



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
245 PEACHTREE CENTER AVENUE NE, SUITE 1200  
ATLANTA, GEORGIA 30303-1257

December 23, 2013

Ms. C. A. Gayheart  
Vice President  
Southern Nuclear Operating Company, Inc.  
Joseph M. Farley Nuclear Plant  
P.O. Drawer 470, BIN B500  
Ashford, AL 36312

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT – NRC PROBLEM IDENTIFICATION  
AND RESOLUTION INSPECTION REPORT 05000348/2013007 AND  
05000364/2013007

Dear Ms. Gayheart:

On November 21, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution biennial inspection at your Joseph M. Farley Nuclear Plant, Units 1 and 2. On November 21, 2013, the NRC inspection team discussed the results of this inspection with you and other members of your staff. The inspection team documented the results of this inspection in the enclosed inspection report.

Based on the inspection sample, the inspection team determined that your staff's implementation of the corrective action program supported nuclear safety. In reviewing your corrective action program, the team assessed how well your staff identified problems at a low threshold, your staff's implementation of the station's process for prioritizing and evaluating these problems, and the effectiveness of corrective actions taken by the station to resolve these problems. In each of these areas, the team determined that your staff's performance was adequate to support nuclear safety.

The team also evaluated other processes your staff used to identify issues for resolution. These included your use of audits and self-assessments to identify latent problems and your incorporation of lessons learned from industry operating experience into station programs, processes, and procedures. The team determined that your station's performance in each of these areas supported nuclear safety.

Finally, the team determined that your station's management maintains a safety-conscious work environment adequate to support nuclear safety. Based on the team's observations, your employees are willing to raise concerns related to nuclear safety through at least one of the several means available.

The NRC inspectors did not identify any findings or violations of more than minor significance.

C. Gayheart.

2

In accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding," 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's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Steven D. Rose, Branch Chief  
Reactor Projects Branch 7  
Division of Reactor Projects

Docket No. 50-348, 50-364  
License No. NPF-2 and NPF-8

Enclosure: Inspection Report 05000348/2013007 and 05000364/2013007  
w/Attachment: Supplemental Information

cc Distribution via ListServ

C. Gayheart.

2

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INSPECTION REPORT 2013 007.DOCX

C. Gayheart.

3

Letter to C. A. Gayheart from Steven D. Rose dated December 23, 2013

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT – NRC PROBLEM IDENTIFICATION  
AND RESOLUTION INSPECTION REPORT 05000348/2013007 AND  
05000364/2013007

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**U.S. NUCLEAR REGULATORY COMMISSION**

**REGION II**

Docket No.: 50-348, 50-364

License No.: NPF-2 and NPF-8

Report No.: 05000348/2013007 and 05000364/2013007

Licensee: Southern Nuclear Operating Company, Inc

Facility: Joseph M. Farley Nuclear Plant

Location: Columbia, AL

Dates: November 4 – 8, 2013  
November 18 – 21, 2013

Inspectors: R. Clagg, Resident Inspector, North Anna, Team Leader  
R. Rodriguez, Senior Project Inspector  
J. Quinones-Navarro, Project Inspector  
J. Sowa, Resident Inspector

Approved by: Steven D. Rose, Branch Chief,  
Reactor Projects Branch 7  
Division of Reactor Projects

Enclosure

## **SUMMARY OF FINDINGS**

IR 05000348/2013007, 05000364/2013007; November 4 – 21, 2013; Joseph M. Farley Nuclear Plant, Units 1 and 2; Biennial Inspection of the Problem Identification and Resolution Program.

The inspection was conducted by a senior project inspector, a project inspector, and two resident inspectors. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

### Identification and Resolution of Problems

The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few number of deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner. However, the inspectors did identify minor performance deficiencies in the area of effectiveness of corrective actions.

The inspectors determined that overall audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

## REPORT DETAILS

### 4. OTHER ACTIVITIES

#### 4OA2 Problem Identification and Resolution

##### .1 Corrective Action Program Effectiveness

###### a. Inspection Scope

The inspectors reviewed the licensee's CAP procedures which described the administrative process for initiating and resolving problems primarily through the use of condition reports (CRs). To verify that problems were being properly identified, appropriately characterized, and entered into the CAP, the inspectors reviewed CRs that had been issued between June 2011 and October 2013, including a detailed review of selected CRs associated with the following risk-significant systems: Auxiliary Feedwater (AFW), Emergency Diesel Generators (EDG), Service Water (SW), and 4160V Switchgear. Where possible, the inspectors independently verified that the corrective actions were implemented as intended. The inspectors also reviewed selected common causes and generic concerns associated with root cause evaluations to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones of safety identified in the NRC's Reactor Oversight Process, the inspectors selected a representative number of CRs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, health physics, chemistry, emergency preparedness, and security. These CRs were reviewed to assess each department's threshold for identifying and documenting plant problems, thoroughness of evaluations, and adequacy of corrective actions. The inspectors reviewed selected CRs, verified corrective actions were implemented, and attended meetings where CRs were screened for significance to determine whether the licensee was identifying, accurately characterizing, and entering problems into the CAP at an appropriate threshold.

The inspectors conducted plant walkdowns of equipment associated with the selected systems and other plant areas to assess the material condition and to look for any deficiencies that had not been previously entered into the CAP. The inspectors reviewed CRs, maintenance history, completed work orders for the systems, and reviewed associated system health reports. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. Items reviewed generally covered a two-year period of time; however, in accordance with the inspection procedure, a five-year review was performed for selected systems for age-dependent issues.

Control Room walkdowns were also performed to assess the main control room deficiency list and to ascertain if deficiencies were entered into the CAP. Operator workarounds and operator burden screenings were reviewed, and the inspectors verified compensatory measures for deficient equipment which were being implemented in the field.

The inspectors conducted a detailed review of selected CRs to assess the adequacy of the root-cause and apparent-cause evaluations of the problems identified. The inspectors reviewed these evaluations against the descriptions of the problem described in the CRs and the guidance in licensee procedure NMP-GM-002-006, "Root Cause Analysis Instruction," and NMP-GM-002-007, "Apparent Cause Determination Instruction." The inspectors assessed if the licensee had adequately determined the cause(s) of identified problems, and had adequately addressed operability, reportability, common cause, generic concerns, extent-of-condition, and extent-of-cause. The review also assessed if the licensee had appropriately identified and prioritized corrective actions to prevent recurrence.

The inspectors reviewed selected industry operating experience items, including NRC generic communications to verify that they had been appropriately evaluated for applicability and that issues identified through these reviews had been entered into the CAP.

The inspectors reviewed site trend reports to determine if the licensee effectively trended identified issues and initiated appropriate corrective actions when adverse trends were identified.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included CR screening meetings and Management Review Committee meetings.

Documents reviewed are listed in the Attachment.

b. Assessment

Problem Identification

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the CAP and there was a low threshold for entering issues into the CAP. This conclusion was based on a review of the requirements for initiating CRs as described in licensee procedure NMP-GM-002, "Corrective Action Program," management's expectation that employees were encouraged to initiate CRs for any reason, and the relatively few number of deficiencies identified by inspectors during plant walkdowns not already entered into the CAP. Trending was generally effective in monitoring equipment performance. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues.

Based on reviews and walkdowns of accessible portions of the selected systems, the inspectors determined that system deficiencies were being identified and placed in the CAP.

### Problem Prioritization and Evaluation

Based on the review of CRs sampled by the inspection team during the onsite period, the inspectors concluded that problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures as described in the CR severity level determination guidance in NMP-GM-002-001, "Corrective Action Program Instructions." Each CR was assigned a severity level at the CAP coordinator (CAPCO) meeting, and adequate consideration was given to system or component operability and associated plant risk.

The inspectors determined that station personnel had conducted root cause and apparent cause analyses in compliance with the licensee's CAP procedures and assigned cause determinations were appropriate, considering the significance of the issues being evaluated. A variety of formal causal-analysis techniques were used depending on the type and complexity of the issue consistent with NMP-GM-002-006 and NMP-GM-002-007.

### Effectiveness of Corrective Actions

Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the inspectors determined that overall, corrective actions were timely, commensurate with the safety significance of the issues, and effective, in that conditions adverse to quality were corrected and non-recurring. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence in that a review of performance indicators, CRs, and effectiveness reviews demonstrated that the significant conditions adverse to quality had not recurred. Effectiveness reviews for corrective actions to prevent recurrence (CAPRs) were sufficient to ensure corrective actions were properly implemented and were effective.

The inspectors identified three performance deficiencies associated with the licensee's effectiveness of corrective actions. These issues were screened in accordance with Inspection Manual Chapter 0612, "Issue Screening," and were determined to be of minor significance and not subject to enforcement action in accordance with the NRC's Enforcement Policy.

- Root Cause Investigation for Corrective Action Record (CAR) 194725, "Unit 1 Containment Tendon Failure," was revised to version 2 on September 27, 2013. Revision 1 of the Root Cause contained Enhancement 1 which required the addition of microbiological analysis to Farley surveillance procedure FNP-1/2-STP-609, "Containment Tendon Surveillance Test." Revision 2 of the Root Cause stated that Enhancement 1 was removed from Root Cause because the actions of the enhancement were included in Corrective Action 2 (AI464428) of the Root Cause. During a review of Corrective Action 2 in Revision 2 of the Root Cause, NRC inspectors determined that the requirement to incorporate microbiological analysis in FNP-1/2-STP-609 was not included. CAP program documents indicate Corrective Action 2 (AI464428) was completed on October 16, 2013. NMP-GM-002-001, "Corrective Action Program Instructions," section 4.8.1 states in part that "the

Enclosure

CAPCO generates Technical Evaluation Action Items from the CAR as needed to implement the Corrective Action Plan." The failure to generate an Action Item to include procedure revisions to FNP-1/2-STP-609 in Corrective Action 2 in Revision 2 of CAR 194725 as required by NMP-GM-002-001 is a performance deficiency. The inspectors determined that this is a failure to implement a procedural requirement that had no safety impact since microbiological attack was not considered to be a significant factor in the tendon failure and is, therefore, minor. The licensee generated CR729473 to address the issue.

- Root Cause Investigation for CAR 194375, Revision 3, "Loss of Shutdown Cooling during Recovery Phase of FNP-1-STP-40.0," contained CAPR 3. This CAPR consisted of Technical Evaluation (TE) 434149 which required the licensee to revise procedure NMP-OS-010, "Protected Train/Division and Protected Equipment Program," to "develop and implement protected equipment guidance to preclude testing, maintenance, or work on or near protected equipment and include a provision to define absolutely necessary conditions that warrant testing, maintenance, or work providing strict controls and oversight required to perform aforementioned tasks." TE434149 was completed on July 12, 2012. Upon review of NMP-OS-010, Version 6.0, NRC inspectors determined that "absolutely necessary conditions that would warrant testing, maintenance, or work near protected equipment" were not defined in the procedure revision. Section 5.2.5 of NMP-OS-010 details conditions for work on protected equipment but similar guidance for conditions that would warrant testing, maintenance, or work near, or in the vicinity of, protected equipment were not detailed in the procedure. NMP-GM-002-001, "Corrective Action Program Instructions," section 4.15.12 requires in part that the action item reviewer "verifies the documented action taken clearly communicates the requested action has been completed." The failure to verify the requirements of CAPR 3 were included in NMP-OS-010 Version 6.0 prior to closing TE434149 is a performance deficiency. The inspectors determined that this is a failure to implement a procedural requirement that had no impact on safety related equipment and caused no safety consequences and is, therefore, minor. The licensee generated CR730054 to address the issue.
- Root Cause Investigation (SL-1) for CAR 192763, "U2 TDAFW pump tripped during performance of STP-22.16," identified several causal factors contributing to the pump trip. In October of 2010, CR114199 was written to revise procedure FNP-1/2-STP-22.23, "Turbine Driven Auxiliary Feedwater Pump Trip and Throttle Valve Indicator Operability Test," to incorporate guidance on how to correctly reset the trip and throttle valve of the Turbine Driven Auxiliary Feedwater Pump (TDAFW) pump. However, this procedure change was allowed to go into the backlog with no urgency specified. On November 8, 2011, the U2 TDAFW pump's trip and throttle valve tripped and troubleshooting revealed that the valve was not fully reset. This valve was tested and reset previously in the shift using FNP-2-STP-22.23. The failure to effectively coincide the risk significance and prioritized correction of identified procedure short falls was identified as root cause number 1. A CAPR revised the guidance for resetting the TDAFW pump's trip and throttle valve in procedure FNP-1/2-STP-22.23. The inspectors questioned whether this CAPR addressed the

procedure prioritization deficiencies identified in root cause number 1. NMP-GM-002-001, "Corrective Action Program Instructions," states in part that CAPRs are a regulatory requirement for SL-1 CARs. The failure to establish a CAPR for root causes identified in SL-1 CARs is a performance deficiency. The inspectors determined that this performance deficiency was minor because there were other corrective actions identified in the CAR that addressed the procedure prioritization deficiencies identified in root cause number 1. The licensee generated CR730067 to address the issue.

c. Findings

No findings were identified.

.2 Use of Operating Experience

a. Inspection Scope

The inspectors examined licensee programs for reviewing industry operating experience, reviewed licensee procedure NMP-GM-008, "Operating Experience Program," reviewed the licensee's operating experience database to assess the effectiveness of how external and internal operating experience data was handled at the plant. In addition, the inspectors selected operating experience documents (e.g., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and plant internal operating experience items, etc.), which had been issued since September 2011 to verify whether the licensee had appropriately evaluated each notification for applicability to Joseph M. Farley Nuclear plant, and whether issues identified through these reviews were entered into the CAP. Procedure NMP-GM-008, "Operating Experience Program," was reviewed to verify that the requirements delineated in the program were implemented at the station.

Documents reviewed are listed in the Attachment.

b. Assessment

Based on a review of documentation related to the review of operating experience issues, the inspectors determined that the licensee was generally effective in screening operating experience for applicability to the plant. Industry operating experience (OE) was evaluated by plant OE Coordinators and relevant information was then forwarded to the applicable department for further action or informational purposes. OE issues requiring action were entered into the CAP for tracking and closure. In addition, operating experience was included in root cause evaluations in accordance with licensee procedure NMP-GM-002-006, "Root Cause Analysis Instruction."

c. Findings

No findings were identified.

.3 Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed audit reports and self-assessment reports, including those which focused on problem identification and resolution, to assess the thoroughness and self-criticism of the licensee's audits and self-assessments, and to verify that problems identified through those activities were appropriately prioritized and entered into the CAP for resolution in accordance with licensee procedure NMP-GM-003, "Self-Assessment Procedure."

Documents reviewed are listed in the Attachment.

b. Assessment

The inspectors determined that the scopes of assessments and audits were adequate. Self-assessments were generally detailed and critical, as evidenced by findings consistent with the inspector's independent review. The inspectors verified that CRs were created to document all areas for improvement and findings resulting from the self-assessments and verified that actions were completed consistently with those recommendations. Generally, the licensee performed evaluations that were technically accurate. Site trend reports were thorough and a low threshold was established for evaluation of potential trends, as evidenced by the CRs reviewed that were initiated as a result of adverse trends.

c. Findings

No findings were identified.

.4 Safety-Conscious Work Environment

a. Inspection Scope

The inspectors randomly interviewed 21 on-site workers regarding their knowledge of the corrective action program at Joseph M. Farley Nuclear Plant and their willingness to write CRs or raise safety concerns. During technical discussions with members of the plant staff, the inspectors conducted interviews to develop a general perspective of the safety-conscious work environment at the site. The interviews were also conducted to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors reviewed the licensee's Employee Concerns Program (ECP) and interviewed the ECP manager. Additionally, the inspectors reviewed a sample of ECP issues to verify that concerns were properly reviewed and that identified deficiencies were resolved and entered into the CAP when appropriate.

Documents reviewed are listed in the Attachment.

b. Assessment

Based on the interviews conducted and the CRs reviewed, the inspectors determined that licensee management emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs, including the CAP and ECP. These methods were readily accessible to all employees. Based on discussions conducted with a sample of plant employees from various departments, the inspectors determined that employees felt free to raise issues, and that management encouraged employees to place issues into the CAP for resolution. The inspectors did not identify any reluctance on the part of the licensee staff to report safety concerns.

c. Findings

No findings were identified.

4OA5 Other Activities

.1 (Closed) Notice of Violation (VIO) 05000364/2013009-01 (EA-12-240), Deliberate Failure to Conduct Fire Watches

a. Inspection Scope

Per Inspection Procedure 92702, "Follow-up on Corrective Actions for Violations and Deviations," the inspectors reviewed the licensee's response to VIO 05000364/2013009-01 (EA-12-240) dated February 8, 2013. The licensee's corrective actions included training for all fire watch personnel, daily verification of fire watch personnel qualifications, performance of unscheduled, random observations of fire watch personnel, periodic security badge access record verification of fire watch personnel, routine review of log entries documenting fire watch personnel activities, and entry of fire watch personnel performance issues into the licensee's CAP. In addition the licensee implemented additional human performance training for contractor personnel and enhanced procedures for the oversight of contractor personnel.

The inspectors also reviewed the licensee's apparent cause determination report, NRC Level III Notice of Violation (CR 605500) and verified implementation of licensee corrective actions.

Documents reviewed are listed in the Attachment.

b. Findings

No findings were identified. This VIO is closed.

4OA6 Meetings, Including Exit

On November 21, 2013, the inspectors presented the inspection results to you and other members of the site staff. The inspectors confirmed that all proprietary information examined during the inspection had been returned to the licensee.

ATTACHMENT: SUPPLEMENTAL INFORMATION

Enclosure

## KEY POINTS OF CONTACT

### Licensee personnel:

B. Arens, Licensing Engineer  
B. Burgess, System Engineer, Auxiliary Feedwater System  
T. Driggers, Nuclear Oversight Assessor  
D. Enfinger, CAP Supervisor  
C. Gayheart, Site Vice President  
D. Hobson, Shift Operations Manager  
L. Hogg, Nuclear Technical Specialist  
J. Horn, Manager, Regulatory Affairs  
J. Hutto, Plant Manager  
V. Locke, Supervisor, Performance Improvement  
R. Martin, Manager, Engineering Programs  
B. Reed, Supervisor, Nuclear Operations Training  
D. Reed, Manager, Operations Support  
L. Riley, Performance Improvement  
C. Thornell, Operations Director  
B. Taylor, Manager, Nuclear Oversight  
S. Wilson, Maintenance CAPCO

### NRC personnel:

F. Ehrhardt, Chief, Branch 2, Division of Reactor Projects  
P. Niebaum, Senior Resident Inspector  
S. Rose, Chief, Branch 7, Division of Reactor Projects

## LIST OF REPORT ITEMS

### Opened and Closed

None

### Closed

05000364/2013009-01(EA-12-240)                  VIO      Deliberate Failure to Conduct Fire Watches  
(Section 4OA5)

### Discussed

None

Attachment

## LIST OF DOCUMENTS REVIEWED

Procedures:

FNP-0-ACP-59, Extension Cord Usage and Temporary Electrical Cable Installation Guidelines, Revision 6.0  
FNP-0-AP-97.0, Maintenance, Qualifications, Quality Control and Processes, Version 16.0  
FNP-0-SOP-0.11, Watch Station Tours and Operator Logs, Version 27.0  
NMP-AD-012, Operability Determinations and Functionality Assessments, Version 12.2  
NMP-AD-012-F01, Prompt Determination of Operability, Version 3.0  
NMP-AD-012-GL01, Prompt Determination of Operability Guideline, Version 5.0  
NMP-AD-022, Regulatory Oversight Process (ROP) Regulatory Process, Version 4.0  
NMP-AD-028, 10 CFR 21 Evaluation and Reporting Requirements, Version 2.0  
NMP-AD-030, Licensee Event Report (LER), Version 3.1  
NMP-ES-002, System Monitoring and Health Reporting, Version 16.0  
NMP-ES-005, Scoping and Importance Determination for Equipment Reliability, Version 12.0  
NMP-ES-039-004, Calculations - Key Calculation Identification & Improvement, Version 2  
NMP-FLS-003-002, Industrial Extension Cord Instructions, Version 1.0  
NMP-GM-002, Corrective Action Program, Version 12.1  
NMP-GM-002-001, Corrective Action Program Instructions, Version 31.1  
NMP-GM-002-002, Effectiveness Review Instruction, Version 3.0  
NMP-GM-002-006, Root Cause Analysis Instruction, Version 9.1  
NMP-GM-002-007, Apparent Cause Determination Instruction, Version 10.1  
NMP-GM-002-008, Common Cause Instruction, Version 3.0  
NMP-GM-002-F09, Root Cause Analysis Report Format, Version 10  
NMP-GM-002-F40, Basic Cause Determination, Version 8.2  
NMP-GM-002-GL03, Cause Analysis and Coding Guideline, Version 22.0  
NMP-GM-003, Self-Assessment Procedure, Version 20.1  
NMP-GM-003-001, Self-Assessment Instructions, Version 4.1  
NMP-GM-008, Operating Experience, Version 15.0  
NMP-GM-010, Supplemental Personnel Control, Version 14.0  
NMP-GM-027, Initiative Submittal Form for the Plant Health Process, Version 1.0  
NMP-OS-006, Operations Performance Indicators, Version 14.0  
NMP-OS-014-001, FNP Time Critical Operator Action Program, Version 2.0

Condition Reports (CR):

551583, 729606, 194725, 729473, 544568, 602518, 607029, 608552, 646896, 648243, 543945, 502261, 336717, 487081, 337862, 380432, 677678, 336390, 706394, 625932, 192605, 684155, 386236, 448425, 637018, 404497, 412333, 415549, 415596, 423715, 439055, 444680, 516102, 570199, 348613, 354261, 357768, 361764, 379163, 409923, 469951, 393307, 701536

Corrective Action Records (CAR):

194725, 194375, 191397, 191430, 192389, 192701, 193489, 194279, 194797, 195680, 196730, 193642, 194391, 194375, 193642, 193207, 194983, 191238, 194880, 207147, 192605, 193183, 192407, 194710, 196857, 206794, 195212, 192605, 193179, 194341, 197781, 207387, 208201, 208248, 193202, 194924, 195025, 195324, 198078, 169645, 169793, 169826, 206794, 193185, 191489, 206821, 192801, 192763, 193182, 193180, 194862, 195378, 207400, 193884, 196097, 206511, 196292, 207872, 207611, 207049

Technical Evaluations (TE):

552248, 464428, 589708, 589711, 615553, 615573, 615579, 357545, 357552, 357559, 357570, 434495, 434497, 434493, 434487, 434480, 434481, 434488, 327740, 327741, 395960, 327799, 574390, 308655, 308845, 308854, 308866, 494462, 316298, 322143, 322283, 331438, 331442, 331504, 331507, 331516, 331519, 331540, 331987, 317175, 317158, 316823, 316824, 317450, 317451, 317457, 317464, 317472, 317474, 317475, 288562, 288558, 288539, 288537, 288536, 288481, 288473, 288468, 288461, 288458, 288444, 288451, 288437, 288432, 288428, 288373, 288372, 288295, 288272, 288237, 288266, 288667, 288761, 288769, 314493, 314736, 314739, 314534, 314552, 314559, 314563, 314566, 314577, 314585, 314589, 314598, 314600, 314696, 314610, 531048, 531055, 531090, 531058, 314617, 314623, 314638, 314750, 314755, 314656, 314659, 314662, 314668, 314671, 314672, 669886, 320361, 320363, 320387, 544701, 544703, 320400, 320435, 320446, 701962, 317340, 317336, 692872, 692870, 589569, 534044, 430914, 534042, 520059, 317343, 504871

Work Orders (WO):

368682, 376929, 376930, 376931, 376932, 376933, 376934, 376953, 346090, 350487, 365740, 344090, 335293

Audits and Self-Assessments:

Fleet-ENG-2013, Nuclear Oversight Audit of Engineering  
 C-AA-2012, Nuclear Oversight Audit of Access Authorization  
 F-OPS-2012, Nuclear Oversight Audit of Operations  
 C-FD-2012, Nuclear Oversight Audit of Fleet Design  
 C-CAP-2013, Nuclear Oversight Audit of Corrective Action Program  
 Fleet-DCM-2013, Nuclear Oversight Audit of Design Change and Modifications  
 Fleet-FP-2012, Nuclear Oversight Audit of Fire Protection  
 Focused self-assessment, 2013 Problem Identification and Resolution Inspection Preparations

Miscellaneous Documents:

Farley Check-In Self-Assessment Plan and Report for INPO Consolidated Event System (ICES)  
 Implementation dated 6/19/13  
 OFPI Component Mispositioning Index report dated 11/7/13  
 Q2-2013, Unit 1 and 2 Auxiliary Feedwater System Health Report  
 Q2-2013, Unit 1 and 2 Fire Protection System Health Report  
 Q2-2013, Unit 1 and 2 Service Water System Health Report  
 Q3-2013, Unit 1 and 2 Emergency Diesel Generators System Health Report  
 Q3-2013, Unit 1 and 2 4160V Switchgear System Health Report  
 Plant Farley OAI Dashboard for Control Room Deficiencies and Operator Workaround  
 OPS-62102H/52102H/40201D, Auxiliary Feedwater System Lesson Plan, Rev. 2  
 Southern Nuclear Company Concerns Program Procedure, Version 12.0