Point Beach 1
3Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2013
Identified By: NRC
Item Type: FIN Finding
Failure to Control Materials Classified as High Winds/Tornado Hazards
The inspectors identified a finding of very low safety significance for the licensee's failure to maintain control over the proper storage and placement of materials that were classified as high winds/tornado hazards, in accordance with procedure NP 1.9.6, "Plant Cleanliness and Storage." Specifically, the inspectors identified that the licensee failed to perform weekly high wind missile hazards inspections since April 17, 2013. As a result, unsecured wooden pallets, wooden planks, metal rods and a metallic desk were discovered by the inspectors near Units 1 and 2 transformer areas. The issue was entered into the licensee's corrective action program (CAP) for resolution as action request AR01882921. The licensee took immediate corrective action to remove and/or properly store the material after the tornado warning on June 17, 2013.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, the unsecured items would have the potential to lead to a more significant safety concern during high wind and tornado events. The inspectors determined the finding to be of very low safety significance because the inspectors answered "No" to each question listed in IMC 0609, Appendix A, Exhibit 1, "Initiating Event Screening Questions." The inspectors determined that the finding has a cross cutting aspect in the area of human performance, work practices, because the licensee did not provide supervisory or management oversight of work activities such that nuclear safety was supported. Specifically, the licensee failed to provide appropriate oversight of work activities such that, when the program owner of the weekly high wind inspection changed, the requirement to perform weekly high winds tornado hazard walkdowns was not understood (H.4(c)).
Inspection Report# : 2013003 *(pdf)*

Significance: G Jun 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Operability Evaluation Process Following Water Leakage into the Control Room
The inspectors identified a finding of very low safety significance and an associated non-cited violation of 10 CFR 50, Appendix B, Criterion V for the licensee's failure to follow procedure EN AA 203 1001, "Operability Determinations/Functionality Assessments." Specifically, following water leakage into the control room, the licensee's immediate operability determination failed to evaluate the effect the leakage had on the control room envelope operability. Additionally, the licensee did not address the functionality of the degraded flood barrier and its impact on operability. This issue was entered into the corrective action program (CAP) as AR01877185. Corrective actions for this issue included performing a test of the control room envelope to demonstrate that appropriate positive pressure could be maintained with the known degraded barrier, and repair of the degraded flood barrier following performance of a functionality assessment.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Protection Against External Factors attribute of the Initiating Event Cornerstone, and

adversely affected the Cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance in accordance with IMC 0609, Appendix A, Exhibit 1, because they answered "No" to the questions under Transient Initiators and External Event Initiators. The inspectors concluded that this finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, because the licensee failed to thoroughly evaluate this problem such that the resolution addressed the cause and evaluated the condition for operability (P.1(c)).
Inspection Report# : 2013003 *(pdf)*

Significance: G Jun 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Incorrect Equipment Selected for Ultrasonic Examination
The inspectors identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, for failure to select an appropriately contoured ultrasonic examination search unit wedge in accordance with procedure NDE 173, "PDI Generic Procedure for the Ultrasonic Examination of Austenitic Piping Welds." Consequently, three elbow to pipe socket welds on the chemical and volume control system (CVCS) line were examined with the incorrectly contoured search unit and this examination would not provide a demonstrated level of accuracy necessary to reliably detect and size thermal fatigue cracks. The licensee entered this condition into the corrective action program (CAP) as AR01860155. To restore compliance with NRC regulations, the licensee considered the option of repeating these weld examinations using a qualified ultrasonic examination technique or the option to seek NRC approval to deviate from the American Society of Mechanical Engineers (ASME) Code Section XI requirements for ultrasonic examination.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," issued September 7, 2012, because the inspectors answered "Yes" to the more than minor screening question, "If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern?" Specifically, the examination of three chemical and volume control system welds was presumed adequate and absent NRC intervention, would have been returned to service for an indefinite period of service, which would have placed the piping at increased risk for undetected thermal fatigue cracking, leakage, or component failure. In accordance with Table 2, "Cornerstones Affected by Degraded Condition or Programmatic Weakness," of IMC 0609, Attachment 4, "Initial Characterization of Findings," issued June 19, 2012, the inspectors checked the box under the Initiating Events Cornerstone because leakage at this chemical and volume control system letdown line could result in a primary system loss of coolant accident. The inspectors determined this finding was of very low safety significance based on answering "No" to the questions in Part A of Exhibit 1, "Initiating Events Screening Questions," in IMC 0609, Attachment A, "The Significance Determination Process (SDP) for Findings At Power," issued on June 19, 2012. The inspectors answered these questions "No" because of the small diameter (2 inch) of the line and because the affected pipe welds were subjected to a VT 2 visual and penetrant testing (PT) examination that did not identify rejectable defects. The primary cause of the failure to select ultrasonic equipment (search unit contour) in accordance with procedure NDE 173 was related to the cross-cutting component of human performance, work practices, because the licensee's management staff did not adequately set up clear expectations for procedure control and adherence for this activity. Specifically, insufficient direction was provided to vendor staff for simultaneous use of two procedures, NDE 178 and NDE 173, with different equipment requirements and restrictions (H.4(b)).
Inspection Report# : 2013003 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Properly Implement a Compensatory Fire Watch As Required by the Fire Protection Program
A finding of very low safety significance and an associated non-cited violation (NCV) of Technical Specification (TS)

5.4.1.h, “Fire Protection Implementation,” for Units 1 and 2, was identified by the inspectors for the licensee’s failure to implement compensatory fire watches for multiple fire zones in the plant auxiliary building, in accordance with the fire protection program requirements. Specifically, the licensee failed to implement the guidelines for compensatory fire watches as described in Operations Manual (OM) 3.27, “Control of Fire Protection and Appendix R Safe Shutdown Equipment” for the affected fire zones. The issue was entered into the licensee’s corrective action program (CAP) as AR01855430.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Initiating Events Cornerstone attribute of Protection Against External Factors (Fire) and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during plant operations. The inspectors evaluated the finding using IMC 0609, Appendix F, because the finding degraded the ability to adequately implement fire prevention and administrative controls affecting the ability to reach and maintain safe shutdown capabilities. A Region III (RIII) Senior Reactor Analyst (SRA) performed a modified Phase 2 evaluation and determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of human performance, work practices, because the licensee failed to define and effectively communicate expectations regarding procedural compliance and personnel did not follow procedures (H.4(b)). Specifically, the expectation for procedural compliance, for when the fire zones become high radiation areas requires that fire rounds are to be performed by Operations instead of security.
Inspection Report# : 2013002 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Unauthorized Transient Combustibles
The inspectors identified a finding of very low safety significance and associated non-cited violation of Technical Specification 5.4.1.h for Units 1 and 2 for the licensee’s failure to control transient combustible materials in accordance with the fire protection program requirements. Specifically, the licensee failed to implement the guidelines specified in Procedure NP 1.9.9, “Transient Combustible Control,” when they installed an energized extension cord (combustible material) for temporary lighting in a combustible exclusion area located in fire zone 151. Upon discovery, the licensee relocated the extension cord and placed the issue into their corrective action program as action request AR01811414.

The inspectors determined that this finding was more than minor in accordance in accordance with IMC 0612, Appendix B, “Issue Screening,” dated September 7, 2012, because it was associated with the Initiating Events cornerstone attribute of Protection Against External Factors (Fire) and adversely affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during plant operations. Specifically, the inspectors determined that the routing of the energized extension cord in the CS pumps area could potentially affect both redundant trains of the charging pumps located in the area; and that the transient combustible materials were routed in a combustible free zone required for separation of redundant trains.because the extension cord was installed in a combustible free zone separating redundant trains required for safe shutdown. The inspectors evaluated the finding using IMC 0612, Appendix E, “Example of Minor Issues,” dated August 11, 2009, and found that it was similar to Example 4.k. This finding was of very low safety significance because the installation of the extension cord represented a low degradation against the combustible controls program. The finding has a cross-cutting aspect in the area of human performance, work control, because the licensee failed to coordinate the approval of a transient combustible control form with the fire protection engineer prior to routing the extension cord thru the containment spray pumps area. (H.3(b))
Inspection Report# : 2012005 *(pdf)*

Mitigating Systems

Significance: G Jun 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Account for Plant-Specific Maintenance History in the Development of Preventive Maintenance Frequency
The inspectors identified a finding of very low safety significance and an associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V for the licensee's failure to follow procedure FP PE 90 01, "Preventive Maintenance Program." Specifically, in 2009, when setting the preventive maintenance frequency for containment isolation valve 1MS 02083, the licensee determined that a 15-year frequency was appropriate instead of the recommended 10 years. The licensee's justification was based on internal maintenance history showing good performance. However, the inspectors' review revealed that the maintenance history for this category of valves did not support this determination. The valve subsequently failed during surveillance on March 21, 2013, after 13 years of service. The licensee entered this issue into the corrective action program (CAP) as AR01858451; corrective actions included replacing the valve and an action to review the preventive maintenance frequencies of critical solenoid operated valves.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Performance attribute of the Barrier Integrity Cornerstone, and adversely affected the Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated this finding using IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process," Checklist 3, and determined that the finding was of very low safety significance because the inspectors determined that a quantitative assessment was not required. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding did not reflect current performance due to the age of the performance deficiency.
Inspection Report# : 2013003 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Adequate Procedures to Respond to Probable Maximum Precipitation Event
A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to establish an abnormal operating procedure (AOP) to respond to a flooding event and for failure to establish procedures for control and maintenance of external flooding design features for the probable maximum precipitation event as described in the FSAR. The issue was entered into the licensee's CAP as AR01856322 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Mitigating Systems Cornerstone attributes of Protection Against External Factors (Flood Hazard) and Procedure Quality, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 2, for the Mitigating Systems Cornerstone, and determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of human performance, resources, because the licensee failed to maintain long term plant safety by maintenance of the external flooding design features (H.2(a)). Specifically, in the recent past, the licensee inappropriately cancelled the preventive maintenance associated with the ditches and storm drains following the completion of the drainage system study in June 2010.

Inspection Report# : 2013002 *(pdf)*

Significance: N/A Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Submit LER 05000266/2012-003-00, "2B-04 Safeguards 480V Bus De-Energized," Within 60 Days
A Severity Level IV (SL-IV) non-cited violation (NCV) of 10 CFR 50.73(a)(1), "Licensee Event Report (LER) System," with an underlying Green issue was identified for the licensee's failure to submit an LER in accordance with 10 CFR 50.73(a)(2)(i)(B) and 10 CFR 50.73(a)(2)(v)(D) within 60 days for a valid loss of safety related electrical bus 2B-04, "Unit 2 480V Safeguards Bus." This issue was entered into the licensee's CAP as AR01851639 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because, if left uncorrected, it would have the potential to lead to a more significant safety concern, since untimely reporting of issues hinders the inspectors' ability to perform to perform timely and adequate regulatory reviews of the cause and underlying issues. Specifically, the inspectors determined that the issue was considered as traditional enforcement because it had the potential for impacting the NRC's ability to perform regulatory functions and constituted an SL-IV NCV, consistent with the examples contained in Section 6.9 of the Enforcement Policy. The inspectors reviewed the underlying issue associated with the mitigating systems cornerstone and determined that the finding has a cross-cutting aspect in the area of problem identification and resolution, evaluation, because the licensee failed to thoroughly evaluate the problem such that the resolutions properly addressed operability and reportability. (P.1(c))
Inspection Report# : 2013002 *(pdf)*

Significance: W Mar 31, 2013
Identified By: NRC
Item Type: VIO Violation
Failure to Establish an Adequate Procedure to Implement Wave Run-Up Design Features
A WHITE finding and a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors in that from January 19, 1996 until March 13, 2013, the licensee failed to have a procedure appropriate to the circumstances to address external flooding as described in the Final Safety Analysis Report (FSAR.) Specifically, Procedure PC 80 Part 7, as implemented, would not protect safety-related equipment in the turbine building or pumphouse because the procedure (1) did not appropriately prescribe the installation of barriers such that gaps in or between the barriers were eliminated to prevent water intrusion, (2) did not protect equipment by requiring barriers to be placed in front of the doors, from 1996 to 2008, as described in the FSAR, and (3) did not require the barriers to protect the plant to an elevation of at least 9 feet (589 foot elevation) as described in the FSAR.

The performance deficiency was screened against the Reactor Oversight Process per the guidance of lMC 0612, Appendix B, and determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attributes of Protection Against External Factors (Flood Hazard) and Procedure Quality, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the licensee's failure to procedurally control and maintain external flooding design features and to provide procedural controls for external events could negatively impact mitigating systems' ability to respond to an external flooding event. The inspectors evaluated the finding using IMC 0609, Attachment 0609.04, Tables 2 and 3, and Appendix A, and determined a detailed risk evaluation was needed. This finding does not present an immediate safety concern, in that, the licensee has taken corrective action and revised procedures implementing wave run-up protection features. Specifically, the licensee's procedure has been revised to direct the installation of jersey barriers in conjunction with the use of sandbags, existing jersey barriers have been modified, and sandbags and additional jersey barriers have been purchased and pre-staged. These issues are being characterized as an apparent violation in accordance with the NRC's

Enforcement Policy, with its final significance to be dispositioned in separate future correspondence. This finding has a cross cutting aspect in the area of problem identification and resolution, corrective action program, because the licensee failed to thoroughly evaluate problems such that the resolutions address causes and extent of conditions [P.1 (c)].

Inspection Report# : 2013002 *(pdf)*
Inspection Report# : 2013011 *(pdf)*
Inspection Report# : 2013012 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure To Update The Fire Emergency Plan
The inspectors identified a finding of very low safety significance and associated non-cited violation of the Point Beach Nuclear Plant Renewed Facility Operating License, because the licensee failed to include electrical and physical hazards, which were installed as a result of the extended power uprate modification, in the Fire Emergency Plan (FEP). Specifically, this failure could have adversely impacted the fire brigade's ability to fight a fire in fire zones 304N and 304S. The issue was entered into the licensee's corrective action program as action request AR01833683 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," dated September 7, 2012, because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to include electrical and physical hazards in FEP 4.12, which were installed as a result of the extended power uprate modification, could have adversely impacted the fire brigade's ability to fight a fire in fire zones 304N and 304S. The inspectors evaluated the finding using IMC 0609, "Significance Determination Process ," Attachment 0609.04, "Initial Characterization of Findings," Tables 2 and 3, and Appendix A, "The Significance Determination Process (SDP) for Findings At Power," Exhibit 2 for the Mitigating Systems Cornerstone, dated June 19, 2012. The inspectors answered "No" to the Appendix A, Exhibit 2.B question for external event mitigating systems (Seismic/Fire/Flood/Severe Weather Protection Degraded). Therefore, inspectors determined the finding to be of very low safety significance. This finding has a cross-cutting aspect in the area of human performance, work control, because the licensee failed to coordinate the work activites associated with the extended power uprate modification such that the impact of the modification was evaluated against all applicable programs, including fire protection, consistent with nuclear safety. (H.3(a))
Inspection Report# : 2012005 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Scoping Of A Non-Safety-Related System Into The Maintenance Rule
• The inspectors identified a finding of very low safety significance and associated non-cited violation of 10 CFR 50.65(b)(2)(i), because the licensee failed to adequately scope a non-safety-related component relied upon to mitigate accidents or transients. Specifically, the licensee failed to include the non-safety-related electrohydraulic control system over pressure delta temperature (OP?T) and over temperature delta temperature (OT?T) automatic runback features, as part of their maintenance effectiveness monitoring program. The issue was entered into the licensee's corrective action program as action request AR01804588 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection

Reports," Appendix B, "Issue Screening," dated September 7, 2012, because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance, and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, failure to monitor the performance or condition of the electrohydraulic control system could impact the ability of the system to initiate a runback and respond to an event in the desired manner. The inspectors evaluated the finding using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," Tables 2 and 3, and Appendix A, "The Significance Determination Process (SDP) for Findings At Power," Exhibit 2 for the Mitigating Systems Cornerstone, dated June 19, 2012. The inspectors answered "No" to the Appendix A, Exhibit 1 questions for mitigating structures, systems, and components, and functionality. Therefore, inspectors determined the finding to be of very low safety significance. The inspectors determined that since the scoping of the systems had occurred more than two years in the past, and the opportunity to reevaluate system scoping had not occurred recently, that the finding did not represent current plant performance, and therefore did not have a cross-cutting aspect associated with it.
Inspection Report# : 2012005 *(pdf)*

Significance: W Oct 29, 2012
Identified By: NRC
Item Type: VIO Violation
Failure To Have Adequate Work Instructions And Procedures For Work Performed On The Turbine-Driven Auxiliary Feedwater Pump
A finding of low to moderate safety significance and an associated Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was self-revealed, in that, on November 8, 2011, the licensee failed to ensure that the work performed on the safety-related turbine for the TDAFW pump 1P-29 via Work Order (WO) 40101094 and routine maintenance procedure RMP 9044-1, an activity affecting quality, was prescribed by documented instructions or procedures of a type appropriate to the circumstances. As a result on May 21, 2012, approximately 70 minutes after the start of the second quarterly Technical Specification (TS) required surveillance test since the November 2011 maintenance, 1P-29 was shut down following failure of the turbine to pump coupling. This issue was documented in the licensee's corrective action program (CAP) as action request (AR) 01768931 and the licensee performed a root cause evaluation. As a remedial corrective action, on May 23, 2012, the licensee performed corrective maintenance to repair the failed coupling and address the turbine to pump alignment issue, and 1P-29 was subsequently returned to service. In addition, on June 20, 2012, the licensee implemented a permanent modification to the turbine exhaust steam piping by installing a wedge between the exhaust pipe flange and the turbine exhaust flange to eliminate stresses on the turbine. At the end of the inspection period, the licensee had implemented corrective actions to address the WO and procedure deficiencies to prevent a future occurrence and continued to implement additional long-term corrective actions.

The finding was determined to be more than minor in accordance with Inspection Manual Chapter (IMC) 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," dated September 7, 2012, because it was associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process (SDP) for Findings At Power," Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012. The finding involved an actual loss of function of a single train of auxiliary feedwater (AFW) for greater than the TS allowed outage time and required a detailed risk evaluation. The Region III Senior Reactor Analyst (SRA) performed a detailed risk evaluation of the finding and concluded the total delta core damage frequency (?CDF) was 8.7E 6/year, which represents a finding of low to moderate safety significance (White). The dominant core damage sequence involved an unsuppressed fire in the control room or cable spreading room, followed by failure of alternate shutdown and failure to recover the AFW function. The inspectors also determined this finding had a cross cutting aspect in the area of problem identification

and resolution, corrective action program, because the licensee failed to implement a corrective action program with a low threshold for identifying issues completely, accurately, and within a timely manner commensurate with their safety significance (P.1(a)). Specifically, during the maintenance that occurred on the TDAFW 1P-29 turbine during November 2011, several conditions adverse to quality were encountered during the actual maintenance activity; however, condition reports were not written to address the issues.

Opened in Inspection Report 2012009, final determination issued in IR 2012010, closed as 2012009-01 in IR 2013009.
Inspection Report# : 2012010 *(pdf)*
Inspection Report# : 2013009 *(pdf)*

Barrier Integrity

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Operability/Functionality Evaluation Process Following Radiation Monitor Failure
The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, for the licensee's failure to follow procedure EN AA 203 1001, "Operability Determinations/Functionality Assessments." Specifically, when the Unit 1 main steam line A release monitor, 1RE 232, went into high alarm due to high ambient temperatures, the licensee's immediate functionality determination failed to evaluate the potential impact of the degraded state of the radiation monitor in the emergency plan. Additionally, a functionality assessment was not requested as specified by the procedure. This issue was entered into the licensee's corrective action program (CAP) as action request (AR) 01902921.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, the failure to perform operability and functionality evaluations, and to recognize conditions that could render equipment inoperable, had the potential to lead to a more significant concern. The inspectors determined that the finding was associated with the Barrier Integrity Cornerstone, because the main steam line radiation monitor provides reasonable assurance that physical design barriers protect the public from radionuclide releases. The inspectors determined the finding to be of very low safety significance in accordance with IMC 0609, Appendix A, Exhibit 1, because they answered "No" to the questions under the Barrier Integrity screening questions. The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to use conservative assumptions in decision making after the receipt of the unexpected high alarm on 1RE 232 and did not request a functionality assessment to ensure that the condition and proposed actions were fully understood. Specifically, operations personnel did not request a documented evaluation to support understanding why the alarming monitor did not affect the functionality of the instrument as it related to the instrument's emergency plan functions. (H.1 (b))
Inspection Report# : 2013004 *(pdf)*

Significance: G Jun 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Lack of Acceptance Criteria for Containment Visual Examinations
The inspectors identified a non-cited violation of 10 CFR 50.55a(g)(4), for failure to define acceptance criteria for containment visual examinations. Consequently, active containment liner degradation (pitting) was identified and the

liner returned to service without defined criteria for accepting this condition. The licensee entered this issue into the corrective action program (CAP) as action requests AR01858862 and AR01861158, and developed visual examination acceptance criteria to restore compliance with this NRC regulation.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening" dated September 7, 2012, because it adversely affected the Barrier Integrity Cornerstone attribute of maintaining the functional integrity of containment. The inspectors also answered "Yes" to the more than minor screening question, "If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern?" Specifically, the lack of acceptance criteria in site procedures for containment visual examinations would become a more significant safety concern in that active liner degradation may not be properly evaluated and/or promptly corrected, resulting in a containment liner breach. In accordance with Table 2, "Cornerstones Affected by Degraded Condition or Programmatic Weakness," of IMC 0609, Attachment 4, "Initial Characterization of Findings," issued June 19, 2012, the inspectors checked the box under the Barrier Integrity Cornerstone because the corrosion induced pitting degraded the containment barrier. The inspectors determined this finding was of very low safety significance based on answering "No" to the Exhibit 3, "Barrier Integrity Screening Questions," in IMC 0609, Attachment A, "The Significance Determination Process (SDP) for Findings At Power," issued on June 19, 2012. Specifically, the inspectors answered "No" to the screening question associated with an actual open pathway (e.g., breach) in the containment and "No" to the question associated with reduction in function of hydrogen igniters in containment. The inspectors determined that the primary cause of the failure to define containment visual examination acceptance criteria was related to the cross-cutting component of human performance, decision-making, because licensee staff did not apply a systematic process, when faced with unexpected plant conditions, to ensure safety was maintained. Specifically, a systematic process for developing acceptance criteria was not applied for the containment visual examinations (H.1(a)).
Inspection Report# : 2013003 *(pdf)*

Significance: G Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Response for Loss of Spent Fuel Pool Cooling Did Not Consider the Most Limited Time to Boil
A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the licensee's failure to account for the most limiting spent fuel pool (SFP) time to boil in calculations and procedures. Specifically, the service water design-basis analysis and abnormal operating procedure (AOP) for loss of SFP cooling used a time to boil value based on non-limiting conditions. The issue was entered into the licensee's CAP as AR01852528 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Integrity Cornerstone, in that, if left uncorrected, it would have lead to a more significant safety concern. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 3, for the Barrier Integrity Cornerstone, and determined the significance of this finding could be evaluated using qualitative criteria in accordance with IMC 0609, Appendix M. With consultation of an RIII SRA, the inspectors determined the finding screened as of very low safety significance because it involved a design-basis event (e.g., loss of cooling accident (LOCA)) on one unit occurring during a short window of time when the SFP is subjected to the maximum allowed heat load shortly after the other unit is defueled. The inspectors did not identify a cross-cutting aspect associated with this finding because the finding was not confirmed to reflect current performance due to the age of the performance deficiency.
Inspection Report# : 2013002 *(pdf)*

Significance: G Mar 31, 2013

Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Operability Evaluation Process for a Degraded Containment Liner
A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors when the licensee failed to perform a prompt operability evaluation as required by station procedures. Specifically, procedure PI AA 205, "Condition Evaluation and Corrective Action," required that a prompt operability evaluation be performed when equipment was determined to be operable but degraded. Had this evaluation been performed, the licensee would have recognized that information did not exist to support operability of the containment liner. The issue was entered into the licensee's CAP as AR01851688 for evaluation and development of corrective actions.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because it was associated with the Barrier Integrity Cornerstone attribute of reactor coolant system (RCS) equipment and barrier performance, and adversely affected the Cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors evaluated the finding using IMC 0609, Appendix A, Exhibit 3, which indicated that a Phase 2 analysis was required per Appendix H. The inspectors and the Region III SRA performed a Phase 2 evaluation using IMC 0609, Appendix H, Table 6.2, and concluded, based on the small size of the hole in the SW piping, that leakage from the containment to the environment would not be greater than 100 percent containment volume per day; therefore, the issue screened as being of very low safety significance. The finding has a cross-cutting aspect in the area of problem identification and resolution, corrective action program, low threshold, because the licensee failed to thoroughly evaluate the breach in the SW system (P.1(a)). Specifically, the lack of a CR that completely and accurately evaluated the hole in the SW system resulted in an unrecognized and unevaluated breach in a system that was considered an extension of the containment.
Inspection Report# : 2013002 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Significance: G Sep 30, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Update FSAR for Radioactive Waste Storage Changes (2RS8)
The inspectors identified a finding of very low safety significance and an associated Severity Level IV (SL-IV) NCV of 10 CFR 50.71(e), "Maintenance of Records, Making of Reports," for the licensee's failure to comply with the requirements to periodically update the Final Safety Analysis Report (FSAR) to include an accurate description of the site's solid waste management system and radiation monitoring system as a result of modifications made to the site. This issue was entered into the licensee's CAP as AR01898640 and AR01898643.

The inspectors determined the finding to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected, this could lead to a more significant safety concern because future changes to the facility, procedures, and programs would not be able to consider the licensing basis information that was removed or never inserted. The finding was determined to be of very low safety significance (Green) in accordance with IMC 0609, Appendix D, "Public Radiation Safety Cornerstone Significance Determination Process," because it involved radioactive material

control but did not result in public exposure greater than 5 mrem [millirem]. Additionally, using IMC 0612, Appendix B, "Issue Screening," the inspectors determined that the violation of 10 CFR 50.71(e) could be dispositioned using traditional enforcement because it had the potential to impact the NRC's ability to perform its regulatory function. The violation was determined to be a SL-IV violation using the NRC's Enforcement Policy, Section 6.1, because the inaccurate information was not used to make an unacceptable change to the facility procedures. The inspectors concluded that this finding did not have an associated cross-cutting aspect.
Inspection Report# : 2013004 *(pdf)*

Significance: G Mar 31, 2013
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to Survey for Neutron Dose from Source Storage
A finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR 20.1501 was self-revealed when the licensee failed to evaluate dose to personnel from neutron radiation. Specifically, on September 5, 2012, it was self revealed to the licensee that unevaluated neutron dose was present in an office area located outside the Radiologically Controlled Area (RCA) due to a source storage room housing a neutron source. This issue was entered into the licensee's CAP as AR01809560. Corrective actions included moving the neutron source into the RCA, performing a condition evaluation, and performing dose estimates to various plant personnel.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because the finding was associated with the Occupational and Public Radiation Safety Cornerstones and adversely affected the cornerstones objective. The inspectors evaluated the finding using IMC 0609, Appendix D, for the Public Radiation Safety Cornerstone, and determined the finding to be of very low safety significance. The finding had a cross-cutting aspect in the area of human performance, work practices, because the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety is supported (H.4(c)). Specifically, the licensee did not provide supervisory oversight to ensure that the survey program was sufficient to ensure compliance with 10 CFR Part 20 requirements.
Inspection Report# : 2013002 *(pdf)*

Significance: G Dec 31, 2012
Identified By: NRC
Item Type: NCV NonCited Violation
Failure To Implement And Maintain Procedures Regarding Breathing Air Quality
The inspectors identified a finding of very low safety significance (Green) and associated non-cited violation of 10 CFR 20.1703 for the failure to implement and maintain written procedures regarding breathing air quality which resulted in the failure to perform breathing air quality tests since December 2011. This issue was entered into the licensee's corrective action program (CAP) as AR01821842. An air quality test was subsequently performed resulting in grade "D" or better air and a review of past air compressor maintenance was performed to provide adequate assurance that breathing air met the grade "D" requirements since the last test in December 2011. The licensee has also made necessary procedural changes to ensure air quality tests are performed on a quarterly basis.

The performance deficiency was determined to be of more than minor safety significance in accordance with IMC 0612, Appendix B, "Issue Screening," because if left uncorrected, it would have the potential to lead to a more significant safety concern. Specifically, continued failure to test for breathing air quality could have resulted in un-breathable air being introduced into the licensee's SCBAs and control room emergency breathing air system. The inspectors also reviewed the guidance in IMC 0612, Appendix E, "Examples of Minor Issues," and did not find any similar examples. In accordance with IMC 0609, Appendix C, "Occupational Radiation Safety Significance Determination Process," the inspectors determined that the finding had very low safety significance (Green) because the finding did not involve: (1) ALARA planning and controls, (2) a radiological overexposure, (3) a substantial

potential for an overexposure, or (4) a compromised ability to assess dose. The primary cause of this finding was related to the cross-cutting aspect of human performance with the component of decision making in that the licensee communicates decisions and the basis for decisions to personnel who have a need to know the information in order to perform the work safely, in a timely manner. (H.1(c))
Inspection Report# : 2012005 *(pdf)*

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Mar 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Update the External Flooding Mitigation Features in the FSAR
An SL-IV NCV of 10 CFR Part 50.71(e), "Maintenance of Records, Making of Reports," was identified by the inspectors for the licensee's failure to comply with the requirements to periodically update the FSAR to include an accurate description of the flooding design and credited mitigation features for the site as a result of a modification made to the plant. The issue was entered into the licensee's CAP as AR01819241 for evaluation and development of corrective actions.

The inspectors used IMC 0612, Appendix B, and determined the performance deficiency could be dispositioned using traditional enforcement. Specifically, the inspectors determined that the issue was considered for traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. The inspectors concluded that the finding is more than minor because, if left uncorrected, this could lead to a more significant safety concern because future changes to the facility, procedures, and programs would not consider the licensing basis information that was removed or never inserted. The finding was determined to be an SL IV violation using Section 6.1 of the NRC's Enforcement Policy because the inaccurate information was not used to make an unacceptable change to the facility or procedures. Since this performance deficiency was dispositioned using traditional enforcement, there is no cross-cutting aspect assigned.
Inspection Report# : 2013002 *(pdf)*

Last modified : December 03, 2013