



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**

REGION III  
2443 WARRENVILLE RD. SUITE 210  
LISLE, IL 60532-4352

March 17, 2015

EA-12-220  
EA-13-125

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 95002 SUPPLEMENTAL INSPECTION REPORT 05000266/2015009; 05000301/2015009 AND ASSESSMENT FOLLOW-UP LETTER**

Dear Mr. McCartney:

On February 6, 2015, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure (IP) 95002, "Supplemental Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," at your Point Beach Nuclear Plant, Units 1 and 2. The enclosed report documents the results of this inspection, which were discussed at the exit meeting on February 6, 2015, with you and other members of your staff.

In accordance with the NRC Reactor Oversight Process (ROP), this follow-up supplemental inspection was performed to continue the assessment of the White inspection finding and associated White Notice of Violation (NOV) with low to moderate safety significance for external wave run-up flooding. An initial 95002 supplemental inspection for this White NOV and an additional White NOV regarding the failure of the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) was performed March 6, 2014. These two White findings, both in the Mitigating Systems Cornerstone placed Point Beach Unit 1 in a degraded cornerstone as of the first quarter of 2013. The initial 95002 inspection was documented in NRC Inspection Report 05000266/2014007 and 05000301/2014007 (ML14115A147), dated April 25, 2014. That inspection concluded that NextEra Energy provided sufficient information to close the TDAFWP White NOV but failed to provide assurance that the corrective actions for the performance issues were sufficient to address the root and contributing causes and prevent recurrence for the White External Wave Run-up Flooding NOV. Subsequently, the White External Wave Run-up Flooding NOV was held open.

This follow-up supplemental inspection specifically reviewed the held-open White Flooding NOV and the common cause analysis. The NRC informed your staff of our intent to continue the supplemental inspection in accordance with IP 95002 in the assessment follow-up letter which

was included in ML14115A147 referenced above. On December 16, 2014, NextEra sent a letter stating that you were ready for the NRC to conduct the supplemental inspection (ML14351A028).

The objectives of this supplemental inspection were to: (1) provide assurance that the root causes and the contributing causes for the risk significant issues were understood; (2) independently assess and provide assurance that the extent of condition and extent of cause of the individual and collective issues were identified; (3) to independently determine if safety culture components caused or significantly contributed to the individual or collective issues; and (4) provide assurance that the corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes.

Based on the results of this inspection, the NRC determined Point Beach had performed an acceptable evaluation of the White Flooding NOV. Your evaluation determined that there were a number of root causes including a less than adequate questioning attitude and less than adequate understanding of the design and licensing basis. To correct these issues and to prevent recurrence Point Beach initiated a safety culture improvement plan and provided additional training on the design and licensing basis.

After reviewing your actions to address the risk-significant performance issue using IP 95002, the NRC concluded that completed or planned corrective actions were sufficient to address the performance that led to the finding. Therefore, in accordance with Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," the White finding and associated NOV that was being held open pending completion of a supplemental inspection and effective corrective actions, are closed, and will only be considered in assessing plant performance until the end of the first quarter of 2015. The TDAFWP White finding had previously been inspected and closed as discussed above and as a result the NRC has determined the performance of both Unit 1 and Unit 2 at Point Beach to be in the Licensee Response Column of the ROP Action Matrix as of the date of this letter.

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS)

E. McCartney

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component of NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

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Anne T. Boland, Director  
Division of Reactor Projects

Docket No. 50-266; 50-301  
License No. DPR-24; DPR-27

Enclosure:  
IR 05000266/2015009; 05000301/2015009  
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 05000266; 05000301  
License No: DPR-24; DPR-27

Report No: 05000266/2015009; 05000301/2015009

Licensee: NextEra Energy Point Beach, LLC

Facility: Point Beach Nuclear Plant, Units 1 and 2

Location: Two Rivers, WI

Dates: February 2 through February 6, 2015

Inspectors: B. Bartlett, Project Engineer, Branch 4, Team Leader  
J. Boettcher, Reactor Engineer, Branch 4  
J. Gilliam, Senior Reactor Inspector  
Division of Reactor Safety Engineering, Branch 3  
J. Steffes, Resident Inspector, Duane Arnold  
P. Zurawski, Senior Resident Inspector, Monticello

Approved by: J. Cameron, Chief  
Branch 4  
Division of Reactor Projects

Enclosure

## SUMMARY OF FINDINGS

Inspection Report 05000266/2015009; 05000301/2015009; 02/02/2015–02/06/2015; Point Beach Nuclear Plant, Units 1 and 2; Supplemental Inspection–IP 95002, Supplemental Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area.

This supplemental inspection was conducted by one Senior Resident Inspector, one Resident Inspector, and three region based inspectors. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG–1649, "Reactor Oversight Process," Revision 5, dated February 2014.

### **Cornerstone: Mitigating Systems**

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95002, "Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," to assess the licensee's evaluation of one White inspection finding that affected the Mitigating Systems Cornerstone.

The inspection team determined the licensee's evaluation of the risk-significant inspection finding met the inspection procedure objectives. The inspection team determined the root cause evaluation (RCE) for the White Notice of Violation (NOV) appropriately evaluated the root and contributing causes, adequately addressed the extent of condition and cause, assessed safety culture, and established corrective actions for the performance issues. In addition to assessing the licensee's evaluations, the inspection team independently performed an extent of condition and extent of cause review of the finding and a review of the site safety culture as it related to the RCE. The team concluded the licensee's RCE and corrective actions, both completed and planned, were sufficient to address the causes and prevent recurrence of the violation.

## REPORT DETAILS

### 4. OTHER ACTIVITIES

#### **Cornerstone: Mitigating Systems**

#### 4OA4 Supplemental Inspection (95002)

##### a. Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95002, "Inspection for One Degraded Cornerstone or Any Three White Inputs in a Strategic Performance Area," to assess the White NOV for external wave run-up flooding. An initial 95002 supplemental inspection for this White NOV and an additional White NOV regarding the failure of the Turbine Driven Auxiliary Feedwater Pump (TDAFWP) was performed March 6, 2014. These two White findings both in the Mitigating Systems Cornerstone placed Point Beach Unit 1 in a degraded cornerstone as of the first quarter of 2013. The initial 95002 inspection was documented in NRC Inspection Report 05000266/2014007 and 05000301/2014007 (ML14115A147), dated April 25, 2014. That inspection concluded that NextEra Energy provided sufficient information to close the TDAFWP White NOV but failed to provide assurance that the corrective actions for the performance issues were sufficient to address the root and contributing causes and prevent recurrence for the White External Wave Run-up Flooding NOV. Subsequently, the External Wave Run-up Flooding NOV was held open.

This follow-up supplemental inspection specifically reviewed the held-open White Flooding NOV and the licensee's common cause analysis. The NRC informed the licensee's staff of the intent to continue the supplemental inspection in accordance with inspection procedure 95002 in the assessment follow-up letter which was included in ML14115A147 referenced above. On December 16, 2014, NextEra sent a letter stating that they were ready for the NRC to conduct the supplemental inspection (ML14351A028).

The objectives of the supplemental inspection included:

- To provide assurance that the licensee understands any and all issues associated with the risk-significant performance issue;
- To determine if the root and contributing causes of the risk-significant performance issue are understood and to ensure the licensee's evaluation addresses extent of condition and extent of cause;
- To independently assess the extent of condition and the extent of cause for the risk-significant performance issue;
- To independently determine if safety culture components caused or significantly contributed to the risk-significant performance issue; and
- To determine if the licensee's corrective actions for the risk-significant performance issue are sufficient to address the root and contributing causes and prevent recurrence.

The inspectors reviewed the five RCEs performed by the licensee, in addition to other assessments, evaluations, and corrective action program (CAP) documentation completed in support of and, as a result of, the RCEs. The inspectors reviewed

corrective actions that were taken or planned to address the identified causes. The inspectors interviewed selected Point Beach, corporate and contractor personnel, and held discussions with these individuals to verify the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and preclude repetition.

### Inspection Results

The attributes of IP 95002 were reviewed for the risk-significant finding. The inspectors concluded the licensee completed an adequate RCE, understood the root and contributing causes, identified and implemented appropriate corrective actions, adequately evaluated the extent of condition and extent of cause, and appropriately addressed the safety culture aspects. In addition, the inspectors performed independent extent of condition, extent of cause, and safety culture reviews and found no significant issues. The inspectors concluded the licensee's actions met the inspection objectives.

Documents reviewed during this inspection are listed in the Attachment.

## .02 Evaluation of the Inspection Requirements

### 02.01 Problem Identification

Determine that the evaluation documented who identified the issue (i.e., licensee-identified, self-revealing, or Nuclear Regulatory Commission-identified) and under what conditions the issue was identified.

The inspectors determined that RCE 01883633, "White Finding–Flooding," Revision 6, specifically stated the flooding issue was identified by the NRC. The evaluation established the issue was identified through an NRC debrief of first quarter issues as an Unresolved Issue (URI). The licensee further identified that condition report (CR) 01750334 was written to document the debriefed URI but inaccurately captured the inspectors' concerns with respect to the adequacy of the use of concrete jersey barriers in lieu of sand bags as required in the Final Safety Analysis Report (FSAR).

The "Common Cause Degraded Cornerstone–Mitigating Systems, Two White Findings," Revision 4, RCE 01896156 reiterated who and during what activities the flooding issue was identified.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the evaluation documented how long the issues existed and prior opportunities for identification.

The licensee's flooding RCE stated a specific time period when the issue existed. The specified timeframe was January 18, 1996, to November 25, 2013. As part of the root cause, the licensee identified several instances in the past for opportunities to identify the issue. Specifically, the licensee's RCE recognized there was a missed opportunity during their review of procedure PC 80 Part 7, "Lake Water Level Determination," after the March 11, 2011, earthquake and tsunami that effected the Fukushima Dai-ichi plant in Japan. The RCE further noted several CAP items which questioned how PC 80 Part 7 was meeting the FSAR requirements. In particular, three CRs questioned how PC 80

Part 7 and the use of jersey barriers were meeting the intent of the design basis. Finally, the licensee identified that a poorly written condition report for an NRC URI failed to identify the concern raised with respect to jersey barrier adequacy. The licensee recognized that for all the instances of prior identification the lack of understanding of the Design and the Current Licensing Basis (CLB) led to the failure to appropriately evaluate the changes that were implemented both physically and procedurally.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the evaluation documented the plant specific risk consequences, as applicable, and compliance concerns with the issue.

The licensee's evaluations individually and collectively addressed the plant specific risk consequences. In addition, the licensee's evaluations included an assessment of compliance.

The flooding RCE stated that during the time the station was not in compliance with FSAR section 2.5, "Hydrology-", mitigating system components were not protected to +9.0 feet as required. Systems not protected during this time period include the station battery chargers, emergency diesel generators and associated alarm and power transfer control panels and the 'A' train of 4160 volt switchgear. The impact of the noncompliance decreased the safety margin for protection against external events, in this case flooding. The licensee stated in the RCE and through interviews that this deficiency represented a serious vulnerability for the station. Furthermore, the licensee stated through interviews that the potential consequences associated with the event occurring would have been significant. The flooding RCE further stated that the issue was not reportable as an unanalyzed condition in accordance with 10 CFR Part 50.73(a)(2)(ii) due to multiple protections for the Turbine Building.

The common cause RCE reiterated the flooding issue non-compliance and individual risk as stated above. The common cause evaluation examines the original two issues collectively to assess if risk had increased overall. The licensee's evaluation concluded that the contribution to plant overall risk was associated with the contribution of each individually and that although the likelihood of each event occurring was small, each represented a significant risk to the site.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

b. Findings

No findings were identified.

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

Determine that the problem was evaluated using a systematic methodology to identify the root and contributing causes.

The inspectors reviewed the flooding RCE and supporting documentation to determine whether a systematic methodology was used to identify the root and contributing causes. The flooding RCE used analysis methods in order to determine and confirm the

developed root and contributing causes. The licensee used Barrier Analysis and Events and Causal Factors Chart as primary tools, Change Analysis and Cause and Effect Diagram as complementary tools and a Why Staircase for confirmatory purposes.

The inspectors reviewed the common cause RCE and supporting documentation to determine whether a systematic methodology was used to identify the root and contributing causes. The common cause evaluation used analysis methods in order to determine and confirm the developed root and contributing causes and look for commonalities between the two white finding issues. The licensee used Cause and Effect and Pareto Analysis as primary tools and a Why Staircase for confirmatory purposes.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the Root Cause Evaluation was conducted to a level of detail commensurate with the significance of the problem.

The inspectors reviewed the RCEs and supporting documentation associated with the above mentioned systematic methodologies to assess the root and contributing causes. The inspectors reviewed the tools used to determine the root and contributing causes and the procedures, engineering evaluations, and corrective action documents to assess the appropriateness of the licensee's conclusions. The inspectors also conducted interviews with individuals associated with the development of the flooding RCE.

The licensee developed the following root causes associated with the flooding issue:

1. "Insufficient questioning attitude (rigor) and management oversight during the procedure change and approval process resulted in the inadequate implementation of the site procedure change, design change and 10 CFR 50.59 screening evaluation processes, resulting in a reduction in flood protection measures when AOP-13B [High Lake Water Level procedure] was cancelled in 1996."
2. "Inadequate evaluation of flood protection condition reports resulted in the station not recognizing the risk significance of not being in compliance with the credited FSAR flood protection measures and untimely resolution of the degraded flood protection."
3. "Less than adequate understanding of the existing external flood protection design and licensing basis contributed to the loss of high lake level protection measures in 1996 when AOP-13B was canceled and the non-resolution when the condition was identified in CAP."

The licensee identified the following contributing causes:

1. "Less than adequate station rigor in follow up of potential flood protection degradation issues identified by the NRC in 2012 contributed to the untimely resolution of the degraded flood protection measures."
2. "Ineffective implementation of several aspects of Safety Culture at PBNP [Point Beach Nuclear Plant]."

The inspectors reviewed the common cause RCE and supporting documentation associated with the above mentioned systematic methodologies to assess the root and contributing causes. The inspectors reviewed the tools used to determine the root and contributing causes and the procedures and corrective action documents to assess the appropriateness of the licensee's conclusions. The inspectors also conducted interviews with individuals associated with the development of the common cause RCE.

The licensee developed the following root causes associated with the common cause RCE:

1. "Rigor (questioning attitude) applied to evaluation of CAP and License Basis issues was less than adequate."
2. "Leadership–Communication and reinforcement of management expectations for evaluation of risk significant conditions was less than adequate."
3. "Inadequate oversight and rigor applied to technical procedure revisions."
4. "Supporting Licensing Basis documentation and knowledge was less than adequate."

The licensee identified the following contributing cause:

1. "Ineffective implementation of several aspects of Safety Culture at PB [Point Beach]."

The inspectors determined that due to the licensee's use of systematic methodology to identify the root and contributing causes the evaluations were conducted to a level of detail commensurate with the safety significance of the issues.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the RCE included a consideration of prior occurrences of the problem and knowledge of prior operating experience.

The inspectors determined the RCE included a consideration of prior occurrences and precursors of the problem and knowledge of prior internal and industry operating experience.

The inspectors noted the RCE discussed that prior opportunities to properly correct the deficiency were missed. This included opportunities in 2004 and 2005, when condition reports were generated questioning the adequacy of wave run-up barriers, given the 1996 procedure change. An additional opportunity occurred in 2012 when an assessment inappropriately contained conclusions regarding the functionality of the wave barriers based upon perceived risk being too low. The licensee's RCE also reviewed the applicability of corrective actions from two apparent cause evaluations associated with a CR for the FSAR not being updated for changes to external flooding plan features. The inspectors noted that these opportunities were factored into the determination of the root causes. The RCE discussed that internal operating experience was reviewed and did not indicate the root causes for this event were a repeat cause.

The inspectors also noted the RCE discussion on industry OE and noted several instances where the causes of other industry deficiencies were similar to the causal

factors identified for the risk-significant issue. This included examples within the industry of other stations identification of weaknesses with flooding mitigation strategies. The licensee identified consistencies between their root cause and the industry root causes of less than adequate evaluation of external flooding related CAP items and less than adequate understanding of the existing external flood protection design and licensing basis.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the RCE addresses the extent of condition and the extent of cause of the problem.

The inspectors reviewed the RCE, extent of cause and condition evaluations, and supporting documentation to determine whether the RCE considered the impact on other systems, structures, equipment, programs, or conditions. The inspectors reviewed the analysis and conclusions of the extent of condition and cause evaluations to assess the adequacy of the licensee's scope. The inspectors reviewed the sampling method utilized by the licensee for the root cause and each of the contributing causes to determine if cross-functional and organizational vulnerabilities that may exist had been identified and addressed.

The inspectors' review for this objective was focused on determining whether the scope of the extent of condition and extent of cause evaluations performed as part of the RCE was adequate. The inspectors evaluated whether the extent of condition review assessed the degree the actual condition may exist in other plant organizations, processes, or human performance. The inspectors also reviewed whether the extent of cause review assessed the applicability of the root cause across disciplines or departments to different programmatic activities, human performance, or different types of systems or structures.

Overall, the inspectors determined that the licensee performed a detailed extent of condition and extent of cause evaluation for the problem. The licensee's evaluation appropriately assessed programmatic, cross-functional, organizational, equipment, and human performance areas for vulnerabilities.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Findings

No findings were identified.

02.03 Corrective Actions

Determine that appropriate corrective actions are specified for each root and contributing cause or that the licensee has an adequate evaluation for why no corrective actions are necessary.

The inspectors determined the licensee had appropriate corrective actions for the root cause and each contributing cause.

The inspectors verified the root causes had associated corrective actions to prevent recurrence (CAPRs). Additionally, the inspectors verified all contributing causes and weaknesses associated with the extent of condition and extent of cause were addressed through corrective actions. A detailed assessment was performed for each CAPR and a sample of contributing cause corrective actions. This assessment included review of corrective action documents and procedures, field walk downs, interviews with selected individuals, and a review of the CLB.

The inspectors concluded that although some of the CAPRs individually would not prevent recurrence, the CAPRs, in totality appeared to be adequate to prevent recurrence of the risk-significant performance issue. For example, one of the root causes for the Common Cause Analysis was "Rigor (questioning attitude) applied to evaluation of the CAP and Licensing Basis Issues was less than adequate". The licensee assigned three CAPRs to address this root cause. The first CAPR added the note "While reviewing evaluations, ensure considerations of and compliance with Licensing Basis, Design Basis, Site Commitments and appropriate Industry Standards" to a number of administrative procedures (Prompt Operability Determinations, Root Cause Evaluations, Functionality Assessment, etc.). The second CAPR updated the Functionality Assessment procedure to require pre-job briefs with a discussion of risk and to require a technical supervisor or manager approval. The inspectors determined that the two CAPRs individually would not prevent recurrence. However, the licensee assigned a third CAPR of the Safety Culture Improvement plan which would address the less than adequate rigor/questioning attitude. The inspectors determined that the root cause was addressed by the Safety Culture CAPR.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the corrective actions have been prioritized with consideration of risk significance and regulatory compliance.

The inspectors concluded the corrective actions were prioritized with consideration of both risk significance and regulatory compliance.

The inspectors assessed the licensee's timeliness of the corrective actions associated with the white finding. The inspectors noted the licensee performed extensive evaluations of the finding and took reasonable actions to correct the root and contributing causes prior to completion of the final revision of the RCE. Specifically, the RCE was subject to multiple independent reviews resulting in additional revisions to address additional causes and corrective actions.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that a schedule has been established for implementing and completing the corrective actions.

The inspectors concluded the licensee established an appropriate schedule for implementing and completing the corrective actions.

The inspectors found the licensee established a schedule for implementing, tracking, and completing the corrective actions. As documented in the RCE, each corrective

action identified an action, an owner, and a reasonable due date. Most of the corrective actions were completed before this supplemental inspection commenced. The inspectors discussed the open corrective actions with the licensee to ensure appropriate due dates were established.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that quantitative or qualitative measures of success have been developed for determining the effectiveness of the corrective actions to prevent recurrence.

The inspectors concluded the licensee developed adequate quantitative or qualitative measures of success for determining the effectiveness of the CAPRs.

The inspectors reviewed the licensee CAPRs and effectiveness reviews (EFRs) for two root cause evaluations; the White Finding–Flooding (RCE 01883633) and the Common Cause–Degraded Mitigating Systems Cornerstone (RCE 01896156). RCE 01883633 had nine CAPRs with seven supporting EFRs. Several CAPR-related interim EFRs and several EFRs associated with contributing causes were complete at the time of the inspection. RCE 01896156 had twelve CAPRs with eighteen supporting EFRs. Several CAPR-related interim EFRs were complete at the time of the inspection.

The inspectors reviewed the completed EFRs and determined each had an appropriate scope including pre-defined success criteria to measure the effectiveness of corrective actions. The inspectors reviewed the overall licensee evaluation and conclusion for each completed EFR noting that the licensee adequately evaluated CAPR related corrective actions for each. Additionally, a number of other interim EFRs were planned for completion in the near future along with a final EFR. The interim EFRs were developed to measure effectiveness at periodic intervals prior to final corrective action and EFR completion. The inspectors reviewed these EFRs and determined they were scheduled to be completed at a reasonable time in the future and consisted of appropriate scope/acceptance criteria for gauging the outcome of the effectiveness review. The planned EFRs were scheduled to be performed by the licensee throughout 2015 and include interviews, observations, CAP reviews, design basis reviews, procedure reviews, and safety culture improvement surveys. For each area reviewed, the inspectors determined measures of success were clearly defined and measurable.

During their review of the license EFRs, the inspectors noted two minor observations:

- RCE 01896156, RC1/CAPR2–The success criteria used a zero tolerance of “no issues” and the licensee’s CAP procedures discouraged this type of success criteria.
- RCE 01896156, RC1/CAPR3–Revision 4, Section C, Page 89 appears to contain an administrative error in that Section C indicated a final EFR for RC1/CAPR3 only whereas the EFR may apply to RC1/RC2/CC1/CAPR3.

The inspectors determined both of the above observations appeared to be of minimum consequence. The above observations were conveyed to the licensee during the inspection.

Overall, the inspectors determined the licensee developed adequate quantitative or qualitative measures of success for determining the effectiveness of the CAPRs.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

Determine that the corrective actions planned or taken adequately address the Notice of Violation that was the basis for the supplemental inspection.

The inspectors determined that the corrective actions taken by the licensee adequately addressed the NOV associated with the White finding which formed the basis for this supplemental inspection.

The inspectors conducted interviews of licensee personnel, conducted plant walk downs, reviewed several RCEs and associated CAPRs and corrective actions, and reviewed applicable procedures, drawings, and calculations to assess whether the licensee's response to the NOV adequately addressed the reason for the violation and whether the licensee implemented appropriate corrective actions to restore compliance.

(1) Implementation of the External Flood Mitigation

Although the onset of a probable maximum external flooding event involves implementation of numerous site procedures at Point Beach, key elements of the external flooding mitigation strategy include the implementation of three procedures, abnormal operating procedure (AOP) 13-C: "Severe Weather Conditions", PBF 2124a: "PBNP Maximum Converted Lake Level Calculation", and RMP 9422: "Circulating Water Pumphouse and Turbine Hall Barrier Placement". AOP 13-C established the entry conditions and overall actions required for mitigation of external and internal flooding. PBF 2124a established the methodology to monitor and predict the onset of lake level flooding conditions. Maintenance procedure RMP 9422 provided guidance on the installation and removal of flood barriers.

The inspectors reviewed the licensee's ability to collectively implement these procedures in response to an external flooding event. Inspector review of these procedures determined they adequately interface with one another to provide an overall external flooding mitigation strategy for Point Beach. Through interviews, the inspectors determined that licensee personnel were aware of the external flooding vulnerability to the site, the external flooding mitigation strategy, the general process by which lake flooding is monitored, and compensatory measures to be taken if lake levels near or exceed pre-defined flood levels.

The inspectors concluded the licensee had established an adequate external flood mitigation strategy.

(2) External Flooding Event Prediction

The inspectors determined the licensee's process and implementing procedure for prediction of the onset of an external flooding event (AOP 13-C and PBF 2124a, "PBNP Maximum Converted Lake Level Calculation") was adequate for the licensee to implement its external flooding mitigation strategy.

The inspectors reviewed the latest revision of PBF 2124a and determined that it provides an adequate methodology to monitor lake levels, including an increased monitoring frequency (monthly to weekly) when rising levels meet pre-defined criteria. AOP 13-C and PBF 2124a initiate RMP 9422, "Circulating Water Pumphouse and

Turbine Hall Barrier Placement” when the corrected mean level of Lake Michigan-Huron is determined greater than or equal to 0.0 feet (commonly referred to as the “Plant Elevation” and a value which flood mitigation strategies are referenced to). In essence, this is a plant specific value which equates to an average Lake Michigan-Huron water elevation of 580.9 feet using several pre-determined Great Lakes measuring locations.

The inspectors determined that collectively AOP 13–C, PBF 2124a, and RMP 9422 provide adequate guidance for obtaining lake level prediction data in a manner that would provide sufficient warning for an external flood that would exceed a lake level requiring compensatory measures to be initiated. Inspectors concluded the licensee had established the capability to predict the onset of an external flooding event.

(3) Procedures, Equipment, and Materials for Flood Barrier Construction

Procedure RMP 9422 is initiated by AOP–13-C and PBF 2124a once the “Corrected Mean Level” of Lake Michigan-Huron exceeds 0.0 feet. In essence, this is a plant specific value which equates to an average Lake Michigan-Huron water elevation of 580.9 feet using several pre-determined Great Lakes locations for measurement.

Recognizing the importance of these procedures in regard to the licensee’s flooding mitigation strategy, the inspectors reviewed the procedures to determine whether the licensee established a satisfactory process by which an external flooding event would be mitigated. Specifically, procedure RMP 9422 provides guidance for the installation and removal of flood barriers for plant protection. This guidance included the use of wave run-up barriers, CGSL stop logs, sandbags and PRESRAY FB33 temporary flood barrier devices to block certain structure openings. Inspectors reviewed this procedure, along with PBF 2124a that was used to predict lake level flood conditions, both individually and collectively. Through review, the inspectors determined the licensee had established procedures which provided an adequate and integrated external flooding mitigation strategy when collectively implemented.

The inspectors also reviewed engineering change documents supporting the mitigation strategy, the flood mitigation equipment stored onsite for use during an external flooding event, and the capability to install the required flood barriers. The inspectors did not intend this to be a detailed design review, but rather an informed determination as to whether the licensee’s external flooding mitigation strategy would protect the site as described in the FSAR.

The inspectors reviewed several Engineering Change packages associated with external flooding, including EC–281811 which was associated with the external wave run-up flood mitigation strategy. Inspector review of that engineering change package noted two stop logs heights being 1 inch and 1.5 inches below the +9.0 feet wave run-up elevation at Turbine Building DOOR–004 and DOOR–013, respectively. Although this was identified by the licensee and addressed as acceptable in EC–281811, the inspectors viewed this as a lack of engineering attention to detail early in the stop log design process which ultimately resulted in stop logs with lower than intended heights and a reduction of design margin. Although the inspectors viewed the licensee actions which resulted in a reduced design margin as a weakness, the collective mitigation strategy, provided by the stop logs and sand bagging, was adequate to meet FSAR wave run-up of +9.0 feet.

The inspectors performed plant walk downs and examined external flood mitigation equipment, including rip-rap along the lake shoreline, concrete wave run-up barriers, CGSL stop logs, sandbags, and PRESRAY FB33 temporary flood barrier devices to block pre-defined structure openings. The inspectors conducted walk downs of the plant areas susceptible to a design basis external flooding event and inspected the mitigation equipment being stored onsite. Although a detailed walk down of the lake shoreline rip-rap had not been conducted by the inspectors, comparison between the conditions visually observed by the inspectors and the associated design drawings allowed the inspectors to conclude the licensee had placed shoreline rip-rap generally consistent with the design. Lastly, the inspectors requested the licensee partially implement its mitigation strategy by installing one of the PRESRAY FB33 temporary flood barriers.

During their review, the inspectors identified several observations/potential weaknesses in regard to either the equipment or procedural implementation for the external flood mitigation strategy. One of the potential weaknesses related to inspector questions as to whether sufficient acceptance criteria existed in RMP 9422, and resulted in the inspectors requesting the licensee to obtain a PRESRAY FB33 device from storage and implement the process of installing it into the designated structure opening. The inspectors observed this evolution and determined the device was adequately installed, however the inspectors conveyed several procedure and process observations to the licensee. The licensee indicated the observations would be incorporated into the CAP. Some of the other inspector observations included:

- RMP 9422 Attachment D, Note (After Step 1.6) stated “Vendor recommendation is to turn the compression clip handle to 90 percent finger tight”. Through interview, the inspectors determined the guidance of this note to be vague relative to “90 percent finger tight” and in potential conflict with opposing guidance stipulated in Step 1.7 (Turn compression clips...until compresses the panel gasket approximately one-quarter inch). During the inspector requested installation of a PRESRAY FB33 barrier, as described in the following bullet, inspectors observed licensee actions and found the installation focused on the one-quarter inch gasket compression procedure criteria. Inspectors interviewed the installation personnel after installing the PRESRAY FB33 door and inquired which criteria took precedence (i.e., 90 percent finger tight or one-quarter inch compression). The individuals who installed the door indicated they felt 90 percent finger tight fell within “craft capability” and further stated whichever of the two criteria was met first would be the point they would stop. Overall, the inspectors concluded the procedure may include opposing acceptance criteria (90 percent finger tight or one-quarter inch compression) and insufficient guidance to validate that the function of the gasket to seal (i.e., compression) is adequate.
- RMP 9422 Attachment D, Steps 1.7 and 1.8 discussed the installation of PRESRAY FB33 flood protection barriers. Step 1.7 states Turn compression clips until downward force compresses the panel gasket approximately one-quarter inch. Step 1.8 stated Turn handle counterclockwise while exerting downward pressure to expand the unit and expand the unit until the seals on both sides are compressed about one-quarter inch. Based on licensee demonstrations on a training related mock-up PRESRAY door, the inspectors developed questions whether the procedure requirement of one-quarter inch gasket compression was achievable. As a result, the inspectors requested the licensee obtain an actual PRESRAY FB33 device being stored for mitigation strategy use and install it in an actual structure opening. Additionally, inspector review of the stated procedure resulted in questions

of how the gasket compression would be validated during actual installation. Inspectors observed the PRESRAY FB33 installation in the structure opening and were satisfied that the required gasket compression stated in the procedure could be met. However, the inspectors still questioned whether sufficient criteria existed in the procedure ensuring some form of validation of the gasket compression during times of actual installation.

- RMP 9422 Attachment F, Steps 25.7 and 26.4 discussed removal and storage of sandbags used during a flooding event. Inspectors determined the procedure lacked guidance for re-inspection of equipment after use and placement in storage to ensure readiness for a subsequent event. The licensee initiated CR 02023238 for clarifying inspection requirements for reusable flood protection equipment.
- During a plant walk down, the inspectors assessed the storage of the stop logs in temporary storage location. The stop logs were stored on the floor and in close proximity to plant equipment immediately next to and behind them. Although the area appeared to be an infrequently accessed area, the inspectors conveyed concern that the current method of storage on the floor presents a possibility for seal damage. Specifically, plant personnel trying to access the adjacent plant equipment could inadvertently step on the stop logs causing damage to them, particularly the seals. When this observation was presented to the licensee they indicated that storing the stop logs on the floor was only temporary and that a permanent storage method of using wall racks was to be implemented.

The inspectors concluded the above observations did not adversely impact the margin of safety. The inspectors determined the procedures and equipment used to mitigate an external flooding event were adequate and could effectively protect Point Beach from a design basis probable maximum flood.

Overall, the inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

### Findings

No findings were identified.

## 02.04 Independent Assessment of Extent of Condition and Extent of Cause

### a. Inspection Scope

As part of the IP 95002 inspection, the inspectors conducted an independent extent of condition and extent of cause review of licensee programs/processes to verify the licensee appropriately considered the CLB of the plant; that procedures were consistent with the CLB, and plant personnel were knowledgeable with the CLB and implementation of the governing procedures. Inspectors reviewed elements of programs and processes to determine whether the causes identified for the risk-significant performance issue affected the current viability of other programs and processes and whether conditions identified in the RCE existed in other programs and processes.

The objective of the review was to independently sample performance and provide assurance the licensee's assessments were sufficiently comprehensive regarding the extent of condition and extent of cause. Extent of condition reviews are required to be focused on the root cause of the condition and its existence in other places, whereas the

extent of cause reviews are to be focused on the root cause of the condition and the degree to which it has resulted in additional weaknesses.

The following provides an overall summary of the licensee's extent of condition for each of the above described RCEs.

#### Root Cause Evaluation 01883633, External Wave Run-Up

The licensee's original extent of condition addressed the following licensing basis external hazards:

- External Flood/Topography (Wave Run-up and Probable Maximum Precipitation);
- Internal Flood Barriers/Drainage;
- Tornado/High Winds;
- Lake Temperature (high);
- Air Temperature (hot/cold);
- Seismic;
- Lake Level;
- General Design Criteria–2;
- B.5.b/Security;
- External Fire;
- Freezing Rain, and;
- Frazzle Ice.

The licensee expanded its extent of condition review following the February 2014 NRC 95002 inspection to incorporate several conditional issues that had been identified since approval of Revision 3 of RCE 01883633. The licensee incorporated the following aspects in the expanded extent of condition scope and extent of condition actions:

- Internal flooding protection measures directly preceding and during the period of the February 2014 NRC 95002 inspection;
- Site and NRC walk downs that identified additional flood protection issues;
- Inclusion of identified issues in the CAP and an assessment for operability impact and corrective action establishment;
- Development and implementation of an Engineering Action Plan to expand the EOC review to include internal flooding protection measures and technical analysis to support the licensing basis;
- Modifications and maintenance corrective actions established to address additional defense-in-depth measures for internal flooding, and;
- Review of the current external event protection procedures (General Design Criteria 2 listed procedures) against the AOPs, EOPs, ECAs, CSPs and selected Annunciator Response Procedures to identify potential conflicts between the response actions for implementation.

## Root Cause Evaluation 01896156, Common Cause Evaluation

The licensee's extent of condition addressed the following:

- Flooding White Finding—Continuing identification of external and internal flood protection issues by the station and the NRC following completion of RCE 01883633 resulted in the extent of condition scope and depth; and
- Degraded Mitigating Systems Cornerstone—The extent of condition included review that Unit 1 was in Column III, Degraded Cornerstone coupled with the TDAFW White Finding being closed in January 2014 with the Flooding White finding being held open, and Unit 2 being in the Regulatory Response column for one White Finding in the Mitigating Systems Cornerstone from external flooding.

Additionally, the inspectors selected three specific areas where a more detailed review of the extent of condition and extent of cause was independently evaluated. Specifically, the inspectors reviewed the following programs and processes:

- Air Temperature (Hot/Cold);
- High Lake Temperature; and
- 10 CFR 50.59.

The inspectors interviewed licensee personnel, reviewed program and process documentation, procedures, and corrective action documents during their independent assessment. In addition, the inspectors conducted field walk downs specific to external flooding protection, air temperature, and high lake temperature. The inspectors looked for plant conditions that may be challenged by design basis events. Additionally, the inspectors assessed the knowledge of Point Beach on related programs and procedures. Specifics regarding each of these targeted inspector reviews follows:

### (1) Air Temperature (Hot/Cold)

The CLB addresses several plant systems including:

- VNPAB, Primary Auxiliary Building Ventilation System (FSAR Sections 7.3 & 7.6);
- VNPH, Circulating Water Pumphouse Ventilation System (FSAR Section 9.6);
- VNCC, Containment Ventilating System (FSAR Section 5.3 and 6.3);
- VNCRD, Control Rod Drive Cooling System (FSAR Sections 3.4, 5.3, & 7.7);
- VNBI, Battery and Inverter Room Ventilation (FSAR Section 8.7);
- VNDG, Diesel Generator Ventilation System, G01/G02 (FSAR Section 8.8);
- VNTB, Turbine Building Ventilation and Façade Areas (FSAR Section 7.3 & 10.1);
- Transformers (FSAR Section 1.2.7); and
- VNCR, Control Room Ventilation System (FSAR Section 9.8).

The inspectors reviewed the CLB, site-specific air temperature issues, and the licensee's extent of condition evaluation for an external air temperature event and the related system vulnerabilities. The inspectors evaluated the extent of condition and extent of cause for the impact of air temperatures on the main feedwater pumps and the

white/yellow battery room and inverter room (ventilation normal operation and ventilation shutdown).

The inspectors determined the licensee's review was adequately scoped as it evaluated air temperature-related issues that had been documented over the past five years. The licensee determined no new issues and/or gaps were identified by its review and concluded that no potential significant issues were identified as a result of its review performed on associated air temperature issues. The inspectors review also did not identify any significance gaps or issues. Overall, the inspectors concluded the licensee appropriately evaluated air temperature as an extent of condition for the risk significant issue associated with this inspection.

(2) High Lake Temperature

The CLB addressed several plant systems including:

- Service Water System (FSAR Section 9.6);
- Containment Ventilating System (FSAR Section 5.3);
- Operating Control Systems (FSAR Section 7.5);
- 125 VDC Electrical Distribution Systems (FSAR Section 8.7);
- Diesel Generator System (FSAR Section 8.8); and
- Primary Auxiliary Building Ventilation System (FSAR Section 9.5).

Inspectors reviewed the CLB, site-specific high lake temperature issues, and the licensee's extent of condition evaluation for an external high lake temperature event and the related system vulnerabilities. The inspectors evaluated the extent of condition and extent of cause for the impact of high lake temperatures on the Unit 1 and Unit 2 containment fan coolers and the containment accident recirculation fan cooler units.

The inspectors determined the licensee's review was adequate. The licensee's review noted system-based calculation discrepancies in that several calculations had not been revised to incorporate a post extended power uprate (EPU) increase in service water temperature (80°F to 85°F). Specifically, the licensee initiated CR 01908842 to address the configuration management issue for the impacted calculations since each still contained 80°F service water temperature as opposed to the post EPU 85°F service water temperature. These calculations included: #98-0086, "Service Water and Circulating Water Inlet Temperature Indication Loop Instrument Uncertainty Calculation"; #N-94-059, "CCW HX-012A-D Service Water Flow versus Temperature Requirement"; and #129187-M-0018, "Service Water System Heat Loads and Temperature at EPU". The licensee had taken action to correct the anomalies noted during its extent of condition review. Overall, the licensee concluded that no significant issues were identified as a result of its review performed on associated high lake temperature issues and, for the one gap identified with calculations containing an incorrect service water temperature, the increased temperature to 85°F had a negligible effect on the calculation results. Inspectors conducted a targeted review regarding the changed service water temperatures subsequent to EPU implementation. The inspectors concluded the licensee's action in response to its self-identified service water temperature calculation discrepancies was satisfactory.

The inspectors review did not identify any significant gaps or issues. Overall, the inspectors concluded the licensee appropriately evaluated high lake temperature as an extent of condition for the risk significant issue associated with this inspection.

(3) 10 CFR 50.59 Evaluation Process

The licensee's RCE 01883633 included a review of relevant 10 CFR 50.59 screenings and evaluations. The licensee determined that the 10 CFR 50.59 process was not effectively used to fully assess and understand the implications on the CLB when it changed the external flood mitigation strategy from sandbags to jersey barriers in 1995. Specifically:

- The basis for the screening conclusion was the 10 CFR 50.59 associated with a 1987 modification that had flawed screening;
- Administrative controls governing the Point Beach 10 CFR 50.59 implementation allowed prescreening a proposed activity in its entirety to an existing screening or evaluation;
- Since the 1987 screening was invalid, the 1995 screening was also invalid;
- Both the 1987 and 1995 screenings failures may have involved human performance errors, however due to the amount of elapsed time the licensee could not ascertain what factors may have been involved with the original evaluations;
- In 2013 an added 10 CFR 50.59 performance error occurred in regard to the barrier installation procedure since the approved procedure allowed engineered concrete blocks to be installed such that they introduced an obstruction for relief of water runoff to Lake Michigan during a probable maximum precipitation event and internal flooding due to a ruptured circulating water expansion joint; and
- In 2013 administrative controls governing the Point Beach 10 CFR 50.59 implementation once again allowed prescreening a proposed activity in its entirety to an existing and valid screening or evaluation.

Ultimately, the licensee determined that an inadequate 10 CFR 50.59 screening for the procedure changes implementing wave run-up flood protection resulted in degraded protection measures for external events. Specifically, the initial concrete barrier installation procedure approved in the mid 1990's introduced a reduction in protection measures for high lake wave run-up. Then, in 2013, a corrective action to resolve inadequate probable maximum precipitation measures resulted in an adverse impact on other flood source protection measures because of the loss of a natural credited drainage path. The licensee concluded that one of the root causes for this involved insufficient questioning attitude (rigor) and management oversight during the procedure change/approval process resulted in the inadequate implementation of the site procedure change, design change, and 10 CFR 50.59 screening evaluation process.

As part of the corrective action for RCE 01883633 on external flooding, the licensee established actions to revise the initial 10 CFR 50.59 training process that included the development of a lessons learned document for qualified 10 CFR 50.59 screening- qualified personnel and procedure writers, development of risk recognition workshops to ensure station personnel understand risk recognition; and conduct read and learn operating experience training for all 10 CFR 50.59 qualified personnel that cautions against using vintage 10 CFR 50.59 screening/evaluations unless validated and

emphasize the requirements to review and understand the CLB.

In relation to the inadequate 10 CFR 50.59 screening issue, the inspectors selected and reviewed several recent procedure changes and 10 CFR 50.59 screening documents during the inspection with the purpose of conducting an independent extent of condition and extent of cause review. Based on the reviews conducted, the inspectors did not identify any additional issues where procedure changes requiring a 10 CFR 50.59 screening had an inadequate screening review or that conflicted with the CLB.

### Assessment

The inspectors reviewed the licensee's extent of condition reviews associated with the above RCEs and determined they appeared to have been conducted by knowledgeable individuals, were appropriately scoped and reviewed the circumstances of the initiating issue, applied an appropriate level of effort to identify relevant causal factors, and included evaluation for uniqueness, recurrence, and potential/actual consequences. Although the licensee's extent of condition reviews resulted in several corrective actions, those corrective actions did not result in any new significant issues.

The inspectors also reviewed the extent of cause evaluations developed by the licensee for both RCEs. The licensee's extent of cause reviews were of sufficient breadth to include other plant areas, programs/processes, or equipment that could be similarly impacted by the root causes identified for both the Flooding White Finding and the Degraded NRC Mitigating System Cornerstone condition. Additionally, the licensee's extent of cause evaluations included consideration as to what may have been inadequate in previous assessment/evaluations, particularly in regard to whether repetitive issues existed. The inspector's review of the licensee's extent of condition and extent of cause evaluations for RCE 01883633 and 01896156 did not identify any significant issues or concerns.

The inspectors did, however, identify two observations, during their review. Both observations were conveyed to the licensee during the inspection. Specifically:

- Regarding RCE 01896156, the inspectors noted that the root cause and extent of condition only focused on issue identification by the NRC and may have missed opportunities to identify weaknesses in site response to assessment feedback from other external stakeholders (i.e., Management Safety Review Committee, Management Review Committees, etc.), and;
- In relation to RCE 01896156, the inspectors noted that root causes 1 and 4 were related to a "knowledge" gap. Since the knowledge gap was associated with a root cause, a CAPR would have normally addressed the issue. However, the inspectors were not able to determine that a specific CAPR existed to prevent recurrence for the identified root cause. The inspectors did however note that as part of a corrective action for root cause 4 that action had been established to address the knowledge gap.

The inspectors concluded these observations did not adversely impact the margin of safety.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

## Findings

No findings were identified.

### 02.05 Safety Culture Consideration

#### a. Inspection Scope

As part of the IP 95002 inspection, the inspectors independently confirmed the safety culture components that contributed to the risk-significant performance issue that was the subject of this inspection were identified in the licensee's RCE. The RCE included a discussion of the applicable safety culture components described in Regulatory Issue Summary 2006–013, "Information on the Changes Made to the Reactor Oversight Process to More Fully Address Safety Culture," (ML061880341) as they applied to the white finding. The licensee determined weaknesses in the areas of decision making, resources, work control, work practices, CAP, and continuous learning environment were the most prevalent safety culture attributes. For each of the identified prevalent and contributing safety culture components, the inspectors confirmed the licensee established appropriate corrective actions to address them.

The inspectors performed a focused inspection to independently determine whether the licensee's RCE appropriately considered whether any safety culture component caused or significantly contributed to the risk-significant performance issue. The inspectors reviewed procedures, CAPs, corrective actions, site safety culture assessments and surveys, and independent safety culture assessments and surveys. The inspectors conducted interviews with the licensee's staff to independently evaluate the site's safety culture. A random sample of non-supervisory and supervisory personnel from several departments, including, but not limited to Engineering, Operations, Maintenance, and Security, were interviewed by the inspectors. In addition, during the course of conducting interviews associated with inspection activities, the inspectors asked interviewees questions related to Safety Conscious Work Environment (SCWE) to determine whether the licensee's staff were reluctant to raise safety concerns or whether fear of retaliation existed for raising safety concerns. The inspectors did not identify concerns related to SCWE during the course of these interviews.

#### Assessment

As part of the RCE, the licensee evaluated the identified root and contributing causes against the safety culture components that could have contributed to the risk-significant performance issue. The licensee determined that weaknesses in the areas of decision making, resources, work control, work practices, CAP, and continuous learning environment were the most prevalent safety culture attributes.

The inspectors independently confirmed a number of the safety culture components that contributed to the risk-significant performance issue were identified in the RCE. For each of the identified prevalent and contributing safety culture components, the inspectors confirmed the licensee established corrective actions to address them. The inspectors confirmed the licensee's root cause, extent of condition, and extent of cause appropriately considered safety culture components described in IMC 0305, Operating Reactor Assessment Program.

In the RCE, the licensee determined that a corrective action to prevent recurrence of the risk-significant finding would be the development and implementation of the Point Beach Nuclear Plant Nuclear Safety Culture Improvement Plan (NSCIP). The inspectors noted that the evaluation section of the NSCIP listed the identified safety culture aspects that were significant contributors and needed focus as determined by the licensee's RCE. The NSCIP, however, did not include all of the same nuclear safety culture aspects listed in the RCE. The licensee did address all of the safety culture aspects in the RCE in the corrective actions attachment of the NSCIP. CR 02023462 was written for this inspector identified item. In addition the inspectors noted that, as part of the NSCIP, a wealth of data is analyzed from several different sources, including metrics from already existing nuclear safety culture improvement initiatives and new activities implemented as part of the NSCIP. The NSCIP discussed reviewing trends and progress with respect to improving nuclear safety culture, but lacks a robust feedback mechanism to ensure trends identified are due to effectiveness of corrective actions or by chance.

The inspectors concluded the licensee met this aspect of the IP 95002 objectives and this item is closed.

b. Findings

No findings were identified.

02.06 Evaluation of Inspection Manual Chapter 0305 Criteria for Treatment of Old Design Issues

The licensee did not request credit for self-identification of an old design issue. Consequently, the subject risk-significant finding was not evaluated against the IMC 0305 criteria for treatment of an old design issue.

40A6 Management Meeting

Exit Meeting Summary

On February 6, 2015, the inspectors presented the inspection results to Mr. McCartney and other members of the licensee's staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

ATTACHMENT: SUPPLEMENTAL INFORMATION

## **SUPPLEMENTAL INFORMATION**

### **KEY POINTS OF CONTACT**

#### Licensee

E. McCartney, Site Vice-President  
B. Woyak, Degraded Cornerstone Recovery Team Leader  
D. DeBoer, Plant General Manager  
L. Christensen, Licensing Project Manager  
B. Scherwinski, Licensing Analyst  
T. Schneider, Licensing Senior Engineer  
M. Millen, Licensing Manager  
L. Nicholson, Licensing Fleet Manager  
R. Weber, Operations Site Director  
P. Wild, Engineering Design Manager  
R. Wright, Recent Plant General Manager  
J. Wilson, Maintenance Site Director  
R. Welty, Radiation Protection Manager  
T. Poindexter, Morgan Lewis Consultant  
K. Landis, Landis Consulting  
B. Dunn, Director Fleet Design Engineering  
F. Eichhorst, Configuration Management Supervisor  
R. Harrsch, Engineering Director  
R. Higgins, Operations Shift Manager  
D. Hofstra, Operations Unit Supervisor  
R. Inman, Control Room Operator  
K. Kinjerski, Procedure Supervisor  
B. Kuchera, Control Room Operator  
M. LeMay, Design Engineer  
A. Nash, Design Engineering Supervisor  
R. Parker, Chemistry Manager  
S. Pfaff, Performance Improvement Supervisor  
J. Pierce, Training Site Manager  
S. Ruesch, Employee Concerns Program Coordinator  
G. Strharsky, Site Quality Manager  
D. Thilmony, Engineering Performance Technician  
R. Seizert, Emergency Preparedness Manager  
J. Ramski, Outage Supervisor  
C. McCillan, Online Manager  
M. Omillian, Training Instructor  
D. Forter, Projects Site Manager  
S. Aerts, Performance Improvement Manager

#### Nuclear Regulatory Commission

J. Cameron, Chief, Reactor Projects Branch 4  
D. Oliver, Senior Resident Inspector, Point Beach  
K. Barclay, Resident Inspector, Point Beach

**LIST OF ITEMS OPENED, CLOSED AND DISCUSSED**

Opened

None

Closed

None

## LIST OF DOCUMENTS REVIEWED

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

### Condition Reports

- CR 01809095; Deficiencies in Procedure PC 80 Part 7 “Lake Level Determination”
- CR 01253488; Potential of No Longer Satisfying a FSAR Commitment
- CR 01276890; High Lake Level Procedure is Insufficient and Contains Discrepancies
- CR 01262008; Weak Design Basis for Use of Concrete Jersey Flood Barrier
- CR 01986000; Flooding Root Cause Evaluation 01883633 10 CFR 50.59 Corrective Action Review
- CR 01954549; Cross-Cutting Theme Aspect P.2, Evaluation
- CR 01912997; Mock 95002: Document Reportability Basis for Flooding White Finding
- CR 01946330; Licensee Actions in Response to Receiving and NRC Severity Level IV Violation
- CR 01922249; Performance Improvement Procedure Compliance Issues
- CR 02001319; Past Operability Review, HELB Barrier Degraded and Not Evaluated
- CR 01970921; Deficiencies with Operations ODM Reviews
- CR 01992433; NOS Finding – Multiple MTN Program Implementation Shortfalls
- CR 02020013; 95002 Information Request – Safety Culture Insp.
- CR 02019267; Weakness in Understanding the DNA Acronym
- CR 01974286; Planning Linkage to Flooding Barrier and Relief Requirements
- CR 01970232; Escalation of the 95002 Recovery Concerns
- CR 01896156-57; Strengthen the Administration Controls that Govern Evaluation of Issues Entered into the Corrective Action Program
- CR 01883633-19; Improve the Rigor and Procedural Guidance for the Performance of Functionality Assessment
- CR 01896156-58; Develop and Implement a Nuclear Safety Culture Improvement Plan (NSCIP) for PBNP
- CR 01896156-40; Improve Considerations for Risk-Significant Decision Making
- CR 188633-44; Update the Design and Licensing Basis Documentation for Final Wave Run-up Strategy
- CR 01896156-13; Revise the POD, POR, ACE, and CE Templates in NAMS
- CR 01896156-11; Establish a Computer Based Training to Reinforce Problem Identification & Resolution
- CR 01980739; Failure to Learn Lessons from Previous 95002 Inspection
- CR 01896156-06; Revise the PB On-Boarding Process and Checklist
- CR 01896156-59; Strengthen the Oversight and Rigor of the Technical Procedure Revision Process
- CR 01896156-10; Implement a Process for UFSAR Ownership and Periodic Reviews
- CR 01883633-08; Implement a Formal Flooding Program the will Maintain Configuration Management for Flooding
- CR 01896156-43; CLB Training- Develop and Provide Training to Engineering and Procedure Writers on Licensing Basis
- CR 01883633-40; Develop and Implement Plant Modifications for a Wave Run-up Event

- CR 01883633-63; Develop and Implement Plant Maintenance Activities for a Wave Run-up Event
- CR 01883633-41; Implement the NextEra Fleet 10 CFR 50.59 Process
- CR 01883633-56; Revise the initial 10 CFR 50.59 Training and Mentoring Guide
- CR 01883663-55; Develop and Share a Lessons Learned Document
- CR 01936649; Changes to Section 10.1 of FSAR
- CR 01930944; Subsoil Drains Cleanout Covers not Water Tight
- CR 01937268; FSAR Change for Section 12.3 Training
- CR 01924668; FSAR Change Request- 12.5 Records
- CR 01937973; Change FSAR Reference in Section 9.4.4
- CR 01985361; Additional Performance Issues with 50.59 Products
- CR 01957204; 10 CFR Pre-Screening Weakness
- CR 01982235; Fleet Review of PBNP 50.59
- CR 01951898; FSAR Periodic Review
- CR 01856318-09; FSAR Not Updated for External Flooding Features – Verify Fleet Modification Procedures for Flooding; June 24, 2014
- CR 01883633-08; Corrective Action Closeout Package (EFR); August 28, 2014
- CR 01883633-19; Corrective Action Closeout Package (EFR); August 25, 2014
- CR 01883633-39; White Finding – Flooding (Interim EFR for RC1: Engineering Review of 50.59): January 29, 2015
- CR 01883633-41; Corrective Action Closeout Package (EFR); August 22, 2014
- CR 01883633-51; White Finding – Flooding (Interim RC2 CAPR1: EN-AA-203-1001 Products (CAPR3); January 29, 2015
- CR 01883633-54; Corrective Action Closeout Package (Conduct a Self-Assessment on PB Implementation of LI-AA-103-1000 Requirements); November 1, 2014
- CR 01883633-56; Corrective Action Closeout Package (EFR); January 16, 2015
- CR 01883633-57; Corrective Action Closeout Package (EOCa); August 25, 2014
- CR 01883633-58; Internal Flooding Plant Modifications 95002-7; June 19, 2013
- CR 01883633-59; Corrective Action Closeout Package (EOCa); August 22, 2014
- CR 01883633-61; EFR for RC1 CAPR4: 10CFR50.59 OE; June 19, 2013
- CR 01896156; Final Effectiveness Review; January 24, 2015
- CR 01896156; Flooding White Finding and Notice of Violation; August 12, 2013
- CR 01896156-10; Corrective Action Closeout Package (RC4 CAPR1); August 4, 2014
- CR 01896156-44; Flooding White Finding and Notice of Violation (EFR); August 12, 2013
- CR 01896156-45; Flooding White Finding and Notice of Violation (EFR); August 12, 2013
- CR 01896318; Closure Summary Document; November 13, 2013
- CR 01932698-03; 95002 Wave Run-up Protection May Conflict with Other Floods-Functionality Assessment; December 9, 2014
- CR 01932698-17; White Finding – Flooding (EFR); June 19, 2013
- CR 01938825; 95002 Inspection: Wave Run-up Thru Storm Drains Not Documented; March 25, 2014
- CR 01939011; 95002 Inspection: FSAR Section 2.5 Discussion of PMP Lack Detail; August 21, 2014
- CR 01942059; 95002 Inspection: Remove Note From PBF-2124; March 4, 2014
- CR 01948109; Internal Flooding Hazards in PAB Not Fully Evaluated; March 13, 2014
- CR 01950128; BG AOP-13C – (S); March 20, 2014
- CR 01985361; Additional Performance Issues With 50.59 Products; January 2, 2015
- CR 01985555; PCR – AOP 9A: August 20, 2014
- CR 01989295; LI-AA-103-1000 Effectiveness Review Results; September 5, 2014
- CR 01989671; PCR - AOP 13-C; September 8, 2014

- CR 01993425; PCR – PBF-2124A; September 24, 2014
- CR 01999433; OI 108 – PCR Approval Overdue; October 16, 2014
- CR 01999441; TS 33 – PCR Approval Overdue; October 16, 2014
- CR 01999443; TS 34 – PCR Approval Overdue; October 16, 2014
- CR 019997282; NP 7.7.9, Facilities Monitoring Program; October 8, 2014

#### NRC Identified

- CR 02022594; During a Document Response to the 95002 Team the Record Copy of Root Cause Evaluation 01985239 was found to be Unsigned
- CR 02022926; Annual Flooding CBT Should Be Updated
- CR 02022941; Trigger Point for a Department HU Trend
- CR 02022774; EC Missing 10 CFR Applicability Milestone
- CR 02022787; Temporary Equipment Labels Absent for Two Barriers
- CR 02022793; Area Drain Not Shown on Drawing C-5
- CR 02022901; Install Z-1109 in Door 011
- CR 02022978; Flood Zone Scaffold Did Not Meet Requirements
- CR 02023238; Flood Barrier and Acceptance Criteria
- CR 02023278; RCE 01883633 Revision 6 Content Error
- CR 02023309; OE Review of Turbine Building Temperature Impacts
- CR 02023310; G02 Floor Drain Clean Out
- CR 02023311; Technical Guidance for Annual FSAR Review
- CR 02023462; NSCIP Paragraph Lacks Detail
- CR 02023614; Exterior Flood Strategy Protection Question
- CR 02023616; NRC Observation on RCE 01954549, Revision 1, P.2 Evaluation

#### Procedures

- FP-E-SE-03; 10 CFR 50.59 and 72.48 Processes, Revision 8
- NP 5.1.8; 10 CFR 50.59 / 72.48; Applicability Screening and Evaluation; Revision 5
- OI 70; Service Water System Operation; Revision 74
- NP 5.1.8; 10 CFR 50.59/72.48 Applicability, Screening and Evaluation; Revision 5
- PI-AA-100-1005; Root Cause Analysis; Revision 11
- PI-AA-100-1006; Common Cause Evaluation; Revision 8
- PI-AA-100-1007; Apparent Cause Evaluation; Revision 9
- NP 8.4.17; PBNP Flooding Program; Revision 18
- LI-AA-101-1003; Updated Final Safety Analysis Report (UFSAR) Updating; Revision 0
- AD-AA-100-1004; Preparation, Revision, Review and Approval of Site-Specific Procedures; Revision 13
- AD-AA-100-1004-F06; Technical Accuracy Review Checklist; Revision 2
- AD-AA-103; Nuclear Safety Culture Program; Revision 5
- FP-G-DOC-04; Procedure Processing; Revision 22
- NA-AA-200-1000; Employee Concerns Program; Revision 0
- PI-AA-100-1005-F03; Nuclear Safety Culture Evaluation Form; Revision 2
- PI-AA-102-1001; Operating Experience Program Screening and Responding to Incoming Operating Experience; Revision 13
- PI-AA-104-1000; Corrective Action; Revision 2
- 0-SOP-VNBI-002; White/Yellow Battery and Inverter Room Ventilation Shutdown; Revision 5
- 0-SOP-VNBI-003; White/Yellow Battery and Inverter Room Ventilation Normal Operation; Revision 10
- RMP 9422; Circulating Water Pumphouse and Turbine Hall Barrier Placement; Revision 0

- 10 CFR 50.59 Evaluation 2014-005; EC 281811 External Wave Run-up Flood Mitigation Strategy; November 3, 2014
- Action Tracking – CAPCO Guidance; Revision 14
- AOP-13C; Severe Weather Conditions; Revision 35 & 38
- BG AOP-13C; Severe Weather Conditions; Revision 16
- EN-AA-203-1001; Operability Determinations/Functionality Assessments; Revision 14
- EN-AA-203-1201; 10CFR Applicability and 10CFR50.59 Screening Reviews; Revision 0
- FG-E-QRT-01; Quality Review Team (QRT); Revision 0
- LI-AA-101-1003; Updated Final Safety Analysis Report (UFSAR) Updating; Revision 0
- LI-AA-103-10000; Regulatory Issue Management; Revision 1
- List of 50.59 Products Associated with Flooding RCE Common Cause Procedure Changes; Requested February 5, 2015
- NP 1.1.5; Periodic Procedure Review; Revision 15 (Draft Related to Corrective Actions)
- NP 7.2.29; External Events Program; Revision 1
- NP 7.7.9; Facilities Monitoring Program; Revision 10
- NP 7.7.9; Facilities Monitoring Program; Revision 12
- NP 8.4.17; PBNP Flooding Barrier/Relief Path Program; Revision 16
- NUC ENG GEN 7005; Mentoring Guide: Prepare or Review a 10CFR Applicability and 10 CFR 50.59 Screening; Revision 0
- OI 108; Turbine Building Ventilation Operation; June 26, 2014
- OI 168; Emergency Diesel Generator Operability; Revision 16
- PB-AT-037; List of 10CFR50.54Q Evaluations (2013-2014); February 2, 2014
- PBF-2124; PPCS Forebay and Pump Bay Level Alarm Setpoints; Revision 16
- PBF-2124a; PBNP Maximum Converted Lake Level Calculation; November 2014
- PC 97 Part 1; SW Flush of 1HX-15A1-A8 Containment Fan Cooler Coils and 1HX-15A Motor Cooler Unit 1; Revision 8
- PC 97 Part 2; SW Flush of 1HX-15B1-B8 Containment Fan Cooler Coils and 1HX-15B Motor Cooler Unit 1; Revision 7
- PC 97 Part 3; SW Flush of 1HX-15C1-C8 Containment Fan Cooler Coils and 1HX-15C Motor Cooler Unit 1; Revision 8
- PC 97 Part 4; SW Flush of 1HX-15D1-D8 Containment Fan Cooler Coils and 1HX-15D Motor Cooler Unit 1; Revision 8
- PC 97 Part 5; SW Flush of 2HX-15A1-A8 Containment Fan Cooler Coils and 2HX-15A Motor Cooler Unit 1; Revision 7
- PC 97 Part 6; SW Flush of 2HX-15B1-B8 Containment Fan Cooler Coils and 2HX-15B Motor Cooler Unit 1; Revision 7
- PC 97 Part 7; SW Flush of 2HX-15C1-C8 Containment Fan Cooler Coils and 2HX-15C Motor Cooler Unit 1; Revision 8
- PC 97 Part 8; SW Flush of 2HX-15D1-D8 Containment Fan Cooler Coils and 2HX-15D Motor Cooler Unit 1; Revision 8
- PCR 01950128; BG AOP-13C-(S); March 20, 2014
- PCR 01989671; 10 CFR Applicability Determination: Severe Weather Conditions; November 18, 2014
- PCR 01989671; 10 CFR 50.59 Evaluation: AOP-13C, Severe Weather Conditions; November 18, 2014
- PCR 01993425; 10 CFR Applicability Determination: Maximum Converted Lake Level Calculation; October 14, 2014
- PCR 01999441; TS 33 – PCR Approval Overdue; October 16, 2014
- PCR 01999443; TS 34 – PCR Approval Overdue; October 16, 2014
- PCR 020022109; BG-AOP-13C-(P) PORC 1/23; October 25, 2014

- PCR 01997282; 10CFR Applicability Determination Form; Revision 0
- PCR EC AOP09A: Service Water System Malfunction; October 31, 2014
- RMP 9200-3; Station Battery D-105 Discharge Tests, Recovery and Equalizing Charge; Revision 17
- RMP 9200-4; Station Battery D-106 Discharge Tests, Recovery and Equalizing Charge; Revision 14
- RMP 9359-6A; D-105 Station Battery, D-107 Battery Charger Maintenance and Surveillances; Revision 8
- RMP 9359-6B; D-106 Station Battery, D-108 Battery Charger Maintenance and Surveillances; Revision 6
- RMP 9422; Circulating Water Pumphouse and Turbine Hall Barrier Placement; Revisions 0 & 1
- SCR 2014-0045; 10 CFR 50.50 Screening Form; October 21, 2014
- SCR 2014-0140-02; 10 CFR 50.59 Screening Form: EC 282055 "High Condenser Pit and Lake Level Alarm Inputs": September 17, 2014
- SCR 2014-0172; 10 CFR 50.59 Screening Form: EC 281811 "External Wave Run-up Flood Mitigation Strategy; November 3, 2014
- SCR 2014-0216; 10CFR50.59 Screening Form: Severe Weather Conditions; November 18, 2014
- TS 33; Containment Accident Recirculation Fan-Cooler Units (Monthly) Unit 1; March 21, 2013
- TS 34; Containment Accident Recirculation Fan-Cooler Units (Monthly) Unit 2; December 11, 2013

#### Assessments

- ACE 01946330; Failure to Perform an Evaluation for a Change to the Current Licensing Basis
- Nuclear Safety Culture Review – Point Beach 1<sup>st</sup> Quarter 2014; March 30 - April 2, 2014
- Organizational Survey Analysis Report; November 21, 2013
- PBN 13-003; Point Beach Nuclear Oversight Report – Engineering Design; March 8, 2013
- PBN 13-016; Point Beach Nuclear Oversight Report – Performance Improvement; November 21, 2013
- PBN 14-006; Point Beach Nuclear Oversight Report – Operations; June 11, 2014
- PBN 14-008; Point Beach Nuclear Oversight Report – Maintenance – Corrective and Preventive; September 19, 2014
- PBN 14-013; Point Beach Nuclear Oversight Report – Degraded Cornerstone Readiness; August 25, 2014
- PBN 14-020; Point Beach Nuclear Oversight Report – Station Readiness for Degraded Cornerstone Inspection; December 17, 2014
- PBSA-PI-14-24; 3Q14 Operating Experience Products Quality Review; October 6-7, 2014
- PBSA-PI-14-30; 4Q14 Operating Experience Products Quality Review; January 12-13, 2015
- Point Beach Nuclear Power Station Assessment of the Point Beach Response to Site External Flood Strategy Implementation Deficiencies; September 3, 2014
- Point Beach Nuclear Power Station Follow-up Assessment For Response to External Flood Strategy Implementation Deficiencies; November 8, 2014
- RCE 01865777; 1SI-831A, 1T-38 Spray Additive Tank Outlet Found Shut; April 14, 2013
- RCE 01883633; White Finding – Flooding, Revision 3; June 19, 2013
- RCE 01883633; White Finding – Flooding, Revision 6; June 19, 2013
- RCE 01896156; Common Cause Degraded Cornerstone – Mitigating Systems, Two White Findings; Revision 4; August 12, 2013
- RCE 01940739; Revision 1, Inadequate Timeline to Install Wave Run-Up Barriers; February 13, 2014

- RCE 01985239; Unit 2 RCS Cold Leg Temperature Indicators 2TI-451A & -451C Readings Drifted Low; August 19, 2014
- PBSA-LIC-14-05; FSAR Maintenance Self-Assessment; July 26, 2014
- Follow-Up Assessment for Response to External Flood Strategy Implementation Deficiencies; November 8, 2014
- Assessment of the Point Beach Response to Site Exterior Flood Strategy Implementation Deficiencies; September 3, 2014
- Functionality Assessment AR01932698-03; 95002 Wave Run up Protections May Conflict with Other Floods; February 12, 2014
- PBSA-ENG-15-05; Quick Hit Assessment AR01883633-51; Quality of EN-AA-203-1001 Products; January 28, 2015
- PBSA-LIC-14-09; Quick Hit Assessment – Regulatory Issue Management; September 8, 2014
- PBSA-PI-15-04; Quick Hit Assessment – Effectiveness Review – CAPR 01896156-57 Corrective Actions; January 24, 2015

### Drawings

- Drawing PBC-7016 Sheet 1; Turbine Building Flood Barriers; Revision 00
- Drawing 55943; PBNP Foundation Plan and Sub-drainage; Revision 18
- Drawing M-165; Turbine Building Floor & Equipment Drainage Area No 3 – Plan at El 8'-0"; Revision 6
- Drawing PB22635; Subsoil Drainage System Manhole Covers & Cleanout Plugs Turbine Bldg & Control Bldg 8'-0" Elevation; Revision 00
- Drawing PBC-7011; Sheet 1; Revision 5

### Calculations

- Calculation 98-0172; Containment Fan Cooler Service Water Acceptance Criteria; Revision 4
- Calculation 2014-06279; Time Available to Respond to Rising Lake Level; Revision 0
- Calculation 2002-0003; Service Water System Design Basis; Revision 4
- Calculation 2014-06279; Time Available to Respond to Rising Lake Level; Revision 0
- Calculation N-93-041; Hydrogen Buildup in the Battery Rooms; Revision 3
- Calculation N-94-064; VNBI [HX-105A/B] Service Water Flow vs Temperature Requirement; Revision 5

### Other

- Faint Signals Executive Summary; December 2014
- Flood Mitigation Tools Tri-fold
- DBD-T-41; Hazards – Internal and External Flooding (Module A) Topical Design Basis Document; Revision 10
- Flooding: Degraded Cornerstone Primer Tri-fold
- Flooding at Point Beach Computer-Based Training
- Leadership Workshop: Safety Culture and the Consideration of Risk in Decision-Making Training
- NSCI Indicator – Rolling 4 Quarters (Excerpt from NSCIT 2014 Summary Review); 2<sup>nd</sup> Quarter 2013 to 1<sup>st</sup> Quarter 2014
- NSCIT Meeting Minutes; May 10, 2013
- NSCIT Meeting Minutes; October 23, 2013
- NSCIT Meeting Minutes; December 12, 2013
- NSCIT Meeting Minutes; February 10, 2014

- NSCIT Meeting Minutes; February 20, 2014
- NSCIT Meeting Agenda; September 2, 2014
- NSCMP Agenda Package; July 16, 2013
- Emergent NSCMP Meeting Minutes; December 18, 2013
- NSCMP Meeting 4Q13 Meeting Summar;, January 6, 2014
- NSCMP Emergent Agenda Material; April 2, 2014
- NSCMP 3Q14 Agenda Material; November 12, 2014
- Nuclear Safety Culture: It's in our DNA Tri-fold
- Nuclear Safety Culture Improvement Plan; Revision 1
- Nuclear Safety Culture Improvement Plan; Revision 2
- Nuclear Safety Culture Questions by Aspect Formatted for the Nuclear Safety Culture Survey
- Safety Conscious Work Environment (SCWE) Workshop PowerPoint
- Safety Culture and the Application of DNA PowerPoint
- CE 013582; Potential of no Longer Satisfying a FSAR Commitment
- CE 014718; Weak Design Basis for Use of Concrete Jersey Flood Barrier
- PBN ESP 014 009L; License Basis Training; Revision 0
- NUC REG 5059 100; 10 CFR 50.59 Introduction Training
- PBN ESP 013 005L; 2013 50.59 & 72.48 Refresher Training
- PBN PIP CAP 001; Corrective Action Program-A Refresher of Fundamentals
- 95002 Inspection Readiness Compliance Matrix for RCE 01883633
- 95002 Inspection Readiness Compliance Matrix for RCE 01896156
- RCE 01883633 White Flooding Finding Corrective Action Status
- CCA 01896156 Degraded Cornerstone Mitigating Systems Corrective Action Status
- RCE 01940739 Inadequate Timeline to Install Wave Run-up Barriers Corrective Action Status
- RCE 01953492 Missed Objectives Corrective Action Status
- EC-281811; Design Change Package Form – External Wave Run-up Flood Mitigation Strategy; Revision 0
- PBF-2031; Aux Building Operations Log; Revision 102
- PBF-2032; Turbine Building Operations Log – U1; Revision 103
- PBF-2033; Turbine Building Operations Log – U2; Revision 88
- PBF-2035; Control Room Log – U2; Revision 83
- WO 40309451-01; Door-003/Install a Flood Barrier at Door 3; September 29, 2014
- SCR 2013-0024; 10 CFR 50.59/72.48 Screening; March 13, 2013
- MOR 2013-23; Missed Opportunity Review Point Beach; July 09, 2013
- STPT 17.1; Heat and Ventilation System; Revision 22

## LIST OF ACRONYMS USED

10 CFR	Title 10 of the Code of Federal Regulations
ACE	Apparent Cause Evaluation
ADAMS	Agencywide Document Access Management System
AOP	Abnormal Operating Procedure
CA	Corrective Action
CAP	Corrective Action Program or Corrective Action Program Document
CAPR	Corrective Action to Prevent Recurrence
CLB	Current Licensing Basis
CR	Condition Report
EC	Engineering Change
EFR	Effectiveness Review
EPU	Extended Power Uprate
FSAR	Final Safety Analysis Report
HELB	High Energy Line Break
IMC	Inspection Manual Chapter
IP	Inspection Procedure
NOV	Notice of Violation
NRC	U.S. Nuclear Regulatory Commission
NSCIP	Nuclear Safety Culture Improvement Plan
OE	Operating Experience
PARS	Publicly Available Records
PBNP	Point Beach Nuclear Plant
PCR	Procedure Change Request
RCE	Root Cause Evaluation
ROP	Reactor Oversight Process
SCWE	Safety Conscience Work Environment
TDAFWP	Turbine Driven Auxiliary Feedwater Pump
URI	Unresolved Issue
WO	Work Order

E. McCartney

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Sincerely,

*/RA/*

Anne T. Boland, Director  
Division of Reactor Projects

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