UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

April 11, 2013

EA-12-106

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

SUBJECT: POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2,
NRC SUPPLEMENTAL INSPECTION REPORT 05000266/2013503;
05000301/2013503

Dear Mr. Meyer:

On March 8, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure 95001 Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area, at your Point Beach Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection results, which were discussed on March 8, 2013, with Mr. G. Vickery, and other members of your staff.

In accordance with the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed to follow-up on a White finding with low to moderate safety significance, which occurred in the second quarter of 2012. This issue was previously documented and assessed in NRC Inspection Report 05000266/2012503; 05000301/2012503 and NRC Inspection Report 05000266/2012504; 05000301/2012504. The NRC was informed by your letters dated September 17, 2012, and December 5, 2012, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and contributing causes for the risk significant issues were understood; (2) the extent of condition and extent of cause of the issues were identified; and (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes.

Overall, the NRC concluded the licensee's root cause analysis adequately identified the root causes, extent of condition, and extent of cause. The NRC also concluded the root cause analysis corrective actions to preclude repetition of the root and contributing causes were appropriately identified.

The NRC has determined that inspection objectives stated above have been met. Therefore, in accordance with Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," the performance issue shall not be considered in the Action Matrix after the end of the first quarter of 2013.

The NRC determined that the staff at Point Beach Nuclear Plant, Units 1 and 2, performed an acceptable evaluation of the White finding. The evaluation identified the primary root cause of the issue originated in 2005 when plant staff changed the emergency plan implementing procedures (EPIPs) to become compliant with regulatory guidance by adding sheltering to their range of protective action recommendations (PARs). At that time, the emergency preparedness staff did not perform comprehensive reviews of Federal guidance and operating experience to ensure correct changes were made to the PAR determination process in the procedures.

The finding was associated with an apparent logic error in a Point Beach Emergency Plan implementing procedure that directed the emergency director to revisit the question of impediments to evacuation after a prior decision to evacuate affected downwind sectors had been implemented by local authorities, resulting in a contradictory recommendation for sheltering being given during an exercise. Additionally, Point Beach EPIPs did not direct PARs when projected dose was greater than protective action guidelines beyond the 10-mile plume exposure pathway. Corrective actions taken to prevent recurrence included revisions to the PAR EPIP and implementation of a comprehensive process for reviews of Federal Guidance and operating experience.

No findings were identified during this inspection.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any), will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Gary L. Shear, Director
Division of Reactor Safety

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

Enclosure: Inspection Report 05000266/2013503; 05000301/2013503
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	05000266; 05000301
License Nos:	DPR-24; DPR-27
Report No:	05000266/2013503; 05000301/2013503
Licensee:	NextEra Energy Point Beach, LLC
Facility:	Point Beach Nuclear Plant, Units 1 and 2
Location:	Two Rivers, WI
Dates:	March 4 through 8, 2013
Inspector:	Robert Jickling, Sr. Emergency Preparedness Inspector
Approved by:	Donald Funk, Acting Chief Plant Support Branch Division of Reactor Safety

Enclosure

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SUMMARY OF FINDINGS

Inspection Report (IR) 05000266/2013503, 05000301/2013503; 03/04/2013 – 03/08/2013; Point Beach Nuclear Plant, Units 1 and 2; Supplemental Inspection – Inspection Procedure (IP) 95001.

This report covers a one week period of announced Supplemental inspection on Emergency Preparedness (EP). The inspection was conducted by one Region III EP inspector. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

The NRC staff performed this supplemental inspection in accordance with IP 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with an apparent logic error in a Point Beach Nuclear Plant (PBNP) Emergency Plan Implementing Procedure (EPIP) that directed the emergency director to revisit the question of impediments to evacuation after a prior decision to evacuate affected downwind sectors had been implemented by local authorities, resulting in a contradictory recommendation for sheltering being given during an exercise. Additionally, PBNP EPIPs did not initiate protective action recommendations (PARs) when projected dose was greater than protective action guidelines beyond the 10-mile plume exposure pathway. The NRC staff previously characterized this issue as having low to moderate safety significance (White), as documented in NRC IR 05000266/2012504; 05000301/2012504.

During this inspection, the inspector determined that the licensee's root cause evaluation was conducted to a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event. The inspector also concluded that the licensee identified reasonable and appropriate corrective actions for the root and contributing causes and that the corrective actions appeared to be prioritized commensurate with the safety significance of the issues.

The licensee determined the root cause originated in 2005 when PBNP staff changed the emergency plan procedures to become compliant with regulatory guidance by adding sheltering to their range of PARs. At that time, the emergency preparedness staff did not perform comprehensive reviews of Federal guidance and operating experience to ensure correct changes were made to the PAR determination process in the procedures. The licensee has taken corrective actions to ensure the PAR EPIPs have been revised to incorporate Federal Guidance and Operating Experience.

A. Inspector-Identified and Self-Revealed Findings

Cornerstone: Emergency Preparedness

No findings were identified.

B. Licensee-Identified Violations

None.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.1 Inspection Scope

This inspection was conducted in accordance with Inspection Procedure (IP) 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation of one White inspection finding in the Emergency Preparedness Cornerstone. The inspection objectives were to:

- Provide assurance that the root causes and contributing causes of risk significant performance issues are understood;
- Provide assurance that the extent of condition and extent of cause of risk significant issues are identified; and
- Provide assurance that licensee corrective actions to risk significant performance issues are sufficient to address the root causes and contributing causes, and to prevent recurrence.

Point Beach Nuclear Plant, Units 1 and 2, entered the Regulatory Response column of NRC's Action Matrix in the second quarter of 2012 as the result of one inspection finding of low to moderate safety significance (White). The finding was associated with an apparent logic error in a PBNP EPIP that directed the emergency director to revisit the question of impediments to evacuation after a prior decision to evacuate affected downwind sectors had been implemented by local authorities, resulting in a contradictory recommendation for sheltering being given during an exercise. Additionally, PBNP EPIPs did not initiate PARs when projected dose was greater than protective action guidelines beyond the 10-mile plume exposure pathway. The details of the finding are documented in previous communications dated June 1, 2012, and July 24, 2012, which included NRC Inspection Report Nos. 05000266/2012503; 05000301/2012503 and 05000266/2012504; 05000301/2012504, respectively.

By letters dated September 17, 2012, and December 5, 2012, the licensee notified the NRC that it had completed its evaluation of the errors in the emergency plan implementing procedures and was ready for the NRC to assess the licensee's evaluation and subsequent corrective actions. In preparation for the inspection, the licensee performed a root cause evaluation (RCE), RCE 01757131-01, Revision 4, for the degraded risk significant planning standard function.

The inspector reviewed the licensee's RCE, in addition to other evaluations conducted in support, and as a result, of the RCE. The inspector reviewed corrective actions that were taken or planned to address the identified causes. The inspector also held discussions with licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and prevent recurrence.

.2 Evaluation of Inspection Requirements

2.01 Problem Identification

a. *Determine whether the evaluation identified who (i.e., licensee, self-revealing, or NRC), and under what conditions the issue was identified.*

The inspector determined that the RCE adequately identified who and under what conditions the issue was identified. The RCE concluded that following the licensee's biennial exercise critique presentation, the NRC identified a potential violation of 10 CFR 50.47(b)(4). The potential violation was due to a degraded risk significant planning standard function concerning PBNP EPIP 1.3, Revision 42, Dose Assessment and Protective Action Recommendations flow chart which incorrectly rescinded a previous evacuation recommendation to the State and counties and directed a shelter PAR to be issued for the same area. The NRC also identified the EPIP, which contained inadequate guidance direct a PAR if projected doses beyond the 10-mile plume exposure pathway exceeded Federal protective action guidance.

The inspector agreed with the licensee's RCE conclusion that the NRC identified the sheltering and greater than 10 miles PARs issues in their emergency plan implementing procedures.

b. *Determine whether the evaluation documented how long the issue existed and, whether there were any prior opportunities for identification.*

The inspector determined that the RCE adequately identified how long the issue existed and whether there were any prior opportunities for identification. The RCE concluded that during a revision to EPIPs 1.1, "Course of Action," and 1.3, "Dose Assessment and Protective Action Recommendations," on July 29, 2005, errors were introduced into the EPIPs. The RCE identified that licensee processes and reviews did not reveal the procedural issues during or after the revisions were implemented. These processes and reviews included drills, training, procedure reviews, self-assessments, and oversight audits.

The inspector determined that the RCE appropriately specified the length of time and prior opportunities the issues existed.

c. *Determine whether the licensee's root cause evaluation documented the plant specific risk consequences and compliance concerns associated with the issue.*

The inspector determined that the RCE adequately documented the plant specific risk consequences and compliance concerns associated with the issue. The RCE concluded that the issues were identified during the performance of an NRC evaluated exercise. The offsite agencies continued to evacuate the public from the specified areas after the licensee changed the PAR notification to shelter. This resulted in no actual challenge to the health and safety of the public and a regulatory non-compliance with a consequence of low to moderate (White). However, the RCE continued to state that use of these EPIPs under different conditions, had the potential to cause confusion of the State and county decision makers, as well as the public which could adversely impact evacuation actions already in progress.

Based upon the above documented observations, the inspector concluded that the licensee appropriately identified the risk consequences associated with compliance and implementation risk in their RCE.

d. Findings

No findings were identified.

2.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

a. *Determine whether the licensee's root cause evaluation applied systematic methods in evaluating the issue in order to identify root causes and contributing causes.*

The inspector determined that the RCE adequately applied systematic methods in evaluating the issue in order to identify root causes and contributing causes. In the licensee's root cause analysis, the licensee used three systematic methods in performing its RCE. The three methods included:

1. Events and Causal Factors Analysis – to identify the events and conditions that led up to the event;
2. Barrier Analysis – to identify the barriers that would have prevented the event from occurring; and
3. Why Staircase – to produce a linear set of causal relationships and use the experience of the problem owner to determine the root cause, contributing causes, and corresponding solutions.

In addition to the systematic methods used above, the licensee provided information from interviews of the exercise participants, an exercise timeline, and historical event timeline in the RCE.

Based upon the above, the inspector determined that the systematic analysis methods used were adequate to evaluate the root and contributing causes of this issue.

b. *Determine whether the licensee's root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.*

The inspector determined that the RCE was conducted to a level of detail commensurate with the significance of the problem. In its root cause analysis, the licensee conducted a focused analysis of the issue using Event and Causal Factor Charting, Barrier Analysis, and Why Staircase methods with additional information and facts from interviews and Federal guidance reviews. The licensee concluded the root cause originated from failures to perform comprehensive reviews of Federal Guidance and Operating Experience to ensure correct changes were made to the PAR determination process in July 2005. Contributing causes identified in the RCE included: 1) Current Federal guidance on PARs was not correctly incorporated into the EPIPs and flowchart when they were changed in July 2005; and 2) Prior training and drills for PAR determination did not discover the procedural errors. The three analysis methods and additional information identified above provided an appropriate level of detail to support the RCE root cause and contributing causes.

Based upon the work performed for this root cause, the inspector concluded that the licensee's RCE was adequate with respect to a level of detail commensurate with the significance to the issue.

c. *Determine whether the licensee's root cause evaluation included consideration of prior occurrences of the problem and knowledge of prior operating experience.*

The inspector determined that the RCE adequately included consideration of prior occurrences of the problem and knowledge of prior operating experience. The licensee's RCE searched its fleet Corrective Action Program database for the same or similar previous occurrences for the last five years and found no prior occurrences. The RCE specified that there were a number of opportunities to identify this issue. An industry Operating Experience (OE) search from 2000 to May 2012 found no similar events. Regulatory Issue Summaries (RISs) in 2003, 2004, and 2005 were considered OE that had not been adequately screened. These RIS documents were not revisited by the staff after the initial reviews had been completed.

Based upon the considerations described in the analysis, the inspector concluded that the licensee's RCE included an adequate consideration of prior occurrences of the issue and knowledge of prior OE.

d. *Determine whether the licensee's root cause evaluation addressed extent of condition and extent of cause of the problem.*

The inspector determined that the RCE adequately addressed the extent of condition and extent of cause of the problem. In its RCE, the licensee addressed the extent of condition by defining the problem statement where, during an exercise, the emergency director incorrectly issued a shelter protective action recommendation for the same area that evacuation protective actions were already implemented due, in part, to the procedure's use of the term "impediment." The licensee determined there were four emergency operations facility emergency directors, and seven active shift managers that could take the role of emergency director and provide PARs in a declared emergency. As part of the corrective actions, all identified individuals were provided an information sharing document of the event and of the EPIP changes to ensure a shelter PAR would not be issued over an evacuation PAR. The licensee also considered two additional emergency response organization positions that provide assistance to the emergency director to determine protective action recommendations, the dose assessment/ protective action recommendation coordinator and the emergency operations facility manager. Eight additional personnel received the same information sharing document as identified above. Lastly, the licensee contacted the State and county emergency response personnel to determine if there were any other terminologies that could create confusion. No other terminology was identified.

The licensee addressed extent of cause by looking at the extent of the root cause, which was PBNP emergency planning staff did not perform comprehensive reviews of Federal guidance and operating experience to ensure correct changes were made to the PAR determination process in the emergency procedures. A review of Federal guidance and operating experience associated with protective action recommendations did not identify any additional gaps in the emergency procedures outside of the issues already identified in the evaluation. The RCE did determine that a change in PARs based on exceeding protective action guidelines, including subsequent wind shifts, needed clarification to

ensure the intent of the guidance is met. The licensee looked at the remaining risk significant planning standard (RSPS) functions of classification, notification and dose assessment and the applicability of not fully integrating the Federal guidance to these. Eighteen Regulatory Issue Summaries from 2002 to 2009 were found to be applicable to these three remaining RSPS functions. Two RIS reviews were identified as lacking rigor in the evaluation closeout documentation. The licensee's safety evaluation subject matter experts were contacted to determine if issues had been identified that resulted in Federal guidance not being properly incorporated into their EPIPs. Responses indicated that there were no issues identified by the site or NRC.

The licensee looked at the contributing causes for additional extent of cause. Contributing Cause Number 1, "Current Federal guidance on protective action recommendations was not correctly incorporated into the EPIPs when they changed in 2005," was reviewed. No other gaps were identified after the emergency procedures were revised to incorporate Federal guidance. Contributing Cause Number 2, "Prior emergency response organization training and drills for PAR determination did not discover the procedural errors," was also reviewed. Initial and continuing training lesson plans for PAR determination needed to be revised to ensure all aspects of the procedure were included. Drills were evaluated to ensure RSPS function elements were included. Lastly, incorporation of all emergency action level initiating conditions into drills and exercises in an eight year cycle was reviewed.

The inspector concluded that the licensee's RCE adequately addressed the extent of condition and extent of cause concerns.

e. *Determine whether the licensee's root cause evaluation, extent of condition, and extent of cause appropriately considered the safety culture components as described in IMC 0305.*

The inspector determined that the RCE, extent of condition, and extent of cause appropriately considered the safety culture components as described in Inspection Manual Chapter 0305.

The inspector reviewed the RCE and validated the licensee had systematically considered each of the safety culture components. Three potential aspects were identified which included: Human Performance 1(a), Human Performance 2(c), and Problem Identification and Resolution 2(b) and concluded, based on the issue identified with event, that the failure was to implement and institutionalize operating experience through changes to stations processes and procedures. The inspector's review of the event did not identify other potential weaknesses in safety culture components.

f. Findings

No findings were identified.

2.03 Corrective Actions

a. Determine whether the licensee specified appropriate corrective actions for each root/contributing cause or that the licensee evaluated why no actions were necessary.

The inspector determined that the licensee specified appropriate corrective actions for the root and contributing causes. The licensee's RCE concluded the root cause was

that PBNP emergency planning staff did not perform comprehensive reviews of Federal guidance and OE to ensure correct changes were made to the PAR determination process in the EPIPs when the procedures were changed in 2005 to include sheltering in its range of PARs.

Contributing Cause Number 1 was identified as current Federal guidance on protective action recommendations was not correctly incorporated in to the procedures and flowcharts in 2005, and Contributing Cause Number 2 was identified as prior emergency response organization training and drills for protective action recommendation determination did not discover the procedural error.

Corrective actions identified in the RCE for the root cause included immediate and subsequent procedure revisions, implementation of a comprehensive process for reviews of Federal guidance and operating experience, and immediate and subsequent training of specific emergency response organization personnel. Corrective actions identified in the RCE for Contributing Cause Number 1 included the PAR flowchart decisions to the continuing training program for select emergency response organization personnel. Corrective actions to address extent of condition and extent of cause included revising the emergency procedures to ensure a shelter recommendation could not be recommended after an evacuation PAR has been provided, information sharing was conducted with the emergency response team members that are involved with PARs, and ensuring applicable Federal Guidance in integrated in all emergency procedures associated with the other three risk significant planning standard functions of classification, notification, and dose assessment. Lessons learned were also incorporated into selected initial emergency response organization training. Additional corrective actions implemented included self-assessments of the risk significant planning standards and an assessment/enhancement of the PBNP emergency preparedness license change process training and qualification program.

The inspector concluded that the corrective actions implemented and planned were appropriate to prevent recurrence of this issue.

b. *Determine whether the licensee prioritized the corrective actions with consideration of the risk significance and regulatory compliance.*

The inspector determined that the licensee adequately prioritized the corrective actions with consideration of the risk significance and regulatory compliance.

The licensee's corrective actions were adequately prioritized in spreadsheet with consideration of the risk significance and regulatory compliance. Initial corrective actions to correct the EPIPs occurred prior to the NRC evaluated exercise inspection exit meeting on April 20, 2012. Emergency response organization members involved in the exercise were provided immediate remediation training, and a RCE was initiated to ensure all causes and conditions were appropriately addressed. Subsequent corrective actions identified in the RCE were adequately prioritized in the spreadsheet and included further refinements to the emergency procedures for regulatory compliance, a desktop guide for conducting emergency preparedness reviews to prevent recurrence of this issue, and initial and continuing training. The corrective action spreadsheet finished with an interim monitoring review and a final effectiveness review to assess the effectiveness of the protective action recommendation process. The inspector concluded that the

corrective actions had been adequately prioritized with consideration of the risk significance and regulatory compliance.

c. *Determine whether the licensee established a schedule for implementing and completing the corrective actions.*

The inspector determined that the licensee adequately established a schedule for implementing and completing the corrective actions.

The licensee established a schedule for corrective action implementation and included the already completed corrective actions. The above mentioned corrective action spreadsheet identified out of the 30 identified corrective actions, 23 were completed, 3 corrective actions were due in February 2013, and 1 to enhance the 10 CFR 50.54(q) reviewer qualification process due in April 2013. A self-assessment to assess the status of all RCE corrective actions is scheduled to be completed in June 2013 and an effectiveness review is scheduled for December 2013.

The inspector concluded that the licensee adequately established and implemented corrective actions in accordance with the schedule.

d. *Determine whether the licensee developed quantitative or qualitative measures of success for determining effectiveness of the corrective actions to prevent recurrence.*

The inspector determined that the licensee adequately developed quantitative or qualitative measures of success for determining effectiveness of the corrective actions to prevent recurrence.

The licensee's RCE identified two opportunities to determine effectiveness of the corrective action implemented. A Quick-Hit assessment will be performed to assess the status of all the RCE corrective actions in June 2013, and an effectiveness review is scheduled for December 2013 to assess the effectiveness of the PAR determination process.

The inspector concluded that the licensee had adequately established measures to validate the effectiveness of the corrective actions to prevent recurrence of the issue.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspector presented the inspection results to Mr. G. Vickery and other members of licensee management team on March 8, 2013. The licensee representatives acknowledged the findings presented. The inspector confirmed that none of the potential report input discussed was considered proprietary. On April 4, 2013, a telephone meeting was conducted with Mr. M. Millen. During the telephone meeting, D. Funk, the Acting Region III Plant Support Branch Chief, discussed the associated performance deficiencies and corrective actions, which fulfills the NRC policy for a regulatory performance meeting.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

G. Vickery, Acting Plant General Manager
S. Cassidy, Communications Manager
H. Hanneman, Licensing Supervisor
C. Hill, Assistant Operations Manager – Training
R. Hopkins, Nuclear Oversight Supervisor
K. Longston, Emergency Preparedness Coordinator
D. Lauterbur, Training Manager
M. Millen, Licensing Manager
P. Polfleit, Fleet Emergency Preparedness Specialist
B. Scherwinski, Licensing
G. Strharsky, Emergency Preparedness Manager
S. Wall, Emergency Preparedness Training Instructor
R. Welty, Radiation Protection Manager
J. Wilson, Maintenance – Mechanical Department Head
P. Wild, Design Engineering Manager

Nuclear Regulatory Commission

S. Burton, Senior Resident Inspector
M. Thorpe-Kavanaugh, Resident Inspector

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Closed

05000266/2012503-01 05000301/2012503-01	VIO	Protective Action Recommendation Weakness

Opened and Discussed

None

LIST OF DOCUMENTS REVIEWED

The following is a partial list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspector 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.

4OA4 Supplemental Inspection (95001)

- Emergency Preparedness Desktop Guide; Conducting EP Related Reviews; February 4, 2013
- EPIP 1.1; Course of Actions; Revisions 62 and 65
- EPIP 1.3; Dose Assessment and Protective Action Recommendations; Revisions 42 and 44
- EP-AA-100-1002; Emergency Preparedness Change Review Committee Guideline; Revision 2
- EP-AA-100-1007; Evaluation of Changes to the Emergency Plan, Supporting Documents, and Equipment (10 CFR 50.54(q)); Revision 1
- Fleet Assessment of Point Beach EP Regulations, Guidance, and Generic Communications; November 16, 2012
- Lesson Plan PBN BEP 061 010L; Emergency Preparedness-Initial; May 11, 2012
- Lesson Plan PBN BEP 054 001L; Emergency Preparedness-Continuing Training; July 5, 2012
- Lesson Plan PBN EPR 122 001L; Emergency Preparedness-Continuing Training; July 3, 2012
- NP 1.8.1; Emergency Preparedness Procedures and Documents; Revision 17
- PI-AA-102; Operating Experience Program
- PI-AA-102-1001; Operating Experience Program Screening and Responding to Incoming Operating Experience Guideline; Revision 10
- Quick Hit Assessment – Risk Significant Planning Standards GAP Assessment; March 1, 2013
- 2012 Third Quarter ERO Drill; Table Top Drill with Snow Storm Impediment; July 19, 2012
- AR01757131; Root Cause; Potential Violation Due to Degraded Emergency Planning Risk Significant Planning Standard Function; January 30, 2013

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access Management System
CFR	Code of Federal Regulations
EP	Emergency Preparedness
EPIP	Emergency Plan Implementing Procedure
ERO	Emergency Response Organization
IP	Inspection Procedure
IR	Inspection Report
NRC	U.S. Nuclear Regulatory Commission
OE	Operating Experience
PAR	Protective Action Recommendation
PARS	Publicly Available Records System
PBNP	Point Beach Nuclear Plant
RCE	Root Cause Evaluation
RIS	Regulatory Issue Summary
RSPS	Risk Significant Planning Standard

The NRC determined that the staff at Point Beach Nuclear Plant, Units 1 and 2, performed an acceptable evaluation of the White finding. The evaluation identified the primary root cause of the issue originated in 2005 when plant staff changed the emergency plan implementing procedures (EPIPs) to become compliant with regulatory guidance by adding sheltering to their range of protective action recommendations (PARs). At that time, the emergency preparedness staff did not perform comprehensive reviews of Federal guidance and operating experience to ensure correct changes were made to the PAR determination process in the procedures.

The finding was associated with an apparent logic error in a Point Beach Emergency Plan implementing procedure that directed the emergency director to revisit the question of impediments to evacuation after a prior decision to evacuate affected downwind sectors had been implemented by local authorities, resulting in a contradictory recommendation for sheltering being given during an exercise. Additionally, Point Beach EPIPs did not direct PARs when projected dose was greater than protective action guidelines beyond the 10-mile plume exposure pathway. Corrective actions taken to prevent recurrence included revisions to the PAR EPIP and implementation of a comprehensive process for reviews of Federal Guidance and operating experience.

No findings were identified during this inspection.

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Sincerely,
/RA/
Gary L. Shear, Director
Division of Reactor Safety

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