Point Beach 2
2Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
A Failure to Provide Sufficient Field Overlap to Ensure 100 Percent Coverage
The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion IX, "Control of Special Processes," for a failure to provide sufficient magnetic field overlap to ensure 100 percent coverage while performing a magnetic particle examination (MT) on a steam generator feedwater nozzle weld. The examiner reexamined the area to meet the Code coverage and entered the issue into its Corrective Action Program (CAP) as action request (AR) 01951316.
The inspectors determined that this issue was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because the inspectors answered "yes" to the More-than-Minor question, "If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern". Specifically, the required MT examination coverage/overlap was not verified/measured but rather assumed to be adequate by the examiner, and absent NRC intervention, would have returned the component to service for an indefinite period of service, which would have placed the nozzle/piping at increased risk for undetected cracking, leakage or component failure. In accordance with Table 2, "Cornerstones Affected by Degraded Condition or Programmatic Weakness," of IMC 609, Attachment 4, "Initial Characterization of Findings," issued June 19, 2012, the inspectors checked the box under the Initiating Events Cornerstone because leakage at this feedwater piping could be a transient initiator contributor.
The inspectors determined this finding was of very low safety significance (Green) 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 for Findings At-Power," issued on June 19, 2012. Specifically, the inspectors answered "no" to the screening question, "Did the finding cause a reactor trip AND the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition (e.g., loss of condenser, loss of feedwater)". The inspectors answered no to this question because the examiner re-examined the area of incomplete coverage and did not identify rejectable flaws. The inspectors determined that the primary cause of the failure to ensure sufficient field overlap while performing a MT examination was related to the cross-cutting component of Human Performance, "Field Presence," because the licensee failed to provide oversight of work activities; including contractors and supplemental personnel. Specifically, proper oversight at the pre-job brief would have ensured the issue of overlap was discussed and understood.
The inspectors determined that proper oversight at the pre-job brief could have ensured the issue of overlap was discussed and understood. Additionally, good direct oversight of the test could have provided the ability to reinforce the correct method of performing the test as well as enabling the site to discover the error instead of the inspector identifying the problem [H.2].
Inspection Report# : 2014002 *(pdf)*

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)*

Mitigating Systems

Significance: G Jun 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain Control of Loose Material in Containment
A finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the failure to follow procedures. Specifically, while Unit 2 was in Mode 3, the licensee left buoyant items in containment that were neither anchored or tethered to a substantial structure nor located in an anchored storage box or receptacle, as required by NP 7.2.28, "Containment Debris Control Program," Revision 5, Step 4.2.8(d)3. The licensee entered the issue into their corrective action program (CAP) and implemented short term corrective actions, which included removing the material from containment and communicating to station personnel the importance of not leaving susceptible material unattended in containment while in Modes 1 through 4. The licensee's long-term corrective actions included creating a site specific procedure that places all the containment debris control requirements in one central location.
The inspectors determined that the finding was more than minor, because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone. The finding adversely affected the cornerstone objective of ensuring 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 for Findings At Power," Exhibit 2, Mitigating Systems Screening Questions, dated June 19, 2012. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Mitigating Systems screening questions. This finding has a cross cutting aspect of Training (H.9), in the area of Human Performance, for failing to provide training and ensure knowledge transfer to maintain a knowledgeable workforce.
Inspection Report# : 2014003 *(pdf)*

Significance: G Jun 30, 2014
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Age Related Relay Failures Result in Inoperable Inverters
A finding of very low safety significance and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was self-revealed for the failure to replace safety-related inverter components at the vendor prescribed 10 year frequency. Specifically, after concluding that safety-related inverter relays were required to be replaced at a 10-year frequency, per vendor direction, the licensee failed to promptly replace the remaining relays that were eighteen years old or evaluate if the relays could remain in service until the next scheduled 10 year inverter overhaul. The licensee entered the issue into their CAP and replaced the remaining K2 relays that were past their 10-year replacement frequency in April and June of 2014 and has plans to replace the remaining K1 relays, which provide alarm only function, in 2015.
The inspectors determined finding was more than minor because it was associated with the Equipment Performance attribute of the Mitigating System cornerstone and affected the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the performance deficiency resulted in three additional K2 relay failures in 2013 and 2014, two of which occurred while the inverters were carry instrument bus loads and caused the inoperability of the associated inverters. 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." Because the finding impacted the Mitigating Systems Cornerstone, the inspectors screened the finding through IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," using Exhibit 2, "Mitigating Systems Screening Questions." The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Mitigating Systems screening questions. This finding has a cross cutting aspect of Resolution (P.3), in the area of Problem Identification and Resolution because the licensee failed to take effective corrective actions to address issues in a timely manner commensurate with their safety significance.
Inspection Report# : 2014003 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Measure Interpass Temperature
The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion IX, "Control of Special Processes," for a failure to measure the interpass temperature while performing welding on the auxiliary feedwater (AFW) piping system in accordance with welding procedure specifications (WPS) FP-PE-B31-P1P1-GTSM-001. Consequently, welding was performed without the Code and procedure required interpass temperature being monitored on a number of welds, a parameter which can affect the mechanical properties of the material being welded. To restore compliance, the welder proceeded to measure the interpass temperature and ensured that the temperature requirement would not have been exceeded. The licensee entered this issue into their CAP as AR 01950601.
The inspectors determined that this issue was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because the inspectors answered "yes" to the More-than-Minor question, "If left uncorrected, would the performance deficiency have the potential to lead to a more significant safety concern". Specifically, absent NRC intervention, the welder would have completed all of the welds without having measured the interpass temperature, a welding parameter which can affect the mechanical properties (e.g., impact properties) of some materials being welded, and could lead to a potential failure of the weld in service. In accordance with Table 2, "Cornerstones Affected by Degraded Condition or Programmatic Weakness," of IMC 609, Attachment 4, "Initial Characterization of Findings," issued June 19, 2012, the inspectors checked the box under the Mitigating Systems Cornerstone because leakage at this AFW piping could degrade short term heat removal. The inspectors determined this finding was of very low safety significance (Green) based on answering "no" to the questions in Part A of Exhibit

1, “Mitigating Systems Screening Questions,” in IMC 0609, Attachment A, “The Significance Determination Process for Findings At-Power,” issued on June 19, 2012. Specifically, the inspectors answered, “yes” to the screening question “If the finding is a deficiency affecting the design or qualification of a mitigating structures systems component (SSC), does the SSC maintain its operability or functionality”. The welder subsequently performed interpass temperature measurements and demonstrated that the temperature would remain below the required temperature of the welds in question, and the issue did not result in the actual loss of the operability or functionality of a safety system.
The inspectors determined that the primary cause of the failure to measure the interpass temperature in accordance with WPS FP-PE-B31-P1P1-GTSM-001 was related to the cross-cutting component of Problem Identification and Resolution, P.4 “Trending”. The organization failed to periodically analyze information from the corrective action program and other assessments in the aggregate to identify programmatic and common cause issues. Point Beach had experienced a number of issues related to welding in the weeks before the interpass temperature issue, leading to some 19 welding-related action request (ARs) being written. The total of these issues presented the site with the opportunity to evaluate if there were problems with the conduct of the welding program. Resulting increased focus could have led to licensee identification of, or prevention of, the lack of taking temperatures.
Inspection Report# : 2014002 *(pdf)*

Significance: G Mar 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform Flood Reviews of Material That Could Affect Flood Relief Paths
The inspectors identified a Green non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the failure to follow procedures. Specifically, the licensee failed to perform a flood review, as required by NP 8.4.17, “PBNP Flooding Barrier / Relief Path Program,” Revision 15, when work activities in the G–02 EDG room left a lightweight wet floor safety sign that could have been transported during a license basis internal flood event and affected the flow capacity of the flood relief slots. The licensee’s short-term corrective actions included removing the material from the G–02 EDG room and communicating to station personnel the importance of not leaving susceptible material unattended. The licensee entered this issue into their CAP as AR 01960472.
The inspectors determined that the finding was more than minor, because, if left uncorrected, it could have the potential to become a more significant safety concern. Specifically, if the licensee was not performing flood reviews for material left unattended during or after work activities, susceptible unattended material could be transported to credited flood relief dampers and impeded the design flow rate required for the dampers to protect safety related equipment. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, “Significance Determination Process,” Attachment 0609.04, “Initial Characterization of Findings,” dated June 19, 2012, and Appendix A, “The Significance Determination Process for Findings At-Power,” Exhibit 4, “External Events Screening Questions,” dated June 19, 2012. The inspectors answered “yes” to question 1 of External Events screening questions since the finding could potentially degrade one train of the emergency power system (a risk-significant system). Thus the inspectors consulted the regional Senior Risk Analyst (SRA).
The SRA performed a detailed risk evaluation using the Point Beach Standardized Plant Analysis Risk Model Version 8.22. For there to be a risk increase due to this deficiency there would have to be a LOOP coincident with a flood event that renders the G–O2 EDG unavailable. The SRA performed a bounding analysis assuming that the flood event occurred coincident with a LOOP. The exposure time for the deficient condition was not more than 15-days. Assuming a 15-day exposure time, the delta CDF was 9.3E-08/yr. The dominant sequence involved a transient initiating event with a consequential LOOP and station blackout. Based on the result of the detailed risk evaluation, the issue was of very low risk significance.
This finding has a cross-cutting aspect of Training (H.9) in the area of human performance, for failing to provide training and ensure knowledge transfer to maintain a knowledgeable workforce. Specifically, the licensee did not ensure that personnel were knowledgeable of need to control material that could transport during an internal flooding event, restrict flood relief paths, and affect flood mitigation features.
Inspection Report# : 2014002 *(pdf)*

Significance: G Mar 06, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Take Corrective Actions to Address External Flooding Procedure Deficiencies
The inspectors identified a finding of very low safety significance and associated non-citied violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," in that from March 13, 2013 until February 14, 2014, the licensee failed to assure that for a significant condition adverse to quality (SQAC), the cause of the condition was determined and corrective actions were taken to preclude repetition. Specifically, the licensee's corrective actions failed to preclude repetition of an SQAC where Procedure PC 80 Part 7, "Lake Water Level Determination," as implemented, would not protect safety-related equipment in the turbine building or Circulating Water Pump House (CWPH). After the licensee had taken corrective actions to improve the wave barrier procedure in response to an NRC-identified NOV, PC 80 Part 7 and other flood protection implementing procedures specified inadequate timelines to ensure wave
run-up flood barriers would be installed prior to the lake level at which wave run-up could impact the site. Corrective actions for this issue included changing the affected procedures to install the wave barriers at a lower lake level, changing the lake level determination surveillance from monthly to weekly, and reducing the allowed installation time for the barriers from 3 weeks to 1 week.

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 correct procedural deficiencies associated with flood barrier construction timelines, could challenge the timely installation of the barriers, which could impact the ability of mitigating systems to respond during an external flooding event. The inspectors evaluated the finding using IMC 0609, Attachment 0609.04, Tables 2 and 3, and Appendix A. Based on a review of Appendix A, Exhibit 2, Item 4.B, the inspectors determined that this issue screened as having very low safety significance (Green).
This finding has a cross-cutting aspect in the area of problem identification and resolution, because the licensee failed to thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. (P.2)
Inspection Report# : 2014007 *(pdf)*

Significance: G Mar 06, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain External Flooding Procedure to Address All Possible CLB Floods
The inspectors identified a finding of very low safety significance and associated non-citied violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," in that from January 19, 1996 until November 25, 2013, the licensee failed to ensure that activities affecting quality were prescribed by documented procedures of a type appropriate to the circumstances to address external flooding as described in the Final Safety Analysis Report (FSAR). Specifically, PC 80 Part 7, "Lake Water Level Determination" directed advanced installation of concrete barriers to protect against deep wave action from the lake, which introduced significant unrecognized blockages in the natural drainage path credited in the FSAR to protect against the probable maximum precipitation and Turbine Building internal flooding events. Corrective actions for this issue included changing the procedure and FSAR to include actions to provide an additional flood relief path through the CWPH building and reliance on internal flood relief dampers for the affected flooding events.
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 external flooding design features to ensure they would not adversely affect the strategy for other flooding events, could negatively impact mitigating systems' ability to respond during external and internal flooding events. 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 required. Following a detailed risk evaluation, Region III SRAs determined that the finding had very low safety significance (Green). This finding has a cross-cutting aspect in the area of problem identification and resolution, because the licensee failed to take effective corrective actions to address issues in a timely manner commensurate with their safety significance. (P.3)
Inspection Report# : 2014007 *(pdf)*

Significance: G Mar 06, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Perform a Required 10 CFR Part 50.59 Evaluation
The inspectors identified a finding of very low safety significance and associated Severity Level IV, non-citied violation of 10 CFR 50.59(d)(1), "Changes, tests and experiments," when, on November 25, 2013, the licensee failed to perform an evaluation against the criteria in 10 CFR 50.59(c)(2) for a change to procedure
PC 80 Part 7 to include actions to maintain functionality of drainage paths during probable maximum precipitation and turbine building flooding events. Specifically,
PC 80 Part 7, "Lake Water Level Determination" was changed to include actions to open the CWPH rollup doors to provide an additional drainage path while wave barriers were in place, without fully evaluating the viability of reliance on additional flood features not credited for external flooding in the Current License Basis (CLB). Corrective actions for this issue included to updating the FSAR to describe the new flood paths, performing a 10 CFR 50.59 screening and 10 CFR 50.59 evaluation for the new drainage path which had put the site outside of the CLB, revising a related functionality assessment, controlling external flooding areas to ensure they are clear of debris, and creating a procedure to install curtains on the CWPH rollup doors during periods when they were required to be open.

The inspectors determined that the licensee's failure to fully evaluate the viability of newly created flooding drainage paths as required by 10 CFR 50.59(d)(1) was a performance deficiency. The inspectors evaluated the performance deficiency using traditional enforcement in conjunction with the SDP because the performance deficiency had the potential to impact the regulatory process. The performance deficiency was screened 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 Design Control, 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 did not fully demonstrate that the availability, reliability, and capability of mitigating systems would be maintained during flooding events due to the site's failure to evaluate the viability of alternate flood drainage paths through the CWPH. The inspectors evaluated the finding using
IMC 0609, Attachment 0609.04, Tables 2 and 3, and Appendix A. Based on a review of Appendix A, Exhibit 2, Item 4.B, the inspectors determined that this issue screened as having very low safety significance (Green). Additionally, in accordance with
Section 6.1.d.2 of the NRC Enforcement Policy, this violation is categorized as a Severity Level IV because the resulting conditions were evaluated as having very low safety significance (Green) by the SDP. This finding has a cross-cutting aspect in the area of problem identification and resolution, because the licensee failed to thoroughly evaluate issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. (P.2)
Inspection Report# : 2014007 *(pdf)*

Significance: G Mar 06, 2014
Identified By: NRC
Item Type: FIN Finding
Failure to Perform a Required 10 CFR Part 50.59 Evaluation
The inspectors identified a finding of very low safety significance and associated Severity Level IV, non-citied violation of 10 CFR 50.59(d)(1), "Changes, tests and experiments," when, on November 25, 2013, the licensee failed to perform an evaluation against the criteria in 10 CFR 50.59(c)(2) for a change to procedure
PC 80 Part 7 to include actions to maintain functionality of drainage paths during probable maximum precipitation and turbine building flooding events. Specifically,
PC 80 Part 7, "Lake Water Level Determination" was changed to include actions to open the CWPH rollup doors to provide an additional drainage path while wave barriers were in place, without fully evaluating the viability of reliance on additional flood features not credited for external flooding in the Current License Basis (CLB). Corrective actions for this issue included to updating the FSAR to describe the new flood paths, performing a 10 CFR 50.59 screening and 10 CFR 50.59 evaluation for the new drainage path which had put the site outside of the CLB, revising a related functionality assessment, controlling external flooding areas to ensure they are clear of debris, and creating a procedure to install curtains on the CWPH rollup doors during periods when they were required to be open.

The inspectors determined that the licensee's failure to fully evaluate the viability of newly created flooding drainage paths as required by 10 CFR 50.59(d)(1) was a performance deficiency. The inspectors evaluated the performance deficiency using traditional enforcement in conjunction with the SDP because the performance deficiency had the potential to impact the regulatory process. The performance deficiency was screened 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 Design Control, 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 did not fully demonstrate that the availability, reliability, and capability of mitigating systems would be maintained during flooding events due to the site's failure to evaluate the viability of alternate flood drainage paths through the CWPH. The inspectors evaluated the finding using
IMC 0609, Attachment 0609.04, Tables 2 and 3, and Appendix A. Based on a review of Appendix A, Exhibit 2, Item 4.B, the inspectors determined that this issue screened as having very low safety significance (Green). Additionally, in accordance with
Section 6.1.d.2 of the NRC Enforcement Policy, this violation is categorized as a Severity Level IV because the resulting conditions were evaluated as having very low safety significance (Green) by the SDP.
Inspection Report# : 2014007 *(pdf)*

Significance: G Mar 06, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish EFR Attributes to Assess the Effectiveness of Corrective Actions
The inspectors identified a finding of very low safety significance (Green) and associated non-citied violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to ensure the effectiveness review attributes for a significant condition adverse to quality would ensure the corrective actions would eliminate or reduce the recurrence rate.
The inspectors determined that the licensee's failure to establish effectiveness review criteria that would have identified whether the corrective action to prevent recurrence (CAPRs) had effectively resolved the conditions was a performance deficiency warranting further review. The inspectors determined that this finding was more than minor in accordance with IMC 0612, Appendix B, because it was affected the Mitigating Systems Cornerstone objective to ensure availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. If left uncorrected, would the performance deficiency have the potential to lead to a more significant

safety concern? The inspectors evaluated the finding using IMC 0609, Appendix A. The inspectors determined the finding was of very low safety significance (Green) because the finding was not a deficiency affecting the design or qualification of a mitigating structure, system or component and did not result in a loss of operability or functionality. In addition, the finding did not represent a loss of system or function, did not represent an actual loss of function of a least a single train for longer than its technical specification allowed outage time, and did not represent an actual loss of function of one or more nontechnical specification trains of equipment designated as high safety-significance. The finding had a cross cutting aspect in the area of problem identification and resolution, specifically resolution, because licensee personnel failed to ensure the corrective actions to prevent recurrence had effective attributes. (P.2)
Inspection Report# : 2014007 *(pdf)*

Significance: G Dec 31, 2013
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow Maintenance and Test Equipment Procedure
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, "Instructions, Procedures, and Drawings," for the licensee's failure to follow procedure NP 8.7.1, "Measurement and Test Equipment [M&TE]." Specifically, the inspectors identified multiple examples where the licensee did not document the withdrawal and use of M&TE in either the M&TE usage log or its electronic equivalent. This issue was entered into the licensee's corrective action program (CAP) as action request (AR) 01925171.

The finding was determined to be more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated September 7, 2012, because, if left uncorrected, the performance deficiency had the potential to lead to a more significant safety concern. Specifically, without accurate M&TE usage logs the licensee may not evaluate all past surveillances affected by failed M&TE, potentially resulting in a failed TS surveillance going undetected. The inspectors determined that the finding was associated with the Mitigating Systems Cornerstone, because not evaluating the prior use of inaccurate M&TE could permit equipment required to mitigate the consequences of the accident to not perform its design and licensing basis functions when called upon. The inspectors determined the finding could be evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, and Appendix A, "The Significance Determination Process for Findings At Power," Exhibit 2, "Mitigating Systems Screening Questions," dated June 19, 2012. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Mitigating Systems screening questions. The inspectors concluded that this finding has a cross-cutting aspect in the area of human performance, decision making, because the licensee failed to effectively communicate the station expectations related to changes in responsibilities for implementing NP 8.7.1.
Inspection Report# : 2013005 *(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)*
Inspection Report# : 2014007 *(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)*

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)*

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

Last modified : August 29, 2014