

July 20, 2006

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 REPORTS 05000266/2006004;
05000301/2006004; 05000266/2006009; 05000301/2006009

Dear Mr. Koehl:

On June 30, 2006, the U.S. Nuclear Regulatory Commission (NRC) completed an integrated inspection at your Point Beach Nuclear Plant, Units 1 and 2. The enclosed inspection report documents the inspection results, which were discussed on June 27, 2006, 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, five findings of very low safety significance were identified. Four of these findings were determined to involve violations of NRC requirements. However, because of the very low safety significance and because they are entered into your corrective action program, the NRC is treating these four findings as non-cited violations (NCVs) consistent with Section VI.A.1 of the NRC Enforcement Policy. If you contest any NCV in this report, 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 copies 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 at the Point Beach Nuclear Plant.

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 2, 2006. 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. 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.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) 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), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Mark A. Satorius, Director
Division of Reactor Projects

Docket Nos. 50-266; 50-301; 72-005
License Nos. DPR-24; DPR-27

Enclosure: Inspection Reports 05000266/2006004; 05000301/2006004;
05000266/2006009; 05000301/2006009
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-266; 50-301; 72-005

License Nos: DPR-24; DPR-27

Report No: 05000266/2006004; 05000301/2006004 and
05000266/2006009; 05000301/2006009

Licensee: Nuclear Management Company, LLC

Facility: Point Beach Nuclear Plant, Units 1 and 2

Location: Two Rivers, Wisconsin

Dates: April 1, 2006, through June 30, 2006

Inspectors: R. Krsek, Senior Resident Inspector
G. Gibbs, Resident Inspector
L. Haeg, Reactor Engineer
M. Kunowski, Project Engineer
B. Jose, Reactor Engineer
J. Robbins, Reactor Engineer
R. Winter, Reactor Engineer
M. Gryglak, Reactor Inspector
S. Bakhsh, Health Physicist
J. Neurauter, Senior Reactor Engineer
T. Ploski, Senior Emergency Preparedness Inspector

Approved by: P. Loudon, Chief
Projects Branch 5
Division of Reactor Projects

Enclosure

SUMMARY OF FINDINGS

IR 05000266/2006004, 05000301/2006004 and IR 05000266/2006009, 05000301/2006009; 04/01/2006 - 06/30/2006; Point Beach Nuclear Plant, Units 1 and 2; Adverse Weather, Operability Evaluations, Surveillance, Problem Identification and Resolution, and Other.

This report covers a 3-month period of inspection by resident inspectors and announced inspections by regional specialists. The emergency preparedness portion of this inspection is being tracked using Inspection Report (IR) No. 05000266/2006009; 05000301/2006009. The baseline inspection for the emergency preparedness portion was conducted by a regional emergency preparedness inspector. The baseline inspection for the Independent Spent Fuel Storage Installation activities were conducted by regional specialists. A Green finding and four Green findings with associated non-cited violations were identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the 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-Revealed Findings

Cornerstone: Initiating Events

- Green. A finding of very low safety significance was identified by the inspectors for failure to control loose materials in the protected area in the vicinity of the main and auxiliary transformers. No violation of NRC requirements occurred. Failure to take action to remove loose material in the protected area has problem identification and resolution cross-cutting aspects involving failure of assigned personnel to identify and correct potential tornado missiles that could be generated from such loose material in the vicinity of the main and auxiliary transformers. Once identified, the licensee initiated a corrective action program document to develop a surveillance procedure to remove loose materials before summer months when potential adverse weather was possible, performed walkdowns of the affected areas, and removed material which could become a potential hazard in high velocity winds and tornadoes.

The inspectors determined that the finding is more than minor because, if left uncorrected, the loose items adjacent to the main and auxiliary transformers would become a more significant safety concern. The issue is of very low safety significance because the finding did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator; the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available; and the finding did not increase the likelihood of a fire or internal or external flooding. The issue is not considered a violation of regulatory requirements because the finding did not affect safety-related structures, systems, or components. (Section 1R01.1)

Cornerstone: Mitigating Systems

- Green. The inspectors identified a Severity Level IV, Non-Cited Violation of 10 CFR 50.59(d)(1) for the licensee's failure to perform an evaluation for compensatory actions taken to maintain the closed function of the emergency core cooling system (ECCS) containment sump isolation valves. Specifically, the licensee established compensatory actions in the event remote operation from the control room of the containment sump recirculation isolation valves (1SI-850A, 1SI-850B, 2SI-850A and 2SI-850B) was ineffective during plant minimum or degraded voltage conditions. The licensee had not completed a causal evaluation by the end of the inspection period; however, the remedial corrective actions to address certain aspects of this issue had been implemented.

Because violations of 10 CFR 50.59 affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because there was a reasonable likelihood that the change requiring the 10 CFR 50.59 evaluation would require NRC review and approval prior to implementation. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance. (Section 1R15.1)

- Green. The inspectors identified a Non-Cited Violation of Technical Specification 5.4.1 for the failure to have adequately established, implemented, and maintained procedures for testing of the control room emergency filtration system. The inspectors observed the performance of the 18-month surveillance for testing of the control room emergency filtration system, per procedure HPIP-11.54. The inspectors noted that the visual inspection, charcoal sampling, collection of the fan flow data, and the compilation/evaluation of fan flow measurement data were conducted but not as specified in the procedure.

The inspectors also determined that a primary cause of this finding was related to the cross-cutting area of problem identification and resolution. The last performance of this test, conducted 18 months prior, revealed numerous performance deficiencies, which included an inadequate procedure and the failure to properly implement portions of the procedure. However, the corrective actions taken for the deficiencies identified during the last performance failed to correct the procedure maintenance and implementation issues associated with procedure HPIP-11.54. The licensee had not completed a causal evaluation by the end of the inspection period; however, the licensee had implemented remedial corrective actions to address certain aspects of this issue.

The inspectors concluded that the finding is greater than minor because it is associated with the procedure quality attribute for maintenance and testing (pre-event) procedures of the Mitigating Systems Cornerstone and affected the cornerstone objective to ensure the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The

inspectors evaluated this finding using the significance determination process and determined that this finding is a licensee performance deficiency of very low risk significance (Green). (Section 1R22.1)

- Green. The inspectors identified a Severity Level IV, Non-Cited Violation of 10 CFR 50.71(e) for the self-revealed failure to update the Final Safety Analysis Report (FSAR) to assure that the information in the report was the latest information developed and contained all changes necessary to reflect information and analyses submitted to the NRC. This finding was self-revealed following the inspectors' identification of numerous FSAR inaccuracies concerning licensee responses to generic docketed correspondence to the commission. This was further corroborated by a follow-up licensee self-assessment and streaming analysis. As a result, the licensee initiated a root cause evaluation which also identified the failure to update the FSAR in response to licensee credited actions, new NRC regulations, programmatic licensee commitments, and certain license amendment safety evaluation reports.

The inspectors determined that a primary cause of the finding was related to the cross-cutting element of human performance due to the failure to have processes and procedures to maintain the current licensing basis and a lack of knowledge by plant staff of regulatory requirements. The licensee has taken immediate remedial corrective actions to address several issues, including the development of a site policy and procedures that defined the current licensing basis. In addition, the licensee has planned comprehensive corrective actions, including a detailed project scope to update the FSAR.

Because violations of 10 CFR 50.71(e) affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because a failure to update the FSAR could have had a material impact on safety or licensed activities. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance. (Section 4OA2.1)

Cornerstone: Other

- Green. The inspectors identified a Severity Level IV, Non-Cited Violation of 10 CFR 50.59(d)(1) for failure to perform a written evaluation of increased design loads on a crane and the auxiliary building. The licensee performed a calculation to demonstrate the capability of the auxiliary building to hold a single-failure-proof crane with a 125-ton load during a seismic event. After the inspectors identified that no written evaluation had been performed, the licensee completed the evaluation and concluded that a license amendment was not required as a result of increased design loads.

Because violations of 10 CFR 50.59 affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because there was a reasonable likelihood

that the change requiring the 10 CFR 50.59 evaluation would require NRC review and approval prior to implementation. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance. (Section 4OA5.2b.1)

B. Licensee-Identified Violations

A violation of very low significance, which was identified by the licensee, has been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. This violation and the licensee's corrective actions are listed in Section 4OA7 of this report.

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. On May 27, 2006, in addition to secondary system valve testing, Unit 1 power was reduced to 50 percent to clean the condensate cooler and the steam generator main feed pump lube oil coolers.

Unit 2 was at 100 percent power throughout the inspection period with the exception of brief downpowers during routine auxiliary feedwater and secondary system valve testing. On June 4, 2006, in addition to secondary system valve testing, Unit 2 power was reduced to 50 percent to facilitate an emergent preventive maintenance activity on a switchyard breaker.

3. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R01 Adverse Weather Protection (71111.01)

.1 Inadequate Licensee Preparations for High Wind Conditions

a. Inspection Scope

The inspectors reviewed the facility's design and the licensee's procedure to verify that structures, systems, and components would remain functional when challenged by the adverse weather conditions, specifically high velocity winds and tornadoes. The inspectors walked down selected plant areas to ensure that licensee actions maintained the readiness of essential systems and that the equipment would be maintained during these adverse weather conditions. Additionally, the inspectors verified proper implementation of the licensee's preparatory procedure.

The inspectors evaluated readiness for susceptibility to adverse weather conditions for the following areas for a total of one weather-related inspection sample:

- Main transformer bays;
- Protected area west of the main transformer bays and east of the auxiliary transformers;
- Protected area east of turbine building; and
- Switchyard.

b. Findings

Introduction: The inspectors identified a Green finding for the licensee's failure to control materials in the protected area and in the vicinity of the Unit 2 main transformer 2X02 and the auxiliary transformers 1X04 and 2X04. The inspectors identified loose

materials adjacent to these areas which could become potential missiles in high velocity winds or tornadoes. No violation of regulatory requirements occurred. The cause of the finding was related to the cross cutting element of problem identification and resolution.

Description: On April 12, 2006, the inspectors conducted a walkdown of the risk significant portions of the main and auxiliary power system to assess the licensee's preparations to preclude or minimize potential damage from high velocity winds associated with severe thunderstorms or tornadoes. During the walkdown of the main and auxiliary transformers, the inspectors noted the storage of a significant quantity of conduit, metal stakes, several wood pallets, empty cable reels, 50-gallon drums and piping, and other metallic material within the vicinity of the subject transformers. The inspectors concluded that high velocity winds or tornadoes combined with the close proximity of the transformers to the large quantity of stored materials increased the potential to damage the transformers or related electrical equipment. This issue was discussed with the licensee. The licensee entered the issue into the corrective action program as Action Request AR01023807. The licensee took immediate action to not only clean the areas identified by the inspectors, but also commenced a general cleaning of outside areas within the protected area to address any possible extent of condition.

The inspectors reviewed Nuclear Procedure (NP) 1.9.6, "Plant Cleanliness and Storage," for actions associated with preparations to preclude or minimize damage from high velocity winds or tornadoes. While the procedure identified that the main transformer for each unit and station switchyard were assigned zones for plant personnel to walk-down, the zone inspection form and procedure did not contain any guidance on specific attributes to look for or proactive elements which required the licensee to minimize the number of missile hazards prior to the onset of seasonal high velocity winds or tornadoes.

The inspectors concluded the licensee did not implement NP 1.9.6, "Plant Cleanliness and Storage," or industry experience by performing effective walkdowns of affected areas, even though the licensee had identified applicable Operating Experience in February 2006 and was evaluating potential procedure changes to NP 1.9.6, "Plant Cleanliness and Storage." Specifically, no prompt corrective action was taken with respect to ensuring that the objectives of the planned procedure changes to preclude or minimize potential damage from high velocity winds associated with severe thunderstorms or tornadoes were implemented prior to the onset of high velocity wind and tornado season.

Analysis: The inspectors reviewed this finding using the guidance contained in Appendix B, "Issue Disposition Screening," of IMC 0612, "Power Reactor Inspection Reports." The inspectors determined that the failure of licensee personnel to control material near risk significant equipment or to appropriately implement Procedure NP 1.9.6, "Plant Cleanliness and Storage," is a performance deficiency which affected the Initiating Events Cornerstone. The inspectors determined that the finding is more than minor because, if left uncorrected, the loose items adjacent to the main and auxiliary transformers could become a more significant safety concern. The inspectors determined that the finding warranted evaluation using the SDP because the finding is associated with an increase in the likelihood of an initiating event.

The inspectors evaluated the finding using IMC 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At-Power Situations." Using the Phase 1 SDP worksheet for the Initiating Event Cornerstone, transient initiator contributor, the inspectors determined that the finding did not contribute to the likelihood of a primary or secondary system loss of coolant accident initiator; the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available; and the finding did not increase the likelihood of a fire or internal or external flooding. Therefore, the finding is determined to be of very low safety significance (Green).

The inspectors also determined that a primary cause of this finding is related to the cross-cutting area of problem identification and resolution. The inspectors determined the licensee had sufficient time and opportunity to have previously identified and corrected the deficiencies in the protected area prior to the onset of the seasonal conditions. Specifically, in February 2006, as a result of operating experience shared with the licensee, AR00908550, "Potential Areas for Improvement in Tornado Missile Inspection," was entered into the corrective action program and identified the shortcomings of NP 1.9.6. Therefore, the failure to take prompt corrective action to remove loose material in the protected area has problem identification and resolution cross-cutting aspects which involved the failure of assigned personnel to identify and promptly correct potential tornado missiles that could be generated from such loose material in the vicinity of the main and auxiliary transformers.

Enforcement: The failure to establish and implement an adequate procedure for housekeeping standards to protect risk significant equipment from high velocity winds was not an activity affecting quality subject to 10 CFR Part 50, Appendix B, nor a procedure required by license conditions or Technical Specifications (TSs). Therefore, while a performance deficiency existed, no violation of regulatory requirements occurred. This is considered a finding of very low safety significance (FIN 0500266/2006004-01; 05000301/2006004-01).

The licensee included this finding in its corrective action program as AR01023807. Planned corrective actions included development of a routine surveillance procedure for a site tornado hazard inspection, as well as identifying areas of concern and items that could be classified as missiles, and conduct of monthly yard inspections for loose material that could become potential tornado missiles.

.2 Review of Licensee System Preparations for Onset of Warm Weather

a. Inspection Scope

The inspectors reviewed the facility design and licensee procedures to evaluate the plant's likely response to summertime hot weather conditions such as lake grass intrusion and high room temperatures for rooms housing safety-related equipment. The inspectors walked down accessible portions of risk-significant equipment and systems susceptible to hot weather and verified that the trash racks and traveling water screens were free from lake grass and other debris which might prevent adequate cooling of plant equipment. The inspectors reviewed the corrective actions and work orders (WOs) written to correct identified problems and assessed whether completion dates

ensured that corrective maintenance was completed prior to the onset of hot weather. For those issues where corrective actions were not completed prior to the onset of hot weather, the inspectors reviewed the impact on equipment operability due to the identified hot weather issue. These observations constituted one system-related inspection procedure sample.

b. Findings

No findings of significance were identified.

1R04 Equipment Alignment (71111.04)

.1 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 whether or not deficiencies existed. 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 system. Partial system walkdowns of the following systems for both units constituted three inspection procedure samples:

- Motor-Driven Auxiliary Feedwater Pump P-38B;
- 480-Volt (V) Alternating Current (AC) Safeguards Busses and 125-V Direct Current (DC) Safeguards Busses; and
- Service Water Trains A, B, and C.

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 ten inspection procedure samples:

- Fire Zone FZ-225/Fire Area A16; Battery Room - D106;
- Fire Zone FZ-228/Fire Area A19; Battery Room - D105;
- Fire Zone FZ-153/Fire Area A04; Charging Pump Room - 1P2B;
- Fire Zone FZ-164/Fire Area A13; Charging Pump Room - 2P2B;
- Fire Zones FZ-333-336/Fire Area A32; North Office in Computer Room, South Office in Computer Room, Computer Room, and Instrument Rack Room;
- Fire Zones FZ-550-555/Fire Area A38; Circulating Water and Service Water Pumphouse;
- Fire Zone FZ-337/Fire Area A33; Control Room Heating, Ventilation, and Air Conditioning Equipment Room;
- Fire Area A01-A; Auxiliary Building, 8-foot Elevation and Below;
- Fire Area A01-CN; Auxiliary Building, 26-foot Elevation, North Wing; and
- Fire Area A01-CS; Auxiliary Building, 26-foot Elevation, South Wing.

b. Findings

No findings of significance were identified.

1R06 Flood Protection Measures - External Floods (71111.06)

a. Inspection Scope

The inspectors completed a walkdown of the 8 foot elevation of the turbine building and the greenhouse to assess the overall readiness of flood protection equipment and barriers for protection against external floods. 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 and risk analyses to evaluate the affects of external flooding on these areas. This walkdown of the flood protection measures constituted one inspection procedure sample for external floods.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Regualification (71111.11)

.1 Resident Inspector Quarterly Observation of Licensed Operator Regualification

a. Inspection Scope

On June 19, 2006, the inspectors observed the 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 NP 2.1.1, "Conduct of Operations."

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 corrective action program (CAP) documents 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:

- Unit 1 and Unit 2, 480-VAC System;
- Unit 1 and Unit 2, Common Control Room Ventilation System; and
- Gas Turbine G05.

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 planned and emergent maintenance activities during the specified work weeks. 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. The inspectors also verified 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 eight inspection procedure samples:

- Planned and emergent maintenance during the week of April 24, 2006;
- Planned and emergent maintenance during the week of May 1, 2006;
- Planned and emergent maintenance during the week of May 8, 2006;
- Planned and emergent maintenance during the week of May 15, 2006;
- Planned and emergent maintenance during the week of May 22, 2006;
- Planned and emergent maintenance during the week of May 29, 2006;
- Planned and emergent maintenance during the week of June 12, 2006; and
- Planned and emergent maintenance during the week of June 19, 2006.

b. Findings

No findings of significance were identified.

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

.1 Unanticipated Entry into Technical Specification 3.7.9, Control Room Emergency Filtration

a. Inspection Scope

On May 30, 2006, control room operators received analyses that the Control Room Emergency Filtration System was inoperable due to a failed 18-month charcoal adsorber test. Upon replacement of the charcoal filter bank, the licensee was unable to meet the required filter efficiency acceptance criteria. Subsequently, plant operations staff, in conjunction with engineering personnel entered the site troubleshooting procedure.

The inspectors evaluated the licensee's operational decision-making involved with this non-routine evolution. In addition, the inspectors evaluated the operators' and engineers' communications during the evolution, and the licensee staff's application and adherence to the operating procedures. The licensee restored the filtration system to operable status on June 3, 2006. This inspection constituted one annual inspection sample.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

.1 Failure to Perform a 10 CFR 50.59 Evaluation of Compensatory Actions

a. Inspection Scope

The inspectors reviewed selected operability recommendations (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. Review of OPR000179, Revision 1, "SI-850 Solenoid Valves Fail Minimum Voltage Criteria in Calculation 2005-008 (CAP071048)," constituted one inspection procedure sample.

b. Findings

Introduction: The inspectors identified a Severity Level IV, Non-Cited Violation (NCV) of very low safety significance for the licensee failing to perform a written evaluation in accordance with 10 CFR 50.59(d)(1) of compensatory actions established in the event remote operation from the control room of the containment sump recirculation isolation valves (1SI-850A, 1SI-850B, 2SI-850A and 2SI-850B) was ineffective when plant voltage was minimum or degraded.

Description: On March 16, 2006, the licensee issued CAP071048, which identified that Calculation 2005-0008, "Minimum Voltage Requirements for Safety Related MCC [Motor Control Center] Control Circuits," performed as part of the Calculation Upgrade Project, revealed that solenoid valves within the control circuits for the containment sump isolation valves (1SI-850A, 1SI-850B, 2SI-850A and 2SI-850B) would not have sufficient voltage to operate under minimum or degraded voltage conditions and failed the acceptance criteria within the calculation. Specifically, the minimum 480-Volt (V) MCC voltage needed to operate the solenoids ranged from 450 V to 460 V to satisfy the 120-V control circuits minimum voltage requirements. At the degraded voltage grid conditions, the minimum 480-V MCC voltage that would be available ranged from 422 V to 427 V. The solenoid valve was required to operate to ensure the containment sump isolation valves were capable of opening and closing to allow for containment recirculation mode of operation or to isolate a leak. The valves might not open or close from the control room under minimum or degraded voltage conditions.

Compensatory measures were necessary to maintain operability of the subject valves. These measures included locally closing the appropriate containment sump "B" isolation valves and actions to restore 480-V safeguards switchgear voltage to an acceptable range, such as: removing non-essential loads or shifting loads from the designated 480-V safeguards switchgear or 480-V safeguards MCC, contacting the grid operator (American Transmission Company) to increase the 345-kiloVolt (kV) system voltage until 480-V safeguards switchgear recovered to greater than 460 V, or manually separating from the offsite power source and connecting the associated emergency diesel generator to the safeguards bus.

During a review of an operability recommendation (OPR 179) for maintaining the closed function of the containment sump isolation valves, the inspectors requested a copy of the safety evaluation for the specified compensatory actions. The inspectors were informed that an evaluation had not been performed because the actions resided in existing plant procedures.

Additionally, during an extent-of-condition review, the inspectors also identified that a similar situation occurred for OPR 154. Operability recommendation OPR 154 was written to address the potential for spurious tripping on over-current, under the minimum voltage that could be expected to occur for limiting degraded voltage conditions, for some Unit 1 and Unit 2, Train A and Train B safeguards 480-VAC switchgear. Compensatory measures were put in place to secure discretionary loads within the limits permitted by Technical Specifications. By limiting the number of loads, the trip settings of the various feeder breakers were not approached. The licensee prepared a matrix and flow and logic charts of acceptable load configurations for the subject buses. However, no 10 CFR 50.59 evaluation was performed for these compensatory measures until a formal procedure was written several months later incorporating the loading requirements. Equipment changes to address the issue were planned as long-term corrective actions.

The inspectors noted that guidance contained in Section 4.4 of Nuclear Energy Institute (NEI) Standard 96-07, "Guidelines for 10 CFR 50.59 Evaluations," Revision 1, which the NRC endorsed in Regulatory Guide 1.187, "Guidance for Implementation of 10 CFR 50.59, Changes, Tests, and Experiments," stated, in part, that if interim

compensatory actions are taken to address a degraded or non-conforming condition, 10 CFR 50.59 is applied to determine whether the compensatory actions impact aspects of the facility described in the FSAR. The inspectors further noted that the licensee's procedure, NP 5.3.7 "Operability Determination," required that "the procedure being relied upon must reference the Operability Recommendation and/or corrective action to correct the condition crediting the operator action." The procedure also stated that "... all compensatory measures implemented as procedure changes or temporary modifications as a result of an operability recommendation SHALL be reviewed in accordance with 10 CFR 50.59." The licensee subsequently issued AR01019916 to document that the subject procedures were not revised to reference the OPR and no 10 CFR 50.59 screening or evaluation were performed.

Analysis: The inspectors determined that the licensee's failure to perform a 10 CFR 50.59 evaluation for the compensatory measures of OPR 179 is a licensee performance deficiency warranting a significance evaluation. Because violations of 10 CFR 50.59 affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because there was a reasonable likelihood that the change requiring the 10 CFR 50.59 evaluation would require NRC review and approval prior to implementation. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance.

Enforcement: 10 CFR 50.59(d)(1) states, in part, that the licensee shall maintain records of changes in the facility, of changes in procedures, and of tests and experiments. Changes as defined in 10 CFR 50.59 include the method of performing or controlling the function. These records must include a written evaluation which provides the bases for the determination that the change, test, or experiment does not require a license amendment. Contrary to this, the licensee failed to perform a written evaluation of compensatory actions for the potential loss of normal actuation of the SI 850 valves from the control room. The results of this violation were determined to be of very low safety significance; therefore, this violation was classified as a Severity Level IV violation of 10 CFR 50.59. Because this violation was of very low significance, non-willful, non-repetitive, and documented in the licensee's corrective action program as AR01019916, this finding is being treated as an NCV, consistent with Section VI.A of the NRC Enforcement Policy (NCV 05000266/2006004-02; 05000301/2006004-02).

At the end of the inspection period the licensee was performing an apparent cause evaluation and a 10 CFR 50.59 evaluation for the compensatory actions.

.2 Additional Operability Evaluations Reviewed

a. Inspection Scope

The inspectors reviewed selected 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 eight procedure samples:

- OPR000153; Calculated Short Circuit Currents Exceed Equipment Ratings (CAP067946);
- OPR000154; Overload Concerns of Safety Related Equipment (CAP067181);
- OPR000154; Revision 1; Overload Concerns of Safety Related Equipment (CAP067181);
- OPR000172; Incorrect RVLIS Narrow Range Zero Reference Assumed in EOP Setpoint Calculation; (CAP070042);
- OPR000173; Filter Material Located Inside Containment: Non-Conformance, Potential Safety Issue; (CAP069465);
- OPR 99-1796, Revision 2; Control Room Emergency Filtration Unfiltered Leakage;
- AR01031626; Main Steam Line Break and Steam Generator Tube Rupture Control Room Dose; and
- OPR000177; Flooding Issue of Circulating Water Pumphouse.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

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 five quarterly inspection procedure samples:

- Reviewed the documentation for and observed the conduct of testing for motor-driven auxiliary feedwater pump P-38B discharge control valve maintenance during the week of April 3, 2006;
- Reviewed the documentation for and observed the conduct of testing for component cooling water pump 1P-11B seal maintenance on April 13, 2006;
- Reviewed the documentation for and observed fast start testing of emergency diesel generator G-01 during the week of May 1, 2006;
- Reviewed the documentation for and observed testing of emergency diesel generator G-01 following governor replacement activities the week of May 8, 2006; and
- Reviewed the post maintenance testing associated with the emergent maintenance on control room emergency filtration unit F-16 on June 3, 2006.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

.1 Failure to Maintain and Implement Procedure for Control Room Filter Testing

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;
- Test data and results were accurate, complete, within limits, and valid;
- Test equipment was removed after testing;
- 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.

This activity constituted one quarterly inspection procedure sample.

b. Findings

Introduction: The inspectors identified an NCV of TS 5.4.1j having very low safety significance (Green) for the failure to have adequate established, implemented, and maintained procedures for TS surveillance testing of the control room emergency filtration system. The cause of the finding was related to the cross-cutting element of problem identification and resolution.

Description: The inspectors observed the May 2, 2006, performance of procedure HPIP-11.54, "Control Room F-16 Filter Testing," a continuous use procedure intended to satisfy the 18-month surveillance requirement of TS Surveillance Requirement (SR) 3.7.9.2 through SR 3.7.9.6 and the Ventilation Filter Testing Program in TS 5.5.10. The inspectors noted that step 4.3 required performance of the system visual inspection and filter bank charcoal sampling in accordance with a vendor's procedure. However, the performance of both the visual inspection and charcoal sampling conducted by engineering and radiation protection personnel was not conducted with a procedure. In addition, steps 5.3.12 and 5.4.14 directed that the fan flow tests on the control room emergency filtration fans W-14A and W-14B be performed in accordance with the applicable procedures at the locations specified in Attachment D of HPIP-11.54, which contained a figure identifying the sample points. However, the inspectors noted that a procedure was not used for the collection of fan flow data nor the compilation and assessment of fan flow measurements.

Finally, steps 5.5.3 and 5.5.4 prescribed performance of two leak tests for filter efficiency per the applicable procedure. The inspectors noted that the vendor performing the test did not utilize a procedure while performing the test. On May 30, 2006, the licensee identified errors in the vendor's original reported efficiency value of 99.27 percent, noting that the vendor's test data demonstrated a result of 99.17 percent. The inspectors reviewed the referenced vendor procedures, last reviewed and approved by the licensee in 1993, and confirmed with licensee staff that the vendor procedures were not being utilized for these portions of the test by the personnel performing the test.

Thus, during the performance of certain portions of HPIP-11.54, on May 2, 2006, the previous vendor procedure was not utilized, nor had the licensee changed HPIP-11.54 to prescribe the actions the licensee had taken to perform the required portions of those tests and inspections mentioned previously.

The inspectors also reviewed the corrective action and root cause evaluation RCE000270, "F-16 Control Room Filter Flow Low Out of Specification per HPIP-11.54," which documented performance issues for the last performance of the test in August 2004. The licensee identified four root causes for this event and concluded that

the procedure deficiencies associated with HPIP-11.54 directly contributed to the August 2004 issues. However, the inspectors noted that the licensee's corrective actions were narrowly focused on the procedure not specifying an air flow test location.

Analysis: The inspectors determined that the licensee's failure to adequately establish, maintain and implement procedures for the TS surveillance testing of the control room emergency filtration system is a performance deficiency warranting a significance evaluation. The inspectors concluded that the finding is greater than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," issued on September 30, 2005, in that, the finding was associated with the procedure quality attribute for maintenance and testing (pre-event) procedures of the Mitigating Systems Cornerstone and adversely impacted the cornerstone objective to ensure the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. In addition, if left uncorrected, the finding would become a more significant safety concern.

The inspectors evaluated this finding using the guidance provided in IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." The inspectors utilized the Mitigating Systems Cornerstone screening questions which were answered no, and subsequently determined the finding screened as Green. Therefore, the inspectors determined that this finding is a licensee performance deficiency of very low risk significance (Green).

The inspectors also determined that a primary cause of this finding is related to the cross-cutting area of problem identification and resolution. The last performance of this test, conducted 18 months prior, revealed numerous performance deficiencies similar to those observed during the performance of the test in May 2006. This included the failure to properly implement and perform applicable procedures which resulted in a root cause evaluation. The licensee documented in RCE000270 that the procedures and policies which identified work for this testing, did not provide sufficient guidance to plant personnel. However, while the licensee's corrective actions addressed the specific failure of the procedure to specify test point locations for air flow measurements, the additional procedure deficiencies were not corrected. The effectiveness review conducted in July 2005 for the corrective actions on procedure changes was also narrowly focused on air flow measurements, as opposed to addressing existing procedure deficiencies.

Enforcement: Technical Specification 5.4.1j requires that written procedures be established, implemented, and maintained, in part, covering surveillance of safety-related equipment and for programs specified in TS 5.5, "Programs and Manuals." Technical Specification 5.5.10, "Ventilation Filter Testing Program," requires implementation of a control room emergency filtration system testing program. Contrary to this, the licensee failed to maintain and adequately implement procedure HPIP-11.54, "Control Room F-16 Filter Testing," performed on May 2, 2006. Specifically, the licensee failed to maintain the procedure and prescribe the actual steps performed for key test steps including, the visual inspection of the system, obtaining the charcoal sample, and collection and analyzing the fan flow test data. In addition, when implemented on May 2, 2006, the referenced applicable procedures for procedure HPIP-11.54 were not utilized. Because of the very low safety significance of this finding

and because the issue was entered into the licensee's corrective action program as AR01028314 and AR01028171, this violation is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000266/2006004-03; 05000301/2006004-03).

The licensee had not completed a causal evaluation by the end of the inspection period; however, the licensee had created corrective actions to evaluate resolution of this issue. In addition, due to additional licensee performance issues concerning the control room emergency filtration system that the licensee identified as a result of the May 30, 2006, TS Action Condition entry (discussed in Section 1R14.1 of this report), the licensee planned to incorporate the issues identified by the inspectors into a root cause evaluation being performed for AR01032855.

.2 Additional Surveillance Tests Reviewed

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 inservice 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 was 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 six quarterly inspection procedure samples:

- IT-07A, -7B, -7C, Service Water Quarterly Test of P-32 A/B/C Service Water Pumps and associated discharge check valves;
- IT-07D, -7E, -7F, Service Water Quarterly Test of P-32 D/E/F Service Water Pumps and associated discharge check valves;
- IT-72 Service Water Valves (Quarterly);
- OP-PT-FP-002 and RMP-9094, Monthly Diesel Engine Driven Fire Pump and Diesel Fire Pump Battery Surveillances;
- PC-29, Gas Turbine and Auxiliary Diesel Load Test; and
- OI-55, Primary Leakrate Calculations for Units 1 and 2.

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors conducted in-plant observations of physical changes to the plant and reviewed the following temporary modifications:

- 2005-017, Unit 2, 2MS-89 Leak Repair Clamp;
- 2004-005, Auxiliary Feed Tunnel Seismic Event Annunciation; and
- 2003-036, Unit 2, Install Blank Flange at CV-3212 and CV-3244.

The review included associated WOs, temporary modification instructions/procedures, and 10 CFR 50.59 screenings and evaluations. The review of the temporary modifications constituted three inspection procedure samples.

b. Findings

No findings of significance were identified.

Cornerstone: Emergency Preparedness

1EP4 Emergency Action Level (EAL) and Emergency Plan Changes (71114.04)

a. Inspection Scope

The inspectors completed screening reviews of the following revisions of the Point Beach Plant's Emergency Plan: Section 2, Revision 44; Section 4, Revision 41; and Appendix B, Revision 23. The inspectors also completed screening reviews of the following Emergency Plan Implementing Procedure (EPIP) revisions: EPIP 1.1, Revision 51; EPIP 1.2, Revision 47; and EPIP 1.2.1, Revision 1. The aforementioned screening reviews were performed to determine whether changes identified in these revisions may have reduced the effectiveness of the licensee's emergency planning and to verify that emergency action level and definitions changes associated with NRC Bulletin 2005-02, "Emergency Preparedness and Response Actions for Security-Based Events," were adequately incorporated in these revisions. The screening reviews of these revisions do not constitute approval of the changes and, as such, the changes are subject to future NRC inspection to ensure that the emergency plan continues to meet NRC regulations.

These activities constituted one inspection sample.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

Cornerstone: Initiating Events

The inspectors reviewed the licensee's recent Performance Indicator (PI) submittal, using definitions and guidance contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 2, to assess the accuracy of the PI data. The inspectors reviewed selected applicable conditions and data from logs, Licensee Event Reports (LERs), and CAPs from July 2002 through July 2004. The inspectors independently re-performed calculations where applicable. The inspectors then validated the information required for each PI definition in the guideline, to determine if the licensee reported the data accurately. The following reviewed PIs constituted two inspection procedure samples:

Unit 1

- Unplanned Power Changes; and

Unit 2

- Unplanned Power Changes.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems (71152)

.1 Failure to Update the FSAR with Responses to NRC Generic Correspondence

a. Inspection Scope

The inspectors reviewed licensee actions to evaluate and resolve issues associated with licensee staff's awareness and understanding of what constituted the plant licensing and design basis. The licensee's evaluation was conducted as RCE000300 (in response to CAP06175). The inspectors' review of RCE000300 constituted one annual inspection procedure sample.

The inspectors verified the following attributes during their review of the licensee's evaluation and corrective actions for CAP06175, RCE000300, and other related corrective action program documents:

- C complete and accurate identification of the problem in a timely manner commensurate with the safety significance and ease of discovery;
- C consideration of the extent of condition, generic implications, common cause and previous occurrences;
- C evaluation and disposition of operability/reportability issues;
- C classification and prioritization of the resolution of the problem, commensurate with safety significance;
- C identification of the root and contributing causes of the problem; and
- C identification of corrective actions which were appropriately focused to correct the problem.

The inspectors discussed the corrective actions and associated condition report evaluations with licensee personnel.

Introduction: A self-revealed Green finding associated with a Non-Cited Violation of 10 CFR Part 50.71(e) was identified for the licensee's failure to update the FSAR to reflect information and analyses submitted to the NRC.

Description: In April 2005, the inspectors identified that the licensee's response and analysis for NRC Generic Letter (GL) 80-113, "Control of Heavy Loads," was not incorporated into the FSAR. This issue was designated Unresolved Item (URI) 2005004-01 in NRC Inspection Report (IR) 2005004. Also in April 2005, NRC inspectors identified that the licensee had not incorporated into processes and the FSAR the analyses and programmatic commitments associated with the response to GL 88-17, "Loss of Decay Heat Removal." During the Unit 1 refueling outage in the fall

of 2005, the inspectors identified similar FSAR anomalies with respect to the licensee's analyses and responses to the NRC for Generic Letters and Bulletins related to the emergency core cooling systems, including:

- GL 85-22, "Potential for loss of Post-LOCA Recirculation Capability Due to Insulation Debris Blockage;"
- GL 97-04, "Assurance of Sufficient Net Positive Suction Head for Emergency Core Cooling and Containment Heat Removal Pumps;"
- GL 98-04, "Potential for Degradation of the Emergency Core Cooling System and the Containment Spray System After a Loss-of-Coolant Accident Because of Construction and Protective Coating Deficiencies and Foreign Material in Containment;"
- Bulletin 2003-01, "Potential Impact of Debris Blockage on Emergency Sump Recirculation at Pressurized-Water Reactors;" and
- GL 2004-02, "Potential Impact of Debris Blockage on Emergency Recirculation During Design Basis Accidents at Pressurized Water Reactors."

In view of the FSAR discrepancies, the NRC inspectors questioned the licensee as to the adequacy of its FSAR updating program. In response, the licensee conducted a self-assessment in November and December 2005 to evaluate the quality, accuracy, and completeness of generic communications responses associated with the emergency core cooling system. This assessment identified that the licensee had failed to update the FSAR as required to reflect the current licensing basis of the facility. The licensee also completed a streaming analysis in December 2005 of current plant performance issues, which likewise raised concerns regarding licensee staff awareness and understanding of the licensing and design basis.

Consequently, as a result of the inspectors' issues and the problems identified by the licensee in response to those issues, the licensee initiated RCE000300, "Personnel Awareness and Understanding of Licensing Basis," to determine the cause and extent of issues that resulted in this current condition and to review current processes, practices, and procedures.

The licensee's root cause analysis, completed on April 27, 2006, concluded that the issues associated with licensee staff awareness and understanding of the licensing basis were not limited to an individual, small group, or department. The licensee identified multiple issues related to the accurate and appropriate incorporation of generic communications and new regulations. In addition, programmatic requirements contained in responses to NRC generic communications have not always been timely or comprehensive. The licensee also identified in the extent-of-condition assessment that updates to the FSAR required as a result of implementation of new regulations, such as station blackout, or issuance of a license amendment have not been timely nor comprehensive.

The licensee identified two root causes for these issues: (1) activities associated with the licensing basis have not been elevated to a level of importance such that the processes and procedures produce predictable successful outcomes; and

(2) management has not defined and communicated clear ownership, roles, and responsibilities associated with licensing basis maintenance and control. The licensee also identified three contributing causes during the root cause evaluation: (1) the process for identifying steps in implementing documents that are regulatory commitments or contain licensing basis information was deviated from during document development and not identified during document review; (2) the licensee had not incorporated NEI 98-03, "Guidelines for Updating Safety Analysis Reports," into site procedures for FSAR updates; and (3) the FSAR review projects, conducted from 1996 to 2001 did not incorporate critical elements contained in the approved plans to ensure improved performance, such as NEI 98-03 and other available industry guidance.

Analysis: The inspectors determined that this issue constituted a performance deficiency because the licensee historically failed to update the FSAR, which impacted the licensee staff's ability to understand the facilities current licensing and design basis. Because findings involving 10 CFR 50.71(e) can affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because a failure to update the FSAR could have had a material impact on safety or licensed activities. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance.

The inspectors noted that the licensee's ability to adequately maintain the FSAR was caused, in part, by a failure to have processes and procedures to maintain the current licensing basis. In addition, licensee staff in multiple onsite organizations lacked the knowledge and understanding of what constituted the facilities license basis. Therefore, the inspectors also determined that a primary cause of this finding is related to the cross-cutting area of human performance.

Enforcement: 10 CFR 50.71(e), "Maintenance of Records, Making of Reports," requires, in part, that the licensee update the FSAR originally submitted as part of the application for the operating license, to assure that the information included in the report contains the latest information developed, including the changes necessary to reflect information and analyses submitted to the NRC. Contrary to this, the licensee has not updated the FSAR to reflect information and analyses submitted to the NRC in response to Generic Letters or Bulletins. In addition, updates to the FSAR as a result of implementation of new regulations or license amendments have also not consistently been updated to the FSAR as required. Because violations of 10 CFR 50.71(e) can impede or impact the regulatory process, this violation was dispositioned using the traditional enforcement process, not the Significance Determination Process. The violation has been reviewed by NRC management and determined to be a Severity Level IV violation of very low safety significance (Green). Because of the very low safety significance of this finding and because the issue was entered into the licensee's corrective action program as CAP069175, this violation is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 05000266/2006004-04; 05000301/2006004-04).

The licensee has entered this finding into the corrective action program as CAP069175 and had identified the root causes, as discussed previously. The licensee has taken immediate remedial corrective actions to address several issues, including the

development of a site policy and procedure that defines the current licensing basis, establishes ownership of license basis documents, defines site staff roles and responsibilities for implementing and maintaining the current licensing basis, and establishes implementing processes and procedures. The licensee also planned additional comprehensive corrective actions to address the training and knowledge aspects of this issue. In addition, the licensee developed and planned additional corrective actions to address the contributing causes and extent-of-condition issues. Finally, the licensee is currently evaluating the necessary project scope to reconcile the FSAR deficiencies; however, the licensee was still establishing timelines for this project at the end of the inspection period.

.2 Routine Resident Inspector Review of Identification and Resolution of Problems

a. Inspection Scope

As discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to determine if issues were entered into the licensee's corrective action system at an appropriate threshold, that adequate attention was given to timely corrective actions, and that adverse trends were identified and addressed. The inspectors also reviewed all CAPs written by licensee personnel during the inspection quarter. The CAPs written by the licensee as a result of inspectors' observations are included in the list of documents in the Attachment to this report.

b. Findings

No findings of significance were identified.

4OA3 Event Followup

.1 (Closed) LER 05000266/2005005-00; 05000301/2005005-00, Postulated Faults with Electrical Current in Excess of Maximum Interrupt Ratings and Nonconservative Degraded Voltage Time Delay Relay Setting Technical Specification.

Licensee Event Report (LER) 266/301/2005-005-00 described the discovery that certain equipment in the electrical distribution system would not ensure, under certain conditions, interruption of a three-phase bolted fault short circuit. These postulated faults would have electrical current in excess of the maximum listed interrupting ratings for designated circuit breakers and associated bus bar bracing. This condition affected the 13.8-kV, 4160-V, and 480-V power panels, motor control centers, and switchgear. The Point Beach Appendix R analysis relied on breaker coordination and fault current interruption to prevent loss of safe shutdown equipment due to common power supply associated circuit concerns. The postulated condition presented the possibility of a fire causing bolted faults that could ignite fires in one or more remote fire areas resulting in additional unanalyzed fire losses due to direct fire damage or uncleared faults.

Also related to this condition was the discovery of a non-conservative Technical Specification for degraded voltage time delay relay settings that could have resulted in certain safety system motors tripping on overcurrent. Such an event could have

prevented the fulfillment of the motor's safety related function to mitigate the consequences of an accident. The licensee identified that under a design basis loss of coolant accident concurrent with a reduced voltage condition, safety-related motors and switchgear could trip their protective devices on overcurrent without the degraded voltage relays being actuated. Affected equipment included certain 480-V switchgear, 480-V motor control centers, both auxiliary feedwater pump motors, and one component cooling water pump motor.

The licensee entered these issues into the corrective action program and committed to: evaluate and implement analytical changes resulting from the completed bolted fault analysis; perform plant modification changes as needed to address short circuit and degraded voltage analysis results; and submit a license amendment to revise the 4160-V degraded voltage allowable value time delays. This licensee-identified violation is also discussed in Section 4OA7 of this report. This LER is considered closed.

- .2 (Closed) URI 05000266/2005004-07; 05000301/2005004-07, Event Notification for Unanalyzed Condition Where Fire Organizational Plan No Longer Aligned with Safe Shutdown Analyses.

On June 8, 2005, the licensee reported a condition under 10 CFR 50.72(b)(3)(ii)(B) after discovering during a review that a revision change to the Fire Organizational Plan inadvertently omitted actions to be taken to preserve safe shutdown equipment in the event of a fire. As a result, the Fire Organizational Plan was no longer aligned with the Safe Shutdown Analysis because of the omission of manual actions necessary to accomplish safe shutdown in the current revision. The licensee took immediate corrective actions to mitigate the consequences of this issue.

The inspectors are closing this Unresolved Item to the pending NRC review of the licensee's evaluations associated with the 10 CFR Part 50.73 report documented in LER 05000266/2005-001-00 for this same issue.

4OA5 Other Activities

- .1 Operation of an Independent Spent Fuel Storage Installation (ISFSI) (60855.1)

Loading Campaign

- a. Inspection Scope

The inspectors reviewed spent fuel loading procedures to verify compliance with the FSAR. The inspectors observed the licensee perform loading of two canisters, Number 21 and Number 23, and the transfer of canister Number 23 to the outdoor storage pad to verify procedural adherence, adequate supervisory oversight, and communication. The inspectors reviewed the loading documentation for canister Number 22. Specifically, the inspectors reviewed the loading procedures, the welding records, the vacuum drying and helium leak testing records, as well as the visual and dye penetrant records. In addition, the inspectors reviewed a number of CAPs associated with dry fuel storage and the licensee's corrective actions taken to address issues that were encountered during the loading campaign.

The inspectors also reviewed procedures associated with radiation protection during the dry fuel storage activities. The inspectors observed the radiation protection personnel perform activities and reviewed documentation to verify that the licensee did not exceed the contamination and radiation dose limits prescribed in the Technical Specifications.

The inspectors reviewed the licensee's 10 CFR 72.212 evaluation to verify that it addressed the NRC issuance of a new amendment to the Certificate of Compliance (CoC). The inspectors also reviewed a number of 10 CFR 72.48 screenings to verify that changes made to the dry fuel storage process or the canister components did not adversely impact the function and the design of the cask system.

The inspectors reviewed the licensee's fuel selection process to verify the process incorporated all of the physical, thermal, and radiological fuel acceptance parameters specified in the current CoC and the Technical Specifications. The inspectors reviewed the fuel selection procedure and the qualification records for each assembly to be loaded in canister Number 21. The inspectors also observed the licensee load fuel into the canister. In addition, the inspectors reviewed the licensee's material record and inventory program to verify the licensee's inventory and record keeping program associated with storage of dry fuel was adequate.

The inspectors reviewed the licensee's training program for the training of new welders and other personnel. The inspectors reviewed qualification records for a new welder and observed the individual weld a mock-up cask. The inspectors interviewed dry fuel storage supervisors regarding the training process and its implementation.

The inspectors reviewed the licensee's monitoring program to verify the monitoring of dry fuel storage was implemented. The inspectors reviewed select records to verify that temperatures of the concrete remained within long-term storage limits. The inspectors assessed the physical condition of the pad and the canisters to confirm the vent screens were free of debris, the temperature thermocouples were in operation, and the pad was free of combustible materials.

The inspectors also reviewed procedures and records of annual inspections performed on the auxiliary building crane and the pneumatic lifting yoke.

b. Findings

(1) Inadequate 10 CFR 72.48 Evaluation of Possible Fuel Cladding Thermal Effects

Introduction: The inspectors identified one unresolved item regarding an inadequate 10 CFR 72.48 screening. The 10 CFR 72.48 screening did not address the thermal aspect of draining all of the water from the canister prior to welding the inner top cover.

Description: In the fall of 2004, the licensee prepared for a dry fuel storage campaign utilizing a new cask design, NUHOMS 32-PT. The licensee's loading procedures deviated (were a change) from the sequence of loading activities as described in the generic operating procedures in Chapter M.8 of the FSAR. The licensee performed a 10 CFR 72.48 screening, No. 2003-0363, dated July 1, 2004, to evaluate the change, which consisted of draining all of the water from the canister cavity prior to welding the

inner top cover on. The FSAR prescribed welding the top inner cover and then draining the remainder of the water from the canister. In its screening, the licensee evaluated hydrogen generation, radiation dose, and criticality concerns that could result from this change to the loading procedures. However, the screening lacked an evaluation of the effect of water removal during draining (and welding) on the fuel cladding temperature and the associated vacuum drying, which had been evaluated for the effect on cladding temperature. The FSAR and TS vacuum drying time limit was based on the initial fuel clad temperature of 215 degrees Fahrenheit. The revised loading process potentially created an additional time period when cladding temperature was elevated that was not accounted for in the analysis of cladding temperature during the vacuum drying.

The licensee loaded five NUHOMS casks utilizing the different loading process. During the 2006 dry fuel storage loading campaign, NRC inspectors questioned the adequacy of the different method used during loading and the adequacy of the 10 CFR 72.48 screening. The licensee entered this item into its corrective action program and issued an operating experience notice to the nuclear power industry. The loading procedure was also revised to reflect the sequence described in the FSAR. The inspectors identified other NUHOMS system users who loaded casks using the same approach of draining water prior to completion of welding activities. Pending the NRC's resolution of the potential generic implications of this issue, it is considered to be an unresolved item (URI 05000266/2006004-05; 05000301/2006004-05).

.2 Operation of an Independent Spent Fuel Storage Installation (ISFSI) (60855.1)

Seismic Analysis of the Auxiliary Building

a. Inspection Scope

The inspectors reviewed the licensee's calculation of the capability of the auxiliary building to support a single failure-proof-crane with a 125-ton load during a seismic event.

b. Findings

(1) Failure to Perform a 10 CFR 50.59 Safety Evaluation

Introduction: The inspectors identified a Severity Level IV, Non-Cited Violation of very low safety significance for the failure to perform a written evaluation in accordance with 10 CFR 50.59(d)(1) for calculation PBNP-305336-S01 to analyze the capability of the auxiliary building to support a single-failure-proof crane with a 125-ton load during a seismic event. A previous structural analysis qualified the auxiliary building to hold a 101-ton lifted load.

Description: In 2004, during an NRC inspection of the licensee's activities to demonstrate readiness to load fuel for dry storage, the inspectors determined that the license had not performed a structural analysis of the auxiliary building to show its capability to hold the NUHOMS casks during a seismic event. The licensee had previously concluded that the auxiliary building could hold a maximum of 101-ton load during a seismic event. The previous analysis addressed loads that were imposed on

the crane and the auxiliary building due to the VSC-24 cask design that was used prior to 2004. Subsequently, the licensee committed to perform a complete analysis of the auxiliary building and the crane to demonstrate the structural adequacy of the auxiliary building to lift the new casks prior to the next loading campaign. NRC review of this analysis was tracked as a URI in IR 07200005/2004-003. The licensee's next loading campaign was scheduled to take place in April 2006. The licensee completed the analysis before April 2006 and concluded that the auxiliary building could hold the crane and a maximum load of 125 tons during an earthquake. In reviewing this analysis, the inspectors determined that the licensee had not performed a 10 CFR 50.59 evaluation to determine whether a license amendment was required due to the increased design loads imposed on the crane and the auxiliary building due to the use of the NUHOMS casks. Subsequently, this issue was entered into the licensee's corrective action program, and a 50.59 screening (No. 2006-0063) and a full 50.59 evaluation (No. 2006-006) were performed. The licensee concluded in its evaluation that a license amendment was not required for the increase in the design load.

Analysis: The inspectors determined that the licensee's failure to use the 10 CFR 50.59 process to evaluate the change of increasing the load on the auxiliary building is a licensee performance deficiency. Because issues involving 10 CFR 50.59 potentially affect the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. In accordance with the NRC Enforcement Policy, this finding is determined to be more than minor because there was a reasonable likelihood that the change requiring the 10 CFR 50.59 evaluation would require NRC review and approval prior to implementation. This finding has been reviewed by NRC management and is determined to be a Green finding, of very low safety significance.

Enforcement: 10 CFR 50.59(d)(1) states, in part, that the licensee shall maintain records of changes in the facility, of changes in procedures, and of tests and experiments. These records must include a written evaluation which provides the bases for the determination that the change, test, or experiment does not require a license amendment. Contrary to this, the licensee failed to perform a written evaluation to assess whether the change of increasing design loads on the crane and the auxiliary building required a license amendment. Because violations of 10 CFR 50.59 can impede or impact the regulatory process, this violation was dispositioned using the traditional enforcement process. The violation has been reviewed by NRC management and determined to be a Severity Level IV violation of very low safety significance (Green). Because this violation is of very low safety significance, non-willful, non-repetitive, and documented in the licensee's corrective action program as CAP 01022449, it is being treated as an NCV, consistent with Section VI.A. of the NRC Enforcement Policy (NCV 05000266/2006004-06; 05000301/2006004-06).

.3 Implementation of Temporary Instruction (TI) 2515/165 - Operational Readiness of Offsite Power and Impact on Plant Risk

a. Inspection Scope

The objective of TI 2515/165, "Operational Readiness of Offsite Power and Impact on Plant Risk," was to confirm through inspection and interviews the operational readiness of offsite power systems in accordance NRC requirements. From March 22 to 28, 2006,

the inspectors reviewed licensee procedures and discussed the attributes identified in TI 2515/165 with licensee personnel. These procedures included operating procedures used to assure the functionality/operability of the offsite power system, as well as the risk assessment, switchyard control, and emergent work procedures that may affect the operability and readiness of the offsite power system.

The information gathered while completing this TI was forwarded to the Office of Nuclear Reactor Regulation (NRR) for further review and evaluation. On May 30, 2006, in response to a question from NRR, the inspectors reviewed a recent revision to a pertinent operating procedure that was not available during the earlier inspection.

b. Findings

No findings of significance were identified.

4OA6 Meetings

.1 Exit Meeting

On June 27, 2006, 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.

.2 Interim Exit Meetings

Interim exits were conducted for:

- Emergency Preparedness inspection with Mr. S. Tulley on June 2, 2006; and
- Dry Fuel Storage inspection with Mr. J. McCarthy on May 19, 2006.

4OA7 Licensee-Identified Violations

The following violation of very low significance (Green) was identified by the licensee and is a violation of NRC requirements that meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600, for being dispositioned as an NCV.

- 10 CFR 50, Appendix B, Criterion III, "Design Control," requires in part, that measures be established for the selection and review for suitability of application of materials, parts, equipment, and processes that are essential to the safety-related functions of structures, systems and components. However, as part of an ongoing licensee program to address the extent of condition of known electrical distribution system issues, plant staff identified, in September 2005, that under certain conditions, the interrupting current of a three-phase bolted fault short circuit could exceed the interrupting rating of the breakers. Also related to this condition was the discovery of a non-conservative TS for degraded voltage time delay relay settings that could have resulted in certain safety system motors tripping on overcurrent. Therefore, contrary to the "Design Control" requirements, PBNP had safety related equipment not suitable for performing

the safety-related functions. This licensee-identified finding was entered into the corrective action program and was determined to be of very low significance following Significance Determination Process analysis and discussions with the Regional Senior Reactor Analysts. The licensee initiated corrective action documents CAP0067167, CAP0067181, and CAP0067183 to develop and track the corrective actions, which include, but were not limited to: evaluate and implement analytical changes resulting from the licensee's completed bolted fault analyses, perform plant modification changes as needed to address short circuit and degraded voltage analysis results, and submit a license amendment request to revise the 4.16-kV degraded voltage allowable value of time delays as required.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

C. Butcher, Site Engineering Director
G. Casadonte, Fire Protection Coordinator
F. Flentje, Senior Regulatory Compliance Engineer
T. Gemske, Emergency Preparedness Supervisor
B. Grazio, Regulatory Affairs Manager
C. Hill, Assistant Operations Manager
C. Jilek, Maintenance Rule Coordinator
R. Johnson, Senior Emergency Preparedness Coordinator
T. Kendall, Engineering Senior Technical Advisor
D. Koehl, Site Vice-President
R. Ladd, Fire Protection Engineer
S. LeBlang, NMC High Level Waste Manager
M. Lorek, Plant Manager
J. McCarthy, Director of Site Operations
J. McNamara, Engineering Supervisor
G. Packard, Operations Manager
L. Peterson, Design Engineer Manager
M. Ray, Emergency Planning Manager/Regulatory Affairs Manager
L. Rogers, Dry Cask Storage Engineer
D. Schuelke, Radiation Protection Manager
J. Schweitzer, Manager of Projects
G. Sherwood, Engineering Programs Manager
C. Sizemore, Training Manager
N. Stuart, Maintenance Manager
P. Wild, Design Engineering Projects Supervisor
R. Womack, Fleet Program Engineering Manager

Nuclear Regulatory Commission

C. F. Lyon, Point Beach Project Manager, NRR
P. Loudon, Chief, Reactor Projects, Branch 5

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000266/2006004-01 05000301/2006004-01	FIN	Failure to Take Adequate Actions for Potential High Wind Conditions (Section 1R01.1)
05000266/2006004-02 05000301/2006004-02	NCV	Failure to Perform a 50.59 Evaluation of Compensatory Measures Described in Operability Recommendation (Section 1R15.1)
05000266/2006004-03 05000301/2006004-03	NCV	Failure to Maintain and Implement Adequate Procedures for Control Room Ventilation Testing (Section 1R22.1)
05000266/2006004-04 05000301/2006004-04	NCV	Failure to Update and Maintain the FSAR as Required by 10 CFR 50.71(e) (Section 4OA2.1)
05000266/2006004-06 05000301/2006004-06	NCV	Failure to Perform a 50.59 Evaluation of Increased Loads on the Auxiliary Building (Section 4OA5.2)

Opened

05000266/2006004-05 05000301/2006004-05	URI	Inadequate 72.48 Screening to Evaluate Possible Thermal Effects on Fuel Cladding (Section 4OA5.1)
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Closed

05000266/2005-005-00; 05000301/2005-005-00	LER	Postulated Faults with Electrical Current in Excess of Maximum Interrupt Ratings and Nonconservative Degraded Voltage Time Delay Relay Setting Technical Specification (Section 4OA3.1)
05000266/2005004-07; 05000301/2005004-07	URI	Event Notification for Unanalyzed Condition Where Fire Organizational Plan No Longer Aligned with Safe Shutdown Analyses (Section 4OA3.2)

Discussed

05000266/2005-001-00	LER	Unanalyzed Condition Due to Inadvertent Omission of Safe Shutdown Equipment (Section 4OA3.2)
07200005/2004-003-01	URI	Seismic Analysis of the Auxiliary Building (Section 4OA5.2)

LIST OF DOCUMENTS REVIEWED

1R01: Adverse Weather

AR00908550; Potential Areas for Improvement in Tornado Missile Inspection
AR01023807; Evaluate OE Regarding Tornado Preparedness
AR0103919; Create an Operations PC for Tornado Hazard Site Inspections
AR01032299; Documentation of Monthly Yard Inspection for Tornado Preparedness
CP 0072; NMC Policy, Seasonal Readiness
PB-LOR-061-004S; Licensed Operator Requalification - Loss of Offsite Power; Revision 0
PC49 Part 6; Securing from Cold Weather; Revision 16
WM-0192; On-Line System Work Order Scope Report; dated June 26, 2006
WM-0099; WR Requirement and Attribute Report, Summer Readiness, dated June 2, 2006
EC-0138; Equipment AR Report, Service Water System; dated June 2, 2006

1R04: Equipment Alignment

CAP053824; Confusing/Conflicting 1X01 "A" Phase Transformer Cooling Fan Breaker Labeling
CL 13E Part 2; Auxiliary Feedwater Valve Lineup Motor Driven; Revision 42
CL 10B; Service Water Safeguards Lineup; Revision 60
O-TS-EP-001; Weekly Power Availability Verification

1R05: Fire Protection

Fire Hazard Analysis Report for Applicable Fire Areas Reviewed; dated December 2005
Fire Area Analysis Summary Report for Applicable Fire Areas Reviewed; dated August 8, 2005
Fire Emergency Plans for applicable Fire Areas Reviewed
AR01037732; Fire Emergency Plans Require Links to the Reference Drawings

1R06: Flood Protection Measures

Drawing C-100; Plant foundation Plan and Sub-Drainage System
NP 8.4.17; PBNP Flooding Barrier Control; Revision 4
AR01027511; Flood Recommendations from GAR 1019570
AR00908558; Turbine Building Flood Dampers Have No Periodic Functional Check
DBD-T-41; Hazards - Internal and External Flooding Topical Design Basis Document

1R11: Licensed Operator Qualifications

PB-LOR-063-001E; Simulator Exercise Guide; Revision 0

1R12: Maintenance Effectiveness

Control Room Ventilation System (VNCR) WOs from January 1, 2004, through May 1, 2006
Maintenance Rule (a)(1) System Action Plan Checklist and Approval, for VNCR System, dated December 12, 2005
Performance Criteria Assessment for VNCR from January 1, 2004, through May 1, 2006

Maintenance Rule Unavailability Data Sheet for VNCR from January 1, 2004, through May 1, 2006
 WO Listing for 480-V System Initiated or Completed between January 1, 2004, and April 1, 2006; dated April 12, 2006
 System Health Report 480-V System; dated February 24, 2006
 Maintenance Rule Evaluation Listing for 480-V System; dated April 12, 2006
 Maintenance Rule Function List for 480-V System; dated April 12, 2006
 Documentation of Maintenance Rule Performance Criteria - 480 V System; dated March 29, 2004
 Performance Criteria Assessments for 480-V System Since January 1, 2003; dated April 12, 2006
 Corrective Action Documents for 480V System; various dates
 Performance Criteria Assessments for Gas Turbine System since April 10, 2004
 Maintenance Rule Unavailability Data Sheet from April 1, 2004, through April 1, 2006
 Station Logs from April 1, 2004, through April 1, 2006
 WOs for Gas Turbine Initiated or Completed Between April 1, 2004 and March 16, 2006
 System Health Report Gas Turbine (GT); dated April 19, 2006
 CAP055661; G-05 Start Failure; dated April 13, 2004
 CAP055697; P-501 G-05 Main Lube Oil Pump in Auto and not Running Causes G-05 Alarm; dated October 5, 2004
 Maintenance Rule (a)(1) System Action Plan, GT; dated October 6, 2003

1R13: Maintenance Risk Assessment and Emergent Work Evaluation

Safety Monitor Calculation Reports Units 1 and 2 for Applicable Work Weeks
 Work Week Execution Schedules for the Applicable Work Weeks
 Operator Logs for Applicable Work Weeks

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

F-16 Filter Test Failure Event Response Action List
 AR01033448; CAP F-16 CREFS Charcoal Filter Housing Condition

1R15: Operability Evaluations

OPR000172; Potential Narrow Range RVLIS Design Deficiency Effect on CSP Actions
 Calculation WEP-SPT-25; Reactor Vessel Level EOP Setpoints; Revision 0
 Critical Safety Procedure (CSP) -ST.0; Unit 1; Revision 3
 BG-CSP-C.1; Response to Inadequate Core Cooling; Revision 21
 CAP070042; Incorrect RVLIS Narrow Range Zero Reference Assumed in EOP Setpoint Calculation
 Letter from Fay, C.W. Wisconsin Electric Power Company to H.R. Denton, NRC; dated October 20, 1981
 OPR000173; Filter Material Located Inside Containment: Non-Conformance, Potential Safety Issue
 OPR99-1796; CREF's Unfiltered Leakage; Revision 2
 OPR for AR01031626; Main Steam Line Break and Steam Generator Tube Rupture - Control Room Dose

OPR000177; Failure of Circulating Water Pumps expansion joint may create flooding in the Circulating Water Pump House; Revision 0

1R19: Post-Maintenance Testing

RMP 9141; Air-operated Valve Testing and Adjustment; Revision 5 - performed April 5, 2006
0-PT-AF-2; P-38B Motor-driven AFW Pump Backup Nitrogen System Pressure Decay Test; Revision 1 - performed April 5, 2006
HPIP-11.54; Control Room F-16 Filter Testing - performed June 3, 2006
TS-9; Control Room Heating and Ventilation System Monthly Checks - performed June 4, 2006
0 SOP-G01-001; Maintenance Operation for EDG G-01; Revision 3 - performed May 3, 4, 2006
RMP 9043-12; Emergency Diesel Generator G-01 Safety Related Protective Relay Calibration; Revision 6 - performed April 27, 2006
CAP070664; G-01 RMP 9043-12, Revision 5, Errors Could Disable G-02 Relays
RMP 9043-16; Emergency Diesel Mini-Power Pack Inspection - performed May 3, 2006
RMP 9043-18; Emergency Diesel Generator G-01 2-Year Relay Maintenance, Revision 4 - performed May 3, 2006
RMP 9043-11; Emergency Diesel Generator G-01 Electrical Inspection; Revision 11
RMP 9043-19; Emergency Diesel Generator G-01 Remote Meter Calibration; Revision 4
RMP 9043-13; Emergency Diesel Generator G-01 Mechanical Inspection; Revision 9
RMP 9043-17; Emergency Diesel Generator G-01 Maintenance Run and Post-Maintenance Testing
PBTP-142; EDG G01 Governor Testing; Revision 0

1R22: Surveillance Testing

AR01031598; Diesel Fire Pump Batteries Out of Spec
HPIP-11.54; Control Room F-16 Filter Testing, dated April 27, 2006; Revision 11 - performed May 2, 2006
Letter from Wisconsin Electric Power Company to the NRC; Response to Generic Letter 99-02, "Laboratory Testing of Nuclear-Grade Activated Charcoal"; dated July 29, 1999
ANSI N510; Testing of Nuclear Air-Cleaning Systems; dated 1980
Contractor Procedure Control Form for Procedure 12-255; Visual Inspection of Nuclear Air Treatment Systems; dated August 9, 1993
Contractor Procedure Control Form for Procedure 12-67; In-Place Leak Test HEPA Stage; dated August 9, 1993
Contractor Procedure Control Form for Procedure 12-68; In-Place Leak Test Adsorber Stage; dated August 9, 1993
Pre-Job Brief for Task ID 339649742, W-14A and -B Fan Testing with Potential Motor Replacement
Pre-Job Brief for Task ID HPIP-11.54, Control Room F-16 Filter Testing
AR01028098; CAP - Procedure Use Issues Related to HPIP-11.54, F16 Filter Test
AR01028171; CAP - NRC Feedback on CREFS Testing HPIP-11.54
AR01028314; CAP - NRC Observations of HPIP-11.54, Control Room F-16 Filter Testing
RCE000270; Root Cause Evaluation - F-16 Control Room Filter Flow Low Out of Specification per HPIP-11.54
CAP OTH029177; Possible RCS leakage tracking improvement
Unit 1 and 2 Primary Leak Rate Logs; January 6 through April 12, 2006

OI 55; Primary Leakage Rate Calculation; Revision 19
Control Room Miscellaneous Shift Log - Sampled for Period Covered
IT-07A, -7B, -7C, Service Water Quarterly Test of P-32 A/B/C Service Water Pumps and Associated Discharge Check Valves
IT-07D, -7E, -7F, Service Water Quarterly Test of P-32 D/E/F Service Water Pumps and Associated Discharge Check Valves
IT-72 Service Water Valves (Quarterly)
OP-PT-FP-002 and RMP-9094, Monthly Diesel Engine Driven Fire Pump and Diesel Fire Pump Battery Surveillances
Fire Protection Evaluation Report; Section 8.2, Surveillance of Fire Protection Systems, Revision 5
PC-29, Gas Turbine and Auxiliary Diesel Load Test

1R23: Temporary Plant Modifications

Temporary Modification EC0000007313; Install Leak Repair Clamp on 2TX-02078; dated March 17, 2006
SCR 2006-036; 10 CFR 50.59 Screening for Temporary Modification EC0000007313; dated March 16, 2006
SCR 2004-0061; 10 CFR 50.59/72.48 Pre-Screening Review; TMod 04-005 - SEI-06213, Auxiliary Feed Tunnel Seismic Event Annunciation; Revision 1
Temporary Modification Extension; TMod 04-005 - SEI-06213, Auxiliary Feed Tunnel Seismic Event Annunciation; dated March 15, 2006
Temporary Modification Initiation; TMod 04-005 - SEI-06213, Auxiliary Feed Tunnel Seismic Event Annunciation; dated March 26, 2004
CAP053989; Compensatory Measures Needed to Implement Seismic EAL 6.1.1.1; dated February 18, 2004
SCR 2003-0394; 10 CFR 50.59/72.48 Pre-screening Review; TMod 04-036 - Install Blank Flanges at CV-3212 and CV-3244; dated November 8, 2003
Temporary Modification Extension; TMod 04-036 - Install Blank Flanges at CV-3212 and CV-3244; dated December 28, 2004
Temporary Modification Initiation; TMod 04-036 - Install Blank Flanges at CV-3212 and CV-3244; dated November 8, 2003

1EP4: Emergency Action Level (EAL) and Emergency Plan Changes

Emergency Plan; Section 2; Revision 44
Emergency Plan; Section 4; Revision 41
Emergency Plan; Appendix B; Revision 23
EPIP 1.1; Revision 51
EPIP 1.2; Revision 47
EPIP 1.2.1; Revision 1

4OA2: Identification and Resolution of Problems

RCE000300, Root Cause Evaluation - Personnel Awareness and Understanding of Licensing Bases; dated April 27, 2006

Snapshot Report PBSA-RA-05-02; Self Assessment of Quality, Accuracy, and Completeness of Generic Communications Responses Associated with Containment Sump Debris and Coatings Issues

4OA5: Other (TI 2515/165)

Operating Procedure (OP) 2A; Normal Power Operation; Revisions 57 and 58
Nuclear Procedure (NP) 2.1.5; Electrical Communications, Switchyard Access and Work Planning; Revisions 6 and 7
NP 10.3.5; Risk Monitoring and Risk Management; Revision 0
NP 10.3.7; On-Line Safety Assessment; Revision 11

4OA5: Operation of an Independent Spent Fuel Storage Installation (ISFSI) (60855.1)

AR01022449; PAB Structure Calculation and 50.59/72.48 Evaluation
AR01026070; NUHOMS Concern re: TS 1.2.17a, Vacuum Drying Time/Draindown; dated April 27, 2006
CAP070969; Degraded Condition at PAB Superstructure Column 10U Baseplate; dated March 10, 2006
CAP01024787; Cask #21 F/As Were Loaded in an Alternative Loading Pattern; dated April 19, 2006
Calculation Package PBNP-305336-S01; Structural Analysis of Central PAB with Crane Load of 125 Tons; Revision 1
Evaluation 2006-006; Structural Analysis of Central PAB with Crane Load of 125 Tons; Revision 0
Fuel Assembly Records for WDSC Serial No. WDSC-32-005
Job File 17; Load NUHOMS TN-32 PT DSC; Revision 3
Point Beach 10 CFR 72.212 and Certificate of Compliance Evaluation Report for NUHOMS-32 PT System; Revision 4
Procedure RP 17; NUHOMS Dry Cask Loading and Storage; Revision 2
Procedure RP 17 Part 1; Preps of TC/DSC; Revision 5
Procedure RP Part 2; Place DSC/TC Into Spent Fuel Pool; Revision 5
Procedure RP 17 Part 3; Loading Spent Fuel Into the Dry Shielded Canister (DSC); Revision 4
Procedure RP 17 Part 4; Remove DSC/TC From Spent Fuel Pool; Revision 5
Procedure RP 17 Part 5; Sealing 32 PT Dry Shielded Canister (DSC); Revisions 6 and 7
Procedure RP 17 Part 6; Move DSC/TC From Decon Area to ISFSI; Revision 5
Procedure FC 7; SNM Inventory; Revision 12
Procedure REI 30.1; Physical Inventory; Revision 6
Procedure; 10 CFR 50.59 and 72.48 Processes; Revision 0
Records ISFSI Daily Monitoring Report; dated September 1 through September 30, 2005
Record WNUHOMS-32; Dry shielded Canister Record; Serial No. WNUHOMS-32-005
Screening SCR 2003-0363; Initial Issuance of RP 17 Procedure Series for the Use of NUHOMS 32 PT Dry Storage System; dated July 7, 2004
Screening SCR 2005-0208; Contr. Proc. MSLT-DSC NMC, Revision 4, Helium Mass Spectrometer Leak Test Procedure; dated September 19, 2005
Screening SCR 2005-0282-01; Revision 5 of RP 17 Part 2, Place DSC/TC into the Spent Fuel Pool; dated November 29, 2005

Screening SCR 2005-0043; Revision 5 of RP 17 Part 4, Remove DSC/TC from the Spent Fuel Pool; dated January 3, 2006
Screening SCR 2006-0008; RP 17 Part 6, Moving DSC/TC from Decon Area to ISFSI; dated January 6, 2006
Screening SCR 2006-0040; RP 17 Part 5, Sealing 32 PT Dry Shielded Canister (DSC); dated March 22, 2006
Screening SCR 2006-0061; Change in Calculation Record for PAB Seismic Analysis; Revision 0
Screening SCR 2006-0063; Evaluation of PAB Superstructure for Supporting PAB Crane Lifts up to 125 Tons Over the Spent Fuel Pool; Revision 0
Welder Qualification Records; 2006
Work Order Package 00222629 01; Perform NDE, VT and MT Inspection Z-784; dated April 20, 2006
Work Order 0508513; Wire Rope Inspection, Primary Auxiliary Crane; dated February 20, 2006
Work Order 0508645; Visual Crane Inspection; dated February 20, 2006
Work Order 0406782001; Annual Crane Maintenance; dated February 10, 2005
Work Order Package 00222935 01; WDSC-32-06 Load Canister; dated May 12, 2006

LIST OF ACRONYMS USED

AC	Alternating Current
AR	Action Request
CAP	Corrective Action Program Document
CFR	Code of Federal Regulations
CoC	Certificate of Compliance
DC	Direct Current
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
EAL	Emergency Action Level
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
EPIP	Emergency Plan Implementing Procedure
FSAR	Final Safety Analysis Report
IMC	Inspection Manual Chapter
IR	Inspection Report
ISFSI	Independent Spent Fuel Storage Installation
kV	kiloVolt
LER	Licensee Event Report
MCC	Motor Control Center
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NP	Nuclear Plant Procedure
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
OPR	Operability Recommendation
PAB	Primary Auxiliary Building
PI	Performance Indicator
RMP	Routine Maintenance Procedure
SDP	Significance Determination Process
SR	Surveillance Requirement
TI	Temporary Instruction
TS	Technical Specification
URI	Unresolved Item
V	Volt
WO	Work Order