurring.

The licensee did enter this issue into the CAP as AR 01670098 and will perform a causal evaluation to evaluate all the identified safety culture issues.

The inspectors determined that the ECP process was being effectively implemented. The program was included in site access training and most personnel remembered the site ECP manager discussing the program at divisional or plant meetings. All personnel stated they would know how to use the system if needed. The inspectors noted through a review of ECP cases that the licensee had appropriately investigated and taken constructive actions to address potential safety culture issues.

The team assessed whether the organization's characteristics and attitudes established, as an overriding priority, that nuclear plant safety issues received the attention warranted by their significance. As a result of the review of the above information, the inspectors concluded the plant's safety culture was adequate. This was similar to the conclusions of the 2010 licensee assessments. The inspectors did note that a significant number of issues with safety culture aspects were contained in the CAP, ECP program, self-assessments, observations, and other sources of information. Therefore, organizational decisions and actions at all levels of the organization should emphasize that production, cost, and schedule goals were developed, communicated, and implemented in a manner that reinforced the importance of nuclear safety.

c. Findings

No findings were identified.

4OA5 Other

- .1 This inspection also counted as a Problem Identification and Resolution sample required by IR 71004, Extended Power Uprate, for both Unit 1 and Unit 2. Refer to specific sections of the report for additional details.

4OA6 Management Meetings

.1 Exit Meeting Summary

On July 21, 2011, the inspectors presented the inspection results to Mr. T. Vehec and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that they returned any proprietary documents.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

L. Meyer	Site Vice-President
J. Costedio	Regulatory Affairs Manager
F. Flentje	Regulatory Affairs Supervisor
A. Mitchell	Performance Improvement Manager
R. Farrell	Radiation Protection Manager
R. Harrsch	Operations Manager
J. Voorhess	Manager, Nuclear Division, Employee Concerns Program
T. Vehec	Plant Manager
S. Pfaff	Performance Improvement Supervisor
R. Flessner	Engineering, Performance Improvement
S. Burnett	Operations, Performance Improvement
B. Scherwinski	Regulatory Affairs
C. Ford	Maintenance Programs Department Supervisor
S. Ruesch	Nuclear Oversight Manager
P. Wild	Design Engineering Manager
J. Kenny	Mechanical Maintenance Manager
B. Wright	Online Scheduling Manager
M. Pederson	Systems Engineering
F. Domke	I&C Systems Supervisor
P. Holzman	Heat Exchanger Testing Engineer
S. Clark	Systems Engineering Supervisor
L. Hawki	Engineering Performance Improvement Manager
J. Schweitzer	Operations Support Manager
J. Pierce	Chemistry Manager

Nuclear Regulatory Commission

M. Kunowski, Chief, Branch 5, Division of Reactor Projects
S. Burton, Senior Resident Inspector

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

None

LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety, but rather, that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

PLANT PROCEDURES

<u>Number</u>	<u>Description or Title</u>	<u>Date or Rev</u>
0-SOP-SW-105	South Service Water Pump Header Isolation	Revision 8
0-SOP-SW-105	South Service Water Pump Header Isolation	Revision 7 Draft
2RMP 9075-1	A-01 4160 V Loss Of Voltage Monthly Surveillance	Revision 14
2RMP 9075-2	A-02 4160 V Loss Of Voltage Monthly Surveillance	Revision 9
2RMP 9359-9A	2D-205 Battery, 2D-207 Battery Charger Maintenance	Revision 1
BALCM Appendix B	Boric Acid Examination Guidelines	Revision 4
BALCM Program	Boric Acid Leakage And Corrosion Monitoring Program	Revision 5
DG-G01	Human Factors Design Document	Revision 10
EN-AA-203-1000	Engineering Evaluation	Revision 0
EN-AA-203-1001	Operability Determinations/Functionality Assessments	Revision 5
EOP-0 Unit 1	Reactor Trip Or Safety Injection	Revision 55
EOP-0 Unit 1	Reactor Trip Or Safety Injection	Revision 54
EOP-0 Unit 2	Reactor Trip Or Safety Injection	Revision 55
EOP-0 Unit 2	Reactor Trip Or Safety Injection	Revision 54
EOP-0.1 Unit 1	Reactor Trip Response	Revision 37
EOP-0.1 Unit 1	Reactor Trip Response	Revision 36
EOP-0.1 Unit 2	Reactor Trip Response	Revision 37
EOP-0.1 Unit 2	Reactor Trip Response	Revision 36
EP Appendix M	Matrix For Emergency Preparedness Equipment	Revision 4
ER-AA-201-2001	System and Program Health Reporting	Revision 3
ER-AA-201-2002	System Performance Monitoring	Revision 1
ER-AA-203-2002	Integrated Project Prioritization	Revision 1
FP-E-MOD-10	Modification Turnover And Closeout	Revision 12
FP-E-SE-04	Conduct Of System Engineering	Revision 6
FP-PA-ARP-01	Action Request Process	Revision 32
FP-PA-OE-01	Operating Experience	Revision 13
FSAR Section 11.5	Radiation Monitoring System	UFSAR 2009
LI-AA-200-1000-10000	NextEra Fleet Licensing Performance Indicators	Revision 04
NA-AA-200	Employee Concerns Program Process Description	Revision 4
NAP-412	Operational Decision-Making	Revision 10
NP 1.2.6	Infrequently Performed Tests Or Evolutions (IPTEs)	Revision 16
NP 1.2.6	Infrequently Performed Tests Or Evolutions (IPTEs)	Revision 15 Draft
NP 1.9.9	Transient Combustible Control	Revision 17

NP 2.1.11	Operational Decision Making Fundamentals	Revision 0
NP 7.7.28	Cable Condition Monitoring Program	Revision 2
NP 7.7.5	MRule Monitoring	Revision 22
NP 8.4.11	Penetrating Barriers	Revision 17
NP 8.5.1	Equipment Identification And Labeling Procedure	Revision 11
NP 800	Employee Concerns Program	Revision 6a
OM 3.26	Use Of Dedicated/Assigned Operators	Revision 13
OM 3.27	Control Of Fire Protection And Appendix R Safe Shutdown Equipment	Revision 41
OM 3.39	Degraded Equipment/Adverse Condition Monitoring Procedure	Revision 3
OM 5.4.4	Control Of Posted Plant Information	Revision 10
OP 4E	Reactor Coolant System Lowered Inventory Requirements Unit 1	Revision 3
OP-AA-100-1000	Conduct of Operations	Revision 1
PI-AA-100-1005	Root Cause Analysis	Revision 3
PI-AA-100-1006	Common Cause Evaluation	Revision 1
PI-AA-100-1007	Apparent Cause Evaluation	Revision 3
PI-AA-100-1008	Condition Evaluation	Revision 1
PI-AA-101	Self Assessment And Benchmarking Program	Revision 6
PI-AA-101	Self-Assessment And Benchmarking Program	Revision 7
PI-AA-102	Operating Experience	Revision 3
PI-AA-203	Action Tracking Management	Revision 4
PI-AA-204	Condition Identification And Screening Process	Revision 12
PI-AA-205	Condition Evaluation And Corrective Action	Revision 12
PI-AA-207	Trend Coding And Analysis	Revision 1
RMP 9305	DB-75 Breaker Routine Maintenance	Revision 19
RMP 9359-5A	D-05 Station Battery, D-07 Battery Charger Maintenance And Surveillances	Revision 5

ARs Reviewed

<u>Number</u>	<u>Description or Title</u>
ACE 01142817	South SW Header Removed From Service In Accordance With 1-SOP-SW-105, ACE Assignment 01
ACE 01159784	Valve Stem Of Manual Isolation Valve SF-2, P-12B SFP Pump Manual Discharge Isolation Valve, ACE Assignment 01, Revision 4
ACE 01163219	Adequacy Of Documentation For Evaluating Seismic II/I With Regard To Unit 1 And Unit 2 Containment Sump Strainers, ACE Assignment 01
ACE 01165673	Potential Non-Compliance With NP 8.4.16 Requirements, ACE Assignment 01, Revision 2
ACE 01175986	Inadequate Evaluation Of Westinghouse NSAL 09-08
ACE 01363240	Increasing Inboard Bearing Oil Leakage On 2P-011B
ACE 01374449	2si-897b Failed To Fully Stroke From The Control Room
ACE 01374551	Reactor Vessel Level Calibration At 70% Level
ACE 01376022	Bechtel Corrective Action Program Is Not Being Effectively Used
ACE 01381584	Inadequate Implementation Of Bechtel QA Program
ACE 01384097	Steam Pressure Dynamics Out Of Tolerance
ACE 01385044	Trend CAP Of Foreign Material In Unit 1 RCS
ACE 01398159	2N-40 OOS: Unavailability Limit Exceeded
ACE 01609804	Unexpected Control Room Alarms; Revision 1
ACE 01619914	Failure To Obtain SRO Approval Prior To Start Of Work
AR 00889394	Calculated Short Circuit Currents Exceed Equipment Ratings
AR 01180534	Panel D13 Short Circuit Currents Exceed Panel Rating
AR 01321492	2P-11A, CCW Pump Excessive Oil Leakage
AR 01331880	OIC Fault On 2P-2C VFD When Starting Pump
AR 01357411	Increased CC Pump Oil Leakage
AR 01358438	RE 230 Drip Pan Corrosion
AR 01358457	Procedure, Process And Controls For SW Header Isolation Work
AR 01360844	RMS Area Monitor Local Readouts
AR 01361361	Added Oil To 1P-11B
AR 01361767	G-02 EDG Tripped On Reverse Power
AR 01362668	Oil Leak On 2P-11B CCW Pump Inboard Bearing
AR 01362964	Enhancements To Our Safety Conscious Work Environment
AR 01363131	2P-11B CCW Pump Oil Collection And Quantification
AR 01363632	Atmosphere Monitor Alarmed In U1 Tendon Gallery
AR 01363811	Potential Design Control Violation For Fuel Oil Volume (NRC)
AR 01363837	Received Unexpected PPCS Alarm: 2RE-229 Alert
AR 01364522	Unsatisfactory Closeout Of CAR 01118728
AR 01364619	D-06 Open Circuit Voltage Above Calculated Value
AR 01365387	During U2 Down Power Two Power Range Recorders Failed To Follow Power Level
AR 01365393	AR 01121653 Closed To Actions Taken But Issue Not Resolved
AR 01365972	NRC Question – Condensate Pump Oil Sampling
AR 01366527	1RE-229 Flow Switch Not Operating Properly
AR 01366759	ACE 01149193 – Failed Quality Review
AR 01366842	RE-105 Removal From Operation
AR 01366885	CAP Closure Prior To Completion Of Assigned Actions
AR 01367132	Inadequate Closeout Of CAP 01141212

AR 01367583	Revise FP-WM-WOI-01 Rev 3 Per CA 1145204-02 (Secondary)
AR 01367586	Corrective Actions Not Completed Satisfactorily
AR 01367604	Questions Regarding Coiled Cables Above P-38A And B
AR 01367681	1N-31 Reads Counts When De-Energized
AR 01367721	2-274/A06 Relay Found Outside Tech Spec Limits
AR 01368155	Out of Tolerance Resistance As-Found values RT06
AR 01368317	1RE-215 Detector Failed High Alarm Check During Calibration
AR 01368319	1RE-215 Detector Bound Tight In Detector Well
AR 01368446	DAM 3 Tx Timeout Errors On RMS System Server In Control
AR 01368725	DAM 3 Failed/Rad Monitors OOS
AR 01368966	ACE Quality Failure
AR 01368988	DAM 3 Communication Failure
AR 01369631	CAP Closed With No Action Taken
AR 01369724	NRC Question On 2P-10A Flange Stud Thread Engagement
AR 01369867	Fouling Of Heat Exchangers
AR 01369933	1FI-2888 Fouled With Grass
AR 01370627	1N-31 Erratic Indication While De-Energized
AR 01371114	Failure Of Effluent Sump Alarm
AR 01371118	Shutdown Safety
AR 01371334	Time Critical Action Verification Process Enhancements
AR 01371774	Numerous RE-315 Alert Alarms
AR 01371960	ACE 01154245 Does Not Meet Minimum Standards
AR 01372026	2RE-128 Module Shuts Down Power Supply When Reinstalling
AR 01372250	North / South SW Header Valve Testing / SW-2890, SW-2891
AR 01372623	Corrective Actions Not Completed
AR 01372706	1RE-211 Containment Air Particulate Detector Is Reading Less
AR 01373001	SOERs 85-3 and 88-3 Not Cited In Site Procedures
AR 01373145	Safety Related Cable Trays In U2 8' Th Under Path Of FWHT
AR 01373984	HX-012D HX Found To Be Approximately 66% Blocked
AR 01373985	Unexpected 2RE-303 Alert And High Alarm
AR 01374038	HX-12D CCW Hx Bryozoa Fouling, GL 89-13 Issue
AR 01374100	RE-230 Leak On U2 Turbine Bldg 8' Floor Contains H-3
AR 01374130	Unit 2 N-32 SRNI Failed To Energize On Rx Shutdown
AR 01374136	Gas Analyzer Alarm Left In During Unit 2 Shutdown
AR 01374162	RE-224 Gas Stripper Building RM Went Into Alert Alarm
AR 01374386	Inadequate Closeout of CAP 01124417
AR 01374387	Inadequate Closeout of CAP 01124029
AR 01374395	CAP 01149819 Inadequate Closeout
AR 01374633	1N-31 SRNI Indicating 100cps While De-Energized Previously WO
AR 01374649	2ICP 04.023-1 Rev 7
AR 01374694	Square Rooters Left Out Of Tolerance
AR 01374906	CCW/HX Fouling
AR 01375044	Received An Unexpected U2 SR High Flux At Shutdown Alarm
AR 01375252	PM To Replace Filters On 1F-003 Closed And Not Worked
AR 01375294	Open Items Identified In EPU Electrical Calculations
AR 01375414	RE-214 Alert Alarm

AR 01375421	SFP Pump Suction Isolation Valve Stem Contacting Adjacent Pipe Insulation
AR 01375480	Thermal Overloads Found Tripped On 2B52-329K
AR 01376144	Safety Related Power Supply Found Out Of Tolerance
AR 01376194	Discrepancies Found During NRC Observed IT IT-04A RHR Test
AR 01376313	2N-42 Calibration As-Found Out Of Tolerances
AR 01376450	Mis-Wiring Of BF Relay Cause Ground Fault
AR 01376609	RE-220 SFP Monitor In Alert
AR 01376772	Intervening Combustible Wire In PAB
AR 01376811	Unplanned LCO Entry Due To Wiring Error EC 13401
AR 01376931	2N-31 Source Range Out Of Tolerance
AR 01376938	1ICP 04.023-1 Rev 8
AR 01377019	Found Bistable NC-101 In 2N-31 Source Range High OOT
AR 01377039	Cap Bank PMT Caused Loss Of Some Electrical Loads
AR 01377858	1P-2C Charging Pump Tripped After Approximately 11 Seconds
AR 01377968	EC 14637 Changed Wiring That Affects UV Testing Procedures
AR 01378102	NRC Inspection: G-01 And G-02 Fire Dampers Are Not Classified
AR 01378129	ACE 01157505 Failed To Meet Minimum Requirements
AR 01378236	NRC Inspection TS Bases 3.8.1 Not Supported By Calc
AR 01378366	SW-2890 – North Hdr Vlv Mid Position When Valve Locally Shut
AR 01378396	DG Room Temperature Calc Has Low Margin
AR 01378732	RE-234/235 Rad Monitor Unable To Be Worked As Scheduled
AR 01378880	50.59 Evaluation 2008-018 Incomplete
AR 01378902	High Calibration Constant On RE-234
AR 01379027	RE-218 Element Apparently Needs Cleaning
AR 01379047	Follow-Up Issue – SCWE Confirmatory Order Inspection
AR 01379245	Issues With Under Voltage Relay Testing
AR 01379249	2RMP 9075-2 Rev8 Temp Change Permanent Revision
AR 01379454	2RE-222, Blowdown Tank Radiation Monitor Went Into Alarm
AR 01379456	1RE-219 Had A 1 Min Average Alarm On RMS Server
AR 01379648	2N-31: MRE Needed
AR 01379779	CAP 01139647 Closeout Not IAW Procedure
AR 01379931	Deficiencies In NP 1.9.6, “Plant Cleanliness And Storage”
AR 01380269	RCE Rejected At TRN Dept CARB
AR 01380574	Cable Submergence Issues
AR 01380584	Status Of RE-218 Is Inhibiting Outage Preps/Water Processing
AR 01380701	RE-224 Readings Trending Up
AR 01380718	1SC-954A Identified Vs. Unidentified Leakage
AR 01380792	Re-224 Average Calculated Efficiency In Spec But Low
AR 01380796	2RE-222 Post Cal. Testing Not Completed Yet On WO 380828
AR 01380896	Out of Tolerance On Threshold Voltage On RE-00218
AR 01380930	Receiving DAM 3 RX And TX Timeouts
AR 01380977	Unexpected Common Area Radiation Monitor High Alarm
AR 01381037	Improving CAP Closure
AR 01381063	SW-2891 S To N Supply Xconn Leak Ck PM – Unable To Complete
AR 01381110	Unexpected 2RE-217 CCW Liquid Monitor Alert Alarms

AR 01381310	Potential Non-Compliance With NP 8.4.16 Requirements
AR 01381337	HELB Penetration M-3-5-17-F203, Potential Spec Non-Compliance
AR 01381464	Inadequate Closure Of CAP-01157499
AR 01381466	Inadequate Cold Weather Preparation CAP Closure
AR 01381584	Inadequate Implementation Of Bechtel QA Program
AR 01381909	SFP Cooler Shell Side Fouling (Increased Mussel Shells)
AR 01382017	CAP 01160639 Inadequate Closure
AR 01382042	RE-242 Monthly Test Failure
AR 01382230	Functionality Assessment Process Shortfalls
AR 01382330	Fire Seals At M-3-5-17 F203 Are Deficient
AR 01382615	D-04 DC Bus Bar Ampacity Condition
AR 01382729	SW-2890 Indicates Intermediate In The Control Room
AR 01382994	SW-2890 Indicates Intermediate In The Control Room
AR 01382997	SW-2891 Indicates Intermediate In The Control Room
AR 01383001	SW-2890 Leaks By 50 GPM During 0-SOP-SW-105
AR 01383095	Received PPCS Alarm "RE-126 Cntnt Hi Range Rad Indication"
AR 01383258	SR NI SUR Spike On Both Channels When Shifting Modes On CSDs
AR 01383347	1N32 Channel Failed to Indicate When Energized
AR 01383653	1N-32 Isolation Amp Output To PPCS Left Out Of Tolerance
AR 01383785	PMO Change May Not Be Appropriate
AR 01383809	System Server Receives Fail Low 1RE-134 At Midnight
AR 01383971	Non-Compliance With NP-8.4.16 HELB Requirements
AR 01384003	RE-230 Waste Water Effluent Rad Monitor Fail External Alarms
AR 01384175	1RE-102, Unit 1 Containment Low Range Monitor Spike High
AR 01384176	Discovered ICC-744A, HX-8B BA Evap CC Supply Throttled
AR 01384500	Outdated HELB Barrier Postings
AR 01385406	Drumming Area Vent Stack (RE-221) Had Multiple Alert Alarms
AR 01385415	1RE-211/212 Secured Without Notifying RP
AR 01385430	ACE 01165947 Quality Did Not Meet Expectations
AR 01385493	ACE 01165036 Quality Did Not Meet Expectations
AR 01385515	Unit 2 Condenser Fouling Increase
AR 01385885	U1 8' Containment Paint Chips And Dust On Sump Pump B Screen
AR 01386083	Inappropriate CAP Closure
AR 01386145	1N-31 NM-106 Out Of Tolerance
AR 01386208	Control Room C01A 3-11 & 4-11 Alarms Disabled During EPU Mod
AR 01386252	2N-40, N1 Fission Channel OOS Greater Than 30 Days
AR 01386492	New AFW Meter Faces Are Not Labeled Properly
AR 01386700	Unit 1 Reactor Startup Was Aborted
AR 01387426	HELB Door 193 Not Closing Properly
AR 01387496	RE-224 LDGS Building Rad Monitor Alert Alarm
AR 01387578	CW System Yellow Work Order Closed with Work Not Performed
AR 01387792	Elevated RMS: RE-214 And RE-221
AR 01387912	ACE 01166586 Failed To Meet Minimum Requirements
AR 01387992	HELB Barrier Controls From AR 01165673
AR 01387996	Effect Of Breached HELB Barrier On Tech Spec Equipment

AR 01388005	Weakness In Past Operability Evaluation For 1HX-015A
AR 01388211	HELB Barrier Compensatory Measures
AR 01388366	NRC EPU Information Request
AR 01388448	Unit 2 MEL Appears To Be Operating Unexpectedly
AR 01388852	B.5.b Walkdown NRC Debrief Enhancement Recommendations
AR 01389331	ACE 01171145-01 Failed To Meet Minimum Requirements
AR 01389520	Question On Prompt Operability Call – AR 01166160
AR 01389524	1RE-219 Alert Alarm
AR 01389948	ACE 01171472 Returned For Additional Work
AR 01389975	RE-230 Effluent Monitor Low Flow
AR 01390330	Delay In D-07 Work Due To HELB Barrier Issue
AR 01390461	2RE-217 Went Into Alert For About 2 Min
AR 01390789	Nuclear Instrumentation Maintenance Rule Criteria
AR 01390824	History Of Inverter Transfer To Alternate Source
AR 01391093	Question Regarding Application Of IEEE 384 To 125VDC Testing
AR 01391406	HX-055A Diesel Cooler Fouling
AR 01391443	Potential Adverse Trend – Mispositioning Events
AR 01391532	WOs 371104 And 363942 Closed With No Action
AR 01391612	CAP 01158754 Not Satisfactorily Addressed
AR 01391623	Potential Inadequate Evaluation of Westinghouse NSAL 09-08
AR 01391731	Unexpected 2RE-215 RMS Alarms
AR 01392152	Unexpected 1RE-229 Fail External Alarms
AR 01392244	Unexpected Alarm: 2RE-222 High Alarm
AR 01393811	U1 Power System Stabilizer Operation On Startup
AR 01393928	EPU Evals Of License Renewal Missed Certain Conditions
AR 01394159	Contingencies May Not Be In Order For U1 Condenser Fouling
AR 01394175	ACE 01175675-02 Was Rejected By CARB
AR 01394317	2Q10 NRC URI-Inverter Transfers To Alt Power During Test
AR 01394857	2RE-222 – Third Occurrence Within 19 Months
AR 01394952	Power Uprate Package Quality
AR 01395125	Failure Of U1 SW Chlorination System
AR 01396318	1RE-217 Was Stuck In Well Due To Corrosion
AR 01396327	Short Circuit Failures Requiring Resolution Prior To EPU
AR 01396926	Tripped D-107 Battery Charger During Testing
AR 01397140	1RE-229 Flow Switch Failure During Quarterly Functional Test
AR 01397189	PBSA-OPS-10-01 Identified Areas For Improvement
AR 01397190	PBSA-OPS-10-01 Identified Enhancements
AR 01397422	NRC PI Cornerstone Owners Areas For Improvement
AR 01397923	Calc N-93-062 Major Revision 3 For 2D-205 Battery
AR 01397925	Calc N-93-061 Major Revision 3 For 1D-205 Battery
AR 01398810	PC 23 Closed To No Work Performed
AR 01399368	Inadequate Calculations To Support Mod EC 15513
AR 01399741	NRC Question On Past Operability Requirements
AR 01400338	Various Errors With EC 12078, 2X-01Transformer Mod
AR 01400403	RE-240 Alert Alarm Light On Remote Meter Needs Replacement
AR 01401275	ACE 01183099 Graded At Below 80

AR 01401329	Initiator Feedback Improvement
AR 01401443	2SC-951 Containment Isolation Valve Stroke Time Testing
AR 01401650	TS Scheduled Too Close to 125% Compliance
AR 01401858	Unit 2 Manual Reactor Trip During Reactor Startup
AR 01402010	NRC Questions Regarding HELB
AR 01402064	Oil Leak on 1P-11A CCW Pump Outboard Bearing
AR 01402154	LER Required For Past HELP Issues
AR 01402178	TI-177, Gas Intrusion Inspection Follow-Up Discussion
AR 01402180	SW-2890 – North Hdr Vlv Mid Position When Valve Locally Shut
AR 01608247	SW Temperature Limit Not Specified For 2HX-15C1-C8 (D1-D8)
AR 01608767	LHSI Sentinel Point Monitoring Results
AR 01609804	Unexpected Control Room Alarms – 1.1% Downpower Required
AR 01610979	Water Seals On Top Of C35 Missing / Degraded
AR 01612401	CDBI FSA Calc 2001-0049, STPT 21.2 VS EPU Implementation
AR 01613514	Chemistry Not Notified Of 1RE-215 Being Taken OOS
AR 01615766	1XY-114 Troubleshooting, Repair, And RTS identified Issues
AR 01616175	Design Flaw In Capacitor Bank Setpoint
AR 01616193	Replacement RMS Isolation Transformer And Parts Needed
AR 01616620	4Q10 Potential NCV On Failure To Submit LER On HELB Issues
AR 01617134	Unit 1 And 2 XY-113 And XY-114 Capacitor Issues
AR 01617227	CR Related To Unit 2 Closed Inappropriately
AR 01617848	Increasing Sample Flow On Sping 24
AR 01618182	Breaker B52-DB25-021 Failed To Open During Testing
AR 01618183	SW-2890 Stopped 25% Open
AR 01618991	INPO IER L3 11-9: Oyster Creek Scram During Startup
AR 01619079	Water Seals On Top Of C35 Missing/Degraded
AR 01619732	AMSAC Function Was Disabled
AR 01619914	Failure To Obtain SRO Approval Prior To Start Of Work
AR 01620143	2FT-925 Found Isolated And Equalized
AR 01620275	ICP 13.001-3 (Sping 23) Found OOT
AR 01620782	Poor Status Control Of SW-2890 Service Water Ring Header
AR 01621239	2N-31 Indicating With Detector De-Energized (2R31)
AR 01621414	Preconditioning Of The Unit 2 CFCS On 9/21/10
AR 01621596	DAM 6 Battery Failed. Found During ICP 13.003 WO 384936 12
AR 01624198	D-05 Battery Voltage – Low Margin
AR 01624591	1RE-229 Did Not Show Fail External When Secured
AR 01624689	2N-31 Failed to Energize on 2R31 Shutdown
AR 01625587	Service Water Chlorination System Chemical Leak
AR 01626072	2N-31 Troubleshooting Inconclusive – Test Equipment Issue
AR 01626344	NRC Observation During Ultrasonic (UT) Exam
AR 01626385	IT 535B Results Indicate Excessive Seat Leakage On 2SI-856B
AR 01626503	Rejected ACEs At Eng CARB
AR 01626625	2N-31: Test High Voltage Cutoff Function (2R31 Mode 6)
AR 01626674	N-31 SRNI Spiked High 2 Times Without Cause
AR 01626693	2N-31 SRNI Counts Drop by 60 cps When N-35 Bypassed

AR 01627172	RE-230 Monitor Going In And Out Of Service Impacting Chemistry
AR 01627428	Issues Noted During Walkdown Of 2LP-447 RV Level
AR 01627924	Mechanical Maintenance Inspection of 2HX-027 A/B
AR 01627998	2N-31 SRNI Counts Fluctuating By 50 cps
AR 01628109	Intermittent Trend Alarms On RE-317
AR 01628109	Intermittent trend Alarms On RE-317
AR 01628928	RE-214, PABVS Process Monitor, Alarm Response
AR 01629007	ACE Action Will Not Reduce Likelihood of Repeat Event
AR 01629371	Sping-21 Fail External
AR 01629378	2PM-368A And 2PM-483A Found Out Of Tech. Spec. Limit
AR 01630690	Unexpected Chlorination System Alarm
AR 01630870	1 ACE And 2 CES Rejected By Station Uprate CARB
AR 01631815	2P-29 AFW Suction Press Control Panel Nest Power Supply
AR 01633234	SW-2890 Indicates Intermediate When The Valve Is Shut
AR 01633248	Control Room Intermediate Indication VS Local Full Shut
AR 01633384	IER1 11-1 Unanalyzed Challenge From Non-Seismic Int Flooding
AR 01634447	CR01632330 Closed to Incorrect Information
AR 01634473	Bechtel Rigging Program Qualification Deficiencies
AR 01634515	IER1 11-1 Non-Seismic Flood Barrier
AR 01634571	Sping-21 Filter Clogged, Causing PPCS Alarm
AR 01634586	Missing Mounting Screw On 2FC-474B-XA Relay Replace Screw
AR 01635304	Error in Recently Approved Electrical Calculations
AR 01636520	CC Temperature Exiting RHR Heat Exchanger
AR 01637106	Work Groups Not Cleaning Up Work Areas
AR 01637576	2N-32: 2R31 ECAD Cables From 2C-131
AR 01637687	Loss Of RE230 Impacts On Chemistry Resources
AR 01637715	Received Unexpected PPCS Alarm: RE-317 Trend
AR 01637903	ACE 01625979 Graded At Below 80
AR 01638987	ACE Does Not Meet Quality Standards
AR 01639521	D-18-10/D-22-10 BKRS Off Created Challenges During ILRT
AR 01639697	AFI CY.1-2 (Continued From CY.1-1, 2009)
AR 01640577	Debris Found During Post-ILRT Inspection
AR 01640776	SW-2890 indicates Intermediate During IT-07G
AR 01641593	N-31 SRNII Counts Rose To 6000 cps And Back Down Over 5 Min
AR 01641618	Spurious RE-224 Gas Stripper Building RMS Alert
AR 01642252	2RE-303, U2 Purge Iodine Detector Fails Low
AR 01642311	RM-Sping-22 Fan Degrading
AR 01642354	Low Flow On Sping-22
AR 01642445	Vacuum Pump Failing On Sping
AR 01642639	Repeated Concerns With SW-2890
AR 01642654	ACE 01629378 Does Not Meet Quality Expectations
AR 01642964	SW-2890 Indicates Intermediate
AR 01644658	Repeat Unexpected "Failed External" Alarm On Sping 21
AR 01645462	TC-06637 Out Of Spec.
AR 01648310	ACE Rejected At Eng CARB
AR 01648765	Disposition Of Uprate Actions After Fall Outage

AR 01649648	Received Unexpected PPCS Alarms Due To Sping-21
AR 01649694	CR Emergency Filtration And Fire Barrier, Past Operability
AR 01649945	ACE 01637440 Graded At Below 80
AR 01651300	FS-4133D Brings In Inadvertent Low Flow Alarm
AR 01651375	2011 PI&R Preps – CR 01393259 Closure Quality
AR 01651418	CA Closed W/Out Action Being Performed (PI&R Preps)
AR 01651427	Inadequate Closeout Of CR 013700053
AR 01651856	1Q11 CAP Closure Quality Quick-Hit Assessment Results
AR 01652090	Operability Determination Implementation, Process Weakness
AR 01652104	D-08 And D-07 Battery Charger Trouble Alarms
AR 01652270	2011 PI&R Preps – CR 01395085 Improperly Closed
AR 01652297	2011 PI&R Preps –Unsat Closure Of CR 01395373
AR 01652330	2011 PI&R Preps – CR 01365829 Closure Quality
AR 01652446	Unexpected D-08 Battery Charger Ground Fault Alarm
AR 01652705	2011 PI&R Preps – CR 01401097 Closure Inadequate
AR 01652781	2011 PI&R Preps – CR 10402010 Assignment Closed Prematurely
AR 01652868	Potential Trend – CAPS Returned From MRC For Cancelled WR
AR 01652875	ACE 01640784 Returned For Additional Work
AR 01652909	Control Room Habitability Engineering Evaluation 03-E19
AR 01653323	HELB Door 193 Held Open
AR 01653458	Two CRs Not Processed Timely
AR 01653591	ACE Rejected At Engineering CARB
AR 01653756	2011 PI&R Preps Licensing Review Of 2009-2011 NRC Finding CR
AR 01653760	2011 PI&R Preps Licensing Review Of 2009-2011 NRC Finding CR
AR 01653788	Received Unexpected PPCS Alarm: Re-317 Trend
AR 01653792	AFW Pump Room Drain Plugged
AR 01653799	Pitting And Corrosion On SW Piping Between SW-833 And SW-364
AR 01653978	CR HVAC Room Floor Seal Needs Re-Coating Maintenance
AR 01654217	SAM at Free Release Found OOS
AR 01655515	ACE Rejected By Licensing
AR 01655732	2CS-110 Handwheel Is Contacting Pipe Above
AR 01655974	Industry Trend – NCVS Regarding Operability Determinations
AR 01657179	ACE 01643652 Graded At Below 80
AR 01657556	CL-20 Pre-Walkdown Issues
AR 01657687	CL 20 Post Outage Containment Closeout Inspection Unit 2
AR 01657712	CL 20 Identified Grey Cord On I-Beam 46' U2 Containment
AR 01657735	2RC-00430 Metal Insulation
AR 01657740	Rope In Conduit Below 2Z-24B1 Upender Motor
AR 01657745	CL 20 Identified Questionable Coating On Keyway Ceiling
AR 01657810	2B-04 Safeguards 480V Bus Was De-Energized
AR 01657864	ACE 01647848 Graded At Below 80
AR 01658989	NRC Resident Inspector Walkdown Of Containment (Follow-Up)
AR 01659381	Containment Sample Flow Indicator Fouled With Algae/Grass
AR 01661717	Incorrect Noun Name On Instrument Face
AR 01661834	Missed LR/GL89-13 Bearing Oil Cooler Inspection
AR 01661865	U1 and U2 Chlorination Frequencies Were Not Met

AR 01663895	Procedure Inadequacy Led To P-206A Being Left In Stop
AR 01664588	1FS-00229 Was Found With Debris Preventing An Alarm
AR 01665314	Unexpected Alarm: Common Process Radiation Monitor High
AR 01665452	PMS-2 Needs Repair (From Sping-21)
AR 01665457	PMS-2 Taken From The Store Room Needs Repair, S/N 383
AR 01665571	PRA Diesel Air Compressor Status
AR 01665986	2F-84A RE-219 Blowdown Sample Filter Plugged
AR 01666038	2RE-00102 High Alarm Setpoint Change Required
AR 01666044	2RE-219 Low Flow Due To Blockage
AR 01666369	RE325 Drum Area Vent LR Gas Rad
AR 01666649	RM-Sping-24 Drum Area Exh Low Range Gas Channel Alert
CAR 10-051	CAR 10-051, 24" SW Butterfly Valve Replacements
CE 01145204	CAPs Closed to Work Orders 1/1/09 – 3/15/09
CE 01165081	Review Initial Classification Of RCS Leak At 1SC-954A, CE Assignment 01
RCE 01358965	1P-11B CCW Pump Oil Bubbler Low
RCE 01368219	Hoist Separation From Lift Beam During P-032E SW Pump Maintenance
RCE 01369845	Work Management Root Cause Evaluation
RCE 01616620	4Q10 Potential NCV On Failure To Submit LER On HELB Issues
TAR 01165673	Potential Non-Compliance With NP 8.4.16 Requirements, Rev. 1
TAR 01169784	Technical Assessment For Reportability For CR 1169784, Rev. 1
WO 00378701	SW-00021 / Valve Leakby
WO 00383699	0SW-02890 – Valve Leaks By 50 GPM During 0-SOP-SW-105
WO 386504-07	Reactor Protection And Safeguards Analog Racks Steam Pressure Refueling Calibration For 2ICP 04.001E
WO 40063428	1XY-114 / Transformer Has 5 Volt Output

OPERATING EXPERIENCE

<u>Number</u>	<u>Description or Title</u>	<u>Date or Rev</u>
OE31354	Diesel Generator Frequency Not Considered In Calculation	June 24, 2010
OE30798	Emergency Diesel Generator Failed To Close	April 12, 2010
IN 2008-18	Loss Of A Safety-Related Motor Control	April 6, 2009
IN 2010-09	Importance Of Understanding Circuit Breaker Control Panel Indications	April 28, 2010

AUDITS, ASSESSMENTS, AND SELF-ASSESSMENTS

<u>Number</u>	<u>Description or Title</u>	<u>Date or Rev</u>
AR 1399171-01	Maintenance Work Order Walkdown Quality Quick Hit Assessment	November 3, 2010
AR 1399496-01	Maintenance Work Order Walkdown Quality Quick Hit Assessment Follow Up	February 11, 2011
PBN 09-024	Point Beach Nuclear Oversight Report – Operations	September 3, 2009

PBN 09-026	Emergency Planning	August 12, 2009
PBN 09-039	Operations – Equipment Control	January 21, 2010
PBN 10-003	2009 4 th Quarter Site Priority DQS Roll-up	February 3, 2010
PBN 10-015	Point Beach Nuclear Oversight Report – Operations	June 9, 2010
PBN 10-023	Point Beach Nuclear Oversight Report – Emergency Planning	August 12, 2010
PBN 10-028	Point Beach Nuclear Oversight Report – Equipment Control	December 28, 2010
PBSA-ENG-11-01	FSA For CDBI Preparations	September 14, 2010
PBSA-EP-10-01	Quick Hit Assessment Checklist For AR 01156883	June 11, 2010
PBSA-EP-10-04	Focused Self-Assessment Report For SAR 01163809	September 22, 2010
PBSA-MTN-10-01	Conduct Of Maintenance Quick Hit Assessment	July 21, 2010
PBSA-MTN-10-06	Review Of Station Power Uprate Work Package Quality	August 17, 2010
PBSA-OPS-09-02	Quick Hit Assessment Report For AR 01155797	June 28, 2011
PBSA-OPS-10-01	Conservative Decision-Making Focused Self-Assessment	September 28, 2010
PBSA-OPS-10-01	Focused Self-Assessment Report For SAR 01150024	September 28, 2010
PBSA-PI-10-27	CAP Feedback	December 7, 2010
PBSA-PROJ-10-01	EPU Implementation	May 12, 2010
PBSA-SRC-10-03	NRC Performance Indicators	September 30, 2010

CONDITION REPORTS GENERATED DURING INSPECTION

<u>Number</u>	<u>Description or Title</u>
AR 01664877	PI&R: CC Bypass Loop Corrosion
AR 01664881	PI&R: CCW Liquid Radiation Monitor Contacts Adjacent Pipe
AR 01665495	Re-Align And Tighten Pipe Support
AR 01665868	2011 PI&R Inspection - Work Request Cancelations
AR 01666221	2011 PI&R: Immediate Operability Determinations
AR 01666232	2011 PI&R: TAR01610979 Adequacy Questioned
AR 01667086	FSAR Appendix A.7, Delete Waterproofing On HVAC Room
AR 01667417	PI&R: RMS Walkdown Observation
AR 01667418	2011 PI&R: RMS Walkdown Observation
AR 01668683	Protective Shrink Tube Around Coaxial Cable
AR 01668861	2011 PI&R: Modification Punchlists
AR 01668923	Potential Trends Related To Potential Schedule Pressure
AR 01668982	2011 PI&R: CAP Risk Ranking Change
AR 01669000	PI&R Inspection: 2PI-2907 Vibration
AR 01669659	Retrospective Review Of U2R31 Potential Concerns Is Needed
AR 01670042	2011 PI&R: Identification of Existing Field Issues
AR 01670046	2011 PI&R: Leak Management Program Observation
AR 01670053	2011 PI&R: ACE Rejection Rate

AR 01670071	2011 PI&R: System Health Trending
AR 01670082	2011 PI&R: Use Of Immediate And Compensatory Corrective Action
AR 01670086	2011 PI&R: Improve Understanding Of Closed To Action Taken
AR 01670091	2011 PI&R: Self-Assessment Performance
AR 01670098	2011 PI&R: Safety Culture Activity And Awareness

MISCELLANEOUS

<u>Number</u>	<u>Description or Title</u>	<u>Date or Rev</u>
	Nuclear Instrumentation (a)(1) System Action Plan	December 9, 2010
	Containment Integrity (a)(1) System Action Plan	April 15, 2010
	Point Beach Daily Quality Summary Report – Bechtel	January 1 To July 13, 2011
	Monthly PBNP Performance Improvement Measures Of Success	January to June, 2011
	Performance Improvement Job Aid For Action Tracking – CAPCO And IST Guidance	January 4, 2011
	Management Review Committee Meeting Agendas	June 28, 29, 30, and July 11, 2011
	System Health Reports, Unit 1 – Non-Risk Significant Systems	April 1, 2009 to March 31, 2011
	System Health Reports, Unit 2 – Non-Risk Significant Systems	April 1, 2009 to March 31, 2011
	Scope Change Request Process Instructions For 1XY-113	March 9, 2011
	System Health Reports, Unit 1 – Risk Significant/Safety-Related Systems	April 1, 2009 to March 31, 2011
	Turnover Control Form For EC 259835 (NAMS)	June 3, 2011
	Turnover Control Form For EC 12052 (Main Feedwater Isolation Valve)	June 5, 2011
	Turnover Control Form For EC 258482 (EC-12054)	June 7, 2011
	Common Cause Evaluation For CAP AR 01175806	August 11, 2010
	Component Mispositioning	May 2011
	Common Cause Evaluation For CAP AR 01175806-10	October 23, 2010
	LMS Qualification Status Verification (Active Students)	June 17, 2010
	Operations PCRA Backlog Scrub	December 23, 2009
	AOC Training Cycle 9B Schedule/TRPR 17.0 Auxiliary Operator	Revision 4; March 25, 2009
	LOCT Cycle 9C Schedule/PB-LOC-TPD, Licensed Operator Continuing Training	Revision 3; June 2, 2009
	LOCT Cycle 9B Schedule/PB-LOC-TPD, Licensed Operator Continuing Training	Revision 4; April 2, 2009

	AOC Training Cycle 9C Schedule/TRPR 17.0 Auxiliary Operator	Revision 6; June 9, 2009
Drawing 018995	P&ID Service Water, PBNP Unit 1	Revision 77
Drawing 018996	P&ID Service Water, PBNP Unit 1	Revision 45
Drawing 019029	P&ID Service Water, PBNP Unit 2	Revision 62
Drawing 080033	P&ID Service Water System, PBNP Unit 1	Revision 26
Drawing 080034	P&ID Service Water, PBNP Unit 1	Revision 66
Drawing 275461	P&ID Service Water System, PBNP Unit 2	Revision 13
Drawing 275463	P&ID Service Water, PBNP Unit 1	Revision 33
Drawing PB19841	P&ID Auxiliary Feedwater System, PBNP Unit 1	Revision 02
Drawing PB19842	P&ID Auxiliary Feedwater System, PBNP Unit 2	Revision 02
EC13822/EC260250)	RE-216, Grass Fouling	Revision A
EC2427/MR 85-068	RMS System	March 4, 1985
Eval 2008-018	Impact Of Revised Containment Heat Sink Paint Thickness On Containment Integrity Analyses (SLB And LOCA) For Units 1 And 2	November 1, 2008
Eval 2009-010	Containment Integrity Evaluation For Increased Paint Thickness On Containment Structures	July 31, 2009
MRE 1610979	C-35, G-02 Control Cabinet, C-34, G-01 Control Cabinet	February 17, 2011
NPM 2009-0208	From S. J. Nikolai To CARB Members; Subject: Minutes From The June 23, 2009 CARB Meeting	June 23, 2009
NPM 2009-0266	From S. A. Pfaff To CARB Members; Subject: Minutes From The July 14, 2009 CARB Meeting	July 14, 2009
NPM 2009-0315	From J. M. Glaser To CARB Members; Subject: Minutes From The August 27, 2009 CARB Meeting	August 27, 2009
NPM 2009-0317	From J. M. Glaser To CARB Members; Subject: Minutes From The September 1, 2009 CARB Meeting	September 1, 2009
NPM 2009-0328	From J. M. Glaser To CARB Members; Subject: Minutes From The September 8, 2009 CARB Meeting	September 9, 2009
NPM 2009-0368	From J. M. Glaser To CARB Members; Subject: Minutes From The September 29, 2009 CARB Meeting	September 29, 2009
NPM 2009-0382	From J. M. Glaser To CARB Members; Subject: Minutes From The October 6, 2009 CARB Meeting	October 6, 2009
NPM 2009-0396	From J. M. Glaser To CARB Members; Subject: Minutes From The October 15, 2009 CARB Meeting	October 15, 2009

ORT 3A	Safety Injection Actuation With Loss Of Engineered Safeguards AC (Train A) Unit 2	Mar 8, 2011
TAR 1610979	Water Seals On Top Of C35 Missing/Degraded	Revisions 1, 2 and 3
WO 00396997	PP-34, Replace Breakers To Resolve Short Circuit Conditions	May 1, 2011
WO 00396998	PP-33, Replace Breakers To Resolve Short Circuit Conditions	May 2, 2011
WR 00030036	2P-2C VFD Unit Having An "IOC" Fault On Start	November 9, 2007
WR 00348636	2P-2C Perform Troubleshooting And Repair	August 14, 2008

LIST OF ACRONYMS USED

ACE	Apparent Cause Evaluation
ADAMS	Agencywide Document Access Management System
AFW	Auxiliary Feedwater
AO	Auxiliary Operator
AR	Action Request
CA	Corrective Action
CAP	Corrective Action Program
CAPR	Corrective Actions to Prevent Recurrence
CAQ	Condition Adverse to Quality
CARB	Corrective Action Review Board
CCE	Common Cause Evaluation
CCW	Component Cooling Water
CE	Condition Evaluation
CFR	Code of Federal Regulations
CR	Condition Report
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
ECP	Employee Concerns Program
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
EFR	Effectiveness Review
EPU	Extended Power Uprate
FSAR	Final Safety Analysis Report
HELB	High Energy Line Break
IMC	Inspection Manual Chapter
IN	Information Notices
IP	Inspection Procedure
IST	Issue Screening Team
IR	Inspection Report
LER	Licensee Event Report
LOOP	Loss Of Offsite Power
MRC	Management Review Committee
MRE	Maintenance Rule Evaluation
NCAQ	Not Condition Adverse to Quality
NCV	Non-Cited Violation
NOS	Nuclear Oversight
NP	Nuclear Plant Procedure
NRC	U.S. Nuclear Regulatory Commission
ODMI	Operations Decision Making Instruction
OE	Operating Experience
OI	Operating Instruction
OPR	Operability Recommendation (Operability Determination)
PARS	Publicly Available Records System
PCR	Procedure Change Request
PI&R	Problem Identification and Resolution
PMT	Post-Maintenance Test
PRA	Probabilistic Risk Assessment
RCE	Root Cause Evaluation
RHR	Residual Heat Removal

RMP	Routine Maintenance Procedure
RP	Radiation Protection
SAM	Small Article Monitor
SCAQ	Significant Condition Adverse to Quality
SCCI	Substantive Cross-Cutting Issue
SCIT	Safety Culture Improvement Team
SCWE	Safety-Conscious Work Environment
SDP	Significance Determination Process
SI	Safety Injection
SW	Service Water
TAR	Technical Assessment for Reportability
TS	Technical Specification
WO	Work Order

L. Meyer

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Sincerely,

/RA/

Michael A Kunowski, Chief
Branch 5
Division of Reactor Projects

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

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Letter to L. Meyer from M. Kunowski dated September 1, 2011

SUBJECT: POINT BEACH NUCLEAR POWER PLANT, UNITS 1 AND 2,
PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000266/2011008; 05000301/2011008

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