Point Beach 2
3Q/2016 Plant Inspection Findings

Initiating Events

Significance: Jun 30, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Perform Required Fire Watches in Areas Containing Transient Combustibles
A finding of very low safety significance and associated NCV of license condition 4.F was identified by the inspectors for the licensee's failure to conduct required fire watch inspections in accordance with the licensee's Fire Protection Program requirements. Specifically, while conducting fire protection walkdowns of both unit's residual heat removal (RHR) pipeway and heat exchanger rooms, the inspectors discovered numerous transient combustible items in areas that the licensee had controlled using tamper seals on the entrances in lieu of physical entry. The licensee's corrective actions included documenting and quantifying the removal of the items from the zones and additional actions to perform additional evaluation of the fire zones.
The finding was determined to be more than minor because the failure to conduct the required fire watch inspections was associated with the Initiating Events cornerstone attribute of Protection Against External Events (Fire) and affected the cornerstone objective of preventing undesirable consequences (i.e., core damage). Specifically, the failure to conduct the required fire watch inspections or meet the alternate measures specified by the licensee's engineers, allowed unanalyzed transient combustibles and ignition sources to be present in fire zones that contained both trains of both unit's RHR pumps, heat exchangers and associated equipment. The inspectors determined the finding could be evaluated in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," Table 2, the inspectors determined the finding affected the Mitigating Systems cornerstone. The finding degraded fire protection defense-in-depth strategies, and the inspectors determined, using Table 3, that it could be evaluated using Appendix F, "Fire Protection Significance Determination Process." The inspectors screened the issue under the Phase 1 Screening Question 1.3.1–A, and determined that determined that the finding was of very low safety significance (Green), because the inspectors determined that the impact of a fire would not prevent either reactor from reaching and maintaining safe shutdown (hot). This finding has a cross-cutting aspect of Bases for Decisions (H.10), in the area of human performance, because the licensee's leadership did not ensure that the bases for operational and organizational decisions are communicated in a timely manner. Specifically, the licensee did not periodically verify the understanding of the individuals assigned to fire watches, in particular, that the relief from physical entry and application of a tamper seal required a thorough tour of the zones following any entry into those fire zones.
Inspection Report# : 2016002 *(pdf)*

Significance: Jun 30, 2016
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
Incorrectly Wiring Causes Transformer Lockout
A finding of very low safety significance and associated NCV's of TS 3.8.1, "AC Sources Operating" and TS 3.8.2, "AC Sources Shutdown," were self revealed for the licensee's failure to follow procedure RMP 9056–9B, "1X–03, Protective Relay Calibration and Testing." Specifically, a wiring error in the 1X–03 connection box, which occurred in 2013, caused the 1X–03 transformer's differential protection circuity to lockout the transformer at current levels below the design protection values. The licensee's corrective actions included correcting the improper wiring in the

1X–03 connection box and evaluating other work performed by the same vendor during that timeframe.
The inspectors determined that the finding was more than minor because it was associated with the Initiating Events cornerstone attribute of Equipment Performance and affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the lockout of 1X–03 caused a loss of one of the licensee's offsite power lines and also caused a loss of power to multiple station battery chargers placing Unit 2 into limiting condition for operation (LCO) 3.0.3. 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 1, Initiating Events Screening Questions, dated June 19, 2012. The inspectors answered "Yes" to the Support System Initiators question; therefore, a Detailed Risk Evaluation was required. Based on the conclusions in the Detailed Risk Evaluation, the SRA determined that the finding was of very low safety significance (Green). This finding has a cross-cutting aspect of Avoid Complacency (H.12), in the area of Human Performance, for failing to implement appropriate error reduction tools. Specifically, the incorrectly performed procedure step, in RMP 9056-9B, clearly specified which terminal point to land the wires on, the terminal points were clearly labeled, and the step required a concurrent verification; however, even with those barriers in place, the task performers still landed the wires on the wrong location.
Inspection Report# : 2016002 *(pdf)*

Significance: Mar 31, 2016
Identified By: Self-Revealing
Item Type: FIN Finding
Failure to Follow Electrical Safety Procedures Results in Plant Transient
A finding of very low safety significance was self-revealed for the licensee's failure to follow electrical safety procedures when hanging danger tags on electrical components with exposed conductors. Specifically, danger tags were attached directly to the exposed energized portion of switchgear test switches, which exposed employees to an electrical hazard and contributed to the lockout of the 2X-01 main transformers and the subsequent Unit 2 plant transient. The licensee's corrective actions included a change to tagging procedures to include specific direction for tagging knife switches. The proposed changes included a prohibition for hanging tags on metal parts of the switches, and installing robust operational barriers using tags plus devices when danger tags are to be utilized.
The inspectors determined that the finding was more than minor because it was associated with the human performance attribute of the initiating events cornerstone, and adversely affected the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure to use insulated tools on exposed electrical equipment greater than 50 volts presented an electrical injury hazard and actually resulted in a plant transient for Unit 2, which included lifting of a pressurizer power-operated relief valve (PORV), loss of forced reactor coolant system (RCS) flow, and actuation of the auxiliary feedwater (AFW) system. The inspectors determined the finding could be evaluated in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," dated June 19, 2012, because Unit 2 was in mode 3 at the time of the event. Additionally, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 1, "Initiating Events Screening Questions," dated June 19, 2012 applied. The inspectors concluded that the finding was of very low safety significance (Green), because the inspectors answered "No" to the Transient Initiators screening question. This finding has a cross-cutting aspect of Resources (H.1), in the area of Human Performance for failing to ensure that personnel, equipment procedures and other resources were available and adequate to support nuclear safety. Specifically, the licensee failed to ensure that employees had all necessary tools, direction, and supervision to support successful work performance.
Inspection Report# : 2016001 *(pdf)*

Mitigating Systems

Significance: Jun 30, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
Submerged Safety-Related Emergency Diesel Generator Fuel Oil Transfer Pump Cables
A finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors, for the failure to maintain emergency diesel generator (EDG) fuel oil transfer pump safety-related cables in an environment for which they were designed. Specifically, the licensee allowed the safety-related cables to be submerged in water, which was outside of their design, in manhole Z–066B. The licensee's corrective actions included pumping the water out of the manholes, repairing the failed sump pump, level switch, and alarm circuit; and performing an engineering evaluation to quantify the level of degradation as a result of the submergence.
The performance deficiency was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and 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," issued on June 19, 2012. Specifically, the inspectors used IMC 0609 Appendix A "SDP for Findings At-Power," issued June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions" to screen the finding. The finding screened as of very low safety significance (Green) because the inspectors answered "Yes" to the question "does the SSC maintain its operability or functionality." Specifically, the submergence of the G–01 and G–02 EDG fuel oil transfer pump cables did not render the transfer pumps inoperable. This finding has a cross-cutting aspect Evaluation (P.2) in the area of problem identification and resolution, because the licensee did not thoroughly evaluate problems to ensure that resolutions address causes and extent of conditions, commensurate with their safety significance. Specifically the licensee failed to thoroughly investigate and prioritize the failure of the manhole alarm and pumping system according to the safety significance of the cables contained within the manholes which led to prolonged and unevaluated submergence of the cables.
Inspection Report# : 2016002 *(pdf)*

Significance: Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Follow Fire Protection Program Requirements for Care, Use and Maintenance of Fire Hose
The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of license condition 4.F for the licensee's failure to have procedures or instructions to prevent firefighting booster hoses from being kinked and/or twisted on hose reels. Specifically, booster hoses were installed on hose reels in both unit's containments and in the turbine building (TB), which were twisted and kinked. The licensee's corrective actions included rewinding hoses in the Unit 2 containment, four hoses in the TB, and creating compensatory measures for hose reels for the Unit 1 containment.

The finding was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Protection Against External Events (Fire) and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Specifically, the licensee failed to ensure that activities such as inspection, testing, and maintenance of fire protection systems were prescribed and accomplished in accordance with documented instructions, procedures, and drawings. In accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," Table 2, the inspectors determined the finding affected the Mitigating Systems cornerstone. The finding degraded fire protection defense-in-depth strategies, and the inspectors determined, using Table 3, that it could be evaluated using Appendix F, "Fire Protection Significance Determination Process." The inspectors screened the issue to Green under the Phase 1 Screening Question 1.3.1–A, because the inspectors determined that the impact of a fire would be limited to one

train/division of equipment for the affected fire areas and at least one credited safe shutdown path would be unaffected. This finding has a cross-cutting aspect of Training (H.9), in the area of human performance, because the licensee did not provide training and ensure knowledge transfer to maintain a knowledgeable, technically competent workforce, and instill nuclear safety values. Specifically, the inspectors determined that operations personnel were not adequately trained to recognize deficiencies associated with firefighting equipment standards, such as kinked and twisted hoses on hose reels, and subsequently failed to initiate actions to remedy such conditions.

Inspection Report# : 2015004 *(pdf)*

Significance: Dec 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
Inadequate Evaluation of Non-Conforming Auxiliary Feedwater System Pipe Defects
The inspectors identified a finding of very low safety significance and associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to maintain a Unit 2 auxiliary feedwater system (AFW) pipe segment containing linear defects in accordance with the design and material specifications. As a corrective action, the licensee performed light filing to remove the defects from this pipe segment. The licensee entered the failure to maintain the AFW pipe segment in accordance with the design into the corrective action program (CAP) as action request (AR) 02084077, and was evaluating additional corrective actions.

This finding was determined to be more than minor in accordance with IMC 0612, Appendix B, because if left uncorrected the performance deficiency had the potential to lead to a more significant safety concern. Specifically, the licensee's failure to maintain the Unit 2 AFW pipe segment containing linear defects in accordance with the design and material specifications could result in an increase in the possibility of pipe leakage or failure. In addition, the failure to maintain the AFW pipe segment containing linear defects in accordance with the design and material specification adversely affected the Mitigating System Cornerstone attribute of Equipment Performance because it could result in failure of AFW piping which would reduce the availability and reliability of the this mitigating system. The inspectors evaluated the finding in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," and Exhibit 2, "Mitigating Systems Screening Questions," of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power." The inspectors answered "Yes" to screening question A.1 of Exhibit 2. Although this finding adversely affected the design or qualification of the AFW pipe segments, the finding screened as very low safety significance (Green), because it did not result in the loss of operability or functionality of the affected pipe segment. This finding has a cross cutting aspect in the Teamwork (H.4) component of the human performance cross cutting area. Specifically, the licensee's Projects Team responsible for the AFW modifications did not effectively communicate and coordinate with the licensee's Programs Engineering Group for resolution of the AFW pipe nonconforming conditions to ensure nuclear safety was maintained.

Inspection Report# : 2015004 *(pdf)*

Barrier Integrity

Significance: Jun 30, 2016
Identified By: NRC
Item Type: FIN Finding
Fuel Assembly Move Sequence Planned Incorrectly

A finding of very low safety significance was identified by the inspectors, for the licensee's failure to follow procedure REI 26.0, "Fuel/Insert/Component Movement Planning." Specifically, the licensee failed to follow procedure REI 26.0, Step 5.5.7.b, which verified that the licensee would not place fuel assemblies with cooling times less than 295 days into spent fuel pool rack foot locations. The licensee's corrective actions included completing additional spent fuel moves, which placed the spent fuel pool into an appropriate configuration.
The inspectors determined that the finding was more than minor, because, if left uncorrected, it had the potential to become a more significant safety concern. Specifically, if the inspectors had not questioned the licensee about spent fuel pool rack foot locations, the spent fuel pool would have remained in an incorrect configuration. The inspectors concluded this finding was associated with the Barrier Integrity cornerstone. 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 L, "B.5.b Significance Determination Process", "Table 2 – Significance Characterization," The inspectors determined that the finding did not meet the criteria in Table 2 for a Greater Than Green significance; therefore, the finding was of very low safety significance (Green). This finding has a cross-cutting aspect of Avoid Complacency (H.12), in the area of Human Performance, for failing to implement appropriate error reduction tools. Specifically, the licensee became desensitized to overriding fuel placement constraints and failed to implement effective human performance tools to prevent the error
Inspection Report# : 2016002 *(pdf)*

Emergency Preparedness

Occupational Radiation Safety

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

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