



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

April 19, 2017

Mr. B. Keith Taber, Vice President
Southern Nuclear Operating Company, Inc.
Vogtle Electric Generating Plant
7821 River Road
Waynesboro, GA 30830

**SUBJECT: VOGTLE ELECTRIC GENERATING PLANT– NRC PROBLEM
IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000424/2017007 AND 05000425/2017007**

Dear Mr. Taber:

On March 10, 2017, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Vogtle Electric Generating Plant, Units 1 and 2. The enclosed report documents the inspection findings, which were discussed on March 10, 2017, with you and other members of your staff.

Based on the inspection samples, the inspectors determined that your staff's implementation of the corrective action program supported nuclear safety. In reviewing your corrective action program, the inspectors 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 inspectors determined that your staff's performance was adequate to support nuclear safety.

The inspectors 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 inspectors determined that your station's performance in each of these areas supported nuclear safety.

In addition, the inspectors determined that your station's management maintains a safety-conscious work environment adequate to support nuclear safety. Based on the inspectors' observations, your employees are willing to raise concerns related to nuclear safety through at least one of the several means available. On the basis of the samples selected for review, the inspectors concluded that in general, problems were properly identified, evaluated, and corrected.

NRC Inspectors documented one finding of very low safety significance (Green) in this report. If you contest this finding or the significance, 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 II; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC resident inspectors at the Vogtle Electric Generating Plant.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with 10 CFR 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

/RA/

Philip McKenna, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket Nos. 50-424, 50-425
License Nos. NPF-68 and NPF-81

Enclosure:
IR 05000424/2017007 and
05000425/2017007 w/Attachment:
Supplemental Information

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT– NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000424/2017007 AND 05000425/2017007 APRIL 19, 2017

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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-424, 50-425

License Nos.: NPF-68, NPF-81

Report No.: 05000424/2017007 and 05000425/2017007

Licensee: Southern Nuclear Operating Company, Inc

Facility: Vogtle Electric Generating Plant, Units 1 and 2

Location: Waynesboro, GA 30830

Dates: February 21 – March 10, 2017

Inspectors: D. Mas-Peñaranda, Project Engineer, Team Leader
N. Staples, Senior Project Engineer
G. Crespo, Senior Construction Inspector
A. Alen, Resident Inspector

Approved by: Philip McKenna, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Enclosure

SUMMARY

IR 05000424/2017007 and 05000425/2017007; 02/21/2017 – 03/10/2017; Vogtle Electric Generating Plant, Units 1 and 2, Corrective Action Program Effectiveness; Biennial Inspection of the Problem Identification and Resolution Program.

The inspection was conducted by one senior project inspector, a project engineer, a senior construction inspector, and a resident inspector. The significance of most findings is identified by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, Significance Determination Process (SDP). Cross-cutting aspects were determined using IMC 0310, Aspects Within Cross-Cutting Areas. The Nuclear Regulatory Commission's (NRC's) program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 6.

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.

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.

Cornerstone: Mitigating Systems

- Green: The NRC identified a Green finding for the licensee's failure to identify the reduced reliability of Unit 1 loop 3 atmospheric relief valve (ARV) 1PV-3020 as a degraded/nonconforming condition, as required by NMP-AD-012, "Operability Determinations and Functionality Assessments," Version 12.5. As a result, corrective maintenance was not prioritized nor conducted at the next available opportunity and led to an additional valve failure in March 12, 2016. The failure to identify aging of 1PV-3020 #285 pilot-to-check valve as a degraded/non conforming condition, as required by NMP-AD-012, was a performance deficiency.

The performance deficiency was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core

damage). Specifically, the performance deficiency prevented the license from prioritizing and conducting corrective maintenance of 1PV-3020 at the next available opportunity, and led to an additional valve failure in March 2016. Using Exhibit 2 of IMC 0609, Appendix A, the inspectors determined that this finding is of very low safety significance (Green) because, although the performance deficiency (PD) affected the design/qualification of the 1PV3020 operability, it did not result in an actual loss of safety system function, and it did not represent a loss of function of one or more than one train for more than its technical specification (TS) allowed outage time or greater than 24 hours. The finding was assigned a cross cutting aspect of "Resolution" in the Problem Identification and Resolution area, because the licensee failed to take effective corrective actions to address aging of the #285 pilot-to-check valve in a timely manner. [P.3] (Section 4OA2.1.c)

REPORT DETAILS

4OA2 Problem Identification and Resolution

1. Corrective Action Program Effectiveness

a. Inspection Scope

The team reviewed the licensee's Corrective Action Program (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 February 2015, and February 2017, including a detailed review of selected CRs associated with the following risk-significant systems: Nuclear Service Cooling Water (NSCW), Main Steam (MS) and Auxiliary Feedwater System (AFW). Where possible, the team independently verified that the corrective actions were implemented as intended. The team also reviewed selected common causes and generic concerns associated with root cause evaluations (RCE) to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones of safety identified in the Reactor Oversight Process (ROP), the team selected a representative number of CRs that were identified and assigned to the major plant departments, including quality assurance, 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 team reviewed selected CRs, verified corrective actions were implemented, and attended meetings where CRs were evaluated for significance to determine whether the licensee was identifying, accurately characterizing, and entering problems into the CAP at an appropriate threshold.

Plant walkdowns of equipment within the selected systems listed above and other plant areas were conducted by inspectors to assess the material condition and to identify deficiencies that had not been previously entered into the CAP. The inspectors reviewed CRs, maintenance history, corrective actions (CAs), completed work orders (WOs) 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-related issues.

Control Room walk-downs were also performed to assess the main control room (MCR) deficiency list and to ascertain if deficiencies were entered into the CAP and tracked to resolution. Operator workarounds (OWA) 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-GL03, Cause Analysis Techniques Guideline.

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 (OE) 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 reviewed licensee audits and self-assessments, including those which focused on problem identification and resolution programs and processes, to verify that findings were entered into the CAP and to verify that these audits and assessments were consistent with the NRC's assessment of the licensee's CAP. The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. CR screening meetings and Management Review Committee (MRC) 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 an appropriately 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, management's expectation that employees were encouraged to initiate CRs. 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 significance determination guidance in NMP-GM-002-001, Corrective Action Program Instructions. Each CR was assigned a priority level at the CR screening 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 was used

depending on the type and complexity of the issue consistent with NMP-GM-002-GL03, Cause Analysis Techniques Guideline.

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 nonrecurring. 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.

c. Findings

Introduction: The team identified a Green finding for the licensee's failure to identify the reduced reliability of Unit 1 loop 3 atmospheric relief valve (ARV) 1PV-3020 as a degraded/nonconforming condition, as required by NMP-AD-012, "Operability Determinations and Functionality Assessments," Version 12.5. As a result, corrective maintenance was not prioritized nor conducted at the next available opportunity and led to an additional valve failure on March 12, 2016.

Description: NMP-AD-012 section 2.0, Definitions, requires Systems, Structures, and Components (SSCs) having a reduced reliability to be considered degraded/nonconforming; additionally, it states that a "reduced capability existed when: (1) equipment failures occur that affect the capability of an SSC to perform its specified function and (2) material properties are degraded due to aging or improper maintenance." Section 4.3.3, "Corrective Action, Tracking, and Resolution," step 5.b states that non-outage work to resolve an operable but degrade/nonconforming condition is scheduled and completed in a timeframe commensurate with safety significance not to exceed the next refueling outage.

On January 8, 2015, the licensee documented the results of a common cause analysis (CAR 213526) conducted to identify causes contributing to historical degraded performance (Maintenance Rule (a)(1) status) of station ARVs. The analysis identified that lack of preventive maintenance on actuator subcomponents containing seals and o-rings, such as the #285 pilot-to-check valve, had resulted in the functional failures of ARVs. The ARV vendor recommended replacement of ARV soft parts (i.e. seals and o-rings) at five years. In July 9, 2015, the licensee identified that the electro-hydraulic pump for 1PV-3020 actuator was running continuously (CR10093787) due to a failed open #285 pilot-to-check valve. This condition affected the valve's capability to perform its specified function as it allowed hydraulic fluid to drain back to the actuator reservoir, preventing the pump from building the required actuator pressure to operate the ARV. During troubleshooting, the licensee was able to re-seat the #285 pilot-to-check valve and restored the ARV to service following successful in-service testing (IST). In March 12, 2016, the licensee once again found the electro-hydraulic pump for 1PV-3020 continuously running due to #285 pilot-to-check valve being failed open (CR10195808). The ARV was again restored and declare operable following re-seating of the #285 pilot-to-check valve and successful IST of the ARV. In April 2016, during the 1PV-3020 actuator maintenance outage, the licensee replaced the #285 pilot-to-check

valve. The inspectors noted the #285 pilot-to-check valve had been in-service for just over five years (last replaced in July 7, 2010, under maintenance Work Order No. 1100906101) at the time of the first valve failure in July 2015, and thus, the failure represented early signs of subcomponent aging degradation. Also, the inspectors noted the licensee did not identify 1PV-3020 as operable but degraded/nonconforming condition following either of the ARV failures.

The inspectors determined the licensee failed to identify the reduced reliability of 1PV-3020 as a degraded/nonconforming condition, in accordance with NMP-AD-012, following the July 9, 2015, ARV failure. As a result, the licensee did not prioritize nor conduct corrective maintenance of the aged #285 pilot-to-check valve at the next available opportunity. Even though corrective maintenance to replace the #285 valve did not require a unit outage the licensee failed to replace the aging subcomponent during the Unit 1 October 2015, refueling outage. Additionally, the #285 valve was recommended to be replaced during a scheduled preventative maintenance outage for 1PV-3020 in November 2015; however, this outage was pushed to May 2016, due to an overloaded work week schedule. This issue was entered into the licensee's corrective action program under condition report 10340979.

Analysis: Failure to identify aging of 1PV-3020 #285 pilot-to-check valve as degraded/nonconforming condition, as required by NMP-AD-012, was a performance deficiency (PD). The PD was more than minor because it was associated with the equipment performance attribute of the mitigating systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the PD prevented the license from prioritizing and conducting corrective maintenance of 1PV-3020 at the next available opportunity, and resulted in an additional valve failure in March 2016. Using Exhibit 2 of IMC 0609, Appendix A, the inspectors determined that this finding was of very low safety significance (Green) because, although the PD affected the design/qualification of the 1PV3020 operability, it did not result in an actual loss of safety system function, and it did not represent a loss of function of one or more than one train for more than its Technical Specification (TS) allowed outage time or greater than 24 hrs. The finding was assigned a cross-cutting aspect of "Resolution" in the Problem Identification and Resolution area because the licensee failed to take effective corrective actions to address aging of the #285 pilot-to-check valve in a timely manner. (P.3)

Enforcement: This finding does not involve enforcement action because no violation of a regulatory requirement was identified. Because this finding does not involve a violation and is of very low safety significance, it is identified as a FIN [05000424/2017007-01, Failure to identify a Degraded Atmospheric Relief Valve]

2. Use of Operating Experience

a. Inspection Scope

The team examined the licensee's use of industry OE to assess the effectiveness of how external and internal OE information was used to prevent similar or recurring problems at the plant. In addition, the team selected OE documents (e.g., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and plant internal OE items, etc.), which had been issued since February 2015, to verify

whether the licensee had appropriately evaluated each notification for applicability to the Vogtle Plant, and whether issues identified through these reviews were entered into the CAP.

b. Assessment

Based on a review of selected documentation related to OE issues, the inspectors determined that the licensee was generally effective in screening OE for applicability to the plant. Industry OE was evaluated at either the corporate or plant level depending on the source and type of the document. 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, OE was included in all apparent cause and root cause evaluations in accordance with licensee procedure NMP-GM-002-GL03, Cause Analysis Techniques Guideline.

c. Findings

No findings were identified.

3. Self-Assessments and Audits

a. Inspection Scope

The team 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 Assessments.

b. Assessment

The team 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 team verified that CRs were created to document areas for improvement and findings resulting from the self-assessments, and verified that actions had been completed consistent with those recommendations. Generally, the licensee performed evaluations that were technically accurate.

c. Findings

No findings were identified.

4. Safety-Conscious Work Environment

a. Inspection Scope

During the course of the inspection, the team assessed the station's safety-conscious work environment (SCWE) through review of the station's Employee Concerns Program (ECP) and interviews with various departmental personnel. The team reviewed a sample of ECP issues to verify that concerns were being properly reviewed.

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.

40A6 ExitExit Meeting Summary

On March 10, 2017, the inspectors presented the inspection results to Mr. B. Keith Taber, Vice President and other members of the site staff. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee personnel

Bruce Bailey, Nuclear Plant Operator
Chris Byrd, Site Nuclear Security Operations Manager
Daniel Komm, Operations Director
Darin Myers, Plant Manager
Dom Sutton, Regulatory Affairs Manager
Earl Berry, Engineering Director
Greg Moxley, Nuclear Plant Operator
James Robinson, Site Systems Manager
Jim Dixon, RP Manager
Karen Morrow, Sr. Engineer (Maintenance Rule Coordinator)
Keith Taber, Site Vice President
Kevin Walden, Licensing Engineer
Larry Smith, Principal Engineer
Steven Bradl, Sr. Engineer
Thad Simmons, Performance Improvement Manager
Tim Baker, Security Manager

NRC personnel

Matt Endress, Senior Resident Inspector

LIST OF REPORT ITEMS

Opened and Closed

05000424/2017007-01 FIN Failure to identify a Degraded Atmospheric Relief Valve

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures:

- 10008-C, "Recording Limiting Conditions for Operation", Version 30, dated: 8/19/2014.
- 10025-C, Work Around Program, Version 3
- 11850-C, Safety Related Equipment Classification, Version 37.1
- 12006-C, "Unit Cooldown to Cold Shutdown", Version 96.5, dated: 09/29/2014.
- 13502-2, Control Rod Drive and Position Indication System, Version 42, dated: 2/27/2014.
- 14236-2, SGFPT A and B Trip T adot, Version 15, dated: 02/12/2016
- 14666-1, Train A Diesel Generator and ESFAS Test, Version 39.1, dated: 10/14/2015.
- 23290-C, Agastat Series 2100 and 7000 Timing Relay Calibration, Version 36.1, dated: 02/15/2017.
- 24762-1, Steam Generator Level (Narrow Range) Protection Channel III 1L -518 Channel Operational Test and Channel Calibration, Version 22
- 24810-1, Delta/Tave LOOP 1 Protection Channel I 1T-411 Channel Operational Test and Channel Calibration, Version 46
- 28912-C, "92-Day Battery and Charger Inspection and Maintenance", Version 66, dated: 02/10/2014.
- NMP-AD-012, Operability Determinations and Functionality Assessment, Version 13.1
- NMP-AD-025, Quality Assurance and Non-Quality Assurance Records Administration, Version 4.0
- NMP-EP-110-GL03, "VEGP EALs – ICs, Threshold Values and Basis", Version 9.0, dated: 10/10/2016.
- NMP-ES-005, Scoping and Importance Determination for Equipment Reliability, Version 16.0
- NMP-ES-027-001, Maintenance Rule Implementation, Version 7.0
- NMP-ES-036, "Underground Pipe and Tanks Monitoring Program", Version 13.0, dated: 12/06/2016.
- NMP-ES-036-001, "Underground Pipe and Tanks Monitoring Program Implementation", Version 10.0, dated: 12/06/2016.
- NMP-GM-002, Corrective Action Program, Version 14
- NMP-GM-002-001, Corrective Action Program Instructions, Version 35.2
- NMP-GM-002-006, Root Cause Analysis Instruction, Version 9.1
- NMP-GM-002-GL03, Cause Analysis Techniques Guideline, Version 27.2
- NMP-GM-003, Self-Assessment and Benchmark Procedure, Version 23.1
- NMP-GM-003-001, Self-Assessment Instructions for Focused Area Self-Assessment (FASA), Version 4.1
- NMP-GM-006, Work Management, Version 13.8
- NMP-GM-006-GL01, Work Planning, Packaging, and Closure, Version 29.1
- NMP-GM-006-GL11, Work Prioritization Matrix, Version 1.6
- NMP-GM-008, Operating Experience Program, Version 15.1
- NMP-GM-011, Procurement, Receipt and Control of Materials and Services, Version 23.2, dated: 4/19/2016.
- NMP-GM-016-F01, Management Review Committee (MRC) Charter, Version 3.0
- NMP-GM-024, Nuclear Safety Culture Program, Version 5.0
- NMP-GM-024-001, Nuclear Safety Culture Monitoring and Review Process, Version 6.0
- NMP-GM-027-F01, "Buried Pipe and Tanks Asset Management Plan Approval to closeout final NEI 09-14 milestone, Version 5.0, dated: 8/13/2014.
- NMP-MA-015, 7300 Process Protection and Control System Printed Circuit Board Management, Version 1.0

NMP-MA-015, 7300 Process Protection and Control System Printed Circuit Board Management, Version 1.0

NMP-SE-006, Security Drill Exercise Program, Version 5.0

NMP-SE-010, MILES Use and Safety, Version 2.2

NMP-SE-021, Security Search Process, Version 1.0

NMP-TR-424, License Operator Continuing Training Exam Development, Version 4.0

NMP-TR-424-F01, LOCT Biennial Written Examination Development Process, Version 3.0

Corrective Action Records (CAR):

262037, 255666, 255952, 257037, 258133, 212674, 260688, 255926, 213052, 255861, 261373, 267468, 212674, 261073, 267056, 256221, 248989, 248989, 262886, 257031, 262443, 260271, 261342, 267524, 262142, 258027, 265401

Condition Reports (CR):

528441, 763510, 805907, 831652, 828421, 833594, 836288, 850221, 855892, 862021, 879125, 887723, 895442, 10074876, 10047673, 10075554, 10080286, 10109661, 10046225, 10046236, 10020718, 10020027, 10150316, 10102010, 10102011, 10122718, 10230073, 10230570, 10238764, 10238729, 10259254, 10256732, 10030995, 10033287, 10044669, 10005530, 10050094, 10033287, 10041868, 10062360, 10082833, 10062924, 10051517, 10051520, 10134943, 10040665, 10294395, 10039376, 10039422, 10039437, 10293456, 10294168, 10294395, 10288732, 10293810, 10002493, 10124315, 10294321, 10119907, 10251396, 10025530, 10135600, 10045159, 10002718, 10011850, 10066747, 10171823, 10039250, 10049581, 10049583, 10050987, 10093787, 10098925, 10109526, 10128576, 10127782, 10127248, 10124872, 10132404, 10127804, 10140029, 10146416, 10207272, 10195808, 10254759, 10255387, 10297594, 10290932, 10027067, 10026837, 10026751, 10053374, 10039748, 10049996, 10055154, 10040724, 10080817, 10117717, 10151991, 10154433, 10185397, 10202669, 10202092, 10213606, 10202097, 10235728, 10263900, 10247634, 10256635, 10303192, 10320546, 10043243, 10063029, 10071546, 10086394, 10100931, 10124191, 10130058, 10133092, 10138254, 10137212, 10139042, 10139042, 10139805, 10167008, 10199066, 10246628, 10259512, 10270198, 10272178, 10273935, 10275305, 10288410, 10292319, 10294121, 10293037, 10309641, 10310225, 10322426, 10242284, 10230287

Condition Reports generated as result of inspection:

10335142, 10340503, 10340414, 10340352, 10333888

Technical Evaluations (TE):

210987, 831652, 834312, 834313, 834315, 896271, 913588, 917925, 921057, 924108, 932389, 962482, 961080, 894470, 894395, 858799, 920196, 917546, 917664, 893624, 915194, 915199, 933111, 965332, 972380, 972382, 972382, 972388, 906222, 906839, 907329, 907799, 907967, 893653, 894220, 894222, 906704, 914710, 919273, 931149, 939481, 871986, 974336, 915772, 916812, 917831, 925594, 933540, 938836, 938836, 938927, 946764, 961529, 967758, 971764, 977230, 915772, 934206, 943253, 950746, 954511, 954523, 954524, 954736, 961842, 965648, 940077, 961034, 953106, 936103, 936624

Work Orders (WO):

SNC618912, SNC736047, SNC668875, SNC680875, SNC689754, SNC677771, SNC689754, SNC689761, SNC680875, SNC689756, SNC732671, SNC736047, SNC602743, SNC668875, SNC672506, SNC680875, SNC613622, SNC613390, SNC629133, SNC640825, SNC650362, SNC650369, SNC655761, SNC642319, SNC544988, SNC570102, SNC570103, C080336001, SNC396683, SNC652535, 1054288301, SNC394769, SNC335799, 2061126501, 0014806401, SNC549782, SNC570216, SNC590051, SNC609903, SNC627852, SNC650166, SNC677891,

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