



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION I
2100 RENAISSANCE BLVD., SUITE 100
KING OF PRUSSIA, PA 19406-2713

November 9, 2015

Mr. Peter Orphanos
Site Vice President
Nine Mile Point Nuclear Station, LLC
Exelon Generation Company, LLC
P.O. Box 63
Lycoming, NY 13093

**SUBJECT: NINE MILE POINT NUCLEAR STATION, LLC - INTEGRATED INSPECTION
REPORT 05000220/2015003 AND 05000410/2015003 AND INDEPENDENT
SPENT FUEL STORAGE INSTALLATION REPORT 07201036/2015001**

Dear Mr. Orphanos:

On September 30, 2015, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Nine Mile Point Nuclear Station, LLC (NMPNS), Units 1 and 2. The enclosed inspection report documents the inspection results, which were discussed on October 16, 2015, with Mr. W. Trafton, Plant General Manager, and other members of your staff.

NRC inspectors 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 personnel.

The inspectors documented one self-revealing finding of very low safety significance (Green) in this report. Additionally, NRC inspectors documented one self-revealing Severity Level IV violation under the traditional enforcement process. The NRC is treating this violation as a non-cited violation (NCV) consistent with Section 2.3.2.a of the Enforcement Policy.

If you contest the 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, Region I; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspectors at NMPNS. In addition, if you disagree with the cross-cutting aspect assigned to any finding, or a finding not associated with a regulatory requirement in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region I, and the NRC Resident Inspectors at NMPNS.

P. Orphanos

-2-

In accordance with Title 10 of the *Code of Federal Regulations* (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's Public Document Room or from the Publicly Available Records 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/

Daniel L. Schroeder, Chief
Reactor Projects Branch 1
Division of Reactor Projects

Docket Nos. 50-220 and 50-410
License Nos. DPR-63 and NPF-69

Enclosure:
Inspection Report 05000220/2015003 and 05000410/2015003 and
Independent Spent Fuel Storage and Installation Report 07201036/2015001
w/Attachment: Supplementary Information

cc w/encl: Distribution via ListServ

P. Orphanos

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No. 50-220 and 50-410

License No. DPR-63 and NPF-69

Report No. 05000220/2015003 and 05000410/2015003

Licensee: Exelon Generation Company, LLC (Exelon)

Facility: Nine Mile Point Nuclear Station, LLC (NMPNS)
Unit 1 and Unit 2

Location: Oswego, New York

Dates: July 1, 2015, through September 30, 2015

Inspectors: K. Kolaczyk, Senior Resident Inspector
E. Miller, Resident Inspector
G. Stock, Resident Inspector
B. Bollinger, Health Physicist
N. Floyd, Reactor Inspector
C. Franklin, General Engineer
C. Graves, Health Physicist
S. Hammann, Senior Health Physicist

Approved by: Daniel L. Schroeder, Chief
Reactor Projects Branch 1
Division of Reactor Projects

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SUMMARY

Inspection Report 05000220/2015003 and 05000410/2015003 and Independent Spent Fuel Storage Installation Report 07201036/2015001; 07/01/2015 – 09/30/2015; Nine Mile Point Nuclear Station, LLC (NMPNS), Units 1 and 2; Follow-Up of Events and Notices of Enforcement Discretion, Other Activities.

This report covered a 3-month period of inspection by resident inspectors and announced inspections performed by regional inspectors. The inspectors identified one self-revealing finding of very low safety significance (Green). In addition, one self-revealing traditional enforcement Severity Level IV non-cited violation (NCV) was identified. The significance of most findings is indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process," dated April 29, 2015. Cross-cutting aspects are determined using IMC 0310, "Aspects Within the Cross-Cutting Areas," dated December 4, 2014. All violations of U.S. Nuclear Regulatory Commission (NRC) requirements are dispositioned in accordance with the NRC's Enforcement Policy, dated February 4, 2015. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 5.

Cornerstone: Initiating Events

- Green. The inspectors identified a self-revealing Green finding (FIN) for Exelon Generation Company, LLC (Exelon) personnel's failure to stop when met with unexpected conditions as required by procedure HU-AA-101, "Human Performance Tools and Verification Practices." On August 21, 2015, a Unit 2 division of normal switchgear was unintentionally deenergized which required an unplanned down power to 90 percent and special operating procedure entry. The loss of the switchgear was the result of installation of an incorrect sized grounding cart in the electric fire pump breaker cubicle during breaker maintenance. Use of the correct sized grounding cart was discussed during the pre-job brief. This resulted in the loss of the electric fire pump, half of the drywell coolers, a heater drain pump, and unplanned reactivity change. Exelon entered this issue into their corrective action program (CAP) for resolution and developed corrective actions which included developing procedures for the use of grounding carts and evaluating where other "skill-of-the-craft" work may pose the same risk.

This finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding is of very low safety significance (Green). The finding has a cross-cutting aspect in the area of Human Performance, challenge the unknown, because Exelon personnel failed to stop when faced with uncertain conditions. Specifically, after having been briefed on the different stab sizes for 1200 amp and 2000 amp grounding carts, Exelon personnel failed to stop and notify supervision when faced with unlabeled grounding carts stored in the same location, Exelon personnel failed to notify supervision or compare stab sizes to ensure the correct grounding cart was used. [H.11] (Section 4OA3)

Miscellaneous

- Severity Level IV. A self-revealing Severity Level IV NCV of Title 10 of the *Code of Federal Regulations* (10 CFR) 72.150, "Instructions, Procedures, and Drawings," was identified when the transporter with the transfer cask and loaded dry shielded canister (DSC)-24 left the Unit 2 designated haul path on July 9, 2015. Specifically, Exelon did not properly implement procedure S-MMP-ISFSI-005, "Site Cask Transportation," to ensure the transporter remained on the heavy haul path at all times; and as a result, the transporter traveled over an unanalyzed surface. Corrective actions included completing a human performance review board investigation, reinforcing with transporter operators the need for the transporter to stay on the heavy haul path while transporting a transfer cask and loaded DSC, and evaluating the asphalt area adjacent to the haul path for damage and for acceptability for continued use.

In accordance with 10 CFR 72.150, the inspectors determined that Exelon did not properly implement S-MMP-ISFSI-005 to ensure the transporter remained on the heavy haul path at all times during transfer of DSC-24 on July 9, 2015. As a result, the transporter traveled over an unanalyzed surface. Because the issue involved independent spent fuel storage installation (ISFSI) operations, consistent with the guidance in Section 2.2 of the NRC Enforcement Policy, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using Example 6.3.d from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV violation. Because this violation involves the traditional enforcement process and was not associated with ISFSI support programs conducted under a 10 CFR 50 license, the inspectors did not assign a cross-cutting aspect to this violation. (Section 40A5)

REPORT DETAILS

Summary of Plant Status

Unit 1 began the inspection period at 100 percent power. On September 4, 2015, Unit 1 automatically scrammed due to a high steam flow signal when a main steam isolation valve (MSIV) unexpectedly closed during MSIV partial stroke testing. Following repairs to the MSIV and other related work during the forced outage, Unit 1 began power ascension on September 6. The reactor went critical on September 6, and the turbine-generator was synchronized to the grid on September 7. Unit 1 reached 100 percent reactor power on September 8. On September 9, operators reduced reactor power to 80 percent to perform a rod pattern adjustment. Operators restored full reactor power later the same day. Unit 1 remained at or near 100 percent power for the remainder of the inspection period.

Unit 2 began the inspection period at 100 percent power. On September 11, 2015, Unit 2 began maximum extended load line limit analysis plus (MELLA+) testing in order to implement this license amendment. On September 12, operators reduced reactor power to 75 percent for MELLA+ testing. On September 13, operators raised reactor power to 85 percent in accordance with the MELLA+ test plan. On September 14, operators reduced reactor power to 75 percent in accordance with the MELLA+ test plan. On September 16, operators restored full reactor power and implemented the MELLA+ license amendment. Unit 2 remained at or near 100 percent power for the remainder of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, and Barrier Integrity

1R04 Equipment Alignment

Partial System Walkdown (71111.04Q – 4 samples)

a. Inspection Scope

The inspectors performed partial walkdowns of the following systems:

- Unit 1 reactor building (RB) emergency ventilation system 11 while maintenance was performed on the normal RB ventilation system on July 14 and 15, 2015
- Unit 1 control room emergency ventilation system during warm weather on July 26, 2015
- Unit 1 emergency condensers 11 and 12 following actuation during the September 4, 2015, scram on September 6, 2015
- Unit 2, Division II, diesel generator following the completion of planned maintenance activities on September 30, 2015

The inspectors selected these systems based on their risk-significance relative to the reactor safety cornerstones at the time it was inspected. The inspectors reviewed applicable operating procedures, system diagrams, the Updated Final Safety Analysis Report (UFSAR), technical specifications (TSs), and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have impacted the system's performance of its intended safety functions. The inspectors also

performed field walkdowns of accessible portions of the systems to verify system components and support equipment were aligned correctly and were operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no deficiencies. The inspectors also reviewed whether Exelon staff had properly identified equipment issues and entered them into the CAP for resolution with the appropriate significance characterization. Documents reviewed for each section of this inspection report are listed in the Attachment.

b. Findings

No findings were identified.

1R05 Fire Protection

Resident Inspector Quarterly Walkdowns (71111.05Q – 5 samples)

a. Inspection Scope

The inspectors conducted tours of the areas listed below to assess the material condition and operational status of fire protection features. The inspectors verified that Exelon controlled combustible materials and ignition sources in accordance with administrative procedures. The inspectors verified that fire protection and suppression equipment was available for use as specified in the area pre-fire plan, and passive fire barriers were maintained in good material condition. The inspectors also verified that station personnel implemented compensatory measures for out of service (OOS), degraded, or inoperable fire protection equipment, as applicable, in accordance with procedures.

- Unit 1 RB 237 (fire area (FA) 1) on July 7, 2015
- Unit 1 RB 318 (FA 2) on July 7, 2015
- Unit 1 RB 340 (FA 2) on July 7, 2015
- Unit 1 battery board 11 room (FA 16B) on July 7, 2015
- Unit 1 battery board 12 room (FA 16A) on July 7, 2015

b. Findings

No findings were identified.

1R06 Flood Protection Measures (71111.06 – 2 samples)

.1 Internal Flooding Review

a. Inspection Scope

The inspectors reviewed the UFSAR, the site flooding analysis, and plant procedures to identify internal flooding susceptibilities for the site. The inspectors review focused on the Unit 1 RB and turbine building. The inspectors verified the adequacy of equipment seals located below the flood line, floor and water penetration seals, watertight door seals, common drain lines and sumps, sump pumps, level alarms, control circuits, and

temporary or removable flood barriers. The inspectors assessed the adequacy of operation actions that Exelon had identified as necessary to cope with flooding in this area and also reviewed the CAP to determine if Exelon was identifying and correcting problems associated with both flood mitigation features and site procedures for responding to flooding.

b. Findings

No findings were identified.

.2 Annual Review of Cables Located in Underground Bunkers/Manholes

a. Inspection Scope

The inspectors conducted an inspection of underground bunkers/manholes subject to flooding that could affect risk-significant equipment. The inspectors performed walkdowns of risk-significant areas, including manhole 2 which, when flooded, can cause flooding on Unit 2 normal switchgear 237-foot elevation, to verify that no in-leakage to the control building was present. When applicable, the inspectors verified proper sump pump operation and verified level alarm circuits were set in accordance with station procedures and calculations to prevent flooding in the future. The inspectors also ensured that drainage was provided and functioning properly in areas where dewatering devices were not installed.

b. Findings

No findings were identified.

1R11 Licensed Operator Regualification Program and Licensed Operator Performance (71111.11Q – 4 samples)

.1 Quarterly Review of Licensed Operator Regualification Testing and Training (2 samples)

a. Inspection Scope

The inspectors observed:

- Unit 1 licensed operator job performance measure which involved venting primary containment using RB emergency ventilation on July 7, 2015
- Unit 2 licensed operator simulator training scenario which involved a service water pump trip, single control rod scram, loss of feedwater, and an anticipated transient without scram with loss of low-pressure emergency core cooling systems on July 21, 2015

The inspectors evaluated operator performance during the simulated event and verified completion of risk-significant operator actions, including the use of special and emergency operating procedures. The inspectors assessed the clarity and effectiveness of communications, implementation of actions in response to alarms and degrading plant conditions, and the oversight and direction provided by the unit supervisor. The inspectors verified the accuracy and timeliness of the emergency classifications made by the shift manager and the TS action statements by the unit supervisor. Additionally, the

inspectors assessed the ability of the crew and training staff to identify and document crew performance problems.

b. Findings

No findings were identified.

.2 Quarterly Review of Licensed Operator Performance in the Main Control Room
(2 samples)

a. Inspection Scope

The inspectors observed:

- Unit 1 control room operations during restoration of reactor protection system (RPS) motor generator set 141 on July 27, 2015
- Unit 2 control room operations during maintenance activities on the control room emergency ventilation system, the control room chart recorders for the hydrogen oxygen analyzer system, and the refuel floor radiation monitors on August 11, 2015

The inspectors reviewed HU-AA-101, "Human Performance Tools and Verification Practices," Revision 009, and verified that procedure use, crew communications, and coordination of plant activities among work groups similarly met established expectations and standards. Additionally, the inspectors observed test performance to verify that procedure use, crew communications, and coordination of activities between work groups similarly met established expectations and standards.

b. Findings

No findings were identified.

1R12 Maintenance Effectiveness (71111.12Q – 2 samples)

a. Inspection Scope

The inspectors reviewed the samples listed below to assess the effectiveness of maintenance activities on structure, system, and component (SSC) performance and reliability. The inspectors reviewed system health reports, CAP documents, maintenance work orders (WOs), and maintenance rule basis documents to ensure that Exelon was identifying and properly evaluating performance problems within the scope of the maintenance rule. For each sample selected, the inspectors verified that the SSC was properly scoped into the maintenance rule in accordance with 10 CFR 50.65 and verified that the (a)(2) performance criteria established by Exelon staff were reasonable. As applicable, for SSCs classified as (a)(1), the inspectors assessed the adequacy of goals and corrective actions to return these SSCs to (a)(2). Additionally, the inspectors ensured that Exelon staff was identifying and addressing common cause failures that occurred within and across maintenance rule system boundaries.

- Unit 1 alternate boron injection system on July 13, 2015
- Unit 1 masonry walls as part of site structures on September 30, 2015

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13 – 8 samples)

a. Inspection Scope

The inspectors reviewed station evaluation and management of plant risk for the maintenance and emergent work activities listed below to verify that Exelon performed the appropriate risk assessments prior to removing equipment from service. The inspectors selected these activities based on potential risk significance relative to the reactor safety cornerstones. As applicable for each activity, the inspectors verified that Exelon personnel performed risk assessments as required by 10 CFR 50.65(a)(4) and that the assessments were accurate and complete. When Exelon performed emergent work, the inspectors verified that operations personnel promptly assessed and managed plant risk. The inspectors reviewed the scope of maintenance work and discussed the results of the assessment with the station's probabilistic risk analyst to verify plant conditions were consistent with the risk assessment. The inspectors also reviewed the TS requirements and inspected portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

- Unit 2 motor-driven fire pump 2FPW-P2 when the diesel-driven fire pump 2FPW-P1 was OOS for planned maintenance and surveillance activities during the week of July 13, 2015
- Unit 1 instrument air compressors 11 and 12 while instrument air compressor 13 was OOS for planned maintenance activities during the week of July 13, 2015
- Unit 1 emergency diesel generator (EDG) 102 OOS because of a test failure on July 20 and 21, 2015
- Unit 1 EDG 102 and EDG 103 and containment spray raw water pumps 111, 121, and 122 during a containment spray 112 scheduled outage window on July 22, 2015
- Unit 1 automatic trip system cabinet 'A' and cabinet 'C', motor generator set 131, RPS 11 neutron instrument drawers during motor generator set 141 work on July 27, 2015
- Unit 2 stator water cooling flow indicator switch 2GMC*FIS116 failed low on August 19, 2015
- Unit 1 planned maintenance on EDG 102 during the week of September 21, 2015
- Unit 1 walkdown of offsite power line 4 during planned outage of offsite power line 3 during the week of September 29, 2015

b. Findings

No findings were identified.

1R15 Operability Determinations and Functionality Assessments (71111.15 – 7 samples)a. Inspection Scope

The inspectors reviewed operability determinations for the following degraded or non-conforming conditions based on the risk significance of the associated components and systems:

- Unit 1 containment spray raw water pump 122 after reaching the action range for pump differential pressure on July 17, 2015
- Unit 2 standby gas treatment 'B' with bowed equipment door and degraded door seal on July 28, 2015
- Unit 1 turbine stop valve 12 with the inability to test the RPS trip circuit on July 29, 2015
- Unit 1 torus cooling function of containment spray following the failure of containment spray bypass line to torus flow control valve FCV-80-118 failed to fully open on July 30, 2015
- Unit 1 shutdown cooling check valve CKV-38-12 leak test at 9.8 gallons per minute on August 17, 2015
- Unit 1 electromagnetic relief valve pilot valve temperature indicating erratic on August 18, 2015
- Unit 1 emergency condenser initiation time delay relay 12-2 due to discrepancies between redundant relays on September 18, 2015

The inspectors evaluated the technical adequacy of the operability determinations to assess whether TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TSs and UFSAR to Exelon's evaluations to determine whether the components or systems were operable. The inspectors confirmed, where appropriate, compliance with bounding limitations associated with the evaluations. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled by Exelon.

b. Findings

No findings were identified.

1R18 Plant Modifications (71111.18 – 4 samples).1 Temporary Modification (1 sample)a. Inspection Scope

The inspectors reviewed the Unit 1 core spray pump 121 gagged relief valve PRV-81-75 to determine whether the modification affected the safety functions of systems that are important to safety. The inspectors reviewed 10 CFR 50.59 documentation and post-modification testing results, and conducted field walkdowns of the modification to verify that the temporary modification did not degrade the design bases, licensing bases, and performance capability of the affected systems.

b. Findings

No findings were identified.

.2 Permanent Modifications (3 samples)

a. Inspection Scope

The inspectors verified that the design bases, licensing bases, and performance capability of the affected systems were not degraded by the modifications listed below. In addition, the inspectors reviewed modification documents associated with the design changes.

- Unit 1 Service Water and Circulating Water chemical injection in accordance with engineering change package (ECP)-10-000289, "Nine Mile Point Unit 1 Service Water and Circulating Water Chemical Addition System – Phase A," and ECP-10-000737, "Nine Mile Point Unit 1 Service Water and Circulating Water Chemical Addition System – Phase B" including the installation of the chemical storage tanks, system configuration, and the service water and circulating water system interactions. The inspectors also reviewed impact of the modification on control room habitability for both units as defined by the UFSAR.
- Unit 2 RB Hardened Vent modification in accordance with ECP-13-000087, "Nine Mile Point Unit 2 Hardened Containment Vent System for 22-Inch Reactor Building Penetration" including the installation of the RB penetration blank, hardened vent piping, as well as piping support components.
- Unit 2 reactor core operating margins associated with power and flow known as MELLA+ in accordance with ECP-12-000448, "MELLA+ Overall Design and Testing Including Standby Liquid Control Changes," ECP-13-000693, "MELLA+ Neutron Monitoring (APRM [average power range monitor] and OPRM DSS-CD) Solution," and ECP-13-000590, "MELLA+ Core Design" including oscillating power range monitor set points, detect and suppress solution-confirmation density protection, and standby liquid control.

b. Findings

No findings were identified.

1R19 Post-Maintenance Testing (71111.19 – 11 samples)

a. Inspection Scope

The inspectors reviewed the post-maintenance tests (PMTs) for the maintenance activities listed below to verify that procedures and test activities adequately tested the safety functions that may have been affected by the maintenance activity, that the acceptance criteria in the procedure were consistent with the information in the applicable licensing basis and/or design basis documents, and that the test results were properly reviewed and accepted and problems were appropriately documented. The inspectors also walked down the affected job site, observed the pre-job brief and

post-job critique where possible, confirmed work site cleanliness was maintained, and witnessed the test or reviewed test data to verify quality control hold point were performed and checked and that results adequately demonstrated restoration of the affected safety functions.

- Unit 1 shutdown cooling pump 11 following relief valve and breaker maintenance on July 17, 2015
- Unit 1 containment spray pump 112 and containment spray raw water pump 112 following breaker preventive maintenance (PM) and packing replacement on July 23, 2015
- Unit 2 reactor core isolation cooling following scheduled outage window on August 6, 2015
- Unit 2, Division I, diesel generator valve lifter adjustment on August 13, 2015
- Unit 2 electric fire pump following motor inspection and PM on August 21, 2015
- Unit 1 liquid poison pump 12 breaker following unplanned maintenance due to breaker failing to close on August 25, 2015
- Unit 1 emergency condenser channel 11-1 initiation time delay drop out relay on September 1, 2015
- Unit 1 electromagnetic relief valve 122 solenoid repair on September 6, 2015
- Unit 2 MELLA+ pressure testing for test condition 2A on September 12, 2015
- Unit 2 MELLA+ level testing for test condition 8 on September 14, 2015
- Unit 2 feedwater control system testing following MELLA+ implementation on September 17, 2015

b. Findings

No findings were identified.

1R20 Refueling and Other Outage Activities (71111.20 – 1 sample)

a. Inspection Scope

The inspectors reviewed the station's work schedule and outage risk plan for the Unit 1 forced outage (1F15-02) which was conducted September 4 through 9, 2015. The inspectors reviewed Exelon's development and implementation of outage plans and schedules to verify that risk, industry experience, previous site-specific problems, and defense-in-depth were considered. During the forced outage, the inspectors observed portions of the startup and heat-up processes and monitored controls associated with the following outage activities:

- Configuration management, including maintenance of defense-in-depth, commensurate with the outage plan for the key safety functions and compliance with the applicable TSs when taking equipment OOS
- Implementation of clearance activities and confirmation that tags were properly hung and that equipment was appropriately configured to safely support the associated work or testing
- Installation and configuration of reactor coolant pressure, level, and temperature instruments to provide accurate indication and instrument error accounting
- Monitoring of decay heat removal operations

- Reactor water inventory controls, including flow paths, configurations, alternative means for inventory additions, and controls to prevent inventory loss
- Activities that could affect reactivity
- Maintenance of secondary containment as required by TSs

1R22 Surveillance Testing (71111.22 – 5 samples)

a. Inspection Scope

The inspectors observed performance of surveillance tests and/or reviewed test data of selected risk-significant SSCs to assess whether test results satisfied TSs, the UFSAR, and Exelon procedure requirements. The inspectors verified that test acceptance criteria were clear, tests demonstrated operational readiness and were consistent with design documentation, test instrumentation had current calibrations and the range and accuracy for the application, tests were performed as written, and applicable test prerequisites were satisfied. Upon test completion, the inspectors considered whether the test results supported that equipment was capable of performing the required safety functions. The inspectors reviewed the following surveillance tests:

- Unit 1, N1-ST-22, Diesel Fire Pump Instrument Air Test and Flow Verification on July 2, 2015
- Unit 1, N1-ST-Q4, Reactor Coolant System Isolation Valves Operability Test on July 27, 2015 (inservice test)
- Unit 1, N1-ST-C1, Liquid Poison System Functional Testing Using Demineralized Water With Squib Valve Plugs Removed on July 27, 2015
- Unit 2, N2-OSP-EGS-M@001, Diesel Generator and Diesel Air Start Valve Operability Test – Division I and II on August 12, 2015
- Unit 2, N2-OSP-SLS-Q001, Standby Liquid Control Pump, Check Valve, Relief Valve Operability Test and ASME XI Pressure Test on September 8, 2015 (inservice test)

b. Findings

No findings were identified.

2. RADIATION SAFETY

Cornerstone: Public Radiation Safety and Occupational Radiation Safety

2RS1 Radiological Hazard Assessment and Exposure Controls (71124.01 – 1 sample)

a. Inspection Scope

The inspectors reviewed Exelon's performance in assessing and controlling radiological hazards in the workplace. The inspectors used the requirements contained in 10 CFR 20, "Standards for Protection Against Radiation"; Regulatory Guide (RG) 8.38, "Control of Access to High and Very High Radiation Areas in Nuclear Plants," Revision 1; TSs; and procedures required by TSs as criteria for determining compliance.

Inspection Planning

The inspectors reviewed the performance indicators (PIs) for the occupational exposure cornerstone, radiation protection program audits, and reports of operational occurrences in occupational radiation safety since the last inspection.

Radiological Hazard Assessment

The inspectors reviewed recent plant radiation surveys and any changes to plant operations since the last inspection to identify any new radiological hazards for onsite workers or members of the public.

Radiological Hazards Control and Work Coverage

The inspectors evaluated in-plant radiological conditions and performed independent radiation measurements during facility walkdowns and observation of radiological work activities. The inspectors assessed whether posted surveys, radiation work permits, worker radiological briefings, the use of continuous air monitoring, and dosimetry monitoring were consistent with present conditions. The inspectors examined the control of highly activated or highly contaminated materials stored within the spent fuel pools and the posting and physical controls for selected high radiation areas, locked high radiation areas, and very high radiation areas to verify conformance with the occupational PI.

Risk-Significant High Radiation Areas and Very High Radiation Area Controls

The inspectors reviewed the controls and procedures for high radiation areas, very high radiation areas, and radiological transient areas in the plant.

Problem Identification and Resolution

The inspectors evaluated whether problems associated with radiation monitoring and exposure control were identified at an appropriate threshold and properly addressed in the CAP.

b. Findings

No findings were identified.

2RS2 Occupational ALARA Planning and Controls (71124.02 – 1 sample)

a. Inspection Scope

The inspectors assessed Exelon's performance with respect to maintaining occupational individual and collective radiation exposures as low as reasonably achievable (ALARA). The inspectors used the requirements contained in 10 CFR 20; RG 8.8, "Information Relevant to Ensuring that Occupational Radiation Exposures at Nuclear Power Plants Will Be As Low As Is Reasonably Achievable," Revision 3; RG 8.10, "Operating Philosophy for Maintaining Occupational Radiation Exposures As Low As Is Reasonably Achievable," Revision 1-R; TSs; and procedures required by TSs as criteria for determining compliance.

Inspection Planning

The inspectors conducted a review of Exelon's collective dose history and trends, ongoing and planned radiological work activities, radiological source term history and trends, and ALARA dose estimating and tracking procedures.

Radiological Work Planning

The inspectors selected the following radiological work activities based on exposure significance for review:

- NM-1-15-00512, Drywell Control Rod Drive Activities
- NM-1-15-00601, Reactor Building Reactor Water Clean-Up System Maintenance
- NM-1-15-00803, Turbine and Generator Activities
- NM-1-15-00901, Fuel Floor Reactor Disassembly/Reassembly
- NM-1-15-00906, Cavity Decontamination Activities

For each of these activities, the inspectors reviewed ALARA work activity evaluations, exposure estimates and exposure reduction requirements, results achieved (dose rate reductions, actual dose), person-hour estimates and results achieved, and post-job reviews that were conducted to identify lessons learned.

Problem Identification and Resolution

The inspectors evaluated whether problems associated with ALARA planning and controls were identified at an appropriate threshold and properly addressed in the CAP.

b. Findings

No findings were identified.

2RS3 In-Plant Airborne Radioactivity Control and Mitigation (71124.03 – 1 sample)

a. Inspection Scope

The inspectors reviewed the control of in-plant airborne radioactivity and the use of respiratory protection devices for radiological protection. The inspectors used the requirements in 10 CFR 20; RG 8.15, "Acceptable Programs for Respiratory Protection," Revision 1; RG 8.25, "Air Sampling in the Workplace," Revision 1; NUREG/CR-0041, "Manual of Respiratory Protection Against Airborne Radioactive Material"; TS; and procedures required by TS as criteria for determining compliance.

Inspection Planning

The inspectors reviewed the UFSAR to identify ventilation and radiation monitoring systems associated with airborne radioactivity controls and respiratory protection equipment staged for emergency use. The inspectors also reviewed respiratory protection program procedures and current PIs for unintended internal exposure incidents.

Use of Respiratory Protection Devices

The inspectors reviewed the adequacy of Exelon's use of respiratory protection devices in the plant to include applicable ALARA evaluations, respiratory protection device certification, respiratory equipment storage, air quality testing records, and individual qualification records.

Self-Contained Breathing Apparatus (SCBA) for Emergency Use

The inspectors reviewed the following:

- Status and surveillance records for three SCBAs staged in-plant for use during emergencies
- SCBA procedures and maintenance and test records
- Refilling and transporting of SCBA air bottles
- SCBA mask size availability
- Qualifications of personnel performing service and repair of this equipment

Problem Identification and Resolution

The inspectors evaluated whether problems associated with the control and mitigation of in-plant airborne radioactivity were identified at an appropriate threshold and addressed by Exelon's CAP.

b. Findings

No findings were identified.

2RS4 Occupational Dose Assessment (71124.04 – 1 sample)

a. Inspection Scope

The inspectors reviewed the monitoring, assessment, and reporting of occupational dose. The inspectors used the requirements of 10 CFR 20, RG 8.40, "Methods for Measuring Effective Dose Equivalent from External Exposure," TSs, and procedures required by TSs as criteria for determining compliance.

Inspection Planning

The inspectors reviewed radiation protection program audits, National Voluntary Laboratory Accreditation Program (NVLAP) dosimetry testing reports, and procedures associated with dosimetry operations.

External Dosimetry

The inspectors reviewed dosimetry NVLAP accreditation, onsite storage of dosimeters, the use of correction factors to align electronic personal dosimeter results with NVLAP dosimetry results, dosimetry occurrence reports, and CAP documents for adverse trends related to external dosimetry.

Problem Identification and Resolution

The inspectors evaluated whether problems associated with the occupational dose assessment were identified at an appropriate threshold and properly addressed in the CAP.

b. Findings

No findings were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification (71151 – 12 samples)

.1 Safety System Functional Failures (2 samples)

a. Inspection Scope

The inspectors sampled Exelon's submittals for the Safety System Functional Failures (MS05) PI for Unit 1 and Unit 2 for the period of July 1, 2014, through June 30, 2015. To determine the accuracy of the PI data reported during those periods, inspectors used definitions and guidance contained in Nuclear Energy Institute (NEI) Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, and NUREG-1022, "Event Reporting Guidelines: 10 CFR 50.72 and 50.73," Revision 3. The inspectors reviewed Exelon's operator narrative logs, operability assessments, maintenance rule records, issue reports (IRs), event reports, and NRC integrated inspection reports to validate the accuracy of the submittals.

b. Findings

No findings were identified.

.2 Mitigating Systems Performance Index (MSPI) (10 samples)

a. Inspection Scope

The inspectors reviewed Exelon's submittal of the MSPI for the following systems for the period of July 1, 2014, through June 30, 2015, for Unit 1 and Unit 2:

Unit 1 and Unit 2

- Emergency Alternating Current Power System (MS06)
- High-Pressure Injection System (MS07)
- Heat Removal System (MS08)
- Residual Heat Removal System (MS09)
- Cooling Water System (MS10)

To determine the accuracy of the PI data reported during those periods, inspectors used definitions and guidance contained in NEI Document 99-02, Revision 7. The inspectors

reviewed Exelon's operator narrative logs, IRs, MSPI basis document, event reports, and NRC integrated inspection reports to validate the accuracy of the submittals.

b. Findings

No findings were identified.

4OA2 Problem Identification and Resolution (71152 – 1 sample)

.1 Routine Review of Problem Identification and Resolution Activities

a. Inspection Scope

As required by Inspection Procedure 71152, "Problem Identification and Resolution," the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify that Exelon entered issues into the CAP at an appropriate threshold, gave adequate attention to timely corrective actions, and identified and addressed adverse trends. In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the CAP and periodically attended screening meetings. The inspectors also confirmed, on a sampling basis, that, as applicable, for identified defects and non-conformances, Exelon performed an evaluation in accordance with 10 CFR 21.

b. Findings

No findings were identified.

.2 Annual Sample: Response to NRC Information Notice (IN) 2011-20 for Unit 2 Structural Monitoring Program

a. Inspection Scope

The inspectors performed an in-depth review of Exelon's response and corrective actions associated with Information Notice (IN) 2011-20, "Concrete Degradation by Alkali-Silica Reaction," which was originally documented in condition report CR-2012-000618. Specifically, IN 2011-20 describes a type of concrete degradation mechanism that is caused by a reaction of the alkalis in the cement with certain silica in the aggregate while in the presence of moisture, which results in micro-cracking of the concrete and degraded mechanical properties. Alkali-Silica Reaction (ASR) can be identified during visual inspection by the unique craze, map, or patterned cracking and the presence of alkali-silica gel; however, the presence of ASR can only be confirmed by optical microscopy performed as part of petrographic examination of concrete core samples.

The inspectors assessed Exelon's problem identification threshold, extent-of-condition reviews, and the prioritization and timeliness of Exelon's corrective actions to determine whether Exelon staff were appropriately identifying, characterizing, and correcting problems associated with this issue and whether the planned or completed corrective actions were appropriate. The inspectors compared the actions taken to Exelon's CAP and the requirements of 10 CFR 50, Appendix B, "Quality Assurance Criteria for Nuclear

Power Plants and Fuel Reprocessing Plants.” In addition, the inspectors independently performed walkdowns of various reinforced concrete structures, reviewed a sample of Exelon’s structures monitoring reports, and interviewed engineering personnel to assess the effectiveness of the implemented corrective actions.

b. Findings and Observations

No findings were identified.

Exelon staff performed an evaluation that involved utilizing a barrier analysis method in response to IN 2011-20. Exelon determined that NMPNS may be susceptible to ASR based on the testing methodology of concrete aggregate used at the time of construction, but concluded that there are no known locations where ASR is currently suspected. Exelon staff determined the Unit 2 specification for testing concrete mixtures utilized American Society for Testing and Materials Standards C227 and C289. However, as described in IN 2011-20, American Society for Testing and Materials has issued updated standards and cautioned that these earlier standards may not accurately predict susceptibility to ASR in late- or slow-expanding aggregates. As a corrective action, Exelon revised their guidance in plant procedure S-MRM-REL-0102, “Structural Monitoring Program,” Revision 00800, to enhance their walkdown process and include specific criteria to identify the potential onset of ASR in concrete.

The inspectors performed independent walkdowns in October 2014 and July 2015 of the station’s concrete structures and observed pattern-like cracking in localized areas of the Unit 2 secondary containment building exterior walls. The inspectors noted that the walkdown procedure utilized in 2010, to perform a walkdown of the secondary containment building, did not include specific criteria to look for evidence of ASR. The inspectors also noted that the secondary containment building was scheduled for its next structural monitoring walkdown in 2016 utilizing the enhanced walkdown procedure. Exelon staff initiated IRs 02402406, 02532485, and 02575166 to address these observations and planned corrective actions to test a sample of concrete. Specifically, Exelon intends to take samples of the secondary containment wall during the fall of 2015 in areas that appear to have pattern-like cracking. Once these samples have been taken, Exelon staff plans to test these samples to determine the susceptibility of the concrete to ASR.

The inspectors reviewed a sample of NMPNS structural monitoring reports documenting walkdowns with the enhanced procedure and compared these with the inspectors’ independent walkdowns of several structures. The inspectors did not identify any conditions similar to those observed on the secondary containment structure. The inspectors concluded Exelon’s overall response to IN 2011-20 was commensurate with the safety significance, was timely, and included appropriate follow-up actions. Specifically, the completed revision of the structural monitoring procedure and planned implementation at the next normally scheduled walkdown was appropriate to address IN 2011-20.

40A3 Follow-Up of Events and Notices of Enforcement Discretion (71153 – 2 samples)Plant Eventsa. Inspection Scope

For the plant events listed below, the inspectors reviewed and/or observed plant parameters, reviewed personnel performance, and evaluated performance of mitigating systems. The inspectors communicated the plant events to appropriate regional personnel, and compared the event details with criteria contained in IMC 0309, "Reactive Inspection Decision Basis for Reactors," issued October 28, 2011, for consideration of potential reactive inspection activities. As applicable, the inspectors verified that Exelon made appropriate emergency classification assessments and properly reported the event in accordance with 10 CFR Parts 50.72 and 50.73. The inspectors reviewed Exelon's follow-up actions related to the events to assure that Exelon implemented appropriate corrective actions commensurate with their safety significance.

- Unit 2 electric fire pump breaker failure and subsequent loss of Division 12 non-safety-related switchgear on August 21, 2015
- Unit 1 automatic reactor scram due to high steam flow when a MSIV went closed during MSIV partial stroke testing on September 4, 2015

b. Findings

Introduction. The inspectors identified a self-revealing Green finding (FIN) for Exelon personnel's failure to stop when met with unexpected conditions as required by HU-AA-101, "Human Performance Tools and Verification Practices," Revision 009. Specifically, on August 21, 2015, a Unit 2 division of normal switchgear was unintentionally deenergized which required an unplanned down power to 90 percent and special operating procedure entry. The loss of the switchgear was the result of the installation of an incorrect sized grounding cart in the electric fire pump breaker cubicle during breaker maintenance. Use of the correct sized grounding cart was discussed during the pre-job brief. This resulted in the loss of the electric fire pump, half of the drywell coolers, a heater drain pump, and an unplanned reactivity change.

Description. Normal switchgear 2NNS-SWG012 is a 4160 volt bus which powers non-safety-related loads such as the electric fire pump and a feedwater heater drain pump. On August 21, the 1200 amp circuit breaker for electric fire pump 2FPW-P2 was removed from its cubicle to perform breaker PM in accordance with N2-EPM-GEN-550, "GE 4.16 kV [kilovolt] Magne-Blast Breaker PM," Revision 00400, through WO C91134356. Electrical maintenance department personnel removed the breaker and installed a grounding cart in the cubicle as a "skill-of-the-craft" task. However, the grounding cart that maintenance personnel installed was not the correct size for the intended application. Specifically, the breaker that was removed was sized for 1200 amps. The grounding cart that was installed was sized for 2000 amps and, as a result, had larger breaker stabs. Unknown to the electricians, the larger breaker stabs damaged the electrical bus contact points in the breaker cubicle. When operators attempted to close the breaker during a PMT, the breaker experienced a ground fault failure caused by the breaker not making full contact in the cubicle. The electrical fault damaged the breaker and also caused a loss of non-safety-related normal switchgear

2NNS-SWG012. In addition to the failure of the electric fire pump, the loss of 2NNS-SWG012 resulted in a trip of one half of the drywell coolers and a heater drain pump. The operators recognized the transient by the heater drain pump trip and responded appropriately by entering N2-SOP-08, "Unplanned Power Changes," Revision 01000, and lowered power to 90 percent.

The installation of the grounding cart was done as a "skill-of-the-craft" task, which meant there was no procedural guidance with respect to the installation. During the pre-job brief for the breaker maintenance, the electricians were briefed on the different stab sizes on 1200 amp and 2000 amp grounding carts. However, when the electricians went to procure the requisite grounding cart, 1200 amp and 2000 amp grounding carts were stored in the same location with no labeling to differentiate them. The electricians failed to recognize that they had procured a 2000 amp grounding cart. When installed into a 1200 amp cubicle, the 2000 amp grounding cart damaged the electrical bus contact points. The failure to recognize the size difference led to the breaker failure and subsequent loss of a division of normal switchgear, heater drain pump trip, and unplanned reactivity change. Following the transient, Exelon generated IR 02544972 and developed corrective actions which included labeling the grounding carts, developing procedures for the use of grounding carts, and evaluating where other "skill-of-the-craft" work may pose the same risk.

Analysis. The inspectors determined that Exelon personnel's failure to stop when met with unexpected conditions as required by HU-AA-101 was a performance deficiency that was reasonably within Exelon's ability to foresee and correct and should have been prevented. This finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Exelon did not ensure adequate measures were in place to prevent the use of an incorrect grounding cart which led to the failure of the electric fire pump breaker. This resulted in the loss of a division of normal switchgear and subsequent loss of a heater drain pump which required a down power to 90 percent. Additionally, this issue was similar to Example 4.b in IMC 0612, Appendix E, "Examples of Minor Issues," issued August 11, 2009, in that the installation of the incorrect grounding cart was not minor if the error caused a plant transient. The installation of the wrong grounding cart resulted in a loss of the electric fire pump, a partial loss of drywell cooling, and an unplanned power change requiring the unit to be lowered to 90 percent. This represents a plant transient; therefore, the performance deficiency was more than minor.

The inspectors evaluated this finding using IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012. The inspectors determined that this finding was of very low safety significance (Green) because while the performance deficiency caused a loss of a division of normal switchgear and a heater drain pump, it did not result in a reactor scram or a loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition.

The finding has a cross-cutting aspect in the area of Human Performance, Challenge the Unknown, because Exelon personnel failed to stop when faced with uncertain conditions. Specifically, Exelon personnel, after having been briefed on the different stab sizes for 1200 amp and 2000 amp grounding carts, and when faced with unlabeled

grounding carts stored in the same location, they failed to notify supervision or compare stab sizes to ensure the correct grounding cart was used [H.11].

Enforcement. The work being performed was not on a safety-related system and there was no use of a procedure required by RG 1.33, “Quality Assurance Program Requirements (Operation),” Revision 2, therefore, this finding does not involve enforcement action because no violation of a regulatory requirement was identified. The issue was entered into Exelon’s CAP as IR 02544972. Because this finding does not involve a violation and is of very low safety or security significance, it is identified as a FIN. **(FIN 05000410/2015003-01, Use of Incorrect Grounding Cart Results in Loss of Electrical Bus)**

4OA5 Other Activities

Operation of an ISFSI at Operating Plants (60855)

a. Inspection Scope

In-office regional reviews were performed on the following two issues that occurred during Exelon’s ISFSI loading campaign.

On June 18, 2015, Exelon discovered an indication on the siphon and vent block to cask shell weld during non-destructive examinations (NDEs) of the adjacent welds of the siphon and vent port covers for DSC-22 (IR 02516170). Exelon performed extent-of-condition NDE on the same weld for DSC-23 and DSC-24 and found similar indications. Exelon and Areva Transnuclear developed a repair plan that followed the requirements listed in American Society of Mechanical Engineers “Boiler and Pressure Vessel Code, Section III, NB-4450, 1998 Edition with Addenda through 2000” for the repairs of weld metal defects. The repair plan was implemented for DSC-22, DSC-23, and DSC-24; and the welds were NDE tested to verify structural adequacy of the weld. The inspectors reviewed IRs, pictures of the weld indications, Areva’s Nonconformance Report 2015-121, and repair plan.

On July 9, 2015, Exelon’s transporter with the transfer cask and loaded DSC-24 left the designated haul path during transport to the ISFSI pad (IR 02526073). The inspectors reviewed IRs, procedures, and Exelon’s evaluation of the adjacent area to the heavy haul path. The inspectors reviewed the certificate of compliance, TSs, and the UFSAR to verify compliance with the conditions of the general license.

b. Findings

Introduction. A Severity Level IV NCV of 10 CFR 72.150, “Instructions, Procedures, and Drawings,” was identified when the transporter with the transfer cask and loaded DSC-24 left the designated haul path on July 9, 2015. Specifically, Exelon did not properly implement procedure S-MMP-ISFSI-005, “Site Cask Transportation,” Revision 00300, to ensure the transporter remained on the heavy haul path at all times; and, as a result, the transporter traveled over an unanalyzed surface.

Description. On July 9, Exelon staff were transferring the transfer cask and loaded DSC-24 from the Unit 2 RB to the ISFSI pad using the transporter. The loaded transporter backed out of the RB; and while traveling along the heavy haul path, the transporter operator rotated the machine 180 degrees to face forward in the direction of the ISFSI pad. During this maneuver, the transporter came off the concrete heavy haul path and onto the asphalt adjacent to the path. The transporter operator immediately returned the transporter to the heavy haul path upon completion of the 180-degree rotation and traveled the remaining distance within the heavy haul path designations. S-MMP-ISFSI-005 states, "The transporter must remain on the heavy haul path at all times. This includes the condition where the operator must abandon the transporter due to overriding personnel safety concerns."

Exelon's initial investigation of the event concluded that the transporter operator, without approval from his supervisor, rotated the machine 180 degrees. This was performed to allow the operator to control the transporter while walking the travel path facing forward. The heavy haul path is a predetermined path that is analyzed to carry the weight of the transporter, transfer cask, and DSC. When the transporter was moved off of the heavy haul path, the transporter traveled over an unanalyzed surface, which could have led to damage to buried utilities or to the asphalt surface. There was also increased risk of the transporter rolling due to the unanalyzed pathway collapsing or asphalt giving way due to the weight of the transporter and DSC. The inspectors determined that the transporter did not travel over any safety-related or important-to-safety buried utilities or damaged any asphalt.

Exelon's corrective actions included conducting a human performance review board investigation, reinforcing with transporter operators the need for the transporter to stay on the heavy haul path while transporting a transfer cask and loaded DSC, and evaluating the asphalt area adjacent to the haul path for damage and for acceptability for continued use.

Analysis. The inspectors determined that Exelon did not properly implement procedure S-MMP-ISFSI-005 to ensure the transporter remained on the heavy haul path at all times as required by 10 CFR 72.150 during transfer of DSC-24 on July 9, 2015. As a result, the transporter traveled over an unanalyzed surface. Because the issue involved ISFSI operations, consistent with the guidance in Section 2.2 of the NRC Enforcement Policy, the inspectors evaluated this performance deficiency in accordance with the traditional enforcement process. Using Example 6.3.d from the NRC Enforcement Policy, the inspectors determined that the violation was a Severity Level IV violation. Because this violation involves the traditional enforcement process and was not associated with ISFSI support programs conducted under a 10 CFR 50 license, the inspectors did not assign a cross-cutting aspect to this violation.

Enforcement. 10 CFR 72.150 states, in part, that the licensee, applicant for a license, certificate holder, and applicant for a certificate of compliance shall prescribe activities affecting quality by documented instructions, procedures, or drawings of a type appropriate to the circumstance and shall require that these instructions, procedures, and drawings be followed. Contrary to the above, Exelon did not follow procedures affecting quality. On July 9, 2015, Exelon did not properly implement quality procedure S-MMP-ISFSI-005 to ensure the transporter remained on the heavy haul path at all times; and as a result, the transporter traveled over an unanalyzed surface. However,

because the violation was of very low safety significance and was entered into Exelon's CAP (IR 02526073), this violation is being treated as an NCV consistent with Section 2.3.2 of the Enforcement Policy. **(NCV 07201036/2015001-01, ISFSI Transporter Traveled Off Heavy Haul Path)**

4OA6 Meetings, Including Exit

On October 16, 2015, the inspectors presented the inspection results to Mr. W. Trafton, Plant General Manager, and other members of the NMPNS staff. The inspectors verified that no propriety information was retained by the inspectors or documented in this report.

ATTACHMENT: SUPPLEMENTARY INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

P. Orphanos, Site Vice President
 W. Trafton, Plant Manager
 T. Barlow, Manager, Emergency Preparedness
 M. Busch, Operations Director
 K. Clark, Manager, Site Security
 M. Gray, Radiological Engineering Manager
 S. Howe, Manager, Chemistry
 M. Khan, Senior Manager, Engineering
 K. Kristensen, Regulatory Principle Engineer
 C. Kronich, Manager, Nuclear Oversight
 M. Kunzwiler, Manager, Site Security Operations
 A. Moisan, Dosimetry Supervisor
 D. Moore, Manager, Regulatory Assurance
 J. Robideau, Regulatory Specialist
 B. Scaglione, Manager, Engineering
 A. Sterio, Director, Site Engineering
 T. Tanguay, Shift Operations Superintendent (Unit 2)
 J. Thompson, Director, Site Maintenance
 J. Tsardakas, Shift Operations Superintendent (Unit 1)
 D. Tulowiecki, Radiation Protection Manager
 J. Westermann, Manager, Emergency Preparedness

LIST OF ITEMS OPENED, CLOSED, DISCUSSED, AND UPDATED

Opened/Closed

05000410/2015003-01	FIN	Use of Incorrect Grounding Cart Results in Loss of Electrical Bus (Section 4OA3)
07201036/2015001-01	NCV	ISFSI Transporter Traveled Off Heavy Haul Path (Section 4OA5)

LIST OF DOCUMENTS REVIEWED

Section 1R04: Equipment Alignment

Procedures

N1-OP-9, N2 Inerting and H2-O2 Monitoring Systems, Revision 04400

N1-ST-V1, Venting/Purging Primary Containment Through the Reactor Building Ventilation System, Revision 00700

Drawings

C-18013-C, Reactor Building Heating, Cooling, and Ventilation System Piping and Instrumentation Diagram (P&ID), Revision 34

C-18014-C, Reactor Containment (Drywell and Torus) Inert Gas (N2) Purge and Fill Drywell Cooling System, Revision 59

C-18017-C, Emergency Cooling System P&ID, Revision 56

C-18047-C, Control Room Heating, Ventilating, and Air Conditioning System P&ID, Revision 47

Miscellaneous

Unit 1 UFSAR, Revision 22

Unit 2 UFSAR, Revision 20

Section 1R05: Fire Protection

Procedure

N1-PFP-0101, Unit 1 Pre-Fire Plans, Revision 00400

Miscellaneous

Unit 1 UFSAR, Revision 22

Section 1R06: Flood Protection Measures

Procedure

S-EPM-GEN-702, Associated Transformer and Switchyard PMs, Revision 01300

Drawings

C-18442-C, Water Disposal Building Waste Disposal System, Section 6-6 and 7-7 Looking North, Systems 70, 77, 85, 98, 105, 202.1, 57.1, 45, 78, Revision 07.00

C-18792-C, Turbine Building Auxiliary Equipment Area Floor Plan Elevation 243 feet 0 inches and 250 feet 0 inches Between Columns C to F, Revision 11

C-19186-C, Turbine Building, Auxiliary Equipment Area, Pier and Wall below Elevation 261 Plan, Revision, 07.00

C-19207-C, Turbine Building, Auxiliary Equipment Area, Reinforcing Detail, Wall on Elevation 237 and 250, H Row 4 to 5, and 4, 5, 11 and 12, Between H and J, Revision 04.00

C-19211-C, Turbine Building, Auxiliary Equipment Area, Reinforcing Detail, Miscellaneous Wall North of F Row, Between 4 and 11, Plan and Section, Revision 03.00

C-19213-C, Turbine Building, Auxiliary Equipment Area, Reinforcing Detail, Slab Elevation 250, Between G and J, Revision 02.00

C-26650-C, Turbine Building Common Modification Failure, Barrier Wall, Revision 00.00

C-35601-C, General Floor Plan Reactor Building Floor Elevation 237 feet 0 inch Turbine Building Floor Elevation 250 feet 0 inch, Revision 06.00

Condition Report

2013-006171

Issue Report

02480280

Work Orders

C92018153

C92081210

C92367311

C92369045

Miscellaneous

Unit 1 Individual Plant Examination, July 1993

Unit 1 UFSAR, Revision 22

Section 1R11: Licensed Operator Regualification Program and Licensed Operator Performance

Procedure

HU-AA-101, Human Performance Tools and Verification Practices, Revision 009

Miscellaneous

1102-CY1504C05A, CY1504 Simulator Job Performance Measure, Revision 1

Section 1R12: Maintenance Effectiveness

Procedures

ER-AA-310-1004, Maintenance Rule – Performance Monitoring, Revision 13

N1-EOP-3, Failure to Scram – Flowchart, Revision 01900

N1-EOP-3.2, Alternate Boron Injection, Revision 00500

N1-PM-Q6, Periodic Review of In-Plant Tools and Equipment Required by EOPs, Revision 00600

N1-ST-C1, Liquid Poison System Functional Test using Demineralized Water with Squib Valve Plugs Removed, Revision 01801

S-MRM-REL-0102, Structural Monitoring Program, Revision 00800

Drawings

C-18011-C, Breathing and Service Air Systems P&ID, Revision 38

C-18019-C, Reactor Liquid Poison System P&ID, Revision 36

C-18573-C, H.S. Air, H.S. Water and Breathing Air Piping, Revision 18

C-35970-C, General Floor Plan, Reactor Building – Floor Elevation 237 feet 0 inches/Turbine Building Floor Elevation 250 feet 0 inches, Revision 6, Sheet 1

C-35971-C, General Floor Plan, Reactor Building – Floor Elevation 261 feet 0 inches/Turbine Building Floor Elevation 261 feet 0 inches, Revision 9, Sheet 1

C-35972-C, General Floor Plan, Reactor Building – Floor Elevation 281 feet 0 inches/Turbine Building Floor Elevation 277 feet 0 inches, Revision 5, Sheet 1

C-35973-C, General Floor Plan, Reactor Building – Floor Elevation 281 feet 0 inches/Turbine Building Floor Elevation 291 feet 0 inches, Revision 3, Sheet 1

C-35974-C, General Floor Plan, Reactor Building – Floor Elevation 298 feet 0 inches/Turbine Building Floor Elevation 300 feet 0 inches, Revision 5, Sheet 1

C-35975-C, General Floor Plan, Reactor Building – Floor Elevation 318 feet 0 inches/Turbine Building Floor Elevation 317 feet 6 inches, Revision 2, Sheet 1

C-35976-C, General Floor Plan, Reactor Building – Floor Elevation 340 feet 0 inches/Turbine Building Floor Elevation 320 feet 0 inches, 333 feet 8 inches, and 369 feet 0 inches, Revision 3, Sheet 1

Condition Reports

1998-003680 2011-003780

Work Order

C91272379

Miscellaneous

Maintenance Rule System Basis Document (Functions 1-LP-F04 and 1-HAS-F05)

Maintenance Rule System Basis Document for RB, Fuel Storage, Track Bay, and Penetrations (Function 1-ST/RB-F01)

Maintenance Rule System Basis Document for Turbine Building General Area (Function 1-ST/TB-F01)

Maintenance Rule System Basis Document for Control Building (Function 1-ST/CB-F01)

Maintenance Rule System Basis Document for Diesel Generator Rooms (Function 1-ST/DGR-F01)

Maintenance Rule System Basis Document for Screen House (Function 1-ST/SH-F01)

Unit 1 UFSAR, Appendix C, Aging Management Program and Time-Limited Aging Analysis Section C.1.33, Structures Monitoring Program, Revision 22

Unit 1 UFSAR, Section III, Buildings and Structures, Revision 22

Section 1R13: Maintenance Risk Assessments and Emergent Work Control

Procedure

N2-OP-26, Generator Stator and Exciter Rectifier Cooling System, Revision 00600

Drawing

PID-26A, P&ID Stator Winding Water Cooling, Revision 19

Issue Reports

02007127 02543458

Work Order

C926913727

Section 1R15: Operability Determinations and Functionality Assessments

Procedures

N1-ISP-036-004, Low-Low reactor level Instrument Trip Channel Test/Calibration, Revision 00600

N1-ST-Q6D, Containment Spray System Loop 122 Quarterly Operability Test, Revision 01001

Drawings

C-18012-C, Reactor Containment Spray Raw Water System P&ID, Revision 26, Sheet 1

C-18012-C, Reactor Containment Spray Raw Water System P&ID, Revision 47, Sheet 2

C-19859-C, Elementary Wiring Diagram Reactor Protection System (Channel 11 Coincident Logic), Revision 48, Sheet 2

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C93119869			

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 CC-AA-112, Temporary Configuration Changes, Revision 23

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02559999

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C93017631

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 ECP-15-000458, Checklist of Configuration Activities
 ESR-15-000373, Temporary Gag for PRV-81-75 on MOR 81-03 Bearing Cooling Coil Lines
 NEI 13-02, Compliance with Order EA-13-109 BWR Mark I and II Reliable Hardened Containment Vents Capable of Operation under Severe Accident Conditions, Revision 1
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 N1-ISP-036-004, Low-Low Reactor Level Instrument Trip Channel Test/Calibration, Revision 00600
 N1-OP-4, Shutdown Cooling System, Revision 04400
 N1-ST-M1B, Liquid Poison Pump 12 Operability Test, Revision 00700
 N1-ST-Q6C, Containment Spray System Loop 112 Quarterly Operability Test, Revision 01102
 N2-EPM-GEN-550, GE 4.16 kV Magne-Blast Breaker PM, Revision 00400
 N2-M+PA-22A, Pressure Regulator Transient Test, Revision 00100
 N2-M+PA-23A, Feedwater Control System Testing, Revision 00100
 N2-M+PA-MASTER, MELLLA+ Master Test Procedure, Revision 00100
 N2-OSP-ICS-Q@002, RCIC Pump and Valve Operability Test and System Integrity Test and ASME XI Functional Test, Revision 01200
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02545557	02544972	02545889
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 N1-ST-Q29, Quarterly Turbine Valve Log, Revision 00500
 OP-AA-108-114 Post-Transient Review, Revision 11

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 N2-OSP-SLS-Q001, Standby Liquid Control Pump, Check Valve, Relief Valve Operability Test and ASME XI Pressure Test, Revision 01600
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2011-003780

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C93118544

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 RP-AA-460, Controls for High and Locked High Radiation Areas, Revision 026

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RP-AA-1008, Unescorted Access to and Conduct in Radiologically Controlled Areas, Revision 004

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Survey 1TB-35034, Turbine Building 300 feet Turbine Operating Floor, March 23, 2015, 0130 hour
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RP-AA-403, Administration of the Radiation Work Permit Program, Revision 006

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RWP NM-1-15-00601, Reactor Building Reactor Water Clean-Up System Maintenance
RWP NM-1-15-00803, Turbine and Generator Activities
RWP NM-1-15-00901, Fuel Floor Reactor Disassembly/Reassembly
RWP NM-1-15-00906, Cavity Decontamination Activities
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RP-AA-301, Radiological Air Sampling Program, Revision 008
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RP-AA-443, Quantitative Respirator Fit Testing, Revision 012
RP-AA-825-1020, Operation and Use of Air Line Supplied Respirators, Revision 000

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SCBA Annual Functional Inspection Reports, September 24, 2014

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02483655	02515069	02530361	02534140

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LER 05000220/2014-005-00, Secondary Containment Inoperable due to Simultaneous Opening of Airlock Doors

LER 05000220/2014-006-00, Secondary Containment Inoperable due to Simultaneous Opening of Airlock Doors

LER 05000220/2015-001-00, Secondary Containment Inoperable due to Simultaneous Opening of Airlock Doors

LER 05000220/2015-002-00, Secondary Containment Inoperable due to Simultaneous Opening of Airlock Doors

LER 05000410/2014-002-00, High-Pressure Core Spray System Inoperability due to Inoperable High-Pressure Core Spray Diesel Generator

LER 05000410/2014-005-00, Secondary Containment Inoperable due to Sustained High Winds

LER 05000410/2014-006-00, Secondary Containment Inoperability Following Auxiliary Boiler Trip

LER 05000410/2014-007-00, Secondary Containment Inoperable due to Simultaneous Opening of Airlock Doors

LER 05000410/2014-008-00, Secondary Containment Inoperable due to Reactor Building Exhaust Fan Trip

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S-MRM-REL-0102, Structural Monitoring Program, Revision 00800

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EC-036B, Reactor Building Expanded Plan Elevation 289 feet to 331 feet, Revision 4

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02402406

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2012-000618

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ECP-13-000087, Modification to Implement a Hardened Containment Vent System, Revision 1

Primary Containment Structural Steel Inspection dated March 30, 2014

Reactor Building Exterior Concrete and Structures Inspection dated July 10, 2009

Screen Well Building Area Inspection dated August 12, 2013

Secondary Containment Specific ASR Inspection dated November 24, 2014
SMR-UNIT2-2014, Structural Monitoring Program 2014 Biennial Report, Revision 0

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HU-AA-102, Technical Human Performance Practices, Revision 007
N1-ST-Q26, Feedwater and Main Steam Line Power Operated Isolation Valves Partial Exercise
Test and Associated Functional Testing of Reactor Protection Trip Logic, Revision 01100
N2-EMP-GEN-550, GE 4, 16 kV Magne-Blast Breaker PM, Revision 00400
N2-ISP-ISC-Q005, Quarterly Functional Test of Reactor Vessel Level 2 and Level 1 Instrument
Channels, Revision 0600
N2-ISP-RPS-Q001, Quarterly Functional Test and Trip Unit Calibration, Revision 00500
N2-SOP-08, Unplanned Power Changes, Revision 01000
S-EPM-GEN-081, Site 13.8 and 6.16 kV Motor Inspection PM, Revision 00103

Issue Reports

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Work Order

C92639600

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Post-Trip Computer Print Out, September 4, 2015
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Teledyne Materials Technical Report E-1289-4, Addendum 1

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PT-NMP-022-A-01 dated June 23, 2015
PT-NMP-022-A-02 dated June 24, 2015
PT-NMP-023-A-01 dated June 23, 2015

PT-NMP-023-A-02 dated June 23, 2015

PT-NMP-023-INFO-01 dated June 19, 2015

PT-NMP-024-INFO-01 dated June 19, 2015

Areva Nonconformance Report Numbers:

2015-117, Revision 0

2015-121, Revision 0

2015-122, Revision 0

2015-123, Revision 0

Human Performance Review Board dated July 9, 2015

LIST OF ACRONYMS

10 CFR	Title 10 of the <i>Code of Federal Regulations</i>
ALARA	as low as reasonably achievable
ASR	alkali-silica reaction
CAP	corrective action program
DSC	dry shielded canister
ECP	engineering change package
EDG	emergency diesel generator
FA	fire area
IMC	Inspection Manual Chapter
IN	information notice
IR	issue report
ISFSI	independent spent fuel storage installation
kV	kilovolt
LER	licensee event report
MELLA+	maximum extended load line limit analysis plus
MSIV	main steam isolation valve
MSPI	mitigating systems performance index
NEI	Nuclear Energy Institute
NCV	non-cited violation
NDE	non-destructive examination
NMPNS	Nine Mile Point Nuclear Station, LLC
NRC	Nuclear Regulatory Commission, U.S.
NVLAP	National Voluntary Laboratory Accreditation Program
OOS	out of service
PI	performance indicator
PM	preventive maintenance
PMT	post-maintenance test
RB	reactor building
RG	Regulatory Guide
RPS	reactor protection system
SCBA	self-contained breathing apparatus
SSC	structure, system, and component
TS	technical specification
UFSAR	Updated Final Safety Analysis Report
WO	work order