April 27, 2005

Mr. Dennis L. Koehl
Site Vice President
Point Beach Nuclear Plant
Nuclear Management Company, LLC
6590 Nuclear Road
Two Rivers, WI 54241-9516

SUBJECT: POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2
NRC INTEGRATED INSPECTION REPORT 05000266/2005003;
05000301/2005003

Dear Mr. Koehl:

On March 31, 2005, the U.S. Nuclear Regulatory Commission (NRC) completed an integrated inspection at your Point Beach Nuclear Plant, Units 1 and 2. The enclosed report documents the inspection findings which were discussed on March 30, 2005, with you and members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations, and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed your personnel.

Based on the results of this inspection, four findings of very low safety significance were identified, three of which involved violations of NRC requirements. However, because these violations were of very low safety significance, non-willful, and non-repetitive, and because the violations were entered into your corrective action program, the NRC is treating these findings as Non-Cited Violations consistent with Section VI.A. of the NRC Enforcement Policy.

In addition to the routine NRC inspection and assessment activities, Point Beach performance is being evaluated quarterly as described in the Annual Assessment Letter - Point Beach Nuclear Plant, dated March 4, 2004. Consistent with Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," plants in the multiple/repetitive degraded cornerstone column of the Action Matrix are given consideration at each quarterly performance assessment review for (1) declaring plant performance to be unacceptable in accordance with the guidance in IMC 0305; (2) transferring to the IMC 0350, "Oversight of Operating Reactor Facilities in a Shutdown Condition with Performance Problems," process; and (3) taking additional regulatory actions, as appropriate. During this inspection period, the NRC reviewed Point Beach operational performance, inspection findings, and performance indicators for the first quarter of 2005. Based on this review, we concluded that Point Beach is operating safely.

We determined that no additional regulatory actions, beyond the already increased inspection activities and management oversight, are currently warranted.

If you contest the subject or severity of a Non-Cited Violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the Resident Inspector Office at the Point Beach Nuclear Plant.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Steven A. Reynolds
Deputy Director
Division of Reactor Projects

Docket Nos. 50-266; 50-301
License Nos. DPR-24; DPR-27

Enclosure: Inspection Report 05000266/2005003; 05000301/2005003
w/Attachment: Supplemental Information

See Previous Concurrences

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REGION III

Docket Nos:	50-266; 50-301
License Nos:	DPR-24; DPR-27
Report No:	05000266/2005003; 05000301/2005003.
Licensee:	Nuclear Management Company, LLC.
Facility:	Point Beach Nuclear Plant, Units 1 and 2.
Location:	6610 Nuclear Road Two Rivers, WI 54241
Dates:	January 1, 2005, through March 31, 2005
Inspectors:	R. Krsek, Senior Resident Inspector M. Morris, Resident Inspector M. Kunowski, Project Engineer J. Giessner, Reactor Engineer
Approved by:	P. Louden, Chief Branch 5 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000266/2005003, 05000301/2005003; 01/01/2005 - 03/31/2005; Point Beach Nuclear Plant, Units 1 and 2; Equipment Alignment and Non-routine Evolutions.

This report covers a 3-month period of baseline resident inspection for the Point Beach Nuclear Plant, Units 1 and 2, conducted by Region III and resident inspectors. Four Green findings, three of which had associated Non-Cited Violations (NCV) were identified during this inspection period. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process". Findings for which the Significance Determination Process (SDP) does not apply, may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

A. Inspector-Identified and Self-Revealing Findings

Cornerstone: Initiating Events

- Green. The inspectors determined that a finding of very low significance (Green) was self-revealed when the feed breaker for nonsafety-related motor control center (MCC) 1B41 opened due to an overloaded bus during monthly turbine lube oil system checks. The licensee subsequently determined that the cause was a failure to appropriately control loads on MCC 1B41. No violation of NRC requirements occurred.

  The issue is more than minor since the finding was associated with the configuration control and procedure quality attributes of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was considered to be of very low significance because the finding did not affect the loss of coolant accident initiators; did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation functions would not be available; and the finding did not increase the likelihood of a fire or flood. The licensee took immediate corrective actions to ensure all loads were properly controlled and had several planned corrective actions which included developing additional load management actions and developing a new procedure regarding load management for this nonsafety-related bus. (Section 1R14.1)

Cornerstone: Mitigating Systems

- Green. A finding of very low safety significance associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings" was identified by the inspectors. The finding was associated with an air leak that inspectors found on an air supply fitting to the minimum flow recirculation control valve for the Unit 2 turbine-driven auxiliary feedwater (TDAFW) pump. The licensee determined that the leak most likely resulted

when a fitting was inadvertently loosened during maintenance. Post-maintenance testing did not detect the loose fitting. Following discovery of the leak by the inspectors 6 days after the maintenance, the licensee entered the issue into its corrective action program, declared the TDAFW pump for Unit 2 inoperable, and repaired the leak.

The inspectors determined that the primary cause of this finding was related to the cross-cutting area of human performance, because the licensee failed to ensure that post-maintenance testing was adequately conducted for the component.

This issue is more than minor because it impacted the operability of a component in the Mitigating Systems cornerstone and affected the objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was screened through the Phase II screening in the Significance Determination Process (SDP) of Inspection Manual Chapter (IMC) 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At Power Situations," since the component was impacted for greater than the Limiting Condition for Operation. The findings was determine to be of very low safety significance based on the review. This finding was a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings." (Section 1R04.1)

- Green. A Green finding associated with a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the failure to take corrective actions for a condition adverse to quality. The inspectors noted that in March 2003, CAP031641 was written to assess the licensee's operational practice of having the two fuel oil duplex strainers on each of the four emergency diesel generators set to dual filter mode instead of single mode. The assessment concluded that the optimal position was single mode because it allowed changing the filter elements with the emergency diesel generator running. The dual filter mode required the emergency diesel generator to be stopped to change the filters. In January 2004, CAP031641 was closed with no actions taken to address this condition adverse to quality.

  The inspectors also determined that the primary cause of this finding was related to the cross-cutting area of problem identification and resolution, because the licensee failed to take any corrective actions to correct this condition adverse to quality.

  This issue was more than minor because if left uncorrected the finding could become a more significant safety concern. In addition, the finding affected the Mitigating Systems cornerstone attributes of configuration control and equipment performance. The inspectors evaluated the finding using IMC 0609, Appendix A, Phase 1 screening for the Mitigating Systems cornerstone and determined that the finding was of very low safety significance because it was not a design or

qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18. (Section 1R04.2)

- Green. A finding of very low safety significance was self-revealed for a violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for an Abnormal Operating Procedure (AOP) that was not adequate for returning safety-related battery chargers to an operable status. Specifically, on February 27, 2005, an offsite line experienced a fault and became disconnected, causing a momentary phase-to-phase short and then a continuous open circuit. The transient caused a loss of power to all in-service safety-related battery chargers. Three of the four chargers were restored using the AOP, but one battery charger could not be promptly restored to service because the AOP was inadequate. The licensee took prompt action to enter the item into the corrective action process and change the procedure.

  The inspectors concluded that the finding was more than minor because if left uncorrected the item could become a more significant safety concern, and it was associated with the procedure quality attribute of the Mitigating Systems cornerstone. The finding was considered to be of very low safety significance since the finding did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event. (Section 1R14.2)

B. Licensee-Identified Violations

No findings of significance were identified.

REPORT DETAILS

Summary of Plant Status

Unit 1 was at 100 percent power throughout the inspection period with the exception of brief downpowers during routine auxiliary feedwater and secondary system valve testing.

Unit 2 began the inspection period at 100 percent power and remained there for the majority of the inspection period with the exception of brief downpowers to support auxiliary feedwater and secondary system valve testing. In addition, on February 27, 2005, a Technical Specification (TS) required shutdown was initiated by the licensee due to a loss of the DC battery chargers. The licensee exited the TS action condition when Unit 2 power was at 99 percent; however, a power reduction to less than 50 percent power continued in accordance with plant procedures due to the loss of offsite power Line 151. Unit 2 was returned to 100 percent power on February 28, 2005.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

1R01 Adverse Weather Protection (71111.01)

a. Inspection Scope

The inspectors walked down accessible portions of risk-significant equipment and systems susceptible to extreme cold weather. The inspectors reviewed the licensee's preparation of the containment facade structures and buildings inside the protected area. The inspectors reviewed the corrective actions and work orders (WOs) written to correct identified problems and assessed whether completion dates would ensure that corrective maintenance was completed prior to the onset of cold weather. The inspectors also walked down areas which had freeze problems during the last 4 years. These observations constituted two inspection procedure samples.

- Unit 1 Facade Freeze Walkdowns; and
- Unit 2 Facade Freeze Walkdowns.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (71111.04)

.1 Partial System Walkdown of Instrument Air Systems

a. Inspection Scope

The inspectors performed a partial walkdowns of accessible portions of the instrument air system which interfaced with the safety injection and auxiliary feedwater systems to determine the operability of the systems. The inspectors utilized system valve lineup checklists, plant drawings, and selected operating procedures to determine if the systems were correctly aligned to perform the intended design functions. The inspectors also examined the material condition of the components and observed operating equipment parameters to determine if there were deficiencies. The inspectors reviewed completed WOs and records associated with the systems for issues that could affect component or train functions. The inspectors used the information in the appropriate sections of the Final Safety Analysis Report (FSAR) to determine the functional requirements of the system. This partial system walkdown constituted one inspection procedure sample.

b. Findings

Introduction: A finding of very low safety significance associated with a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings" was identified by the inspectors. The finding was associated with an air leak that the inspectors identified on an air supply fitting to the minimum flow recirculation control valve for the Unit 2 turbine-driven auxiliary feedwater (TDAFW) pump. The licensee concluded that the most likely cause of the leak was maintenance conducted 6 days earlier when the fitting was inadvertently loosened. Post-maintenance testing had not detected the loose fitting.

Description: On February 16, 2005, during a walkdown of air system components with risk significance, the inspectors identified an audible air leak of significance on the piping for the minimum flow recirculation control valve by isolation valve 2AF-126 on the Unit 2 TDAFW pump. In response to this, the licensee initiated corrective action program document (CAP) 062122 and the pump was declared inoperable. Maintenance was conducted and the compression fitting below 2AF-216 was tightened approximately a quarter turn to stop the leak. The licensee then conducted a Maintenance Rule Evaluation (MRE 336) and determined this to be a Maintenance Preventable Functional Failure.

The licensee determined that the fitting may have been inadvertently disturbed during adjustment of valve spring tension when maintenance was conducted on the recirculation valve on February 10, 2005, under WO 0413878. The licensee noted that with this specific type of compression fitting a small rotation of the capture nut would loosen the fitting. The WO and the associated procedure directed that joints were to be leak checked after the maintenance on the valve and fixed as necessary. Maintenance personnel indicated to the inspectors that a faint noise was heard after the maintenance, but no leak was found during the checks that followed, and no further action was

pursued. The allowable air leakage amount for this system had a stringent acceptance criterion to ensure the valve would perform its design function.

Analysis: The inspectors determine that failure to conduct an adequate post-maintenance test on the air system associated with the Unit 2 TDAFW pump recirculation valve was a performance deficiency warranting a significance evaluation. The inspectors evaluated the finding using NRC IMC 0612, "Power Reactor Inspection Reports," and determined the finding to be more than minor since it impacted the operability of a component in the Mitigating Systems cornerstone and affected the objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

The finding was initially screened through Phase 1 of IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At Power Situations," and the criteria were met to require a Phase 2 evaluation since the component was impacted for greater than the Limiting Condition for Operation (TS Action Condition Completion Time) of 72 hours. The finding was screened through the Phase 2 process with review by a Region III senior reactor analyst. The exposure time window used was 3-30 days, assuming the unavailability began at the end of the maintenance window for the Unit 2 TDAFW pump (6 days prior). The inspectors used the site-specific risk-informed inspection notebook, revision 1, dated May 1, 2002. Since the motor-driven auxiliary feedwater pumps were available and credited in sequences as remaining mitigation capability, the most dominant sequence for consideration was the loss of service water sequence since there is no auxiliary feedwater backup available. The process credited reasonable actions and response times which an operator would be expected to perform based on already approved training and procedures. The results of the determination yielded a very low safety significance (Green).

The inspectors also determined that the primary cause of this finding was related to the cross-cutting issue in the area of human performance, because the licensee failed to take reasonable action to ensure the post-maintenance testing was adequately conducted for the component.

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," states, in part, that activities affecting quality shall be accomplished in accordance with instructions, procedures or drawing, of a type appropriate to the circumstances. Contrary to this, the post-maintenance testing on the Unit 2 TDAFW recirculation valve pursuant to WO 0413878, an activity affecting quality, was not adequately accomplished to ensure the system was capable of performing the design function following maintenance. Therefore, the inspectors determined this finding was a violation of Criterion V, "Instructions, Procedures and Drawings." Because this violation was determined to be of very low safety significance and because the issue was entered in the corrective action program (as CAP062122), this violation is being treated as an NCV consistent with Section VI.A of the NRC Enforcement Policy (NCV 05000301/2005003-01).

The licencee took prompt corrective action to repair the leak and to ensure the system could meet its design requirements. The licensee also evaluated the activity in their maintenance rule process.

.2 Partial System Walkdown of Emergency Diesel Generator G-02

a. Inspection Scope

The inspectors performed partial walkdowns of accessible portions of the G-02 emergency diesel generator and associated 4160-volt system to determine the operability of the systems. The inspectors utilized system valve lineup and electrical breaker checklists, plant drawings, and selected operating and alarm response procedures to determine if the systems were correctly aligned to perform the intended design functions. The inspectors also examined the material condition of the components and observed operating equipment parameters to determine if there were deficiencies. The inspectors reviewed completed WOs and corrective actions associated with the systems for issues that could affect component or train functions. The inspectors used the information in the appropriate sections of the FSAR to determine the system functional requirements. This partial system walkdown constituted one inspection procedure sample.

b. Findings

Introduction: A Green finding associated with an NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified by the inspectors for the failure to take corrective actions for a condition adverse to quality. The inspectors noted that in March 2003, CAP031641 was written directing the assessment of operational practice of having the two fuel oil duplex strainers on each of the four emergency diesel generators set to dual filter mode instead of single mode. The assessment concluded that the optimal position for the strainers was single mode because this configuration allowed for changing of the filter elements with the emergency diesel generator running. The dual mode required the emergency diesel generator be stopped to change the filters. In January 2004, CAP031641 was closed with no actions taken to address this condition adverse to quality.

Description: During emergency diesel generator walkdowns in January 2005, the inspectors noted that both duplex fuel oil filters on the emergency diesel generators were set to dual filter mode instead of single filter mode. The inspectors also noted that CAP031641, "Component Instruction Manual and Component Manufacturer Differ on Operation of G03/G04 Duplex Fuel Oil Strainer," written in March 2003, questioned the alignment of the fuel oil system duplex strainers during an emergency diesel generator assessment. The CAP identified that the current operating practice was to have the fuel oil filter set to dual filter mode. In addition, the CAP documented that the component manufacturer manual stated that the control valve could be positioned to utilize both elements simultaneously, but that this configuration defeated the purpose of the duplex feature.

The inspectors reviewed the condition evaluation conducted in response to the CAP. It concluded that the operating procedures for all four emergency diesel generators should be revised to control the selector valves in single filter mode, as well as providing guidance for repositioning the valve and performing filter replacement should the need arise. The inspectors noted, however, that CAP031641 was closed out in January 2004 with no action taken to address this condition adverse to quality. The inspectors raised

this concern and the licensee initiated CAP061595, “Emergency Diesel Generator Fuel Oil Duplex Strainer Operation,” and again concluded that the preferred position for the duplex fuel strainers and filters was the single mode. The evaluation further concluded that this was the only configuration which provided for the changing of the filter elements while the emergency diesel generator was running. With the duplex fuel strainers in dual mode, an operating emergency diesel generator would have to be stopped for the filters to be changed. The licensee created a corrective action to correct this condition adverse to quality.

Analysis: The inspectors determined that the failure to promptly correct the use of the filters in the dual mode, a condition adverse to quality, was a licensee performance deficiency warranting a significance evaluation. This issue was more than minor because if left uncorrected the finding could become a more significant safety concern, in that, during an accident or event with a diesel operating, the licensee would have to stop the diesel to change both fuel oil filters. In addition, the finding affected the Mitigating Systems cornerstone attributes of configuration control and equipment performance for operating equipment lineup and reliability of the emergency diesel generators. The finding also affected the Mitigating Systems cornerstone objective to ensure the reliability and capability of systems that respond to initiating events to prevent undesirable consequences.

The inspectors evaluated the finding using IMC 0609, Appendix A, Phase 1 screening for the Mitigating Systems cornerstone and determined that the finding was of very low safety significance because the finding was not a design or qualification deficiency that was confirmed to result in a loss of function per Generic Letter 91-18. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution, in that the licensee failed to take any corrective actions to correct this condition adverse to quality.

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” requires, in part, that measures be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, and nonconformances, be promptly identified and corrected. Contrary to this requirement, the licensee failed to promptly correct issues associated with the configuration control of both fuel oil duplex strainers on all four emergency diesel generators. Specifically, this issue was initially identified in March 2003, in CAP031641, which was closed in January 2004 with no corrective actions taken to address this condition adverse to quality. Therefore, the inspectors determined this finding was a violation of Criterion XVI. Because this violation was of very low significance, non-willful, non-repetitive, and documented in the licensee’s corrective action program as CAP031641, this finding is being treated as an NCV, consistent with Section VI.A. of the NRC Enforcement Policy (NCV 05000266/2005003-02; NCV 05000301/2005003-02).

At the end of the inspection, the licensee evaluated the issue and concluded again that the optimal position was in the single filter mode. The licensee planned to implement a procedure change to control both fuel oil duplex filters on each diesel generator through Corrective Action CA061307.

.3 Additional Partial System Walkdowns

a. Inspection Scope

The inspectors performed partial walkdowns of accessible portions of risk-significant systems to determine the operability of the systems. The inspectors utilized system valve lineup and electrical breaker checklists, tank level books, plant drawings, and selected operating procedures to determine if the systems were correctly aligned to perform the intended design functions. The inspectors also examined the material condition of the components and observed operating equipment parameters to determine if there were deficiencies. The inspectors reviewed completed WOs and calibration records associated with the systems for issues that could affect component or train functions. The inspectors used the information in the appropriate sections of the FSAR to determine the functional requirements of the systems. Partial system walkdowns of the following systems constituted four inspection procedure samples:

- Service Water (SW) Pump, P-32E, Electrical Line-up During Maintenance;
- Train "B" Component Cooling Water (CCW) System;
- Auxiliary Feedwater (AFW) System During AF-4002, Mini-Recirculation Maintenance; and
- Emergency Diesel Generator G-03, Following Maintenance.

b. Findings

No findings of significance were identified.

.4 Semiannual System Walkdown

a. Inspection Scope

The inspectors performed a complete system alignment inspection of the 125-volt direct current (DC) system. This safety-related system was selected based on the risk-significance of the system in the licensee's probabilistic risk assessment. The walkdown of the 125-volt DC system constituted one inspection procedure semiannual sample.

The inspection consisted of the following activities:

- Review of plant procedures (including selected abnormal and emergency procedures), drawings, and the FSAR to identify proper system alignment;
- Review of outstanding or completed temporary and permanent modifications to the system;
- Review of open corrective action program documents and WOs that could impact operability of the system; and
- Walkdown of mechanical and electrical components in the system to assess alignment, component accessibility, availability, and current condition.

The inspectors also reviewed selected documented issues to determine if the issues were properly addressed in the licensee's corrective action program.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

.1 Walkdown of Selected Fire Zones

a. Inspection Scope

The inspectors conducted fire protection walkdowns which focused on the following attributes: the availability, accessibility, and condition of fire fighting equipment; the control of transient combustibles and ignition sources; and the condition and status of installed fire barriers. The inspectors selected fire areas for inspection based on the area's overall fire risk contribution, as documented in the Individual Plant Examination of External Events or the potential to impact equipment which could initiate a plant transient.

In addition, the inspectors assessed these additional fire protection attributes during walkdowns: fire hoses and extinguishers were in the designated locations and available for immediate use; unobstructed fire detectors and sprinklers; transient material loading within the analyzed limits; and fire doors, dampers, and penetration seals in satisfactory condition. The inspectors also determined if minor issues identified during the inspection were entered into the licensee's corrective action program. The walkdown of the following selected fire zones constituted nine inspection procedure samples:

- Fire Zone FZ 226, 125-Volt DC Electrical Equipment Room;
- Fire Zone FZ 305, 4160-Volt AC [Alternating Current] Vital Switchgear Room;
- Fire Zone FZ 308 and 309, Diesel Generator G-01 and G-02 Rooms ;
- Fire Zone 316 and 300, Unit 1 Turbine Building 26-Foot General Area and Lube Oil Reservoir;
- Fire Zone FZ 524, 525, and 531, Unit 1 Containment Facade;
- Fire Zone FZ 596 and 600, Unit 2 Containment Facade;
- Halon System; Turbine Hall on 26-Foot Elevation;
- Fire Zone FZ 142, CCW Pump Room; and
- Fire Zone FZ 151, Safety Injection Pump Room.

b. Findings

No findings of significance were identified.

1R06 Flood Protection Measures - Internal Floods (71111.06)

a. Inspection Scope

The inspectors completed a walkdown of flood zones to assess the overall readiness of internal flood protection equipment and barriers. The inspectors evaluated flood protection features, such as flood doors, door gaps, and subsoil drains, to determine if the components were in satisfactory physical condition, unobstructed, and capable of

providing an adequate flood barrier. The inspectors also reviewed design basis documents (DBDs) and risk analyses and evaluated the affects of a rupture of non-seismically qualified tanks in the containment facades on the submergence of primary containment sump recirculation valve limit switches. The walkdown of the following selected flood zones constituted two inspection procedure samples:

- Unit 1 and Unit 2 Residual Heat Removal (RHR) Pump Room; and
- AFW Ventilation and Pump Rooms.

b. Findings

No findings of significance were identified.

1R07 Heat Sink Performance (71111.07)

.1 Review of Containment Fan Coil Inspection

a. Inspection Scope

The inspectors assessed the condition and cleanliness of the Unit 2 'D' containment fan cooler heat exchanger and the effectiveness of biofouling controls through direct observation of the component during scheduled testing and inspection activities. In addition, the inspectors reviewed the inspection results against pre-established licensee acceptance criteria to determine if the number of plugged tubes affected heat exchanger operability. The inspectors also determined if the inspection frequency was appropriate to detect degradation prior to the loss of heat removal capabilities below design basis values. Finally, the inspectors interviewed the program engineer to determine whether previous thermal performance test results appropriately considered test instrument inaccuracies. This review of heat sink performance constituted one inspection procedure sample.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11)

.1 Resident Inspector Quarterly Observation of Licensed Operator Requalification

a. Inspection Scope

During Licensed Operator Requalification Cycle 05-01, the inspectors observed operating crew performance during a simulator as found requalification examination. The inspectors also reviewed some of the changes to the simulator model against modifications made in the plant. Observation of the requalification quarterly evaluation constituted one inspection procedure sample.

The inspectors assessed crew performance in the areas of:

- Clarity and formality of communications;
- Understanding of the interactions and function of the operating crew during an emergency;
- Prioritization, interpretation, and verification of actions required for emergency procedure use and interpretation;
- Oversight and direction from supervisors; and
- Group dynamics.

Crew performance in these areas was also compared to licensee management expectations and guidelines, as presented in Nuclear Plant Procedures Manual Procedure (NP) 2.1.1, “Conduct of Operations,” Revision 1.

b. Findings

No findings of significance were identified.

1R12 Maintenance Effectiveness (71111.12)

a. Inspection Scope

The inspectors performed maintenance effectiveness reviews of the systems listed below. The inspectors reviewed repetitive maintenance activities to assess maintenance effectiveness, including maintenance rule activities, work practices, and common cause issues. Inspection activities included, but were not limited to, the licensee's categorization of specific issues, including evaluation of performance criteria, appropriate work practices, identification of common cause errors, extent of condition, and trending of key parameters. Additionally, the inspectors reviewed implementation of the Maintenance Rule (10 CFR 50.65) requirements, including a review of scoping, goal-setting, performance monitoring, short-term and long-term corrective actions, functional failure determinations, and current equipment performance status.

For each system reviewed, the inspectors reviewed significant WOs and CAPs to determine if failures were appropriately identified, classified, and corrected, and if unavailable time was correctly calculated. The reviews of maintenance effectiveness for the following components and systems constituted three inspection procedure samples:

- 125-Volt DC System;
- Instrument Air System; and
- Units 1 and 2 Safety Injection System Return to (a)(2) Status.

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessment and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors reviewed risk assessments for the following maintenance activities, completing risk assessment and emergent work control inspection procedure samples. During these reviews, the inspectors compared the licensee's risk management actions to those actions specified in the licensee's procedures for the assessment and management of risk associated with maintenance activities. The inspectors assessed whether evaluation, planning, control, and performance of the work was done in a manner to reduce the risk and minimize the duration where practical, and whether contingency plans were in place where appropriate.

The inspectors used the licensee's daily configuration risk assessment records, observations of shift turnover meetings, and observations of daily plant status meetings to determine if the equipment configurations were properly listed, that protected equipment was identified and controlled as appropriate, and that significant aspects of plant risk were communicated to the necessary personnel. The reviews of maintenance risk assessment and emergent work evaluation constituted seven inspection procedure samples:

- Planned and emergent maintenance during the week of January 3, 2005;
- Planned and emergent maintenance during the week of January 24, 2005;
- Planned and emergent maintenance during the week of January 31, 2005;
- Planned and emergent maintenance during the week of February 21, 2005;
- Planned and emergent maintenance during the week of February 28, 2005;
- Planned and emergent maintenance during the week of March 14, 2005; and
- Planned and emergent maintenance during the week of March 31, 2005.

b. Findings

No findings of significance were identified.

1R14 Personnel Performance Related to Non-Routine Plant Evolutions and Events (71111.14)

.1 Loss of NonSafety-Related Bus 1B41

a. Inspection Scope

The inspectors reviewed the operators response to the January 8, 2005, loss of 480-volt AC motor control center (MCC) 1B41. The inspectors also reviewed CAPs generated as a result of this event, the apparent cause evaluation which was performed, and the operational decision-making issue evaluation document. The inspectors assessed whether the operators implemented the required actions in the appropriate abnormal operating procedures, the issues were appropriately entered into the licensee's corrective action program with the appropriate significance characterization, and the proposed corrective actions were appropriate to address the cause.

b. Findings

Introduction: The inspectors determined that a finding of very low significance (Green) was self-revealed when the feed breaker for nonsafety-related MCC 1B41 opened due to an overloaded bus during monthly turbine lube oil system checks. The licensee subsequently determined that the cause was a failure to appropriately control loads on MCC 1B41. No violation of NRC requirements occurred.

Description: On January 8, 2005, at 14:52, a loss of the 480-volt MCC 1B41 occurred while operators were performing Periodic Check (PC) 23, Section 3, "Monthly Turbine Lube Oil System Checks." The MCC 1B41 was energized by feeder breaker 1B52-7D, which tripped, initiating this event. This particular MCC was critical for continued operation of the Unit 1 main turbine generator and auxiliary equipment, and if not restored promptly would necessitate a reactor and turbine trip.

Control room operators immediately recognized that breaker 1B52-7D was open when a white light lit, which indicated either an overload condition or a breaker switch disagreement condition. The shift manager directed the control operator to attempt one reset and closure of the breaker, in accordance with plant operating procedures. This action successfully closed the feeder breaker and re-energized the downstream MCC 1B41, and no additional bus fault indications were present following restoration. Because of the momentary loss of MCC 1B41, a steam flow-feed flow transient occurred due to the loss of and subsequent recovery of reheat steam to the moisture separator reheaters. However, subsequent evaluations conducted by the licensee, and reviewed by the inspectors, determined that reactor power did not exceed 100 percent during the transient.

The licensee immediately began troubleshooting in accordance with Routine Maintenance Procedure (RMP) 9201. In parallel, the licensee entered the operational decision-making issue process to determine both short- and long-term corrective actions to address the MCC 1B41 overload concern. Finally, the licensee took short-term actions to reduce the loads on MCC 1B41 to improve operating margin and minimize the potential of tripping breaker 1B52-7D on overload again.

The licensee determined that the cause of the event was an overloaded MCC bus, where normally energized loads, in combination with the loads being tested as part of the monthly turbine lube oil system checks, caused current to exceed the trip setpoint of the feeder breaker. The licensee concluded a significant factor in the overload was that the licensee changed the mode of operating two main transformer cooling fans in recent years, adding these fans as a cold weather operational load, without recognizing the consequences of this additional load on MCC 1B41 during cold weather periods when additional heater loads are placed on MCC 1B41. The licensee concluded that while safety-related 480-volt MCC equipment was controlled by calculations and procedures, similar processes did not exist for nonsafety-related 480-volt MCCs to ensure loads are properly controlled. Therefore, a proposed corrective action was to generate new procedures to assist in controlling essential nonsafety-related bus loads.

Analysis: The inspectors determined that the failure to appropriately control loads on nonsafety-related 480-volt AC MCC 1B41 was a performance deficiency which warranted a significance determination.

The inspectors determined that the finding was more than minor in accordance with IMC 0612, Appendix B, "Issue Disposition Screening," since the finding was associated with the configuration control and procedure quality attributes of the Initiating Events cornerstone and adversely impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations.

Using IMC 0609, Appendix A, "SDP Phase 1 Screening Worksheet for IE [Initiating Events], MS [Mitigating Systems], and B [Barrier Integrity] Cornerstones," the inspectors determined that only the Initiating Events cornerstone was affected. The inspectors determined the finding was of very low safety significance because the finding did not affect the loss of coolant accident initiators, the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation functions would not be available, and the finding did not increase the likelihood of a fire or internal/external flood. Therefore, the finding screened out as Green.

Enforcement: The failure to appropriately control loads on nonsafety-related 480-volt AC MCC 1B41 was not an activity affecting quality, as required by 10 CFR Part 50, Appendix B. Therefore, no violation of regulatory requirements occurred. This was considered a finding of very low safety significance (FIN 05000266/2005003-03).

The licensee entered this issue into the corrective action program as CAP061375, "Loss of 480-Volt AC Motor Control Center 1B41." The licensee took immediate corrective actions to administratively control loads on MCC 1B41 to ensure all loads were appropriately controlled, and immediately initiated the formal operational decision making process to determine long-term solutions. As a result, planned corrective actions included pursuing an increase in the overload setpoint of the feed breaker for MCC 1B41 or removing a large load from the bus, update administrative procedures to require the operators to check the ammeter load condition on the motor control center prior to starting certain loads, update operating procedures for transformer cooling fans to be controlled in automatic rather than manual to further reduce bus loads, and convert operations notebook information regarding load management guidelines into a new procedure.

.2 Loss of Safety-Related Battery Chargers

a. Inspection Scope

On the morning of February 27, 2005, an electrical fault occurred approximately 7 miles from the plant on the plant's Line 151 offsite power line. The fault resulted in numerous alarms and lit annunciators in the main control room and the tripping off of all four operating safety-related battery chargers, the running and standby nonsafety-related instrument air compressors, a Unit 2 charging pump, and several nonsafety-related ventilation fans. The loss of all chargers initially placed the plant into TS 3.0.3, requiring the commencement of a shutdown of both reactors. The loss of the instrument air

compressors could have eventually resulted in a dual unit reactor trip on closure of the air-operated main steam isolation valves after instrument air header pressure decreased sufficiently.

Shortly after the event, the resident inspectors arrived onsite to assess the situation and the licensee's immediate response. Subsequently, resident and regional inspectors, with assistance of technical specialists from the NRC's Office of Nuclear Reactor Regulation, further assessed the immediate response and the licensee's follow-on actions. Included in the NRC's assessment were interviews of managers, engineers, and operators involved in or knowledgeable of the event and the subsequent actions and a review of the battery chargers' design basis, operator logs, event response and abnormal operating procedures (AOPs), and the offsite grid operator's assessment of the fault. This inspection activity constitutes one inspection procedure sample.

b. Findings

Introduction: A Green finding associated with an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for an AOP that was not adequate for returning one of the four battery chargers to operable status.

Description: On February 27, 2005, one end of a short segment "bridge" line connecting the "C" phase of the Line 151 offsite power line to a transmission tower became disconnected, causing a momentary (3 cycles) phase-to-phase short and then a continuous open circuit. Offsite grid and Point Beach switchyard protective relaying isolated the Line 151 line from the switchyard but not before plant equipment was affected. Licensed control room reactor operators responded to the resultant numerous alarms, annunciators, and tripped components. The equipment that tripped off because of the fault was controlled by non-automatic resetting contactors, which tripped as designed, on the 3-cycle voltage dip caused by the fault. The voltage dip, however, was not long enough to actuate the undervoltage relays of the safety-related electrical buses.

Within 2 minutes of the event, and before any significant affect on reactor operating parameters occurred, reactor operators restarted the instrument air compressors. Within 12 minutes, the operators had restarted the charging pump, several fans, and three of four battery chargers. To restore the chargers, a senior reactor operator utilized AOP 0.0, "Vital DC System Malfunction," Revision 24, and directed a reactor operator who manipulated switches in the main control room. When the licensed operators were unable to restore the fourth charger, D09, to service, auxiliary operators (AOs) were dispatched to the charger to investigate. The AOs found the 480-volt AC input breaker integral to the charger in a tripped condition and an adjacent integral DC output breaker closed. The operators believed that this configuration was not addressed in AOP 0.0 (AC breaker open, DC breaker closed), which directed personnel to close the AC breaker and then close the DC output if the charger failed to operate after the contactor was closed. This direction was also believed contrary to a placard posted on the charger which stated that when energizing the charger, operators close the AC breaker before the DC breaker to prevent DC filter capacitor charging current from tripping the DC breaker. The AOP direction was also not consistent with the AOs'

recollection of starting chargers, based on System Operating Procedure 0-SOP-DC-002, "125 VDC System, Bus D-02 & Components," Revision 9.

Because of these discrepancies, the senior reactor operator directed the AOs to open the DC breaker, close the AC breaker, and then close the DC breaker. When the AOs closed the DC breaker, a DC fuse in D09 failed and maintenance personnel were subsequently directed to repair the charger. The charger was eventually returned to service several minutes after the 2-hour completion time of TS Action Condition (TSAC) 3.8.4.A. Technical Specification 3.8.4 required that an inoperable DC electrical power subsystem be returned to service in 2 hours or a dual-unit reactor shutdown be commenced.

As a corrective action, the licensee revised AOP 0.0 to include a wider-range of possible charger breaker configurations that might be encountered by operators and to include additional information on adjusting charger input and DC bus voltages before energizing an isolated charger. This revision was made as part of the corrective actions from Condition Evaluation CE015364, written, in part, to address the inadequacy of AOP 0.0.

As part of the inspectors' assessment, additional problems were identified, several of which are discussed below. In response to the event, the licensee did not use any of its formal event evaluation or operational decision-making procedures, yet two shutdown TSACs had been entered because of the event and the plant equipment response on February 27 had not been seen in previous offsite line fault events. A CAP (CAP062363) was written for the loss of the Line 151 but none was written for the trip of the breaker and the blown fuse in D09 until NRC inspectors questioned licensee personnel. And finally, the D09 formal operability determination did not address that the D09 AC input breaker, a molded-case circuit breaker, may not have been tested in over 20 years. Other supporting data for the AC breaker, such as the wide vendor acceptance band, was not discussed.

Analysis: The inspectors determined that a performance deficiency existed because the licensee failed to provide an adequate procedure for the restoration of the D-09 safety-related battery charger. The inspectors concluded that the finding was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Disposition Screening," dated June 20, 2003, in that the finding was associated with the procedure quality attribute of the Mitigating Systems cornerstone and affected the associated cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage).

The inspectors completed a significance determination of this issue using IMC 0609, "Significance Determination Process," Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," dated September 10, 2004, and determined that the finding did not involve a design or qualification deficiency, did not represent a loss of safety function, and did not involve an external initiating event; therefore, the finding was considered to be of very low safety significance (Green).

Enforcement: Revision 24 of AOP 0.0 did not provide operators with information necessary to address reasonably-expected charger casualty configurations, including

only the DC breaker tripped or only the AC breaker tripped. This failure was contrary to Criterion V, "Instructions, Procedures, and Drawings," of 10 CFR Part 50, Appendix B, which states, in part, that activities affecting quality (such as restoration of the charger) shall be prescribed by and accomplished in accordance with documented instructions, procedures, or drawings, and that instructions, procedures, or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.

Because of the very low safety significance (Green) of the finding and because the licensee had entered this issue into its corrective action program as CAP062363, the failure of the licensee to provide adequate information in AOP 0.0 is considered an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000266/2005003-04; 05000301/2005003-04).

As an immediate corrective action, the licensee revised AOP 0.0 to include a wider range of possible charger breaker configurations that might be encountered by operators and included additional information on adjusting charger input and DC bus voltages before energizing an isolated charger. This revision was made as part of the corrective actions from Condition Evaluation CE 15364, written, in part, to address the inadequacy of AOP 0.0. In addition, at the end of the inspection period, a detailed Apparent Cause Evaluation was performed which evaluated the overall fault, its impact to the plant and proposed corrective actions.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed selected operability evaluations (OPRs) associated with issues entered into the licensee's corrective action system. The inspectors reviewed design basis information, the FSAR, TS requirements, and licensee procedures to determine the technical adequacy of the operability evaluations. In addition, the inspectors determined if compensatory measures were implemented, as required. The inspectors assessed whether system operability was properly justified and that the system remained available, such that no unrecognized increase in risk occurred. The reviews of the following operability evaluations constituted 10 inspection procedure samples:

- Unit 2 Reactor Coolant Drain Tank Vent Containment Isolation Valve, 2WG-1787 (OPR 119);
- Reactor Coolant Pump Seal Performance and App R Compliance (OPR 117);
- Time to Equalize Primary and Secondary Pressures in Steam Generator Tube Rupture Event (OPR 121);
- Errors Identified in Calculation 93-098 (OPR 115);
- Meteorological System Licensing/Design Basis Apparent Discrepancy (OPR 124);
- Questionable Resistance Readings During Unit 2 Train B 480-Volt Relay Testing (OPR 118);
- Complications with D09 Charger Restoration (OPR 122);
- Review of CAP 014161 For Continued Aging of Governors for Emergency Diesel Generators G-01, G-02, G-03, and G-04 Since Disposition (OPR 112);

- Immediate Operability Evaluation of CAP062397, Dose Rate and Shielding Concern at C-59 Panel; **and**
- **MCCB [Molded-Case Circuit Breaker] Maintenance Not in Accordance With Industry Standards (OPR 113).**

b. Findings

No findings of significance were identified.

1R16 Operator Workarounds (71111.16)

a. Inspection Scope

The inspectors reviewed operator workarounds with particular focus on the method by which instructions and contingency actions were communicated to and reviewed with on-shift licensed operators. Documents reviewed during this inspection are listed in the attachment to this report. This review constituted one inspection sample.

The inspectors completed the sample by reviewing:

- Operator Workaround 0-03R-007MS, which directs the moisture separator reheater inlet steam control valves to be manually opened and closed.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

.1 Selected Post-Maintenance Test Reviews

a. Inspection Scope

During completion of the post-maintenance test inspection procedure samples, the inspectors observed in-plant activities, and reviewed procedures and associated records to determine if:

- Testing activities satisfied the test procedure acceptance criteria;
- Effects of the testing were adequately addressed prior to the commencement of the testing;
- Measuring and test equipment calibration was current;
- Test equipment was within the required range and accuracy;
- Applicable prerequisites described in the test procedures were satisfied;
- Affected systems or components were removed from service in accordance with approved procedures;
- Testing activities were performed in accordance with the test procedures and other applicable procedures;
- Jumpers and lifted leads were controlled and restored where used;
- Test data and results were accurate, complete, and valid;

- Test equipment was removed after testing;
- Equipment was returned to a position or status required to support the operability of the system in accordance with approved procedures; and
- All problems identified during the testing were appropriately entered into the corrective action program.

During this inspection period, the inspectors completed the following inspection procedure samples, which constituted 10 quarterly inspection procedure samples:

- AF-4002, TDAFW Pump Mini Flow Recirculation Valve Operator on February 5, 2005;
- SW Suction to Unit 1 and 2 TDAFW Pumps on February 5, 2005;
- SW Pump P-32E Discharge Check Valve on January 25, 2005;
- Unit 2 Condenser Steam Dump 2MS-2054 and 2053 on January 21, 2005
- Unit 1 RHR, RH-626 Controller, RHR Heat Exchanger Bypass Valve, on March 3, 2005;
- Unit 2 AFW-4007 Mini Flow Recirculation Valve for P-38A Motor-Driven AFW Pump on March 18, 2005;
- D-09 Battery Charger Testing on February 28, 2005;
- DY01 Instrument Inverter Synchronization Testing on February 28, 2005;
- Unit 2 2WG-1787, Reactor Coolant Drain Tank Containment Isolation Valve on January 28, 2005; and
- Strainer F-222 for G-02 Corrective Maintenance WO January 27, 2005.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

During completion of the inspection procedure samples, the inspectors observed in-plant activities and reviewed procedures and associated records to determine if:

- Preconditioning occurred;
- Effects of the testing were adequately addressed by control room personnel or engineers prior to the commencement of the testing;
- Acceptance criteria were clearly stated, demonstrated operational readiness, and were consistent with the system design basis;
- Plant equipment calibration was correct, accurate, properly documented, as-left setpoints were within required ranges, and the calibration frequency was in accordance with TSs, the FSAR, procedures, and applicable commitments;
- Measuring and test equipment calibration was current;
- Test equipment was used within the required range and accuracy;
- Applicable prerequisites described in the test procedures were satisfied;
- Test frequencies met TS requirements to demonstrate operability and reliability;
- Tests were performed in accordance with the test procedures and other applicable procedures;

- Jumpers and lifted leads were controlled and restored where used;
- Test data and results were accurate, complete, within limits, and valid;
- Test equipment was removed after testing;
- Where applicable for in-service testing activities, testing was performed in accordance with the applicable version of Section XI, American Society of Mechanical Engineers Code, and reference values were consistent with the system design basis;
- Where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component declared inoperable;
- Where applicable for safety-related instrument control surveillance tests, reference setting data were accurately incorporated in the test procedure;
- Where applicable, actual conditions encountering high resistance electrical contacts were such that the intended safety function could still be accomplished;
- Prior procedure changes had not provided an opportunity to identify problems encountered during the performance of the surveillance or calibration test;
- Equipment was returned to a position or status required to support the performance of its safety functions; and
- All problems identified during the testing were appropriately documented and dispositioned in the corrective action program.

During this inspection period, the inspectors completed the following inspection procedure samples, which constituted eight quarterly inspection procedure samples:

- 1-TS-ECCS-002, Unit 1 Emergency Core Cooling System Venting on January 14, 2005;
- 2ICP 02.001WH, “Reactor Protection and Engineered Safety Features White Channel Analog 92 day Test”, on January 13, 2005;
- IT 95, “Atmospheric Dump Valves (Quarterly) Unit 2", on January 17, 2005;
- D-09 Battery Charger Full Design Basis Testing on March 11, 2005;
- TS-82; G-02 Diesel Generator Monthly Test on March 13, 2005;
- TS-84; G-04 Diesel Generator Monthly Test on March 18, 2005;
- IT-05; Unit 1 Containment Spray Pump Testing on March 3, 2005; and
- D06 Battery Testing on February 28, 2005.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

.1 Temporary Modifications

a. Inspection Scope

The inspectors conducted in-plant observations of physical changes to the plant and reviewed Temporary Modification 04-013 - Unit 1 Facade Cable Tray Heat Tent. The review included the electrical loading and the areas covered by the tent. The review of the temporary modification constituted one inspection procedure sample.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA4 Cross-Cutting Aspects of Findings

.1 A finding described in Section 1R04.1 of this report had, as the primary cause, a human performance deficiency, in that, the licensee failed to ensure the post-maintenance testing was adequately conducted for the component. Since the AFW piping adjacent to the fitting in question may have been inadvertently moved, the sensitivity to air leaks was not present or brought to other senior personnel when an apparent air noise was heard.

.2 A finding described in Section 1R04.2 of this report had, as the primary cause, a problem identification and resolution deficiency, in that, the licensee failed to take corrective actions for a condition adverse to quality.

4OA3 Event Followup (71153)

.1 (Closed) Licensee Event Report (LER) 50-301/2004-003-00: Reactor Shutdown Required by Containment Penetration TSAC 3.6.3.C.

On November 19, 2004, a pinhole steam leak was discovered inside containment on the body of valve 2MS-465D, the first-off low side root isolation valve for the Unit 2 “A” steam generator steam line flow transmitter. The leak could not be isolated from the main steam line. The affected portion of the main steam line was credited as a closed system boundary for containment penetration P-1, the “A” main steam line penetration. Accordingly, TS Condition 3.6.3.C, which is applicable to penetration flow paths with only one containment isolation valve and a closed system, was entered and Required Action C.1 was initiated, which required isolation within 72 hours. Since the repair of the leak required a shutdown, a reactor shutdown and cooldown were promptly initiated. Unit 2 entered Mode 5 on November 21, 2004 and the valve body leak was repaired. Unit 2 returned to 100 percent power on November 25, 2004.

The cause of the leak was determined to be either a materiel defect in the valve body or an improper weld from original installation, which failed due to cyclic loading. This LER was reviewed by the inspectors and no findings of significance were identified. The licensee documented the forced shutdown in the corrective action program. This LER is considered closed.

4OA6 Meetings

.1 Exit Meeting

On March 30, 2005, the resident inspectors presented the inspection results to Mr. D. Koehl and members of his staff, who acknowledged the findings. The licensee

did not identify any information, provided to or reviewed by the inspectors, as proprietary in nature.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

D. Koehl, Site Vice-President
J. McCarthy, Director of Site Operations
M. Lorek, Plant Manager
J. Shaw, Manager of Reactor Vessel Head Replacement Project
A. Capristo, Regulatory Affairs Manager
N. Stuart, Maintenance Manager
G. Casadonte, Fire Protection Coordinator
G. Corell, Chemistry Manager
J. Schweitzer, Site Engineering Director
R. Milner, Business Planning Manager
G. Packard, Nuclear Oversight Manager/Operations Manager
G. Sherwood, Engineering Programs Manager
B. Cole, Internal Assessment Supervisor
C. Jilek, Maintenance Rule Coordinator
T. Kendall, Engineering Senior Technical Advisor
B. Kopetsky, Security Coordinator
F. Flentje, Senior Regulatory Compliance Engineer
R. Ladd, Fire Protection Engineer
B. Dungan, Operations Manager
M. Ray, Emergency Planning Manager
L. Peterson, Design Engineer Manager
C. Sizemore, Training Manager
R. Davenport, Production Planning Manager
C. Hill, Assistant Operations Manager
P. Smith, Licensed Operator Requalification Training Group Lead
J. Strharsky, Planning and Scheduling Manager
W. Smith, Site Assessment Manager
D. Schuelke, Acting Radiation Protection Manager

Nuclear Regulatory Commission

H. Chernoff, Point Beach Project Manager, NRR
P. Louden, Chief, Reactor Projects, Branch 5

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000301/2005003-01	NCV	Air Leak on AFW Recirculation Flow Control Valve (Section 1R04.1)
05000266/2005003-02 05000301/2005003-02	NCV	Emergency Diesel Generator Fuel Oil Filters in Duplex (Section 1R04.2)
05000266/2005003-03	FIN	Overload and Trip of Nonsafety-Related Bus (Section 1R14.1)
05000266/2005003-04 05000301/2005003-04	NCV	Inadequate Procedure Delays Return of Battery Charger (Section 1R14.2)

Closed

05000301/2005003-01	NCV	Air Leak on AFW Recirculation Flow Control Valve (Section 1R04.1)
05000266/2005003-02 05000301/2005003-02	NCV	Emergency Diesel Generator Fuel Oil Filters in Duplex (Section 1R04.2)
05000266/2005003-03	FIN	Overload and Trip of Nonsafety-Related Bus (Section 1R14.1)
05000266/2005003-04 05000301/2005003-04	NCV	Inadequate Procedure Delays Return of Battery Charger (Section 1R14.2)
05000301/2004-003-00	LER	Reactor Shutdown Required by Containment Penetration TSAC 3.6.3.C (Section 4OA3.1)

Discussed

None.

LIST OF DOCUMENTS REVIEWED

1R01 Adverse Weather

WO 9922317; U1F SW Corner Cable Entrance Drain Freeze Prot CKT; May 5, 2000
PBNP [Point Beach Nuclear Plant Drawing WE FF-E-526; U1 Facade Freeze Protection FF-E-526 Scheme 1FF502 and 1FF506; Revision 1; April 28, 2003
TLB-15 Minor; Waste Holdup Tank ID W 684-J-967 T-19; Revision 4

1R04 Equipment Alignment

CAP061818; Inappropriate Ladder Use Observed; Identified by NRC; February 1, 2005
Tag Series: 0 SW P-32E/SW-32E MM REV0-1; SW-32E; P-32E SW Pump Discharge Check; January 24, 2005
Tag Series: 0 SW P-32E-M EM REV0-1; P-32E-M; SW Pump Motor; January 24, 2005
PB Drawing West 110 & 018 Sh3; Auxiliary Coolant System; Revision 41; July 19, 2004
IT 800; Component Cooling Water System Valves (Biannual); Unit 1; Revision 0
IT 805; Component Cooling Water System Valves (Biannual); Unit 2; Revision 0
1-CL-CC-001; Component Cooling; Unit 1; Revision 10
IT-12; CCW Pumps and Valves; Unit 1; Revision 29; November 1, 2004
PB Drawing West 4998466 SH394B; Elementary Wiring Diagram SW Pump P-032E; Revision 1
CAP062040; G-04, Number 12 Cylinder, Kiene Test Valve, Threads Galled
RMP 9141; Air-Operated Valve Testing and Adjustment; Revision 5; October 13, 2004
CAP057635; AFW Recirculation AOVs Not Set Up in Conformance with Calculations; June 28, 2004
CAP062122; Unplanned TSAC Entry Due to Air Leak on 2P-29 AFWP Mini Recirc Valve; February 16, 2005
Maintenance Rule Evaluation 000336; Unplanned TSAC Entry Due to Air Leak on 2P-29 AFWP Mini Recirc Valve; February 18, 2005
WO 0413878; AF-04002, 2P-29 AFP Mini Recirc Control; July 1, 2004

1R05 Fire Protection

Fire Zone FZ 226, Area A17 and A18, 125-Volt DC Electrical Equipment Room
Fire Zone FZ 305, Area A24, 4160-Volt Vital Switchgear Room
Fire Zone FZ 308 and 309, Area A27 and A28, Diesel Generator G-01 and G-02 Rooms
Fire Zone 316 and 300, Area A01E, Unit 1 Turbine Building 26-Foot General Area and Lube Oil Reservoir;

1R06 Flood Protection Measures

CAP062485; Inappropriate Flooding Design Bases Used for AFW Pump Room Fire Wall (MR 99-034); March 3, 2005
AOP-9A; SW System Malfunction; Revision 20
Drawing —71; PB 31M08400200107; Area 8 Auxiliary Building Sections AA, DD, EE, FF, & HH; Revision 7
Drawing —72; PB 31M08400200206; Area 8 Auxiliary Building Section B-B; Revision 6

NEPB-87-250; Evaluation of SOER 85-5 Internal Flooding of Power Plant Buildings; April 16, 1987
PBNP IPE Section 3.3; Internal Flooding Analysis; 1995
DBD-T-41; Hazards - Internal and External Flooding (Module A); Revision 0
NPC95-00559; Review of Individual Plant Examination Submittal for Internal Events; January 26, 1995
NPC-27204; Flooding Resulting from Non-Category I Failure; February 17, 1975
NPC-36690; Regarding the Potential for Flooding from Postulated Ruptures of Non-Category 1 (Seismic) Systems; November 20, 1975
PBNP FSAR; SW System; August, 2004
Calculation P-91-011; -19' Elevation Flood Time; November 14, 1990
NEPB-85-213; Response to INPO SER 50-84 and Supplement 1 Internal Flooding of Power Plant Buildings; August 6, 1985
PBNP Drawing —333; Wall Penetrations Area 8; Revision 3
PBNP Bech Drawing 10447 P-113 SH 1; SW North and South Supply Header Area 3; Revision 1
CAP061162; Flooding Concerns with AFW Pump Room (Western Portion); February 18, 2005
TLB-15 Minor; Waste Holdup Tank ID W 684-J-967 T-19; Revision 4
Calculation Number 2002-0046; SW Flow From a Break in the CCW HX Room; December 20, 2002
NP 8.4.17; PBNP Flooding Barrier Control; Revision 3

1R07 Heat Sink Performance

PBNP Generic Letter 89-13; Program Document; Revision 4; September 8, 2004
OI 131 Performance Test of 2HX-15D1-D8 Containment Fan Cooler Unit 2

1R11 Licensed Operator Qualifications

LOR 05-01; TRPR 33.0 - Licensed Operator Requalification Training; Revision 0

1R12 Maintenance Effectiveness

Performance Criteria Assessments for 125V Since January 1, 2003
PBF-7029; Documentation of Maintenance Rule Performance Criteria; 125VDC
NP 10.2.4; Work Order Processing; Revision 17
CAP061911; NP 10.2.4 Work Order Processing - Classification of WO Type is Not Clear; February 7, 2005
CA061477; Work Order Type Definition Change Negatively Impacts Maintenance Rule Reviews; February 7, 2005
CAP061728; Work Order Type Definition Change Negatively Impacts Maintenance Rule Reviews; January 27, 2005
Observation Report 2004-004-3-022; Definition of WOs for Maintenance WO Backlog Reduction; February 9, 2005
Work Order by System Since January 1, 2003;125 VDC Electrical and Instrument Air
GL 88-14 "Instrument Air Supply System Problems Affecting Safety-Related Equipment" PBNP responses docketed dated 20 Feb 89, 27 Jul89, 9 Jan 91,3 May 91,8 Jul 91,5 Sep 91

CAP search "instrument air", “air system”
All Open WO on Instrument Air
Maintenance Rule Preventable Functional Failure (MRPFF) for Instrument Air
Maintenance Rule Functional Failure (MRFF) for Instrument Air
Health Reports Instrument Air 2004

1R13 Maintenance Risk Assessment and Emergent Work Evaluation

Report of Work Week Activity Numbers for E12; February 13 - 19, 2005
Report of Work Week Activity Numbers for E06; January 2 - 8, 2005
Report of Work Week Activity Numbers for E09; January 23 - 29, 2005
Report of Work Week Activity Numbers for F04; March 19, 2005

1R14 Personnel Performance Related to Non-Routine Plant Evolutions and Events

CAP062363; Loss of 151 345 KV Line; dated February 27, 2005
CAP062365; Inability to Transfer Instrument 1DY-01 Bus Loads After Line 151 Perturbation; dated February 28, 2005
CAP062393; D-09 Output Fuse Blew During Restart After Bus 151 Loss; dated February 28, 2005
CAP062523; D08 Station Battery Recovery; dated March 4, 2005
CAP062545; D-07, 8, and 9 Are Discovered to be Operated Beyond Design; dated March 6, 2005
CAP062663; NP 5.3.3 (Incident Investigation) Was Not Used; dated March 10, 2005
CAP062771; NP 10.4.3 (Forced Outage Response) Was Not Considered; dated March 15, 2005
CAP063023; Inadequate 10CFR50.59 Screening for AOP 0.0 Temporary Change 2005-0012; dated March 24, 2005
CAP063115; Local Battery Charger Information May Not Be Correct in All Cases; dated March 29, 2005
CAP063117; Documentation of AOP or EOP Usage Could Be Lost; dated March 29, 2005
Operability Recommendation (OPR)000122; Complications With D-09 Charger Restoration; Revisions 0 and 1
OPR000123; D-07, D-08, D-09 Westinghouse Battery Chargers May Not Meet Design Basis; Revision 0
Station Log Entries Report; dated February 27 and 28, 2005
AOP 0.0; Vital DC System Malfunction; Revision 24 and Temporary Change Number 2005-0012
0-SOP-DC-002; 125 VDC System, Bus D-02 & Components; Revision 9
NP 10.4.3; Derate/TSAC or Forced Outage Response; Revision 0
NP 1.1.8; Troubleshooting Process; Revision 1
Operations Manual (OM) 3.7; AOP and EOP Procedures Sets Use and Adherence; Revision 12
RMP 9359-7; DC Station Battery Charger D-07, D-08 and D-09 Maintenance Procedure; Revision 6
Design Basis Document DBD-19; 125 VDC System; Revision 7
Work Order 0500806; Replace Blown Fuse; dated February 27, 2005

Written Statement by a Senior Reactor Operator Related to the Loss of Line 151; dated March 28, 2005
Modifications E-206 and E-207; Upgrade of Power Supplies to Instrument Busses; dated March 2, 1981
Westinghouse Drawing 499B466, Sheet 551; Elementary Wiring Diagram Swing Station Battery Charger Normal Supply D-09; Revision 5

1R15 Operability Evaluations

WO 0413883; AF-04007; P-38A AFP Mini Recirc Control; February 1, 2004
Unit 2 Reactor Coolant Drain Tank Vent Containment Isolation Valve, 2WG-1787
OPR 000117; Reactor Coolant Pump Seal Performance and App R Compliance
OPR 000121; Time to Equalize Primary and Secondary Pressures in Steam Generator Tube Rupture Event
OPR 000115; Errors Identified in Calculation-93-098
OPR 000118; Questionable Resistance Readings During Unit 2 Train B 480Volt Relay Testing
OPR 000122; Complications with D09 Charger Restoration
OPR 000114; Review of CAP014161 For Continued Aging of EGM for G01-4 EDGs Since Disposition
OPR 000113; MCCB Maintenance Not in Accordance with Industry Standards
Schematics/Logics WEST 883D195 Sh 5
CAP062593; Meteorological System Licensing/Design Basis Apparent Discrepancy; March 8, 2005
CAP062873; Clarification Regarding OD/OPR Expectations Needed; March 18, 2005
OPR 000124; Meteorological System Licensing/Design Basis Apparent Discrepancy; March 18, 2005
1RMP 9071-1; A-05 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 15; December 28, 2004
1RMP 9071-2; A-06 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 12; December 28, 2004
2RMP 9071-1; A-05 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 14; December 15, 2004
2RMP 9071-2; A-06 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 13; December 15, 2004
1RMP 9071-1; A-05 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 16; January 28, 2005
1RMP 9071-2; A-06 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 13; January 28, 2005
2RMP 9071-1; A-05 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 15; January 11, 2005
2RMP 9071-2; A-06 4160/480 Degraded and Loss of Voltage Monthly Surveillance; Revision 14; January 11, 2005
CAP062397; Dose Rate and Shielding Concern at C-59 Panel During CSP-Z-1

1R16 Operator Workarounds

Operator Workaround 0-03R-007MS, which directs the moisture separator reheater inlet steam control valves to be manually opened and closed.

1R19 Post-Maintenance Testing

RMP-9359-7; DC Station Battery Charger D07, D08, and D09 Maintenance Procedure; Revision 6; TCN 2005-0011; March 4, 2005
WO 0500825; D-09 Swing Station Battery Charger; March 4, 2005
RMP 9201; Control and Documentation for Troubleshooting and Repair Activities; Revision 2
Drawing 499B466 SH 1633; Aux Safety Instr. Panel (ASIP) Battery Charger Alarms; Revision 10; November 10, 2004
Drawing 499B466 SH 1634; Aux Safety Instr. Panel (ASIP) Battery Charger Alarms; Revision 8; March 29, 2003
Drawing West 499B466; Swing Station Battery Charger Normal Supply; Revision 5; January 8, 2000
Drawing West 499B466 SH 550; Elementary Wiring Diagram D-05 DC Station Battery Charger Supply D-07; Units 1 & 2; Revision 5; May 27, 2000
RMP 9359-8; DC Station Battery Charger D-107, D-108 and D-109 Maintenance Procedure; Revision 5
RMP 9359-7; DC Station Battery Charger D-07, D-08 and D-09 Maintenance Procedure; Revision 6
IT-07F; Unit PBO; P-32 F Service Water Pump (Quarterly); Revision 16; September 9, 2004
WPM 2.PI-GT-SM-RP200; Welding Procedure for Carbon Steels Group P-1 to P-1, GTAW and SMAW, with Required 200E F Preheat, Exempt from Post-Weld Heat Treatment; Revision 0
RMP 9328; SW-32A-F SW Pump Discharge Check Valve Inspection; Revision 6
WCD 0309374; WO Work Plan Addendum 1; P-32E SW Pump Discharge Check; January 25, 2005
WCD 0309374; WO Work Plan; P-32E SW Pump Discharge Check; January 24, 2005
RMP 9201; Control and Documentation for Troubleshooting and Repair Activities; Revision 2
PC 11 Part 3; Condenser Steam Dump Valve Test (Quarterly); Revision 11
WO 0410827; HX-11A/B RHR HX Bypass Flow Hand Control Station; June 22, 2004
IT-07E; Unit PBO; P-32E Service Water Pump (Quarterly); Revision 16
SCR 2005-0053; Instrument Bus Static Inverter Frequency Adjustment Procedure; March 4, 2005
1RMP 9036-9; Unit PB1; Instrument Bus Static Inverter Frequency Adjustment Procedure; Revision 0
WO 0500518; 1P-9 AFP Mini Recirc Control; February 5, 2005
RMP 9141; Air-Operated Valve Testing and Adjustment; Revision 5
1-AF-04002; Troubleshooting Plan; February 2, 2005
WO 0310849; Main Steam Dump to Condenser Dump Control Oper; January 3, 2005
OP 3D; Post Reactor Trip Stabilization to Hot Standby; Attachment A Status Verification; Revision 1
TS 3; Main Turbine Stop and Governor Valves with Turbine Trip Test (Quarterly); Unit 1; Revision 40
OP 1C Startup to Power Operation; Unit 1; Revision 4
OP 3A; Power Operation to Hot Standby; Revision 69
RMP 9138-5; Condenser Steam Dump Valve Maintenance; Revision 3
RMP 9138-5; Condenser Steam Dump Valve Maintenance; Revision 4

CAP061973; Stroke Time Performance of 2WG-1787 Was Not as Expected; February 9, 2005
WO 0500455; T-16 RCDT Vent Operator; January 25, 2005
CAP061762; Diagnostic Testing of 2WG-01787 Shows Signs of Possible Degradation; January 28, 2005
OPR000119 (Rev. 0); Diagnostic Testing of 2WG-01787, T-16 RCDT Vent Valve, Shows Signs of Possible Degradation; February 1, 2005
Troubleshoot Plan 1-AF-04002; February 1, 2005
WO 0413879; 1P-29 AFP Mini Recirc Control; February 1, 2005
RMP 9141; Air-OPERATED Valve Testing and Adjustment; Revision 5
CMP 2.5.2.1; Setup Parameters for Category 1 Air Operated Valves; Revision 3; February 3, 2005
Analysis of AF-04014 Diagnostic Testing; February 3, 2005
RMP 9043-27; Emergency Diesel Generator G-02 Maintenance Run and Post-Maintenance Testing; Revision 4; October 17, 2001

1R22 Surveillance Testing

RMP 9046-1; Station Battery 92 Day 12 Month Surveillance Tests; Revision 39
TS 84; Unit PBO; Emergency Diesel Generator G-04 Monthly; Revision 18;
CAP062373; Complications with D-09 Station Battery Charger Restoration; February 28, 2005
IT 05; Containment Spray Pumps and Valves (Quarterly); Revision 47
2ICP 02.001WH; Reactor Protection and Engineered Safety Features White Channel Analog 92 day test; Revision 6, dated Aug 28,2003
CAP061497; Limit Switch Operation in Cold Weather; January 15, 2005
ASME OM Code-1995; Table ISTC 3.6-1; Inservice Test Requirements; ISTC 4 Testing Methods
IT 95; Atmospheric Steam Dump Valves (Quarterly) Unit 2; March 6, 2003

1R23 Temporary Plant Modifications

10 CFR 50.59/72.48 Pre-screening Review; TMod 04-013 - Unit 1 Facade Cable Tray Heat Tent; October 6, 2004
Temporary Modification Extension; TMod 04-013; Unit 1 Facade Cable Tray Heating Tent
Configuration Change Process Screening; TMod 04-013; Unit 1 Facade Cable Tray Heating Tent; August 20, 2004
Temporary Modification Initiation; TMod 04-013; Unit 1 Facade Cable Tray Heating Tent; October 8, 2004
Part B - Design Considerations, Requirements, and Standards; TMod 04-013; October 5, 2004
Part A - Engineering Programs and Departmental Reviews; TMod 04-013; October 5, 2004
PBNP Site Specific Design Input Checklist; TMod 04-013; Unit 1 Facade Cable Tray Heating Tent; October 5, 2004

Condition Reports Initiated for NRC Identified Issues

CAP061274; NRC Request for Additional Information - License Renewal; January 3, 2005
CAP061297; NRC Issues License Amendments 215 and 220; January 4, 2005
CAP061319; Training Materials not Evaluated During the Conduct of CE 014877; January 5, 2005
CAP061340; FSAR Section 11.8.1 and 11.8.2 Descriptions of Radioactive Material Safety Program; January 6, 2005
CAP061454; NRC Request for Additional Information - License Renewal; January 13, 2005
CAP061471; NRC Issues Errata Correction to Unit 1 License; January 13, 2005
CAP061491; Quality of Documentation and Tracking to Address Electrical Penetration 2Q-03; January 14, 2005
CAP061518; NRC Request for Additional Information for AMP B3.3; January 17, 2005
CAP061562; Investigation of a Report of Leakage from 1MS-2015 Air Regulator; January 19, 2005
CAP061595; EDG FO Duplex Strainer Operation; January 20, 2005
CAP061597; Issue with Access and Platform Ladder Safety Chains Identified; January 20, 2005
CAP061598; Additional Platform Swing Gates or Safety Chains Needed Unit 1 Facade; January 20, 2005
CAP061616; NRC Observation of the Performance of 2ICP 02.001WH; January 21, 2005
CAP061646; Deviation from Literal Compliance with Flooding Licensing Basis; January 24, 2005
CAP061678; NRC Request to Confirm Information from Conference Call - License Renewal; January 25, 2005
CAP061692; NRC Raises Question on PBNP's Methodology for IST Valve Position Indication Test; January 26, 2005
CAP061703; Appropriateness of Pre-staged P-tubing Being Challenged; January 26, 2005
CAP061767; DBD-01 (AFW System) Appears to be Deficient with Respect to TDAFWP Operation; January 28, 2005
CAP061781; Postulated Debris in Fire Water May Challenge TDAFP Operability; January 31, 2005
CAP061788; Foreign Obligations Incurred with New RV Head and CRDMs; January 31, 2005
CAP061792; Safety Swing Gates Needed on Two Working Platforms; January 31, 2005
CAP061799; Scaffold Up After Expected Removal Date; February 1, 2005
CAP061818; Inappropriate Ladder Use Observed; February 1, 2005
CAP061839; NRC Request for Additional Information License Renewal; February 2, 2005
CAP061866; Process for Rebaselining Acceptance Criteria Following Maintenance Not Clearly Documented; February 4, 2005
CAP061892; Temp Storage Permit Not Completed as Required; February 4, 2005
CAP061912; 2P10B Not Shown Unavailable in Schedule or Safety Monitor; February 7, 2005
CAP061938; Near Miss on AF-4016; February 8, 2005

CAP062076; NRC Issues License Amendments 216 and 221; February 15, 2005
CAP062097; Facade Freeze - Annual Temporary Modification; February 15, 2005
CAP062098; Design Input Checklists Do Not Prompt Evaluation of EP Attributes; February 15, 2005
CAP062100; Evaluation Needed of BRE's into NEI 99-01 EALs; February 16, 2005
CAP062101; NRC Bulletin 2005-01 Requires 30 and 90 Day Responses; February 16, 2005
CAP062103; NRC Requests Supplemental Information for Steam Generator Report; February 16, 2005
CAP062122; Unplanned TSAC Entry Due to Air Leak on 2P-29 AFWP Mini Recirculation Valve; February 16, 2005
CAP062129; Scaffolds Up After Expected Removal Dates; February 17, 2005
CAP062137; Flooding Analysis Concern Regarding Area East of Tunnel Between Turbine Bldg's; January 17, 2005
CAP062139; Does SEI-06213 Installation Need to Consider Flooding Effects; January 17, 2005
CAP062146; Uncontrolled Material in Plant to Support Recurrent Testing; February 18, 2005
CAP062162; Flooding Concerns with AFW Pump Room (Western Portion); February 18, 2005
CAP062169; Work Order Backlog - Ensure No MR Functional Failures Classified Incorrectly; February 18, 2005
CAP062172; Operable But Non-Conforming or Degraded WOs Classification in Question; February 18, 2005
CAP062186; Description of Required Operator action in FSAR Not Supported; February 21, 2005
CAP062293; Evaluation of DB Flooding Issues Need to be Considered for EAL RAI Response; February 24, 2005
CAP062385; Safety Monitor Risk from Recent Loss of Line 151; February 28, 2005
CAP062430; Unit 2 Turbine Hall Zurn Strainer Leakage; March 1, 2005
CAP062485; Inappropriate Flooding Design Bases Used for AFW Pump Room Fire Wall (MR 99-034); March 3, 2005
CAP062454; CAP Inappropriately Screened; March 2005
CAP062518; Use of Operational Decision Making Process for 345KV Line 111 Outage; March 4, 2005
CAP062548; Apparent Lack of Commercial Dedication Evaluation for Installed Plant Equipment; March 7, 2005
CAP062552; Temporary Storage Permit; March 7, 2005
CAP062560; CAL Commitment - NRC Review Comments on OR-08-016.5; March 7, 2005
CAP062562; FSAR Description of Containment Spray System Operation Contains Errors; March 7, 2005
CAP062624; Certain Sub-Steps in EOP 1.3/1.4 Are No Longer Necessary; March 9, 2005
CAP062631; Operability Determination Procedure May Not Incorporate Current Guidance; March 9, 2005
CAP062637; Limit Switch Operation in Cold Weather; March 10, 2005
CAP062663; NP 5.3.3 (Incident Investigation) Was Not Used; March 10, 2005
CAP062682; Tygon Tubing Identified on Monitor Tanks Loop Seal; March 11, 2005

CAP062716; Posting Configuration for Spare RCP Motor in Turbine Hall; March 14, 2005
CAP062762; NRC Resident Questioned Low Containment Pressure Guidance; March 15, 2005
CAP062763; Enhancement Opportunities Identified with Security Vehicle Barrier Calculation; March 15, 2005
CAP062768; Potential Industrial Safety Issue in Old WCC Concerning Saw Usage; March 15, 2005
CAP062771; NP 10.4.3 (Force Outage Response) Was Not Considered; March 15, 2005
CAP062789; Heat Lamps are Attached to Valve Handwheels; March 16, 2005
CAP062802; Enhancement Opportunity Identified with Key Control for AVBS; March 16, 2005
CAP062805; Security Procedure Update Enhancement; March 16, 2005
CAP062806; Potential Security Drill/Training Enhancements; March 16, 2005
CAP062830; Revision of PBNP PAB Structural Capacity Calculation; March 17, 2005
CAP062841; Psychologist License Expiration Date Not on Results Letters; March 17, 2005
CAP062958; Water Seeping Through Ceiling in DG Building Above 2A06 Switchgear; March 22, 2005
CAP063000; NRC Identified Issue During License Renewal Walkdown; March 23, 2005
CAP063012; NRC Resident Identified Issue with Instrument Operator Aid Awareness; March 24, 2005
CAP063023; Inadequate 10 CFR 50.59 Screening for AOP 0.0 Temporary Change 2005-0012; March 24, 2005
CAP063032; CL-1E Not Updated for U2R27; March 24, 2005
CAP063054; RCE 251 CATPR#2 Actions May Not Have Been Effective; March 26, 2005
CAP063057; Regulatory Analysis of NRC Inspection Report IR 2004-011; March 26, 2005
CAP063059; Replacement of SW Valves; March 26, 2005
CAP063078; Evaluate FAC Program Engineering Analysis Criterion for Non-Safety Related Pipe; March 28, 2005
CAP063088; KNPP NRC Resident Questions Regarding U2R27 Shutdown Safety; March 28, 2005
CAP063118; Potential Noncompliance with WO Procedure Requirements (NP 10.2.4); March 29, 2005
CAP063183; NRC Questions Regarding Parametric Values; March 31, 2005
CAP063187; NRC Questioning Adequacy/Timeliness of Corrective Actions; March 31, 2005
CAP063242; U2 Sump B Level Alarms Questioned; April 2, 2005
CAP063245; Work Cart Near Sample Lines; April 2, 2005

LIST OF ACRONYMS USED

AC	Alternating Current
AFW	Auxiliary Feedwater
AO	Auxiliary Operator
AOP	Abnormal Operating Procedure
CAP	Corrective Action Program Document
CE	Condition Evaluation
CCW	Component Cooling Water
CFR	Code of Federal Regulations
DC	Direct Current
DBD	Design Basis Document
FSAR	Final Safety Analysis Report
IMC	Inspection Manual Chapter
LER	Licensee Event Report
MCC	Motor Control Center
MRE	Maintenance Rule Evaluation
NCV	Non-Cited Violation
NP	Nuclear Plant Procedures Manual Procedure
NRC	Nuclear Regulatory Commission
PBNP	Point Beach Nuclear Plant
OPR	Operability Evaluation
RHR	Residual Heat Removal
RMP	Routine Maintenance Procedure
SDP	Significance Determination Process
SOP	System Operating Procedure
SW	Service Water
TDAFW	Turbine-Driven Auxiliary Feedwater
TSAC	Technical Specification Action Condition
TS	Technical Specification
WO	Work Order