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

February 3, 2014

Mr. Eric McCartney
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 INTEGRATED INSPECTION REPORT
05000266/2013005; 05000301/2013005

Dear Mr. McCartney:

On December 31, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Point Beach Nuclear Plant, Units 1 and 2. The enclosed report documents the results of this inspection, which were discussed on January 9, 2014, with you and other members of your staff.

Based on the results of this inspection, two NRC-identified findings of very low safety significance were identified. The findings involved violations of NRC requirements. Additionally, one licensee-identified violation is listed in Section 4OA7 of this report. However, because of their very low safety significance, and because the issues were entered into your corrective action program, the NRC is treating the issues as non-cited violations (NCVs) in accordance with Section 2.3.2 of the NRC Enforcement Policy.

If you contest the subject or severity of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the Resident Inspector Office at the Point Beach Nuclear Plant. In addition, if you disagree with the cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Point Beach Nuclear Plant.

As a result of the Safety Culture Common Language Initiative, the terminology and coding of cross-cutting aspects were revised beginning in calendar year (CY) 2014. New cross-cutting aspects identified in CY 2014 will be coded under the latest revision to Inspection Manual Chapter (IMC) 0310. Cross-cutting aspects identified in the last six months of 2013 using the

previous terminology will be converted to the latest revision in accordance with the cross-reference in IMC 0310. The revised cross-cutting aspects will be evaluated for cross-cutting themes and potential substantive cross-cutting issues in accordance with IMC-0305 starting with the CY 2014 mid-cycle assessment review.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and 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/

Jamnes L. Cameron, Chief
Branch 4
Division of Reactor Projects

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

Enclosure:
Inspection Report 05000266/2013005; 05000301/2013005
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:	05000266/2013005; 05000301/2013005
Licensee:	NextEra Energy Point Beach, LLC
Facility:	Point Beach Nuclear Plant, Units 1 and 2
Location:	Two Rivers, WI
Dates:	October 1, 2013, through December 31, 2013
Inspectors:	D. Betancourt, Acting Senior Resident Inspector B. Bartlett, Acting Senior Resident Inspector K. Barclay, Resident Inspector V. Myers, Health Physicist J. Jandovitz, Project Engineer D. McNeil, Senior Operations Engineer D. Reeser, Operations Engineer J. Laughlin, Emergency Preparedness Inspector
Approved by:	J. Cameron, Chief Branch 4 Division of Reactor Projects

Enclosure

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SUMMARY OF FINDINGS

Inspection Report (IR) 05000266/2013005, 05000301/2013005; 10/01/2013 – 12/31/2013; Point Beach Nuclear Plant, Units 1 & 2; Post-Maintenance Testing, and Problem Identification and Resolution.

This report covers a 3-month period of inspection by resident inspectors and announced baseline inspections by regional inspectors. Two Green findings were identified by the inspectors. The findings were considered non-cited violations (NCVs) of NRC regulations. The significance of inspection findings is indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using IMC 0609, "Significance Determination Process" dated June 2, 2011. Cross-cutting aspects are determined using IMC 0310, "Components Within the Cross Cutting Areas" dated October 28, 2011. All violations of NRC requirements are dispositioned in accordance with the NRC's Enforcement Policy dated July 9, 2013. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process" Revision 4, dated December 2006.

Cornerstone: Mitigating Systems

- Green. The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to follow procedure NP 8.7.1, "Measurement and Test Equipment [M&TE]." Specifically, the inspectors identified multiple examples where the licensee did not document the withdrawal and use of M&TE in either the M&TE usage log or its electronic equivalent. This issue was entered into the licensee's corrective action program (CAP) as action request (AR) 01925171.

  The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, without accurate M&TE usage logs the licensee may not evaluate all past surveillances affected by failed M&TE, potentially resulting in a failed TS surveillance going undetected. The inspectors determined that the finding was associated with the Mitigating Systems Cornerstone, because not evaluating the prior use of inaccurate M&TE could permit equipment required to mitigate the consequences of the accident to not perform its design and licensing basis functions when called upon. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Mitigating Systems screening questions. The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to effectively communicate the station expectations related to changes in responsibilities for implementing NP 8.7.1 (H.1(c)). (Section 4OA2.3)

Cornerstone: Barrier Integrity

- Green. A self-revealed finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, occurred when a surveillance procedure was

performed with several steps marked not applicable which resulted in Unit 1 power rising over the license limit. Specifically, when the Unit 1 turbine-driven auxiliary feedwater pump was operated as part of a post-maintenance test, the discharge isolation valves remained open which resulted in a small unplanned positive reactivity change. This issue was entered into the licensee's CAP as AR 01920721.

The inspectors determined that this finding was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the failure of the control room operators to respond promptly could have led to the final reactor power being higher than during this issue. The inspectors determined that the finding was associated with the Initiating Events Cornerstone, specifically the configuration control attribute of operating equipment lineup. The inspectors determined that the finding could be evaluated using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions." The finding was determined to be of very low safety significance (Green) because the inadequate work instructions did not result in a reactor trip. The inspectors determined that the finding had a cross-cutting aspect in the area of human performance, work control, planning, because a human performance error was made during the planning process in an effort to reduce the work load during the test, and due to a cognitive error, the post-maintenance test was made inadequate. Specifically, steps were marked non-applicable that would have placed the pump discharge valves in their required position for the next portion of the surveillance test (H.3(a)). (Section 1R19)

- Violations of very low safety that were identified by the licensee have been reviewed by the NRC. Corrective actions taken or planned by the licensee have been entered into the licensee's CAP. These violations and CAP tracking numbers are listed in Section 4OA7 of this report.

REPORT DETAILS

Summary of Plant Status

Unit 1

The unit operated at or near full power throughout the quarter with three exceptions. The unit reduced power to approximately 96 percent on November 8 for auxiliary feed water pump testing; the unit reduced power to approximately 96 percent on November 14 for auxiliary feed water pump testing; and the unit reduced power to 48 percent on November 30 to repair the 1P-28A main feed water pump. The unit returned to full power on December 4 and operated at or near full power for the remainder of the quarter.

Unit 2

The unit operated at or near full power throughout the quarter with the exception of a down power to 48 percent that occurred on December 5, for a biannual main turbine and governor valves turbine trip test.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01)

.1 Winter Seasonal Readiness Preparations

a. Inspection Scope

The inspectors conducted a review of the licensee's preparations for winter conditions to verify that the plant's design features and implementation of procedures were sufficient to protect mitigating systems from the effects of adverse weather. Documentation for selected risk-significant systems was reviewed to ensure that these systems would remain functional when challenged by inclement weather. During the inspection, the inspectors focused on plant specific design features and the licensee's procedures used to mitigate or respond to adverse weather conditions. Additionally, the inspectors reviewed the Final Safety Analysis Report (FSAR) and performance requirements for systems selected for inspection, and verified that operator actions were appropriate as specified by plant specific procedures. Cold weather protection, such as heat tracing and area heaters, was verified to be in operation where applicable. The inspectors also reviewed CAP items to verify that the licensee was identifying adverse weather issues at an appropriate threshold and entering them into their CAP in accordance with station corrective action procedures. Documents reviewed are listed in the Attachment to this report. The inspectors' reviews focused specifically on the following plant systems due to their risk significance or susceptibility to cold weather issues:

- G-05 gas turbine; and
- facade freeze protection system.

This inspection constituted one winter seasonal readiness preparations sample as defined in Inspection Procedure (IP) 71111.01-05.

b. Findings

No findings were identified.

1R04 Equipment Alignment (71111.04)

.1 Quarterly Partial System Walkdowns

a. Inspection Scope

The inspectors performed partial system walkdowns of the following risk-significant systems:

- diesel fire pump;
- Unit 1 motor-driven auxiliary feedwater (AFW) pump while Unit 1 turbine-driven AFW (TDAFW) pump was out-of-service; and
- G-04 gas turbine after run.

The inspectors selected these systems based on their risk significance relative to the Reactor Safety Cornerstones at the time they were inspected. The inspectors attempted to identify any discrepancies that could impact the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures, system diagrams, FSAR, Technical Specification (TS) requirements, outstanding work orders (WOs), condition reports, and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have rendered the systems incapable of performing their intended functions. The inspectors also walked down accessible portions of the systems to verify system components and support equipment were aligned correctly and operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no obvious deficiencies. The inspectors also verified that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers and entered them into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

These activities constituted three partial system walkdown samples as defined in IP 71111.04-05.

b. Findings

No findings were identified.

1R05 Fire Protection (71111.05)

.1 Routine Resident Inspector Tours (71111.05Q)

a. Inspection Scope

The inspectors conducted fire protection walkdowns which were focused on availability, accessibility, and the condition of firefighting equipment in the following risk-significant plant areas:

- fire zone 165, Unit 2 charging pump A;
- fire zone 166, 2B32 motor control center room;
- fire zone 306, D-06 battery room; and
- fire zone 307, D-05 battery room.

The inspectors reviewed areas to assess if the licensee had implemented a fire protection program that adequately controlled combustibles and ignition sources within the plant, effectively maintained fire detection and suppression capability, maintained passive fire protection features in good material condition, and implemented adequate compensatory measures for out-of-service, degraded or inoperable fire protection equipment, systems, or features in accordance with the licensee's fire plan. The inspectors selected fire areas based on their overall contribution to internal fire risk as documented in the plant's Individual Plant Examination of External Events with later additional insights, their potential to impact equipment which could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. Using the documents listed in the Attachment to this report, the inspectors verified that fire hoses and extinguishers were in their designated locations and available for immediate use; that fire detectors and sprinklers were unobstructed; that transient material loading was within the analyzed limits; and fire doors, dampers, and penetration seals appeared to be in satisfactory condition. The inspectors also verified that minor issues identified during the inspection were entered into the licensee's CAP. Documents reviewed are listed in the Attachment to this report.

These activities constituted four quarterly fire protection inspection samples as defined in IP 71111.05-05.

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program (71111.11)

.1 Resident Inspector Quarterly Review of Licensed Operator Requalification (71111.11Q)

a. Inspection Scope

On November 12, 2013, the inspectors observed a crew of licensed operators in the plant's simulator during licensed operator requalification training to verify that operator performance was adequate, evaluators were identifying and documenting crew performance problems, and training was being conducted in accordance with licensee procedures. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;

- prioritization, interpretation, and verification of annunciator alarms;
- correct use and implementation of abnormal and emergency procedures;
- control board manipulations;
- oversight and direction from supervisors; and
- ability to identify and implement appropriate TS actions and Emergency Plan actions and notifications.

The crew's performance in these areas was compared to pre-established operator action expectations and successful critical task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator requalification program simulator sample as defined in IP 71111.11

b. Findings

No findings were identified.

.2 Resident Inspector Quarterly Observation of Heightened Activity or Risk (71111.11Q)

a. Inspection Scope

On November 30, 2013, the inspectors observed activities in the control room during a power reduction to 48 percent power for removal of the 1P-28A main feedwater pump from service for maintenance; on December 5th the inspectors observed activities in the control room during power ascension after repairs to 1P-28A were complete; and on December 9th the inspectors observed activities in the control room during surveillance testing. These were activities that required heightened awareness or were related to increased risk. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;
- prioritization, interpretation, and verification of annunciator alarms (if applicable);
- correct use and implementation of procedures;
- control board (or equipment) manipulations;
- oversight and direction from supervisors; and
- ability to identify and implement appropriate TS actions and Emergency Plan actions and notifications (if applicable).

Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator heightened activity/risk sample as defined in IP 71111.11.

b. Findings

No findings were identified.

.3 Biennial Written and Annual Operating Test Results (71111.11A)

a. Inspection Scope

The inspectors reviewed the overall pass/fail results of the Biennial Written Examination, administered by the licensee from September 13 – October 18, 2012, and the Annual Operating Test, administered by the licensee from October 14 – November 29, 2013, required by 10 CFR 55.59(a). The results were compared to the thresholds established in IMC 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process (SDP)," to assess the overall adequacy of the licensee's Licensed Operator Requalification Training (LORT) Program to meet the requirements of 10 CFR 55.59. (02.02)

This inspection of the LORT Program constituted one sample as defined in IP 71111.11-05.

b. Findings

No findings were identified.

.4 Biennial Review (71111.11B)

a. Inspection Scope

The following inspection activities were conducted during the weeks of November 11, 2013, and November 18, 2013, to assess: 1) the effectiveness and adequacy of the facility licensee's implementation and maintenance of its systems approach to training (SAT) based LORT Program, put into effect to satisfy the requirements of 10 CFR 55.59; 2) conformance with the requirements of 10 CFR 55.46 for use of a plant referenced simulator to conduct operator licensing examinations and for satisfying experience requirements; and 3) conformance with the operator license conditions specified in 10 CFR 55.53. The documents reviewed are listed in the Attachment to this report.

- Licensee Requalification Examinations (10 CFR 55.59(c); SAT Element 4 as defined in 10 CFR 55.4): The inspectors reviewed the licensee's program for development and administration of the LORT biennial written examination and annual operating tests to assess the licensee's ability to develop and administer examinations that are acceptable for meeting the requirements of 10 CFR 55.59(a).

  - The inspectors conducted a detailed review of two biennial requalification written examinations to assess content, level of difficulty, and quality of the written examination materials. (02.03)

  - The inspectors conducted a detailed review of 10 job performance measures (JPMs) and 6 dynamic simulator scenarios to assess content, level of difficulty, and quality of the operating test materials. (02.04)

  - The inspectors observed the administration of the annual operating test to assess the licensee's effectiveness in conducting the examinations, including the conduct of pre-examination briefings, evaluations of individual operator

and crew performance, and post-examination analysis. The inspectors evaluated the performance of one crew in parallel with the facility evaluators during two dynamic simulator scenarios, and evaluated various licensed crew members concurrently with facility evaluators during the administration of several JPMs. (02.05)

- The inspectors assessed the adequacy and effectiveness of the remedial training conducted since the last requalification examinations and the training planned for the current examination cycle to ensure that they addressed weaknesses in licensed operator or crew performance identified during training and plant operations. The inspectors reviewed remedial training procedures and individual remedial training plans. (02.07)

- Conformance with Examination Security Requirements (10 CFR 55.49): The inspectors conducted an assessment of the licensee's processes related to examination physical security and integrity (e.g., predictability and bias) to verify compliance with 10 CFR 55.49, "Integrity of Examinations and Tests." The inspectors reviewed the facility licensee's examination security procedure, and observed the implementation of physical security controls (e.g., access restrictions and simulator Input/Output controls) and integrity measures (e.g., security agreements, sampling criteria, bank use, and test item repetition) throughout the inspection period. (02.06)

- Conformance with Operator License Conditions (10 CFR 55.53): The inspectors reviewed the facility licensee's program for maintaining active operator licenses and to assess compliance with 10 CFR 55.53(e) and (f). The inspectors reviewed the procedural guidance and the process for tracking on-shift hours for licensed operators, and which control room positions were granted watch-standing credit for maintaining active operator licenses. Additionally, medical records for 12 licensed operators were reviewed for compliance with 10 CFR 55.53(i). (02.08)

- Conformance with Simulator Requirements Specified in 10 CFR 55.46: The inspectors assessed the adequacy of the licensee's simulation facility (simulator) for use in operator licensing examinations and for satisfying experience requirements. The inspectors reviewed a sample of simulator performance test records (e.g., transient tests, malfunction tests, scenario based tests, post-event tests, steady state tests, and core performance tests), simulator discrepancies, and the process for ensuring continued assurance of simulator fidelity in accordance with 10 CFR 55.46. The inspectors reviewed and evaluated the discrepancy corrective action process to ensure that simulator fidelity was being maintained. Open simulator discrepancies were reviewed for importance relative to the impact on 10 CFR 55.45 and 55.59 operator actions as well as on nuclear and thermal hydraulic operating characteristics. (02.09)

- Problem Identification and Resolution (10 CFR 55.59(c); SAT Element 5 as defined in 10 CFR 55.4): The inspectors assessed the licensee's ability to identify, evaluate, and resolve problems associated with licensed operator performance (a measure of the effectiveness of its LORT program and their ability to implement appropriate corrective actions to maintain its LORT Program

up to date). The inspectors reviewed documents related to licensed operator performance issues (e.g., recent examination and inspection reports including cited and non-cited violations; NRC End-of-Cycle and Mid-Cycle reports; NRC plant issue matrix; licensee event reports; licensee condition/problem identification reports including documentation of plant events and review of industry operating experience). The inspectors also sampled the licensee's quality assurance oversight activities, including licensee training department self-assessment reports. (02.10)

This inspection constituted one Biennial Licensed Operator Requalification Program inspection sample as defined in IP 71111.11-05.

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)

.1 Maintenance Risk Assessments and Emergent Work Control

a. Inspection Scope

The inspectors reviewed the licensee's evaluation and management of plant risk for the maintenance and emergent work activities affecting risk-significant and safety-related equipment listed below to verify that the appropriate risk assessments were performed prior to removing equipment for work:

- replacement of SW-9 south service water strainer inlet.

These activities were selected based on their potential risk significance relative to the Reactor Safety Cornerstones. As applicable for each activity, the inspectors verified that risk assessments were performed as required by 10 CFR 50.65(a)(4) and were accurate and complete. When emergent work was performed, the inspectors verified that the plant risk was promptly reassessed and managed. The inspectors reviewed the scope of maintenance work, discussed the results of the assessment with the licensee's probabilistic risk analyst or shift technical advisor, and verified plant conditions were consistent with the risk assessment. The inspectors also reviewed TS requirements and walked down portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met. Documents reviewed are listed in the Attachment to this report.

This maintenance risk assessment and emergent work control activity constituted one sample as defined in IP 71111.13-05.

b. Findings

No findings were identified.

1R15 Operability Determinations and Functional Assessments (71111.15)

.1 Operability Evaluations

a. Inspection Scope

The inspectors reviewed the following issues:

- calculation errors associated with the D-105 battery; and
- calculation errors associated with the D-106 battery.

The inspectors selected the potential operability issues based on the risk significance of the associated components and systems. The inspectors evaluated the technical adequacy of the evaluations to ensure that TS operability was properly justified and the subject components or systems remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TS and FSAR to the licensee's evaluations to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations. Additionally, the inspectors reviewed a sampling of corrective action documents to verify that the licensee was identifying and correcting any deficiencies associated with operability evaluations. Documents reviewed are listed in the Attachment to this report.

This operability inspection constituted two samples as defined in IP 71111.15-05.

b. Findings

No findings were identified.

1R19 Post-Maintenance Testing (71111.19)

.1 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed the following post-maintenance activities to verify that procedures and test activities were adequate to ensure system operability and functional capability:

- post-maintenance testing (PMT) of north service water strainer (Unit 1);
- PMT of G-03 emergency diesel generator (Unit 1);
- PMT of 1P-11A component cooling water pump (Unit 1);
- PMT of 1P-29 TDAFW pump (Unit 1);
- PMT of 2P-11A component cooling water pump breaker replacement (Unit 2);
- PMT of G-05 gas turbine weather hood over the air intake (Unit 2); and
- PMT of 1P-53 AFW pump (Unit 2).

These activities were selected based upon the structure, system, or component's ability to impact risk. The inspectors evaluated these activities for the following (as applicable):

the effect of testing on the plant had been adequately addressed; testing was adequate for the maintenance performed; acceptance criteria were clear and demonstrated operational readiness; test instrumentation was appropriate; tests were performed as written in accordance with properly reviewed and approved procedures; equipment was returned to its operational status following testing (temporary modifications or jumpers required for test performance were properly removed after test completion); and test documentation was properly evaluated. The inspectors evaluated the activities against TSs, the FSAR, 10 CFR Part 50 requirements, licensee procedures, and various NRC generic communications to ensure that the test results adequately ensured that the equipment met the licensing basis and design requirements. In addition, the inspectors reviewed corrective action documents associated with post-maintenance tests to determine whether the licensee was identifying problems and entering them in the CAP and that the problems were being corrected commensurate with their importance to safety. Documents reviewed are listed in the Attachment to this report.

This inspection constituted seven post-maintenance testing samples as defined in IP 71111.19-05.

b. Findings

Failure to Provide Adequate Work Instructions

Introduction: A self-revealed finding of very low safety significance (Green) and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, occurred on November 14, 2013, when a surveillance procedure was performed with several steps marked “Not Applicable,” (N/A) which resulted in Unit 1 power rising over the license limit. Specifically, when the Unit 1 TDAFW pump was operated as part of a PMT, the discharge isolation valves remained open which resulted in a small unplanned positive reactivity change.

Description: During a routine PMT, the Unit 1 TDAFW pump was operated following valve timing strokes. However, some valve timing strokes were not required for the PMT and were marked as N/A prior to the performance of the test. The stroke time tests that were marked N/A would have left the pump discharge isolation valves in the closed position. As the valves were already in their open position, this had the effect of leaving the valves open. When the TDAFW pump was started the operators believed that the pump would discharge only through the minimum flow line back to the condensate storage tank (CST); but in fact, the pump also discharged through the main discharge isolation valves to the steam generators (SGs).

The CST water was significantly cooler than the normal feedwater system and the addition of the cool water resulted in reactor power increasing. The operators observed pump parameters that were not as expected and quickly determined that their flow path was not as expected. The operators took immediate action to reduce reactor power but the positive reactivity that had already been added resulted in the plant briefly increasing power to about 1809.54 megawatt thermal (MWt), which was above the licensed limit of 1800 MWt. Reactor power was quickly restored to less than the licensed limit. Reactor power did not increase above the analyzed limit.

The inspectors reviewed plant data and verified the licensee’s assessment of reactor power levels and duration times.

Analysis: The inspectors determined that the licensee's failure to provide adequate work instructions such that the TDAFW pump discharge isolation valves were left open when they were required to be closed was a performance deficiency warranting further review.

The inspectors determined that this finding was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the failure of the control room operators to respond promptly could have led to the final reactor power being higher than during this issue. The inspectors determined that the finding was associated with the initiating events cornerstone, specifically the configuration control attribute of operating equipment lineup. The inspectors determined that the finding could be evaluated using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions." The finding was determined to be of very low safety significance (Green) because the inadequate work instructions did not result in a reactor trip.

The inspectors determined that the finding has a cross-cutting aspect in the area of human performance, work control, planning, because during the planning process a human performance error was made in an effort to reduce the work load during the test and due to cognitive error the PMT was made inadequate. Specifically, steps were marked as N/A that would have placed the pump discharge valves in their required position for the next portion of the surveillance test (H.3(a)).

The inspectors determined that the failure to follow license condition 4.A, "NextEra Point Beach is authorized to operate the facility at reactor power levels not in excess of 1800 megawatts thermal," was a performance deficiency. The inspectors determined that this issue was of minor significance since the maximum level reached was inside analyzed limits and the operators took action to bring the power level below the license limit after identification. The licensee was informed of the minor violation and entered the issue into the CAP. This failure to comply with license condition 4.A constituted a minor violation that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, requires, in part, that activities affecting quality be prescribed and accomplished by procedures appropriate to the circumstance, and shall be accomplished in accordance with those instructions and procedures. The licensee implemented safety-related TDAFW pump procedure IT-08A, Revision 71, on November 14, 2013, in accordance with 10 CFR Part 50, Appendix B, Criterion V.

Contrary to the above, on November 14, 2013, the licensee failed to have a procedure appropriate to the circumstance needed to operate the Unit 1 TDAFW pump. Specifically, procedure IT-08A failed to ensure that the TDAFW pump discharge isolation valves were closed prior to starting the pump in minimum recirculation mode.

Because this violation was of very low safety significance and it was entered into the licensee's CAP as AR 01920721, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy **(NCV 05000266/2013004-01; Failure to Provide Adequate Work Instructions).**

1R22 Surveillance Testing (71111.22)

.1 Surveillance Testing

a. Inspection Scope

The inspectors reviewed the test results for the following activities to determine whether risk-significant systems and equipment were capable of performing their intended safety function and to verify testing was conducted in accordance with applicable procedural and TS requirements:

- IT-06 Train B containment spray pump and valve test (inservice testing); and
- TS 82 emergency diesel generator G-02 monthly test (routine).

The inspectors observed in-plant activities and reviewed procedures and associated records to determine the following:

- did preconditioning occur;
- the effects of the testing were adequately addressed by control room personnel or engineers prior to the commencement of the testing;
- acceptance criteria were clearly stated, demonstrated operational readiness, and were consistent with the system design basis;
- plant equipment calibration was correct, accurate, and properly documented;
- as-left setpoints were within required ranges; and the calibration frequency was in accordance with TSs, the FSAR, procedures, and applicable commitments;
- measuring and test equipment calibration was current;
- test equipment was used within the required range and accuracy; applicable prerequisites described in the test procedures were satisfied;
- test frequencies met TS requirements to demonstrate operability and reliability; tests were performed in accordance with the test procedures and other applicable procedures; jumpers and lifted leads were controlled and restored where used;
- test data and results were accurate, complete, within limits, and valid;
- test equipment was removed after testing;
- where applicable for inservice testing activities, testing was performed in accordance with the applicable version of Section XI, American Society of Mechanical Engineers code, and reference values were consistent with the system design basis;
- where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component was declared inoperable;
- where applicable, actual conditions encountering high resistance electrical contacts were such that the intended safety function could still be accomplished;
- prior procedure changes had not provided an opportunity to identify problems encountered during the performance of the surveillance or calibration test;
- equipment was returned to a position or status required to support the performance of its safety functions; and
- all problems identified during the testing were appropriately documented and dispositioned in the CAP.

Documents reviewed are listed in the Attachment to this report.

This inspection constituted one routine surveillance testing sample and, one inservice testing sample, as defined in IP 71111.22, Sections -02 and -05.

b. Findings

No findings were identified.

1EP4 Emergency Action Level and Emergency Plan Changes (IP 71114.04)

a. Inspection Scope

The Office of Nuclear Security and Incident Response headquarters' staff performed an in-office review of the latest revisions to the Emergency Plan and various Emergency Plan Implementing Procedures (EPIPs) located under ADAMS Accession Numbers ML123260699, ML123560139, ML13077A438, ML13107B368, ML13107B350, ML13123A335, and ML13126A1029, as listed in the Attachment to this report.

The licensee transmitted the EPIP revisions to the NRC pursuant to the requirements of 10 CFR Part 50, Appendix E, Section V, "Implementing Procedures." The NRC review was not documented in a safety evaluation report and did not constitute approval of licensee-generated changes; therefore, this revision is subject to future inspection. The documents reviewed are listed in the Attachment to this report.

This emergency action level and emergency plan change inspection constituted no samples as defined in IP 71114.04-05.

b. Findings

No findings were identified.

1EP6 Drill Evaluation (71114.06)

.1 Emergency Preparedness Drill Observation

a. Inspection Scope

The inspectors evaluated the conduct of a routine licensee emergency drill on October 8, 2013, to identify any weaknesses and deficiencies in classification, notification, and protective action recommendation development activities. The inspectors observed emergency response operations in the control room and technical support center to determine whether the event classification, notifications, and protective action recommendations were performed in accordance with procedures. The inspectors observed event classification and notification activities performed by the crew. The inspectors also attended the post-evolution critique for the scenario. The focus of the inspectors' activities was to note any weaknesses and deficiencies in the crew's performance and ensure that the licensee evaluators noted the same issues and entered them into the corrective action program. As part of the inspection, the inspectors reviewed the scenario package and other documents listed in the Attachment to this report.

This emergency preparedness drill inspection constituted one sample as defined in IP 71114.06-05.

b. Findings

No findings were identified.

2. RADIATION SAFETY

2RS2 Occupational As-Low-As-Reasonably-Achievable Planning and Controls (71124.02)

The inspection activities supplement those documented in NRC IR 05000266(301)/2013003 and constituted one complete sample as defined in IP 71124.02-05.

.1 Radiological Work Planning (02.02)

a. Inspection Scope

The inspectors selected the following work activities of the highest exposure significance:

- SG eddy current testing;
- remove/reinstall reactor vessel head;
- fuel motion; and
- scaffolding outage activities.

The inspectors compared the results achieved (e.g., dose rate reductions, person-rem used) with the intended dose established in the licensee's as-low-as-reasonably-achievable (ALARA) planning for these work activities. The inspectors compared the person-hour estimates provided by maintenance planning and other groups to the radiation protection group with the actual work activity time requirements, and evaluated the accuracy of these time estimates. The inspectors assessed the reasons (e.g., failure to adequately plan the activity, failure to provide sufficient work controls, etc.) for any inconsistencies between intended and actual work activity doses.

The inspectors determined whether post-job reviews were conducted and if identified problems were entered into the licensee's CAP.

b. Findings

No findings were identified.

.2 Verification of Dose Estimates and Exposure Tracking Systems (02.03)

a. Inspection Scope

The inspectors reviewed the assumptions and basis (including dose rate and man-hour estimates) for the current annual collective exposure estimate for reasonable accuracy for select ALARA work packages. The inspectors reviewed applicable procedures to

determine the methodology for estimating exposures from specific work activities and the intended dose outcome.

The inspectors evaluated whether the licensee established measures to track, trend, and if necessary, to reduce occupational doses for ongoing work activities. The inspectors assessed whether trigger points or criteria were established to prompt additional reviews and/or additional ALARA planning and controls.

The inspectors evaluated the licensee's method of adjusting exposure estimates, or re-planning work, when unexpected changes in scope or emergent work were encountered. The inspectors assessed whether adjustments to exposure estimates (i.e., intended dose) were based on sound radiation protection and ALARA principles or if they were just adjusted to account for failures to control the work. The inspectors evaluated whether the frequency of these adjustments called into question the adequacy of the original ALARA planning process.

b. Findings

No findings were identified.

.3 Source Term Reduction and Control (02.04)

a. Inspection Scope

The inspectors used licensee records to determine the historical trends and current status of significant tracked plant source terms known to contribute to elevated facility aggregate exposure. The inspectors assessed whether the licensee made allowances or developed contingency plans for expected changes in the source term as the result of changes in plant fuel performance issues or changes in plant primary chemistry.

b. Findings

No findings were identified.

.4 Problem Identification and Resolution (02.06)

a. Inspection Scope

The inspectors evaluated whether problems associated with ALARA planning and controls are being identified by the licensee at an appropriate threshold and were properly addressed for resolution in the licensee's CAP.

b. Findings

No findings were identified.

4. OTHER ACTIVITIES

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

4OA1 Performance Indicator Verification (71151)

.1 Safety System Functional Failures

a. Inspection Scope

The inspectors sampled licensee submittals for the Safety System Functional Failures performance indicator (PI) for Units 1 and 2 for the fourth quarter 2012 through the third quarter 2013. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the Nuclear Energy Institute (NEI) Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 6, dated October 2009, and NUREG-1022, "Event Reporting Guidelines 10 CFR 50.72 and 50.73," definitions and guidance, were used. The inspectors reviewed maintenance rule records, condition reports, and event reports, to validate the accuracy of the submittals. The inspectors also reviewed the licensee's CAP to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two safety system functional failure samples as defined in IP 71151-05.

b. Findings

No findings were identified.

.2 Mitigating Systems Performance Index - Emergency AC Power System

a. Inspection Scope

The inspectors sampled licensee submittals for the Mitigating Systems Performance Index (MSPI) - Emergency AC [Alternating Current] Power System PI for Units 1 and 2, for the third quarter 2012 through the third quarter 2013. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99-02 were used. The inspectors reviewed the licensee's operator narrative logs, MSPI derivation reports, condition reports, and event reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's CAP to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two MSPI emergency AC power system samples as defined in IP 71151-05.

b. Findings

No findings were identified.

.3 Mitigating Systems Performance Index - High Pressure Injection Systems

a. Inspection Scope

The inspectors sampled licensee submittals for the MSPI - High Pressure Injection Systems PI for Units 1 and 2, for the third quarter 2012 through the third quarter 2013. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99-02 were used. The inspectors reviewed the licensee's operator narrative logs, condition reports, MSPI derivation reports, and event reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's CAP to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two MSPI high pressure injection system samples as defined in IP 71151-05.

b. Findings

No findings were identified.

.4 Mitigating Systems Performance Index - Residual Heat Removal System

a. Inspection Scope

The inspectors sampled licensee submittals for the MSPI - Residual Heat Removal System PI for Units 1 and 2, for the third quarter 2012 through the third quarter 2013. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99-02 were used. The inspectors reviewed the licensee's operator narrative logs, condition reports, MSPI derivation reports, and event reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's CAP to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two MSPI residual heat removal system samples as defined in IP 71151-05.

b. Findings

No findings were identified.

.5 Mitigating Systems Performance Index - Cooling Water Systems

a. Inspection Scope

The inspectors sampled licensee submittals for the MSPI - Cooling Water Systems PI for Units 1 and 2, for the third quarter 2012 through the third quarter 2013. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99-02 were used. The inspectors reviewed the licensee's operator narrative logs, condition reports, MSPI derivation reports, and event reports to validate the accuracy of the submittals. The inspectors also reviewed the

licensee's CAP to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two MSPI cooling water system samples as defined in IP 71151-05.

b. Findings

No findings were identified.

4OA2 Identification and Resolution of Problems (71152)

.1 Routine Review of Items Entered into the Corrective Action Program

a. Inspection Scope

As part of the various baseline inspection procedures discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify they were being entered into the licensee's CAP at an appropriate threshold, that adequate attention was being given to timely corrective actions, and that adverse trends were identified and addressed. Attributes reviewed included: identification of the problem was complete and accurate; timeliness was commensurate with the safety significance; evaluation and disposition of performance issues, generic implications, common causes, contributing factors, root causes, extent-of-condition reviews, and previous occurrences reviews were proper and adequate; and that the classification, prioritization, focus, and timeliness of corrective actions were commensurate with safety and sufficient to prevent recurrence of the issue. Minor issues entered into the licensee's CAP as a result of the inspectors' observations are included in the Attachment to this report.

These routine reviews for the identification and resolution of problems did not constitute any additional inspection samples. Instead, by procedure they were considered an integral part of the inspections performed during the quarter and documented in Section 1 of this report.

b. Findings

No findings were identified.

.2 Daily Corrective Action Program Reviews

a. Inspection Scope

In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a screening of items entered into the licensee's CAP. This review was accomplished through inspection of the station's daily condition report packages.

These daily reviews were performed by procedure as part of the inspectors' daily plant status monitoring activities and, as such, did not constitute any separate inspection samples.

b. Findings

No findings were identified.

.3 Semi-Annual Trend Review

a. Inspection Scope

The inspectors performed a review of the licensee's CAP and associated documents to identify trends that could indicate the existence of a more significant safety issue. The inspectors' review was focused on repetitive equipment issues, but also considered the results of daily inspector CAP item screening, licensee trending efforts, and licensee human performance results. The inspectors' review nominally considered the period of the second through third quarter of 2013, although some examples expanded beyond those dates where the scope of the trend warranted.

The review also included issues documented outside the normal CAP in major equipment problem lists, repetitive and/or rework maintenance lists, departmental problem/challenges lists, system health reports, quality assurance audit/surveillance reports, self-assessment reports, and maintenance rule assessments. The inspectors compared and contrasted their results with the results contained in the licensee's CAP trending reports. Corrective actions associated with a sample of the issues identified in the licensee's trending reports were reviewed for adequacy.

This review constituted one semi-annual trend inspection sample as defined in IP 71152-05.

b. Observations

After the inspectors observed multiple condition reports in the CAP related to noncompliance with the licensee's Measurement and Test Equipment (M&TE) procedure, the inspectors focused a portion of the semi-annual trend sample on M&TE procedure compliance to determine if an unrecognized trend existed. The inspectors' review of the licensee's M&TE procedural compliance CRs over the past 18 months included a nuclear oversight audit related to M&TE usage, a licensee M&TE self-assessment, and a trend CR written earlier in 2013 for an increase in M&TE events. The inspectors also toured the plant evaluating the condition of the M&TE storage lockers and sampled approximately forty closed work orders to assess recent M&TE usage.

The inspectors identified the following examples of failing to follow procedure NP 8.7.1, "Measurement and Test Equipment," during their review:

- During the inspectors' review of M&TE calibration work orders, the inspectors found that in approximately one-third of the work orders sampled, M&TE was checked out and then returned after a significant period of time and also returned after the completion of multiple work orders. This was contrary to procedure NP 8.7.1, step 4.3.7(c), which states "The individual signing out M&TE to a job, WO, etc., is responsible for maintaining M&TE until it is returned to its check out location. Check out duration is job duration or due date shown on calibration sticker." The NRC determined that this performance deficiency was of minor

significance since no examples were identified where equipment was used beyond its calibration date. The inspectors also identified that when M&TE was found out of calibration the licensee performed the appropriate evaluations.

- During their review, the inspectors also discovered a piece of M&TE which was checked out past its calibration expiration date while being used for a safety-related work order. This was contrary to procedure NP 8.7.1, step 4.3.7(c), which states: "The individual signing out M&TE to a job, WO, etc., is responsible for maintaining M&TE until it is returned to its check out location. Check out duration is job duration or due date shown on calibration sticker." The NRC determined that this performance deficiency was of minor significance because the licensee determined that the M&TE was used prior to the calibration due date expiring and, when sent offsite for calibration, the M&TE was found to have maintained its accuracy with no adjustments needed.

- During plant tours the inspectors found the M&TE storage lockers unsecured on multiple occasions. This was contrary to procedure NP 8.7.1, step 4.3.9, which states in part: "All active M&TE shall be stored in a manner that prevents unauthorized use and damage. When applicable, equipment shall be kept in locked and clearly marked storage areas or cabinets." The NRC determined that this performance deficiency was of minor significance because the inspectors did not identify any circumstances of uncalibrated M&TE being used on safety-related equipment.

- During a plant tour, the inspectors found sensitive electronic M&TE piled in a storage container intermixed with steel wrenches and other heavy mechanical M&TE. This was contrary to procedure NP 8.7.1, step 4.3.9, which states in part: "All active M&TE shall be stored in a manner that prevents unauthorized use and damage." The NRC determined that this performance deficiency was of minor significance because the inspectors did not identify any circumstances of damaged M&TE being used on safety-related equipment.

The licensee entered these minor violations into their CAP and restored compliance. These failures to comply with NP 8.7.1 and 10 CFR 50 Appendix B, Criterion V, "Procedures," constituted minor violations that are not subject to enforcement action in accordance with the NRC's Enforcement Policy. In addition to these minor violations, the inspectors identified one more than minor violation, which is discussed below for the licensee's failure to properly check out multiple pieces of M&TE for use on safety-related equipment.

c. Findings

Failure to Follow Maintenance and Test Equipment Procedure

Introduction: The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to follow procedure NP 8.7.1, "Measurement and Test Equipment." Specifically, the inspectors identified multiple examples where the licensee did not document the withdrawal and use of M&TE in either the M&TE usage log or its electronic equivalent.

Description: After the inspectors observed multiple condition reports in the CAP related to noncompliance with the licensee's M&TE procedure, the inspectors focused a portion of the semi-annual trend sample on M&TE procedure compliance to determine if an unrecognized trend existed. As part of the assessment, the inspectors selected 10 completed WOs from the operations and maintenance disciplines and asked the licensee to provide the associated M&TE usage logs. The licensee's search of usage logs found that for the 23 pieces of M&TE associated with the 10 WO samples, five examples were identified where M&TE was either not checked out or not checked in properly. The inspectors concluded that three of the examples would have been recoverable in that the errors would have been identified if a review was being performed for failed M&TE. The remaining 2 examples were not documented in either the M&TE usage log or electronic equivalent for the work that was performed. The licensee entered this into the CAP and was performing an apparent cause evaluation at the completion of the inspection period.

Analysis: The inspectors determined that the licensee's failure to sign out M&TE on either the required form PBF-9190, "M&TE Usage Log Form," or its electronic equivalent, was contrary to the requirements of procedure NP 8.7.1, "Measurement and Test Equipment," Revision 20, Step 4.3.7(a), and was a performance deficiency. The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, without accurate M&TE usage logs the licensee may not evaluate all past surveillances affected by failed M&TE, potentially resulting in a failed TS surveillance going undetected. The inspectors determined that the finding was associated with the Mitigating Systems Cornerstone, because not evaluating the prior use of inaccurate M&TE could permit equipment required to mitigate the consequences of the accident to not perform its design and licensing basis functions when called upon.

The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, Mitigating Systems Screening Questions, dated June 19, 2012. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Mitigating Systems screening questions.

The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to effectively communicate the station expectations related to changes in responsibilities for implementing NP 8.7.1. Specifically, as the station transitioned from an attendant oriented M&TE checkout process to a self-service M&TE checkout process, the licensee did not effectively communicate the changes in responsibilities and requirements for individuals checking out M&TE (H.1(c)).

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. The licensee accomplished the withdrawal and tracking of M&TE for use on safety-related equipment with NP 8.7.1. Procedure NP 8.7.1,

Step 4.3.7(a) states in part, that PBF-9190 or electronic equivalent shall be used to withdraw all M&TE.

Contrary to the above, on multiple occasions in 2013, the licensee failed to perform NP 8.7.1, Step 4.3.7(a), when withdrawing and using M&TE during safety-related surveillance activities. On July 23, 2013, the licensee failed to document, in PBF-9190 or electronic equivalent, the withdrawal or use of M&TE ICTI-306, a calibrated multimeter for testing of the 1P-29 AFW suction header pressure trip. On August 14-15, 2013, the licensee failed to document in PBF-9190 or electronic equivalent, the withdrawal or use of M&TE OPSSW-024, a calibrated stopwatch, for testing of the 2P-53 motor-driven AFW pump and associated valves. Because this violation was of very low safety significance and it was entered into the licensee's CAP as AR 01925171, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy **(NCV 05000266/2013005-02; 05000301/2013005-02, Failure to Follow Maintenance and Test Equipment Procedure).**

.4 Selected Issue Follow-Up Inspection: Unit 2 Thermal Overpower

a. Inspection Scope

On September 12, 2012, an anonymous individual initiated AR 0190339, "Unit 2 Overpower on 04-25-2012, No AR, No Log." The action request stated that there was a continuous dilution on April 25, 2012 at 100 percent power to compensate for xenon building in after a power increase. It also mentioned that the crew added 20 gallons of acid, had rods inserted, and reduced turbine load in order to bring reactor power down. Additionally, it stated that no log entry or action request was written. The inspectors reviewed data from the plant process computer to validate the information, and found that the sequence of events as described in the action request matched what was contained in the plant process computer.

The NRC conducted a review which covered the power history for Point Beach Unit 2 over the last two years. During the review, the inspectors discovered that on April 25, 2012, Unit 2 exceeded its license power limit, and that there was no control room log entry for the event and no AR documenting the event. The power history for the day in question showed that Unit 2 power maximum instantaneous power for April 25, 2012, was 1806 megawatt thermal (MWt). The license power limit is 1800 MWt.

During this inspection period, the inspectors reviewed Unit 2's power history over the last two years, and discussed the April 25, 2012 event with licensing and plant management.

This review constituted one in-depth problem identification and resolution sample as defined in IP 71152-05.

b. Observations and Findings

One licensee-identified violation is documented in Section 4OA7.

The licensee initiated a condition evaluation to evaluate the condition identified in AR 0190339 in order to evaluate the circumstances surrounding the event. The evaluation concluded that the plant did not exceed 1810.8 MWt, which was the analyzed limit in the FSAR, but that it did exceed the licensee limit for 41 minutes. Additionally, it concluded

that correct actions were taken to address the overpower condition. The inspectors reviewed the event and concluded that the operators took action to bring the power level below the license limit after identification.

The inspectors determined that the failure to follow license condition 4.A, "NextEra Point Beach is authorized to operate the facility at reactor power levels not in excess of 1800 megawatts thermal," was a performance deficiency. The inspectors determined that this issue was of minor significance since the maximum level reached was well inside analyzed limits, and the operators took action to bring the power level below the license limit after identification. The licensee was informed of the minor violation. This failure to comply with license condition 4.A constituted a minor violation that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

During the review of the licensee's evaluation of the condition identified in AR 0190339, the inspectors found that the licensee initially determined that there was no issue associated with operators not making a log entry or writing a condition report. It stated that operations personnel behaved as expected. The inspectors considered that the failure to document the overpower of Unit 2 which occurred on April 25, 2012, was contrary to the requirements of procedure PI-AA-205, "Condition Evaluation and Corrective Action," which established that conditions adverse to quality be entered into the corrective action program. Exceeding license power limits is a nonconformance with the license and therefore a condition adverse to quality. Additionally, the inspectors determined that the licensee did not follow procedure OP-AA-100-1000, "Conduct of Operation," which required that "unexpected alarms that are not the result of current plant conditions or evolutions in progress" be documented on the narrative logs. Following the receipt of an unexpected reactor thermal overpower alarm falls under those requirements.

The inspectors discussed their concerns with licensee management and expressed their concern regarding the condition evaluation justifying the behavior of not writing a log entry or an action request for an overpower event. Following conversations with multiple managers, the inspectors learned that similar concerns were raised by at least one manager onsite. Specifically, the concern was that the condition evaluation did not address the behaviors associated with the event. The licensee then stated that the condition evaluation would be revised.

.5 (Closed) Unresolved Item 05000266/2012002-07; 05000301/2012002-07) Past Reportability of Degraded Hazard Barrier Doors Not Performed

a. Inspection Scope

In NRC IR 05000266/2012002 the inspectors identified an adverse trend regarding the lack of evaluation of operability of degraded hazard barrier doors. Specifically, the inspectors identified 85 action requests related to door deficiencies from the 6-month period of September 2011 through March 2012. The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to perform an operability evaluation for the impact of deficient door to function as a high-energy line break (HELB) barrier, fire (safe shutdown) door, and flood barrier (NCV 05000266/2012002-08, 05000301/2012002-08; Failure to Perform Operability Evaluations as Required by Procedure). Additionally, the inspectors were unable to identify any technical assessment for reportability performed for the action

requests identified. As such, the inspectors questioned whether the additional identified issues were potentially reportable for the previous three-year period and opened unresolved item (URI) 05000266-2012002-07; 05000301/2012002-07, "Past Reportability of Degraded Hazard Barrier Doors Not Performed."

In response to the URI the licensee generated AR 01751811 to review the operability evaluations for doors with respect to the design aspects of HELB, fire (safe shutdown), flood barriers, and other features such as ventilation boundaries from September 2011 through March 2012. This review found 51 doors that were potentially affected. The inspectors questioned the licensee's corrective action, as it focused on the preventive maintenance practices for doors; only reviewed a six-month period; and did not address the potential reportability concerns identified by the URI. In response the licensee determined that this condition report was focused on mechanical deficiencies and re-opened the condition report as part of AR 01751804 to evaluate the reportability aspects for the previous three-year period.

The inspectors reviewed the licensee's evaluation of the issue and discussed it in NRC IR 05000266/2013004, with one item remaining open for further evaluation. During the review, the inspectors discovered that AR 01376102 discussed a door that was propped open for an indeterminate period of time. When the inspectors reviewed the associated documentation, they found that the door was concluded to be functional. The inspectors questioned the reportability for the breach of this HELB/flood barrier, because the impact on the safety-related equipment the door was protecting was not assessed in the initial action request nor was it assessed through the licensee's evaluation performed in response the URI. The inspectors questioned the HELB source and what the door was protecting. Through discussions with engineering staff it was determined the HELB source was main steam and the door was protecting both trains of the TDAFW pumps, both trains of the motor-driven AFW pumps, and the train A vital switchgear buses (1A05/1A06). At the conclusion of the third quarter inspection period, the licensee initiated AR 01904265 to evaluate the impact of this condition on the above described safety-related equipment with a 30-day due date.

The inspectors reviewed the licensee's evaluation of the propped open door and concluded that the safety-related components protected by the open door would have retained the ability to perform their required safety functions. This URI is closed.

b. Findings

No findings were identified.

4OA3 Follow-Up of Events and Notices of Enforcement Discretion (71153)

.1 Notification of Unusual Event due to Flooding in the Circulating Water Pump House

a. Inspection Scope

On Sunday October 13, 2013, at 9:46 a.m. CST, Point Beach, Units 1 and 2 declared a Notice of Unusual Event due to flooding in the circulating water pumphouse. The apparent source of the leak was a packing gland leak on the north main service water strainer, which led to approximately two inches of water in the affected room. The affected area of the circulating water pumphouse contained three safety-related service water pumps. The discovery of water in the room was made by a security officer during

rounds. The declaration was made under the Initiating Condition of HU1, "Natural and Destructive Phenomena Affecting the Protected Area," and the Emergency Action Level of HU 1.6, which is uncontrolled flooding in areas of the plant that has the potential to affect safety-related equipment needed for the current operation mode.

Following notification of the leak the licensee entered AOP-9A, "Service Water System Malfunction," and proceeded to isolate the affected strainer at approximately 9:50 a.m. Since the service water ring header did not have a continuous flow path following the isolation of the strainer, the licensee entered condition 'C' of TS 3.7.8, "Service Water System," which required them to verify the system is capable of providing the required cooling water flow to the required equipment, and to restore the service water ring header continuous flow path within seven days. Based on the isolation of the leak, removal of the water, and no damage to equipment, the licensee terminated the Unusual Event at 12:45 p.m. The service water strainer was repaired and returned to service the following day.

The inspectors responded to the plant following declaration and completed walkdowns to determine if there was damage to the area. No apparent damage to the safety-related equipment was identified. Additionally, the inspectors reviewed the proposed repairs to the strainer and reviewed the sequence of events with plant management. Documents reviewed are listed in the Attachment to this report.

This event follow-up review constituted one sample as defined in IP 71153-05.

b. Findings

No findings were identified.

4OA5 Other Activities

.1 Institute of Nuclear Power Operations (INPO) Plant Assessment Report Review

a. Inspection Scope

The inspectors reviewed the final report for the INPO plant assessment conducted in June 2013. The inspectors reviewed the report to ensure that issues identified were consistent with the NRC perspectives of licensee performance and to verify if any significant safety issues were identified that required further NRC follow-up.

b. Findings

No findings were identified.

4OA6 Meetings Including Exit

.1 Exit Meeting Summary

On January 9, 2013, the inspectors presented the inspection results to Mr. E. McCartney, Site Vice President, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

.2 Interim Exit Meetings

Interim exits were conducted for:

- the inspection results for the area of occupational ALARA planning and controls with Mr. R. Wright, Plant General Manager, on October 25 2013; and
- the inspection results of the Requalification Training Program with Mr. D. Lauterbur on November 22, 2013.

The inspectors confirmed that none of the potential report input discussed was considered proprietary. Proprietary material received during the inspection was returned to the licensee.

4OA7 Licensee-Identified Violations

The following violation of very low safety significance (Green) was identified by the licensee and is a violation of NRC requirements which meet the criteria of the NRC Enforcement Policy, for being dispositioned as an NCV.

.1 Failure to Document an Overpower Event

The licensee identified a finding of very low safety significance (Green) and associated NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," which requires, in part that activities affecting quality shall be accomplished in accordance with instructions, procedures and drawings. Specifically, licensee procedure PI-AA-205, "Condition Evaluation and Corrective Action," establishes that conditions adverse to quality be entered into the corrective action program. Exceeding license power limits was a nonconformance with the operating license and therefore a condition adverse to quality. This issue was entered into the CAP as AR 0190339.

The performance deficiency was determined to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, if left uncorrected, failure to document conditions adverse to quality could lead to a more significant event since over power conditions would not be evaluated. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, Mitigating Systems Screening Questions, dated June 19, 2012. Since the finding involved the mismanagement of reactivity by operator(s) (e.g., reactor power exceeding the licensed power limit), the inspectors determined that IMC 0609, Appendix M, needed to be used. Since the highest power level achieved was within the analyzed limits in the FSAR the inspectors screened the finding as having very low safety significance (Green).

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

E. McCartney, Site Vice President
G. Vickery, Operations Director
M. Millen, Licensing Manager
G. Strharsky, EP Manager
J. Atkins, Systems Engineering Manager
B. Beltz, Assistant Operations Manager
F. Hennessy, Performance Improvement Manager
J. Keltner, Chemistry Manager
J. Pruitt, Site Quality Manager
R. Welty, Radiation Protection Manager
D. Lauterbur, Training Manger
B. Scherwinski, Engineering Analyst II
T. Schneider, Licensing
C. Trezise, Director Special Projects
T. Lesniak, Mechanical Maintenance Department Head
R. Amundson, NRC Exam Coordinator
M. Angle, Training
D. Argall, Security
R. Baird, General Supervisor, Training
S. Bowe, Assistant Ops Manager, Training
R. Bretton, Simulator Supervisor
R. Clark, Licensing
L. Germann, EP Coordinator
A. Gustafson, Training
K. Locke, Licensing

Nuclear Regulatory Commission

J. Cameron, Chief, Branch 4, Division of Reactor Projects

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

05000266/2013005-01	NCV	Failure to Provide Adequate Work Instructions (Section 1R19)
05000266/2013005-02; 05000301/2013005-02	NCV	Failure to Follow Maintenance and Test Equipment Procedure (Section 4OA2.3)

Closed

05000266/2013005-01	NCV	Failure to Provide Adequate Work Instructions (Section 1R19)
05000266/2013005-02; 05000301/2013005-02	NCV	Failure to Follow Maintenance and Test Equipment Procedure (Section 4OA2.3)
05000266/2012002-07; 05000301/2012002-07	URI	Past Reportability of Degraded Hazard Barrier Doors Not Performed (Section 4OA2.5)

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.

1R01 Adverse Weather Protection

- AOP-13C; Severe Weather Conditions; Revision 30
- AR01230528; Potential for G-03/4 Radiator Fans to Trip Breaker When Freewheeling Backwards
- AR01818243; Main Feed Isolation Valves (MFIVS) Design Issues Associated
- AR01867675; CWP Post Mod Test Schedule Not Followed
- AR01892211; Error in Calculation 129187-K-0012
- AR01901196; Thermostat Controller Not Working Right
- AR01901201; Delta Between Units on Cold Weather Protection
- AR01901397; 2FFCP 1-B Façade Freeze Primary
- AR01901468; Insulation Missing From Heat Traced Piping
- AR01901474; Heat Traced Valve/Piping Missing Insulation
- AR01901478; Missing Insulation Around Façade Freeze Wires
- AR01901654; 2P-68A Freeze Protection
- AR01929073; G-03/G-04 Radiator Question
- BG AOP-13C; Severe Weather Conditions; Revision 14
- FSAR Section 2.6; Meteorology; UFSAR 2010
- Function Lists for all Maintenance Rule Systems; Façade Freeze Protection; August 29, 2012
- NPM 2004-0476; Internal Correspondence From T. Kendall to NP File; Subject: Licensing Basis Position for Wind-Milling of G-03 & G-04 Radiator Fans; July 26, 2004
- OI 106; Façade Freeze Protection; Revision 33
- OM 3.30; Operations Snow Emergency Staffing; Revision 3
- OP-AA-102-1002; Seasonal Readiness; Revision 1
- PC 49 Part 4; Auxiliary Building Miscellaneous and Facades; Completed September 10, 2013
- PC 49 Part 5 Cold Weather Checklist Outside Areas and Miscellaneous; Completed October 11, 2013
- Site Certification Letter from L. Meyer to M. Nazare for Cold Weather Readiness Period (CWRP) Per OP-AA-102-1002 Seasonal Readiness; September 24, 2013

1R04 Equipment Alignment

- 0-PT-FP-002; Monthly Diesel Engine-Driven Fire Pump Functional Test; Revision 12
- AR01848969; SW-288 and 289 Alignment
- AR01860002; Switch Found Out of Position During Tag Hang
- AR01872670; Valve Position Indication Not as Expected
- AR01902250; Slider Found Out of Position for D-108 Charger in 2C20
- AR01914521; Valve Found Out of Position Shut Vs. Locked Shut
- CL 11A G-04; G-04 Diesel Generator Checklist; Revision 10
- CL 13E Part 2; Auxiliary Feedwater Valve Lineup Motor Driven; Revision 49
- CL 19; Fire Protection System Valves; Revision 44
- Drawing 019016; M-217 Auxiliary Feedwater System, Sheet 1; Revision 97
- Drawing 094110; Fire Water; Revision 47

- Drawing 094111; Fire Protection Water, Sheet 2; Revision 38
- Drawing PB19841; Auxiliary Feedwater System Sh. 3; Revision E
- OP 1C; Startup to Power Operation Unit 1; Revision 26
- TS 84; Emergency Diesel Generator G-04 Monthly; Revision 32

1R05 Fire Protection

- AR01929452; Door 142 Does Not Close on its Own (NRC Identified)
- AR01929453; Halon Bottle Inspection Tags (NRC Identified)

1R11 Licensed Operator Requalification Program

- Closed Computer Simulator Work Requests (NAMS); Multiple Work Orders; various dates
- AR01715842; During IT-13 Train A CCW Pump & Valve Testing on Unit 2
- AR01725148; Place-Keeping Error Made During VCT Fill & Dilution
- AR01757638; Unanticipated Axial Flux Response During Load Swing
- AR01823101; Unanticipated MOB [Manually Operated Breaker] Impact on G-04 Wattmeter
- End-of-Cycle/Segment Reports for Licensed Operator Continuing Training Program; various dates 2011 through 2013
- Feedback Summaries for Licensed Operator Continuing Training Program; various dates 2012 and 2013
- FP-T-SAT-71; NRC Exam Security Requirements; Revision 5
- FP-T-SAT-81; Simulator Testing and Documentation; Revision 8
- Incorrect Valve Manipulation was Conducted; December 14, 2011
- OM 4.3.8; Control of Time Critical Operator Actions; Revision 2
- OP-1B; Point Beach Nuclear Plant Operating Procedures, Reactor Startup December 10, 2011; Revision 65
- O-PC-081.4 Part 1; AOP-10A, C and E Time Line Validation; No Revision
- O-PC-081.4 Part 2; OPS Manager: (or designee); No Revision
- Operations Department Self-Evaluation Meeting Results; 2011 3rd Trimester (September through December)
- Operations Department Self-Evaluation Meeting Results; 2012 1st Trimester (January through May)
- Operations Department Self-Evaluation Meeting Results; 2012 2nd Trimester (May through August)
- Operations Department Self-Evaluation Meeting Results; 2012 3rd Trimester (September through December)
- PBF-2094; NRC License Active Status Tracking, Multiple Forms; Revision 3
- PBF-6097; Operations Watch Stander Temporary Restriction Form, Multiple Forms; Revision 6
- PBN JPM P000.015.COT; Respond to a Loss of Component Cooling Water; Revision 11
- PBN JPM P000.029.AOT; Lineup LDGS Ventilation for High Airborne Condition; Revision 6
- PBN JPM P000.031b.COT; Respond to a RCP Malfunction; Revision 5
- PBN JPM P000.046a.AOT; Locally Operate Diesel Fire Pump; Revision 1
- PBN JPM P000.047b.AOT; Respond to Loss of Spent Fuel Pool Cooling; Revision 0
- PBN JPM P000.055.COT; Align a Train of SI for Containment Sump Recirculation Following Containment Spray Recirculation; Revision 1
- PBN JPM P008.007.AOT; Control Temperature/Flow of CCW System Component Heat Exchangers; Revision 0
- PBN JPM P026.005.COT; Secure Containment Spray; Revision 8

- PBN JPM P045.005.COT; Synchronize Turbine Generator to the Grid with Output at Minimum Load; Revision 9
- PBN JPM P061.007b.AOT; Operate the Motor-Driven Auxiliary Feedwater Pumps; Revision 0
- PBN LOC 12E 003E; 2012 Biennial Written Exam (RO & SRO); September 11, 2012
- PBN TRQM 18.32; Activation of an Inactive RO License, Multiple Forms; Revision 8
- PBN TRQM 18.34; Post NRC Examination license Activation, Multiple Files; Revision 9
- Point Beach Closed Simulator Work Orders (SWOs); Multiple Work Orders; various dates
- Point Beach Nuclear Plant Simulator Performance Test Procedure; Test Number: T-5 (SCT 6.5.5); March 26, 2013
- Point Beach Nuclear Plant Simulator Performance Test Procedure; Test Number: T-1 (SCT 6.5.1) Manual Reactor Trip; November 13, 2013
- Point Beach Nuclear Plant Simulator Performance Test Procedure; Test Number: SCT.6.2.1, 100% Power Steady State Performance Test; December 5, 2012
- Point Beach Nuclear Plant Simulator Plant Comparison Test Procedure; Plant Comparison for U1 Trip; August 14, 2012, and March 26, 2013
- Point Beach Nuclear Training Department, TWR - Simulator Report; Multiple Work Requests; November 14, 2013
- Point Beach Open Simulator Action Requests (SARs); 2POR-6117 Turbine Speed/Gov Valve Position; November 13, 2013
- Point Beach Open Simulator Work Orders (SWO's); Multiple Work Orders; various dates
- Point Beach Simulator Action Requests (SAR's); Multiple Requests; various dates
- SIMGL C1.4; Point Beach Nuclear Plant Simulator Guideline, Simulator Modifications and Core Load Changes; Revision 6
- TR-AA-230-1 005-F04; Feedback Summary, Multiple Items; Revision 0
- TR-AA-230-1004-F04; Training Remediation, Multiple Forms; Revision 1
- TR-AA-230-1009; Training Examination Security; Revision 0

1R13 Maintenance Risk Assessments and Emergent Work Control

- Station Log; October 11 to October 15, 2013
- 0-SOP-SW-105; South Service Water Pump Header Isolation; Revision 9
- Safety Monitor; Units 1 and 2; October 14 to October 15, 2013
- AR01318445; Safety Monitor Look Ahead Wrong for SW Pump Header OOS
- Log Entries Report; Various Dates February 20, 2006 to October 15, 2013

1R15 Operability Evaluations

- AR01813170; Issues Identified in Calc N-93-058 (DC Calc for D-105)
- AR01912002; SW-2911-BS Leak Impact on SW Flow Model and Req'd POD
- AR01915750; Extent of Condition Review Calc N-93-059 (DC Calc for D-106)
- AR01918006; 1P-11A, CCW Pump Inboard Oil Leak
- EN-AA-203-1001; Operability Determinations / Functionality Assessments; Revisions 9 and 12
- Open NRC Resident Inspector Requests; October 22, 2013
- POD 01915750; Extent of Condition Review Calculation N-93-059 (DC Calculation for D-106); November 6, 2013

1R19 Post-Maintenance Testing

- 1-SOP-CC-001; Component Cooling System; Completed November 7, 2013
- 1-TS-RE-001; Power Level Determination Unit 1; Revision 3
- AR01749564; IT 12 Train A – 1P-11A, Component Cooling Water Pump and Val
- AR01855079; G-05 Gas Turbine Generator Hunting at Base Load

- AR01855079; G-05 Gas Turbine Generator Hunting at Base Load
- AR01861556; Potential Trap In 0-SOP-SW-101 for Restoration
- AR01861557; SW-4 Not in Expected Position
- AR01863880; 1SC-966C Stroked Out Side Acceptance Criteria
- AR01865743; 1SI-876B Difficult to Operate and Packing Leak
- AR01865745; 1SI-D-13 Has Packing Leak
- AR01865814; Attempted Valve Manipulation Prior to PMT
- AR01869831; TS 83 – PAPR (CA 6/28/13 Due Date)
- AR01874319; RMP 9043-37A – Emergency Diesel Generator G-03 Post Maintenance
- AR01877254; G-05 Excessive “Hunting” at Peak Load
- AR01879944; HPIP 11.54, Control Room F-16 Filter Testing has Fatal Flaw
- AR01885830; (P) IT 08A (CA Due Date 8/19/13)
- AR01888885; Failed PMT
- AR01893515; Noted Unsat Conditions on Breaker B52-DB25-024 Maintenance
- AR01896504; High Resistance Readings Found on Contacts During Maint
- AR01896556; RIC Test Anomaly Shows Questionable Results
- AR01901188; Minor Gov. Fluctuations During PMT Run of 2P-29 TDAFW Pump
- AR01912487; PMT Unsat for K-2A
- AR01918176; Clarification For EDG Alignment During PMT
- AR01920344; Repeat PMT Step for RMW Relay
- AR01920721; IT-08A Improper N/A Leads to Unexpected Feeding of S/G’s
- Calculation 2001-0049; 480V Switchgear 2B-03 Circuit Breakers Input Data
- Calculation ATD-0296; Evaluation of Closing the Vent on the CCW Surge Tank; July 11, 2008
- Calculation/Addendum/Evaluation 2005-0010; Vendor Calculation/Evaluation Review Form; Component Cooling Water System Relief Valve Capacity; August 18, 2006
- CE 1903539; Reactor Thermal Output (RTO) Exceeded the Plant Processing Computer System (PPCWS) Alarm Set Point; November 21, 2013
- Daily Log; Various Dates November 14 to November 26, 2013
- DBD-24; ESF Actuation System; Revision 7
- Drawing 172324; Battery Charger Supplies; Revision 2
- Drawing 17859; Logic Diagrams, Index & Symbols; Revision 14
- Drawing 17862; 4160V Bus Schemes; Revision 21
- Drawing 17863; 480V Bus Schemes; Revision 11
- Drawing 17865; Safeguards Actuation Signals; Revision 25
- Drawing 17867; Safeguards Sequence Logic; Revision 19
- Drawing 21164; Component Cooling Water Pump 2P-011A; Revision 17
- Drawing 50160; 480V Switchgear Reference Drawing; Revision 20
- Drawing 93975; Safeguard Sequence; Revision 19
- FSAR Section 10.2; Auxiliary Feedwater System (AF); UFSAR 2013
- FSAR Section 8.4; 4.16K VAC Electrical Distribution System (4.16 kV); UFSAR 2010
- FSAR Section 8.8; Diesel Generator (DG) System; UFSAR 2012
- FSAR Section 8; Introduction to the Electrical Distribution Systems; UFSAR 2010
- FSAR Section 9.1; Component Cooling Water (CC); UFSAR 2012
- IT 08A; Cold Start of Turbine-Driven Auxiliary Feed Pump and Valve Test (Quarterly) Unit 1; Completed November 15, 2013
- IT 12 Train A; 1P-11A, Component Cooling Water Pump and Valves Unit 1; Completed November 7, 2013
- OE 26128; Emergency Service Water Discharge Strainer Inspection Cover (Perry); Event Date December 27, 2007
- OP 2A Unit 1; Normal Power Operation Unit 1; Revision 3
- Report of Calibration; Fluke 189 Digital Multimeter; September 19, 2013

- RMP 9006-2A; Component Cooling Water Pump Mechanical Seal (John Crane) Overhaul With Double Row Outboard Thrust Bearing; Revision 4
- RMP 9006-2A; Component Cooling Water Pump Mechanical Seal (John Crane) Overhaul With Double Row Outboard Thrust Bearing; Completed November 5, 2013
- RMP 9043-16; Emergency Diesel Mini-Power Pack Inspection; Completed October 28, 2013
- RMP 9043-16A; Emergency Diesel Mini-Power Pack Inspection; Completed October 30, 2013
- RMP 9043-33; Emergency Diesel Generator G-03 Mechanical Inspection; Completed October 29, 2013
- RMP 9043-37A; Emergency Diesel Generator G-03 Post-Maintenance Run and Testing; Completed November 3, 2013
- SCR 2012-0093; Revision to IT 08A Following the Rebaselining of 1P-29 TDAFW IST Acceptance Criteria; May 31, 2012
- SCR 2013-0063; Revise IT 60 After Post Maintenance Rebaselining of 1SC-966C During U1R34; April 9, 2013
- TRM 2.1 U1; Core Operating Limits Report (COLR) Unit 1 Cycle 35; Revision 15
- TS 83; Emergency Diesel Generator G-03 Monthly; Completed November 7, 2013
- WO 00391834; CEAC-014 Calibration
- WO 00391836; CEML-010 Calibration
- WO 40117732; CEML-013 Calibration
- WO 40123815; CEAC-014 Calibration
- WO 40175114; MCTW-132 Calibration
- WO 40197237; B52-DB50-071, Breaker Maint Per RMP 9303 and RMP 9369-1
- WO 40202195; CEAC-005 Calibration
- WO 40202200; CEML-010 Calibration
- WO 40205530; 1P-011A Replace Inboard and Outboard Seal and Bearings
- WO 40241255; 1P-29T / As Found Alignment W/Oct 2013 IT-08A RCE
- WO 40245846; G-05 / Weather Hood Over Air Intake Per EC 278757
- WO 40273003; SW-02911-BS Packing Leak

1R22 Surveillance Testing

- AR01892795; 2ICP 02.001BL WO40205617-01 RP & ESF Blue 92Day Surveillance
- AR01902511; Manual Control of Charging Required to Perform 1ICP-2.1 Blue
- AR01902566; Adjusted Station Battery Chargers D-07, D-107 & D-108
- AR01902641; 1FC-474A/B Found OOT Low During 1ICP 2.001BL
- AR01923836; Tech Spec Validation and Awareness
- FSAR Section 8.8; Diesel Generator (DG) System; UFSAR 2012
- IT 06 Train B; Train B Containment Spray Pump and Valves Unit 2; Revision 2
- PB_Online; Execution Week Look-Ahead; December 1, 2013
- TS 3.8.1; AC Sources – Operating; Unit 1-Amendment 201, Unit 2 – Amendment 206
- TS 82; Emergency Diesel Generator G-02 Monthly; Completed December 9, 2013

1EP4 Emergency Action Level and Emergency Plan Changes (71114.04)

- Emergency Plan, Appendix B; Emergency Classification; Revisions 26 and 27
- Emergency Plan, Appendix L; Meteorological Monitoring System Design, Testing and Calibration; Revision 3
- EPIP 1.1; Course of Actions; Revision 64
- EPIP 1.2; Emergency Classification; Revision 51
- EPIP 1.3; Dose Assessment and Protective Action Recommendations; Revision 44
- EPIP 1.2.1; Emergency Action Level Technical Basis; Revision 9, 10, 11, and 12

- Evacuation Time Estimate Study Update

1EP6 Drill Evaluation

- NARS Form for Drill; October 8, 2013 7:49 a.m.
- Point Beach Emergency Preparedness Drill Scenario; October 8, 2013

2RS2 Occupational ALARA Planning and Controls (71124.02)

- RP-AA-104; ALARA Program; Revision 2
- RP-AA-104-1000; ALARA Implementing Procedure; Revision 5
- NP 4.2.29; Source Term Reduction Program; Revision 11
- Point Beach Nuclear Plant 5-Year ALARA Plan 2013-2017
- U1R34 Radiation Protection Outage Report
- RWP 13-1014 and related ALARA package; Fuel Motion
- RWP 13-1023 and related ALARA package; S/G Eddy Current Testing
- RWP 13-1011 and related ALARA package; Remove/Reinstall RV Head
- RWP 13-1019 and related ALARA package; Scaffolding Outage Activities
- AR01863321; SG Eddy Current Exceeded Dose Goal >25 percent; April 5, 2013
- AR01862884; Dose Estimate Exceeded; April 4, 2013
- AR01914630; NRC Observation – Handling of Bulk Work; October 23, 2013
- AR01889914; Potential Trend in Station Radiation Exposure Control Events; July 17, 2013
- AR01866641; Unplanned Dose Due to Boric Acid on Valves; April 17, 2013

4OA1 Performance Indicator Verification

- 1T-38 U1 Spray Additive Tank 26' PAB; March 21, 2007
- 3Q/2013 Performance Indicators; Units 1 and 2; Safety System Functional Failures (PWR)
- ACE 01649202; Oil Leakage from 2P-10B RHR Pump during ORT-3B; Completed March 5, 2013
- AR Record Search for ACEs; September 1, 2012 to November 19, 2013
- AR Record Search for Diesel Generator ARs; October 1, 2012 to October 15, 2013
- AR Record Search for MRFFs; September 1, 2012 to November 19, 2013
- AR Record Search for RCEs; September 1, 2012 to November 19, 2013
- AR01807392; W-187 D-305/1/2D-205 Stn Batt Rm Air Supply Fan (Tripped)
- AR01826212; Generator to Engine Coupling is Degraded
- AR01832106; NRC Questions Regarding AR 1649202, 2P-10B Losing Oil
- AR01833833; G-02 Diesel Day Tank Level is Lowering
- AR01841035; Perform MRFF Evaluation For W-13A2 Fan Trips
- AR01849994; Unexpected Unit 2 RWST Low Level Alert Alarm
- AR01851639; Late Licensee Event Report
- AR01853624; Spurious 2T-13 RWST Low Level Alert Alarm
- AR01856043; 1C-2D1 Door Latch Cam Interlock is Out of Adjustment
- AR01856532; P-032A Control Switch Failure After 6 Months
- AR01856795; 1RH-706A Exceeded Its Admin Seat Leakage During IT-530A
- AR01870475; G-04 Control Panel (C-082) Found Signs of Overheating to ER2
- AR01874609; ER2 Transformer in C-082 Second Cubicle Needs to be Replaced\
- AR01883159; MSPI Data in CDE Incorrect
- AR01883299; 1T-38 Spray Add Tank Level Low-Low Switch Failed
- AR01884529; G-03 FO Transfer Pump P-206B Started Late
- AR01890255; MSPI Data Error in CDE ESF Starts
- AR01890824; 2LI-939, A Accumulator Level Failing Low

- AR01896960; Wrong Gasket Used on G-02 Blow Off Cover
- AR01898187; Past Operability Reviews May be Warranted
- AR01901575; RHR MSPI Unavailability Incorrectly Excluded
- AR01903536; MSPI Basis Doc AF Operational Estimates Need Revision
- AR01904620; EDG Liner Bore Found Out of Sync
- AR01905501; 2LI-934 Drifting Low
- AR01905899; G-03 No. 5 Cylinder Piston Ring Anomaly
- AR01909953; 2LT-939 Drifting Low
- CE 01870475; During Walkdown of G-04 EDG Control Panel C-082, Signs of Overheating to an Inductive Reactor (ER2); Completed May 21, 2013
- CE 01874489; 1SI-00840A T-38 Spray Additive Tank Vacuum Breaker Failed Its As-Found Test Per WO 4009519-03; June 13, 2013
- CR Change Request Approval; CR 01874489; June 10, 2013 and July 31, 2013
- Drawing 019004; Instrument Air; Revision 47
- LER 2012-001-00; Unit 2 Manual Reactor Trip; August 26, 2012
- LER 2012-002-02; Condition Prohibited by Technical Specification 3.7.5, Auxiliary Feedwater; December 18, 2012
- LER 2012-003-00; 2B-04 Safeguards 480V Bus De-Energized; August 28, 2012
- LER 2012-004-00; Unit 1 Manual Reactor Trip; October 3, 2012
- LER 2012-005-01; Potential Operation Prohibited by Technical Specifications; June 27, 2013
- LER 2013-001-00; Loss of Offsite Power to Unit 1 Safeguards Buses; April 5, 2013
- LER 2013-002-00; Condition Prohibited by Technical Specifications; June 13, 2013
- Log Entries Report; Various Dates November 8, 2012 to July 20, 2013
- LTCA/LTCP Request Form; CR 1874489; Requested August 1, 2013
- Maintenance Rule Functional Failure Evaluation; Event: 1LT-426 PZR Level Failed Channel Check on Rounds; Event Date September 28, 2013
- Maintenance Rule Functional Failure Evaluation; Event: 2LI-934 Drifting Low; Event Date September 20, 2013
- MRE 01624317-05; 2P-15B Oiler Bump; Prepared March 29, 2011
- MRE 01649202-01; 2P-10B Oil Leak; Prepared June 7, 2011
- MRFF Evaluation; Vacuum Relief Valve Failed As-Found Test – IST Program; July 15, 2013
- MSPI Derivation Report; MSPI Cooling Water System; Unavailability Index; Units 1 and 2; September 2013
- MSPI Derivation Report; MSPI Cooling Water System; Unreliability Index; Units 1 and 2; June - September 2013
- MSPI Derivation Report; MSPI Emergency AC Power System; Unavailability Index; Units 1 and 2; September 2013
- MSPI Derivation Report; MSPI Emergency AC Power System; Unavailability Index; Units 1 and 2; June 2013
- MSPI Derivation Report; MSPI Emergency AC Power System; Unreliability Index; Units 1 and 2; September 2013
- MSPI Derivation Report; MSPI Emergency AC Power System; Unreliability Index; Unit 1; September 2013
- MSPI Derivation Report; MSPI Heat Removal System; Unreliability Index; Units 1 and 2; October 2013
- MSPI Derivation Report; MSPI High Pressure Injection System; Unavailability Index; Units 1 and 2; June - September 2013
- MSPI Derivation Report; MSPI High Pressure Injection System; Unreliability Index; Units 1 and 2; September 2013
- MSPI Derivation Report; MSPI Residual Heat Removal System; Unavailability Index; Units 1 and 2; September 2013

- MSPI Derivation Report; MSPI Residual Heat Removal System; Unavailability Index; Units 1 and 2; June 2013
- MSPI Derivation Report; MSPI Residual Heat Removal System; Unreliability Index; Units 1 and 2; June 2013
- MSPI Derivation Report; MSPI Residual Heat Removal System; Unreliability Index; Units 1 and 2; September 2013
- MSPI Indicator Margin Remaining in Green for September 2013; Units 1 and 2; October 15, 2013
- MSPI Monthly Unavailability and Verification for AF System for February 2013; Completed October 11, 2013
- MSPI Monthly Unavailability and Verification for CC System for April 2013; Completed May 1, 2013
- MSPI Monthly Unavailability and Verification for CC System for August 2013; Completed September 7, 2013
- MSPI Monthly Unavailability and Verification for CC System for January 2013; Completed February 4, 2013
- MSPI Monthly Unavailability and Verification for CC System for November 2012; Completed December 3, 2012
- MSPI Monthly Unavailability and Verification for CC System for September 2013; Completed October 3, 2013
- MSPI Monthly Unavailability and Verification for CC System for September 2012; Completed October 2, 2012
- MSPI Monthly Unavailability and Verification for EAC System for August 2013; Completed September 9, 2013
- MSPI Monthly Unavailability and Verification for EAC System for April 2013; Completed May 6, 2013
- MSPI Monthly Unavailability and Verification for EAC System for February 2013; Completed October 15, 2013
- MSPI Monthly Unavailability and Verification for EAC System for January 2013; Completed February 4, 2013
- MSPI Monthly Unavailability and Verification for EAC System for November 2012; Completed December 4, 2012
- MSPI Monthly Unavailability and Verification for EAC System for September 2012; Completed October 2, 2012
- MSPI Monthly Unavailability and Verification for EAC System for September 2013; Completed October 3, 2013
- MSPI Monthly Unavailability and Verification for RH System for April 2013; Completed May 2, 2013
- MSPI Monthly Unavailability and Verification for RH System for August 2013; Completed September 9, 2013
- MSPI Monthly Unavailability and Verification for RH System for January 2013; Completed February 5, 2013
- MSPI Monthly Unavailability and Verification for RH System for November 2012; Completed December 5, 2012
- MSPI Monthly Unavailability and Verification for RH System for September 2013; Completed October 1, 2013
- MSPI Monthly Unavailability and Verification for RH System for September 2012; Completed October 1, 2012
- MSPI Monthly Unavailability and Verification for SI System for August 2013; Completed September 9, 2013

- MSPI Monthly Unavailability and Verification for SI System for September 2013; Completed October 1, 2013
- MSPI Monthly Unavailability and Verification for SW System for April 2013; Completed May 2, 2013
- MSPI Monthly Unavailability and Verification for SW System for August 2013; Completed September 4, 2013
- MSPI Monthly Unavailability and Verification for SW System for January 2013; Completed February 5, 2013
- MSPI Monthly Unavailability and Verification for SW System for November 2012; Completed December 4, 2012
- MSPI Monthly Unavailability and Verification for SW System for September 2013; Completed October 2, 2013
- MSPI Monthly Unavailability and Verification for SW System for September 2012; Completed October 1, 2012
- MSPI Monthly Unavailability and Verification; SI System for April 2013; Completed May 2, 2013
- MSPI Monthly Unavailability and Verification; SI System for January 2013; Completed February 4, 2013
- MSPI Monthly Unavailability and Verification; SI System for November 2012; Completed December 5, 2012
- MSPI Monthly Unavailability and Verification; SI System for September 2012; Completed October 1, 2012
- NEI 99-02; Regulatory Assessment Performance Indicator Guideline; Revision 6
- NRC ROP MSPI Basis Document for PBNP; Revision 21, June 2013
- PBNP Inservice Testing Background Valve Data Sheet; Containment Spray System; December 11, 2009
- POR 01874489; Operability of Spray Add System with Both SAT Vacuum Breakers Inoperative; December 9, 2013
- Station Log; Various Dates August 31, 2012 to July 30, 2012

4OA2 Identification and Resolution of Problems

- AR01777722; Control and Use of Operations Measurement and Test Equipment
- AR01794651; CCW Pump Replacement Project Delayed
- AR01797288; U1 SGBD Flow Raised 10 KLBM/HR by Itself
- AR01809226; Engineering Holds Not Completed Prior to MS 34 Closure
- AR01821584; 1N-40: Align Wide Range Log Power to RTO
- AR01822732; Update ENS EN48402 For Unit 2 Steam Dump Opening
- AR01842274; Potential Trend – At Risk Work Week Trend
- AR01848486; M&TE Missing from Storage Locations and Not Checked Out
- AR01849233; Potential Trend – Maintenance & Test Equipment Issues
- AR01852890; Work Order Closeout Process is Broken
- AR01863218; Continued Issues With NERC Testing
- AR01863383; Status Level Alarm Trend Cap
- AR01863873; NI Unavailability Exceeds 80%
- AR01865327; Potential Trend – I&C Planning Resources
- AR01869647; Engineering Change Request Backlog
- AR01870435; Trend AR to Review HU Clock Resets for Supply Chain
- AR01870884; Potential Trend For 50.59 Screening for Scaffolds
- AR01872025; Violations With Cross-Cutting Aspects to HU.4B
- AR01872700; Crew Resets Electrical Maintenance

- AR01874635; Potential Trend – Issues With Outage Milestones
- AR01877896; ICTI-679 Missing and Not Checked Out in Inventory
- AR01878950; Potential Trend – Tagging Issues
- AR01879822; WR's Being Pushed Due To Parts Issues Trend CAP
- AR01885867; Tool Crib M&TE Cabinets Not Locked When Crib Not Manned
- AR01886671; Water Left Standing After Testing
- AR01887997; Reactivity Management Concern with EH Turbine Controls
- AR01890859; Significant Gaps in Mispositioning Identification and Trends
- AR01891543; Potential Adverse Trend-Rad Monitors and HI Ambient Temps
- AR01891827; Check Valve Failed to Close on Pump Shifting
- AR01891861; Indicated RTO Exceeded License Limit
- AR01899456; Potential Adverse Trend in Maintaining FSAR
- AR01902692; Adverse Trend on Maintaining the FSAR
- AR01903539; Unit 2 Overpowered on 4-25-2012, No AR, No Log Entries
- AR01911616; NP 8.7.1 Step 4.7.2 Not Followed
- AR01911980; MCHC-003 Calibration Extended with No Eval Form
- AR01922695; MTE Returned After Calibration Due Date
- AR01922776; Maintenance MTE Lockers Not Locked
- AR01923114; Third Quarter NRC-Identified MTE Issues
- AR01923777; Control Side Tool Crib
- AR01925171; MTE Was Not Properly Checked Out
- AR01928729; NRC 4Q13 Proposed Performance Deficiencies (MTE)
- CE 1847931; Scope Stability Trending Data Indicates Carryover Work; February 21, 2013
- Condition Evaluation for AR01877896; ICTI-679 Dual Display Crystal Gauge Missing; Evaluate Control and Checkout Process; July 1, 2013
- Condition Evaluation for AR01911616; Step 4.7.2 of NP 8.7.1 Not Followed With WO 40197237-02; October 28, 2013
- Electronic Test Equipment Job History for ICTI-455; February 27 to August 27, 2013
- Electronic Test Equipment Job History for ICTI-851; August 13, 2013
- Electronic Test Equipment Job History for MCMM-056; August 13, 2013
- Electronic Test Equipment Job History for MCMM-056; June 6, 2013
- Electronic Test Equipment Job History for MCOM-079; May 29, 2013
- Electronic Test Equipment Job History for MCTW-132; October 29 to November 5, 2013
- NextEra Energy Quality Assurance Topical Report (FPL-1); Revision 14; November 21, 2013
- NP 8.7.1; Measurement and Test Equipment; Revisions 20 and 21
- OP 2A Unit 1; Normal Power Operation Unit 1; Revision 2
- OP 2A Unit 2; Normal Power Operation Unit 2; Revision 3
- OP-AA-100-1000; Conduct of Operations; Revision 10
- Ops Log Entries for April 25, 2012
- PBF-9190, M&TE Usage Log for CEML-011 / CEAC-011; May 22 to June 13, 2013
- PBF-9190, M&TE Usage Log for CEML-012 / CEAC-018; April 24 to May 26, 2013
- PBF-9190, M&TE Usage Log for CEML-013 / CEAC-019; June 8 to August 27, 2013
- PBF-9190, M&TE Usage Log for OPS SW-022; April 17 to June 16, 2013
- PBF-9190, M&TE Usage Log for OPSSW-027; April 23 to August 15, 2013
- PBF-9190, M&TE Usage Log for OPSSW-027; April 23 to August 15, 2013
- PBF-9191, M&TE Evaluation Record for MCHC-003; September 10, 2013
- PI-AA-204; Condition Evaluation and Screening Process; Revision 21
- PI-AA-205; Condition Evaluation and Corrective Action; Revision 21
- Quick Hit No. PBSA-MTN-13-11, For AR01811557-01; Perform Quick Hit of the M&TE Program; July 8, 2013
- WO 40071811; 1P-011B Replace Inboard and Outboard Seal and Bearings

- WO 40096324; Group F Mechanical Maintenance Items Inspection and Maintenance
- WO 40140122; 1RC-00546D – Replace Relief Valve – IST Program
- WO 40148401; MCAT-005 Calibration
- WO 40176882; MCOM-029 Calibration
- WO 40178263; ICTI-030 Calibration
- WO 40179850; MCHT-015 Calibration
- WO 40180525; MCCR-015 Calibration
- WO 40181084; MCTW-062 Calibration
- WO 40185181; MCTW-089 Calibration
- WO 40197154; MCPI-006 Calibration
- WO 40197696; MCCT-002 Calibration
- WO 40200208; MCMM-044 Calibration
- WO 40207044; MCMM-038 Calibration
- WO 40207046; MCMM-042 Calibration
- WO 40208872; IT-405, 2P-53 Motor-Driven Auxiliary Feed Pump and Valves
- WO 40208948; 125V, Station Tech Spec Batteries Weekly Inspection
- WO 40218959; G-04 EDG Vibration (Quarterly)
- WO 40219496; MCMM-036 Calibration
- WO 40223490; IT-03, Train B, 1P-10B Low Head SI Pumps/Vlvs
- WO 40225943; 2C-20 Calibrate DC Instrument Bus Voltage Alarm
- WO 40243424; 1ICP-2.32 – 1P 29 Auxiliary Feedwater Suction Header
- WO 40255867; 1ICP 2.3B – RP Logic Test – Train B

4OA3 Follow-Up of Events and Notices of Enforcement Discretion

- AOP-9A; Service Water System Malfunction; Completed October 13, 2013
- AR01911809; SW-2911-BS Packing Blown Out / UE Declared
- AR01911868; SW-2912-BS Replace Packing Gland Bolts Per EC 280175
- AR01914884; Possible Inappropriate Use of 25% Grace for TS Surveillances
- AR01915762; Transformer Sill Containment Concerns
- EN 49433; Unusual Event; October 13, 2013 9:46 a.m.
- NARS Form for EN 49433; October 13, 2013 9:54 a.m.
- SCR 2007-0150-01; MOD EC 11174 CWPH Flood Relief Modification; October 29, 2009
- Station Log; October 12 – 13, 2013

LIST OF ACRONYMS USED

AC	Alternating Current
ADAMS	Agencywide Document Access Management System
AFW	Auxiliary Feedwater
ALARA	As-Low-As-Is-Reasonably-Achievable
AR	Action Request
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CST	Condensate Storage Tank
CY	Calendar Year
DRP	Division of Reactor Projects
EPIP	Emergency Plan Implementing Procedure
FSAR	Final Safety Analysis Report
HELB	High Energy Line Break
IMC	Inspection Manual Chapter
INPO	Institute of Nuclear Power Operations
IP	Inspection Procedure
IR	Inspection Report
LORT	Licensed Operator Requalification Training
M&TE	Measurement and Test Equipment
MSPI	Mitigating System Performance Index
MWt	Megawatt Thermal
N/A	Not Applicable
NCV	Non-Cited Violation
NRC	U.S. Nuclear Regulatory Commission
PARS	Publicly Available Records
PI	Performance Indicator
PMT	Post-Maintenance Testing
SAT	Systems Approach to Training
SDP	Significance Determination Process
SG	Steam Generator
TDAFW	Turbine-Driven Auxiliary Feedwater
TS	Technical Specification
URI	Unresolved Item
WO	Work Order

previous terminology will be converted to the latest revision in accordance with the cross-reference in IMC 0310. The revised cross-cutting aspects will be evaluated for cross-cutting themes and potential substantive cross-cutting issues in accordance with IMC-0305 starting with the CY 2014 mid-cycle assessment review.

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Sincerely,

/RA/

Jamnes L. Cameron, Chief
Branch 4
Division of Reactor Projects

Docket Nos. 50-266; 50-301
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Letter to Eric McCartney from Jamnes Cameron dated February 3, 2014.

SUBJECT: POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
NRC INTEGRATED INSPECTION REPORT
05000266/2013005; 05000301/2013005

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