



POINT  
BEACH

December 28, 2015

NRC 2015-0076  
10 CFR 50.73

U. S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Washington, DC 20555

Point Beach Nuclear Plant, Unit 2  
Docket 50-301  
Renewed License Nos. DPR-27

Licensee Event Report 301/2015-005-01  
Main Transformer Lockout and Associated Loss of Buses Results in System Actuation -  
Revision

Enclosed is Licensee Event Report (LER) 301/2015-005-01 for Point Beach Nuclear Plant, Unit 2. NextEra Energy Point Beach, LLC, is providing this revised LER to report a system actuation.

This letter contains no new regulatory commitments.

If you have any questions please contact Mr. Bryan Woyak, Licensing Manager, at 920/755-7599.

Very truly yours,

NextEra Energy Point Beach, LLC

A handwritten signature in cursive script, appearing to read "Eric McCartney".

Eric McCartney  
Site Vice President

Enclosure

cc: Administrator, Region III, USNRC  
Project Manager, Point Beach Nuclear Plant, USNRC  
Resident Inspector, Point Beach Nuclear Plant, USNRC  
PSCW



**LICENSEE EVENT REPORT (LER)**

(See Page 2 for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

<b>1. FACILITY NAME</b> Point Beach Nuclear Plant Unit 2	<b>2. DOCKET NUMBER</b> 05000301	<b>3. PAGE</b> 1 OF 2
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**4. TITLE**  
Main Transformer Lockout and Associated Loss of Buses Results in System Actuation

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	Rev NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	29	2015	2015	005	01	12	28	2015	NA	NA

<b>9. OPERATING MODE</b> MODE 3	<b>11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)</b>			
<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)	
<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	
<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)	
<b>10. POWER LEVEL</b> 0%	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)
<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71 (a)(4)	
<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71 (a)(5)	
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER	
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A	

**12. LICENSEE CONTACT FOR THIS LER**

FACILITY NAME Thomas P. Schneider, Senior Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 920-755-7797
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**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

<b>14. SUPPLEMENTAL REPORT EXPECTED</b> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) X NO	<b>15. EXPECTED SUBMISSION DATE</b>	MONTH NA	DAY NA	YEAR NA
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**ABSTRACT (Limit to 1400 spaces i.e. approximately 15 single-spaced typewritten lines)**

On October 29, 2015, during Unit 2 refueling outage activities, a main transformer lockout was generated when a short circuit was created while performing a tagout clearance activity. The main transformer lockout resulted in a loss of non-vital 4KV buses, which resulted in actuation of the Steam and Motor Driven Auxiliary Feedwater Pumps.

Unit 1 was at full power and none of the Unit 1 systems were affected by this event.

This event is being reported pursuant to 10 CFR 50.73(a)(2)(iv)(A), for the auxiliary feedwater system actuation.



**LICENSEE EVENT REPORT (LER)  
CONTINUATION SHEET**

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Point Beach Nuclear Plant Unit 2	2. DOCKET 05000301	6. LER NUMBER			3. PAGE 2 OF 2
		YEAR 2015	SEQUENTIAL NUMBER 005	REV NO. 01	

**NARRATIVE**

**Description of the Event:**

At 0348 on October 29, 2015 while in MODE 3 during the Unit 2 refueling outage a main transformer lockout was generated when a short circuit was created while performing a tagout clearance activity. The main transformer lockout resulted in a loss of non-vital 4KV buses and a loss of all non-safeguards power. The loss of the two non-vital 4KV buses resulted in actuation of the Steam and Motor Driven Auxiliary Feedwater Pumps.

The loss of the non-vital 4KV buses also resulted in a loss of both Reactor Coolant Pumps. While establishing natural circulation cooling of the Reactor Coolant System (RCS), the Pressurizer Power Operated Relief Valve (PORV) momentarily opened and immediately reseated.

Unit 1 was at full power and none of the Unit 1 systems were affected by this event.

This 60-day licensee event report is being submitted in accordance with the requirements of 10 CFR 50.73(a)(2)(iv)(A), for the auxiliary feedwater system actuation.

**Cause of the Event:**

The System Actuation event occurred as a result of inadvertent contact of a metallic tagout clearance tool between two adjacent knife switches. Further investigation revealed that previous procedural guidance that could have prevented this event had been inappropriately removed from the procedure after an equipment modification. Also contributing to the event was that the procedure details for controlling knife switches and the knowledge of knife switch configuration was less than adequate.

**Analysis of the Event:**

During investigation into the cause of this event, the root cause evaluation team identified that a procedure guiding operations of transformers and electrical equipment was revised based on a station modification. The procedure revision removed guidance for tagout clearance activities for knife switches. The clearance and tagging procedure also did not provide sufficient guidance for installing tagout clearances on knife switches. The team also identified a collective knowledge gap amongst personnel with respect to where power was located on these knife switches.

The procedural deficiencies along with the knowledge gap resulted in the loss of the two non-vital 4KV buses causing the Steam and Motor Driven Auxiliary Feedwater Pumps to automatically actuate. The Auxiliary Feedwater System functioned normally upon actuation.

Unit 1 plant systems were not affected by this condition.

**Corrective Actions:**

The main transformer, associated non-vital busses, plant systems and resultant auxiliary feedwater system actuation were restored to the required lineup. The causes of the event are being addressed in the corrective action program.

**Safety Significance:**

This event has been deemed to be of low safety significance given the mode of operation, equipment affected and the equipment available to maintain safe and stable plant conditions. There was no change in Probabilistic Risk Assessment (PRA) for Unit 1 or Unit 2. No radiological or industrial safety issues resulted directly from this event.

**Similar Events:**

There have not been similar events of system actuation from similar causes that were reported in the last three years.

**Component Failure Data:**

None