



**UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PA 19406-1415**

January 15, 2010

Mr. George H. Gellrich, Vice President
Constellation Generation Nuclear Group, LLC
Calvert Cliffs Nuclear Power Plant, LLC
1650 Calvert Cliffs Parkway
Lusby, Maryland 20657-4702

**SUBJECT: CALVERT CLIFFS NUCLEAR POWER PLANT, UNIT 1 AND 2; NRC
INSPECTION PROCEDURE 95001 SUPPLEMENTAL INSPECTION REPORT
05000317/2009503 and 05000318/2009503**

Dear Mr. Gellrich:

On December 4, 2009, the U.S. Nuclear Regulatory Commission (NRC) Staff completed a supplemental inspection pursuant to Inspection Procedure 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," at your Calvert Cliffs Nuclear Power Plant Units 1 and 2. The enclosed inspection report documents the inspection results, which were discussed at the exit meeting on December 4, 2009, with Mr. J. Spina and other members of your staff.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed because a finding of white safety significance was identified at Calvert Cliffs in the first quarter of 2009. This issue was documented previously in NRC Inspection Report Nos. 05000317/2008502, 0500318/2008502. The NRC staff was informed on October 9, 2009, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and contributing causes for the risk-significant issues were understood; (2) the extent of condition and extent of cause of the issues were identified; and, (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

The inspectors determined that your staff performed a comprehensive evaluation of the white finding. Your staff's evaluation identified the primary root cause of the issue to be that the Constellation organization did not recognize the true scope of the project to upgrade the emergency action level guidance. Specifically, the structured review and assessment process was not adequate when the Calvert Cliffs Nuclear Power Plant Emergency Action Levels (EALs) were converted to the Nuclear Energy Institute (NEI) 99-01, Revision 4, based EAL scheme.

G. Gellrich

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Based on the results of this inspection, no findings of significance were identified.

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 (PARS) component of NRC's document system, Agencywide Document Access and Management System (ADAMS). ADAMS is accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,



James M. Trapp, Chief
Plant Support Branch 1
Division of Reactor Safety

Docket No. 50-317, 50-318
License No. DPR-53, DPR-69

Enclosure: Inspection Report 05000317/2009503 and 05000318/2009503
w/Attachment: Supplemental Information

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G. Gellrich

2

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Sincerely,

/RA/

James M. Trapp, Chief
Plant Support Branch 1
Division of Reactor Safety

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos.: 50-317, 50-318

License Nos.: DPR-53, DPR-69

Report Nos.: 05000317/2009503 and 05000318/2009503

Licensee: Constellation Generation Nuclear Group, LLC

Facility: Calvert Cliffs Nuclear Power Plant, LLC

Location: Lusby, Maryland

Dates: November 30 – December 4, 2009

Inspectors: Stephen T. Barr, Senior Emergency Preparedness Specialist
John R. Cherubini, Physical Security Inspector

Approved by: James M. Trapp, Chief
Plant Support Branch 1
Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

Inspection Report (IR) 05000317/2009503, 05000318/2009503; 11/30/2009 – 12/04/2009; Calvert Cliffs Nuclear Power Plant Units 1 and 2; Supplemental Inspection Procedure (IP) 95001.

This announced inspection was conducted by two regional inspectors. No findings of significance were identified during this inspection. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Cornerstone: Emergency Preparedness

The U.S. Nuclear Regulatory Commission (NRC) staff performed this supplemental inspection in accordance with IP 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess Constellation's evaluation associated with the Calvert Cliffs emergency action level (EAL) table fission product barrier matrix error, with respect to the threshold associated with the potential loss of the containment barrier. This error resulted in a degraded emergency preparedness risk significant planning standard function for assessment actions (10CFR 50.47(b)(4)). This performance issue was previously characterized as having low to moderate risk significance (white) in NRC Inspection Report Nos. 05000317/2008502, 05000318/2008502. During this supplemental inspection, the inspectors determined that Constellation had performed a comprehensive evaluation of the incorrect EAL matrix and staff performance issues. However, the NRC inspectors identified one example where minor decreases in effectiveness (DIEs) had been introduced into the current EALs. Specifically, a reduction in several safe shutdown locations was not identified as a DIE. These DIEs were not risk-significant, in that the EAL set met the intent of the NEI 99-01 scheme; however, Constellation inappropriately eliminated events that would have been classified under the previous scheme, without prior NRC approval.

The licensee's evaluation determined the root cause of the issue associated with the white finding was that their organization did not recognize nor understand the true scope of the EAL change project. This resulted in the absence of a thorough, structured review and assessment process that would assure the NUMARC/NESP-007 based EALs were properly converted to the NEI 99-01, Revision 4, based EAL scheme without causing a decrease in effectiveness of the Calvert Cliffs Emergency Plan. Constellation implemented appropriate corrective actions that addressed the root cause and contributing causes. They also conducted an extent of condition review for other EALs and associated tables to ensure they were consistent with regulatory and industry guidance.

Given the licensee's acceptable performance in addressing the EAL deficiencies, the white finding associated with this issue will only be considered in assessing plant performance through the fourth quarter of 2009, in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program." Further implementation of the licensee's corrective actions may be reviewed during future inspections.

Findings

No findings of significance were identified.

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REPORT DETAILS

4 OTHER ACTIVITIES

4OA7 Supplemental Inspection (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95001 to assess Constellation's evaluation of a white finding, which affected the emergency preparedness cornerstone in the reactor safety strategic performance area. The inspection objectives were to:

- provide assurance that the root and contributing causes of risk-significant issues were understood;
- provide assurance that the extent of condition and extent of cause of risk-significant issues were identified; and,
- provide assurance that the licensee's corrective actions for risk-significant issues were or will be sufficient to address the root and contributing causes and to preclude repetition.

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the first quarter of 2009 as a result of one inspection finding of low to moderate safety significance (white). The finding was associated with incorrect EAL tables regarding the fission product barrier matrix. From August 31, 2005, through April 10, 2008, Constellation did not maintain in effect an Emergency Plan that met the standards in 10CFR 50.47(b)(4) for assessment actions. The finding was characterized as having white safety significance based on the results of the IMC 0609, Appendix B, "Emergency Preparedness Significance Determination Process."

The licensee staff informed the NRC on October 9, 2009, that they were ready for the supplemental inspection. In preparation for the inspection, the licensee performed a root cause analysis (RCA), per condition report (CR) IRE-027-361, to identify weaknesses that existed in the emergency planning organization which allowed a risk-significant finding to occur and to determine the organizational attributes that resulted in the white finding. The licensee also compiled a safety culture component assessment.

The inspectors reviewed the licensee's RCA and other evaluations conducted in support of, and as a result of, the finding. The inspection scope included a review of the following documents: (1) the CR IRE-027-361 root cause analysis report (RCAR); (2) relevant corrective action program reports (CAPs); (3) emergency planning (EP) program procedures; (4) the extent of condition determination; and, (5) the adequacy of both completed and planned corrective actions. The inspectors interviewed the root cause team leader and several members of the organization responsible for corrective actions taken or scheduled.

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.02 Evaluation of the Inspection Requirements

02.01 Problem Identification

- a. IP 95001 requires that the inspection staff determine that the licensee's evaluation of the issue documents who identified the issue (i.e., licensee-identified, self-revealing, or NRC-identified) and the conditions under which the issue was identified.

The licensee identified this issue. The EAL issue related to the white finding was initially identified with CR IRE-027-361 in February 2008. Other EAL issues were identified during Constellation's RCAR investigation, and all were resolved as part of the same CR. The inspectors verified that this information was documented in the licensee's RCAR.

- b. IP 95001 requires that the inspection staff determine that the licensee's evaluation of the issue documents how long the issue existed and prior opportunities for identification.

Constellation's RCAR documented that the issue originated in August 2005 when Calvert Cliffs adopted the new EAL scheme. The issue was corrected on April 10, 2008, when the licensee correctly revised the EAL fission product barrier matrix.

Constellation's event documentation provided an adequate history of the issue, which included the licensee having identified four additional EAL discrepancies which were deviations from the NEI 99-01 guidance. These four deviations were all discovered and corrected prior to the identification of the issue which was the subject of the finding, and all were prior opportunities for identification of additional deficiencies in the EAL scheme as implemented in August 2005.

The inspectors identified that Constellation had one additional earlier opportunity to consider the adequacy of the Calvert Cliffs conversion to the NEI 99-01 EALs, when the Constellation staff identified an inaccurate EAL threshold in September 2005 (CR IRE-028-444). The initial set of NEI 99-01 EALs contained an incorrect spent fuel pool water level threshold for event classification (EAL A.U.1.4.1). Constellation corrected the EAL, but the associated extent of condition was limited and failed to explore if other EALs had been improperly implemented.

The inspectors determined that the licensee's evaluation identified how long the issue existed and was adequate with respect to prior opportunities for identification.

- c. IP 95001 requires that the inspection staff determine that the licensee's evaluation documents plant specific risk consequences, as applicable, and compliance concerns associated with the issue.

Constellation's RCAR assessed both the actual and potential consequences associated with the finding. The licensee determined they had not missed any actual event classifications as a result of the EAL deviations and that neither the site staff nor the public had received any radiation dose as a result of any of the EAL deviations. The RCAR analyzed a number of related event scenarios to determine if the EAL deviations had the potential to affect proper event classification. This analysis included all errors

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identified with the EAL table in addition to the error that resulted in the white finding. The results of the licensee's evaluation determined that event declarations may have been delayed, but that in almost all cases the proper declaration would have been made based on redundant EALs or based on co-existing conditions. The analysis did identify one Alert classification that could have been missed as a result of the 0C diesel generator building not being included as a Safe Shutdown Area in the EALs. The RCAR discussed the compliance concerns in various sections of the report, including: event reconstruction; actual consequences; human performance aspects of the safety culture component assessment; and, corrective actions.

The inspectors concluded that Constellation did a thorough job of evaluating and describing the risks and possible consequences of the inappropriate EALs. The RCAR also properly considered the compliance concerns associated with the finding.

d. Findings

No findings of significance were identified.

02.02 Root Cause, Extent of Cause, and Extent of Condition Evaluation

- a. IP 95001 requires that the inspection staff determine that the licensee evaluated the issue using a systematic methodology to identify the root and contributing causes.

The licensee used the following methods, per procedure CNG-CA-1.01-1004, "Root Cause Analysis," to complete the RCAR:

- event and causal factor charting;
- comparative timeline charting;
- barrier analysis; and,
- "why" staircase safety culture component assessment.

The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

- b. IP 95001 requires that the inspection staff determine that the licensee's RCAR was conducted to a level of detail commensurate with the significance of the issue.

The RCAR reviewed by the inspectors was Constellation's fourth revision of the effort. Constellation's own self-reviews and challenge boards had found the three previous reports lacking in the full assessment of the root cause and extent of condition. The licensee's final root cause evaluation was thorough and identified the primary root cause to be that the organization did not recognize nor understand the true scope of the project such that a structured review and assessment process was implemented to assure all NUMARC/NESP-007 EALs were accurately converted to the NEI 99-01, Revision 4, scheme. The RCAR identified that process and organizational errors led to the finding. The inspectors determined that Constellation's final root cause evaluation had been performed to an appropriate level of detail, and was appropriate for the significance of the issue.

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- c. IP 95001 requires that the inspection staff determine that the licensee's RCAR included a consideration of prior occurrences of the issue and knowledge of operating experience.

The root cause investigation did a good job of expanding to include several additional examples of EAL deviations that were discovered by the licensee, but did not include a September 2005 discrepancy as previously discussed. The investigation also identified that Constellation did not effectively use available operating experience (e.g., industry events, NRC generic communications, etc.) at the time of the EAL scheme modification. The RCAR did provide a corrective action to assure that operating experience will be considered when Calvert Cliffs transitions to the NEI 99-01, Revision 5, EAL scheme later this year. The inspectors determined that the licensee's RCAR included consideration of prior occurrences of the problem and knowledge of operating experience.

- d. IP 95001 requires that the inspection staff determine that the licensee's RCAR addresses the extent of condition and extent of cause of the issue.

The licensee's extent of condition and common cause review included: a review of all EALs, conducted by an EP director from a different site; a review of all EALs by a change comparison consultant; a line-by-line proof reading review by an administrative assistant; a review of all EALs by a challenge board; and, a management-directed review of all the EALs by a multi-disciplined team of Constellation staff.

The licensee's root cause effort did a good job of investigating and identifying other NEI 99-01 EALs that had not been properly defined. The challenge board effort was effective in bringing the Calvert Cliffs EALs into alignment with the NEI 99-01, Revision 4, scheme. However, the investigation team did not have a complete understanding of the regulatory definition of a decrease in effectiveness (DIE), and the NRC inspectors identified one additional example where minor DIEs had been introduced into the current EALs. Specifically, a reduction in several safe shutdown locations was not identified as a DIE. These DIEs were not risk-significant, in that the EAL set met the intent of the NEI 99-01 scheme; however, Constellation inappropriately eliminated events that would have been classified under the previous scheme, without prior NRC approval. The licensee took immediate corrective actions to eliminate these DIEs by supplementing the EALs. The inspectors independently evaluated these DIE deficiencies per the guidance in IMC 0612, Appendix B, "Issue Screening," and Appendix E, "Examples of Minor Issues." Minor violations of NRC requirements are not subject to enforcement action in accordance with the NRC Enforcement Policy.

The inspectors concluded that the licensee's RCAR adequately addressed the extent of condition and the extent of cause of the issue.

- e. IP 95001 requires that the inspection staff determine that the licensee's root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0305.

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The RCAR discussed safety culture aspects and contained a safety culture component assessment. The licensee found some weaknesses and significant contributors in the following areas: decision making; resources; work control; work practices; and, problem identification and resolution. Other areas identified as factors included management safety behaviors and organizational change management. The inspectors determined that the licensee effort was thorough and adequately captured the safety culture aspects of the performance deficiency.

f. Findings

No findings of significance were identified.

02.03 Corrective Actions

- a. IP 95001 requires that the inspection staff determine that (1) the licensee specified appropriate corrective actions for each root cause and/or contributing cause, or (2) an evaluation that states no actions are necessary is adequate.

The RCAR identified short-term and long-term corrective actions to resolve the identified root and contributing causes of this issue. The corrective actions included: (1) emergency planning implementing procedure revisions; (2) submittal of future NEI 99-01, Revision 5, EAL changes to the NRC for approval; (3) EAL training for key emergency response organization positions; (4) revision and implementation of non-technical error prevention tools to be used at CCNPP; and, (5) revision and implementation of the fleet change management procedure. The inspectors determined that the proposed and implemented corrective actions were appropriate and addressed each root and contributing cause.

- b. IP 95001 requires that the inspection staff determine that the licensee prioritized corrective actions with consideration of risk significance and regulatory compliance.

The inspectors determined that the corrective actions derived from the root cause report had been generated and implemented at a pace commensurate with their significance and were properly prioritized. The inspectors concluded that Constellation's approach to the implementation of corrective actions was an appropriate method to influence behavior in the area of EAL scheme changes and changes to the emergency plan.

- c. IP 95001 requires that the inspection staff determine that the licensee established a schedule for implementing and completing the corrective actions.

Constellation implemented compensatory actions for all the EAL deviations identified during the development of the RCAR, pending the completion of final corrective actions. Corrective actions completed by the licensee were implemented in a timely manner. The inspectors determined that the schedule to complete open corrective actions was reasonable. The three corrective actions remaining open included: (1) a corporate review of the EP procedural changes; (2) an assessment and revision of the fleet change management procedure and process; and, (3) an effectiveness review. The

licensee initiated new corrective actions to address the NRC-identified discrepancies discussed in Section 02.02.d of this report.

The inspectors determined the corrective actions were appropriately scoped and defined. The inspectors identified that while the corrective actions were appropriately defined, two of the corrective actions described as implemented had not been completely accomplished. These corrective actions involved modifications to EP procedures EP-1-100, "Preparation and Control of The Emergency Response Plan," and EP-1-301, "Administration of Revisions and Changes to the Emergency Response Plan Implementation Procedures and the Emergency Response Plan". This issue would likely have been identified during the licensee's pending corporate EP review of these two procedures, by which the inspectors determined the discrepancies would be corrected.

The inspectors determined that an appropriate schedule had been established for implementing and completing the corrective actions.

- d. IP 95001 requires that the inspection staff determine that the licensee developed quantitative and/or qualitative measures of success for determining the effectiveness of the corrective actions to preclude repetition.

An effectiveness review was included as a corrective action in the RCAR and was designed to provide further licensee management follow-up and assessment of the program changes which resulted from this issue. These measures included:

- an assessment of all EAL changes that had been made as a result of the RCAR;
- a review of all corrective actions to prevent recurrence to determine completion and the success of those actions as they relate to EP program changes and other change management projects; and,
- an assessment of all EAL changes, and other significant emergency plan changes, made between October 2009 and April 2011 (this date was chosen to include the planned transition to the NEI 99-01, Revision 5, EALs), to assure that the changes were appropriate and made in compliance with all regulatory requirements.

The inspectors determined that quantitative and qualitative measures of success had been developed for determining the effectiveness of the corrective actions to preclude repetition.

- e. IP95001 requires that the inspection staff determine that the licensee's corrective actions planned or taken adequately address the Notice of Violation (NOV) that was the basis for the supplemental inspection.

The NRC issued an NOV to Constellation in a letter dated April 3, 2009. The NRC determined that the information regarding the reason for the violation, the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance was or will be achieved was sufficiently described in NRC

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Inspection Report Nos. 05000317/2008502, 05000318/2008502, such that Constellation was not required to respond in writing to the NOV. The licensee restored full compliance with the issue related to the finding on April 10, 2008. As for the minor DIE violations discussed in Section 02.02.d, Constellation initiated CR 2009-008802, with a scheduled completion date of May 14, 2010, and took immediate actions to correct those discrepancies. During this supplemental inspection, the inspectors confirmed that the licensee's RCAR, and planned and completed corrective actions, addressed the NOV and remaining open regulatory issues.

f. Findings

No findings of significance were identified.

40A6 Exit Meeting Summary

On December 4, 2009, the inspectors presented the inspection results to Mr. James A. Spina, Site Vice President, and other members of his staff, who acknowledged the results. The inspectors asked the licensee if any of the materials examined during the inspection should be considered proprietary. The licensee did not identify any proprietary information.

Regulatory Performance Meeting

In accordance with IMC 0305, "Operating Reactor Assessment Program, the NRC staff conducted a Regulatory Performance Meeting directly following the exit meeting on December 4, 2009, between Mr. James M. Trapp, Chief of Plant Support Branch 1, NRC Region I, and Mr. James A. Spina, Calvert Cliffs Site Vice President, and other members of the licensee's staff.

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ATTACHMENT

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

J. Spina, Site Vice President
L. Larragoite, Fleet Manager of Nuclear Safety and Security
J. Jones, Fleet Director of Emergency Preparedness
M. Fick, Site Director of Emergency Preparedness

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Opened and Closed

None

Closed

05000317/2008502 and 05000318/2008502-01	VIO	Incorrect EAL scheme
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LIST OF DOCUMENTS REVIEWED

Procedures

EP-1-100, Preparation and Control of The Emergency Response Plan, Revision 00300
EP-1-301, Administration Of Revisions And Changes To The Emergency Response Plan
Implementation Procedures And The Emergency Response Plan, Revision 00200
ERPIP-3.0, Immediate Actions, Revision 37

Other Documents

Category Root Causal Analysis, Implementation of Emergency Plan Emergency Actions Levels
(EALs) with a Decrease in Effectiveness, Revision 4
99-01-EAL-TB, Calvert Cliffs Nuclear Power Plant Technical Bases, April 8, 2009
CR-2009-007341, Apparent Cause Evaluation by Licensed Operator Requalification Curriculum
Review Committee, November 23, 2009
CR-2009-006517, Apparent Cause Evaluation by Operations, October 15, 2009
50.54(q) Screening, ERPIP-3.0, Immediate Actions, Attachment 3, Rev/Change No: 38

50.54(q) Screening, ERPIP-3.0, Immediate Actions, Attachment 3, Rev/Change No: 39
50.54(q) Screening, ERPIP-3.0, Immediate Actions, Attachment 3, Rev/Change No: 40
50.54(q) Screening, ERPIP-3.0, Attachment 24, Add new action to security attachment, Rev/Change No: 04001
50.54(q) Screening, Correct EAL A.U.1.4.1 for SFP Water level and use of ARM indication for both the EAL Criteria attachment to ERPIP 3.0 and EAL Technical Bases Document, Rev/Change No: 04002
50.54(q) Screening, Reformatting of ERPIP 3.0 Immediate Actions for Attachment 2, 3, 4,9,11 and 13 from two column style to narrative style, Rev/Change No: 04100

Condition Reports

CR-IRE-027-361, EAL A.A.6.2.3 Fire, Explosion, or Steam Leak in any safe shutdown area does not meet the intent of NEI 99-01 Revision 4 Guidance.
CR-IRE-008-345, The Basis Document for ERPIP A.U.1.4.1 States Minimum SFP Level per TS is 56.7 Feet when the level is 65 feet 8.5 inches.
CR-IRE-027-551, During extent of condition review of IRE-027-361 clarification needed for EAL A.A.3.3.3
CR-IRE-027-552, Editorial correction noted by peer review EAL H.S.3.1.1
CR-IRE-028-082, The safe shutdown table does not include the OC Diesel Generator Building
CR-IRE-028-180, Procedure package for ERPIP 3.0, rev 38 does not contain all of the necessary documentation explaining the reason for the change.
CR-IRE-028-182, Emergency Response Plan out of date and still in use
CR-IRE-028-183, EALs aligned with basis document but may not be aligned with NEI 99-01 guidance
CR-IRE-028-353, Not clear on how to apply Tech Specs to EAL A.U.1.2.1 and A.U.1.3.1
CR-IRE-028-435, Immediate change made to ERPIP 3.0 but Technical Basis Document did not get completed and distributed at the same time
CR-IRE-028-440, Potential deviations with EALs found by RCAR team
CR-IRE-028-441, EALs A.U.1.2.1 and A.U.1.3.1 in reactor fuel category have error traps
CR-IRE-028-445, During 2004 EAL Upgrade five deviations removed from proposed NEI 99-01 Rev 4 scheme
CR-IRE-028-935, Snapshot Self Assessment of Ginna Unusual Event
CR-IRE-028-406, ERPIP 3.0 Attachment 4 phone number does not match Emergency Response Plan Rosters

LIST OF ACRONYMS

ADAMS	Agencywide Documents Access and Management System
CFR	Code of Federal Regulations
CR	Condition Report
DIE	Decrease in Effectiveness
EAL	Emergency Action Level
EP	Emergency Preparedness
ERO	Emergency Response Organization
ERPIP	Emergency Response Plan Implementing Procedure
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IR	Inspection Report
NEI	Nuclear Energy Institute
NRC	Nuclear Regulatory Commission
OE	Operating Experience
RCAR	Root Cause Analysis Report
SDP	Significance Determination Process
SFP	Spent Fuel Pool
TS	Technical Specifications