



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION IV
1600 E. LAMAR BLVD
ARLINGTON, TX 76011-4511

December 20, 2017

EA-17-057

Mr. John Dent, Jr.
Vice President-Nuclear and CNO
Nebraska Public Power District
Cooper Nuclear Station
72676 648A Avenue
P.O. Box 98
Brownville, NE 68321

SUBJECT: COOPER NUCLEAR STATION – FINAL SIGNIFICANCE DETERMINATION OF GREEN FINDINGS; NRC BASELINE INSPECTION REPORT 05000298/2017012

Dear Mr. Dent:

This letter provides you the final significance determination of the preliminary White finding discussed in NRC Inspection Report 05000298/2017011 (Agencywide Documents Access and Management System (ADAMS) Accession No. ML17223A459) dated August 14, 2017. The finding involved two apparent violations of Technical Specification 5.4.1.a for the failure to: (1) implement inspection instructions to examine the emergency transformer bus insulation for discoloration and repair the associated components; and (2) maintain adequate instructions for performing high potential testing of the emergency transformer bus bars. Indications of corona-related degradation on the emergency transformer bus were not identified and repaired, which resulted in a bus fault, a loss of the emergency transformer, and a loss of the supplemental diesel generator on January 17, 2017.

At your request, a Regulatory Conference was held on November 7, 2017, to discuss your views on this issue. A summary of this meeting was issued on November 16, 2017 (ADAMS Accession No. ML17324A280). During the meeting, your staff described your assessment of the significance of the finding and the corrective actions taken to resolve it, including the apparent cause evaluation of the finding. The details associated with the points and perspectives you presented, as well as the NRC's perspectives on these items and resulting impacts on the final significance determination, are provided in the enclosed report.

After considering the information developed during the inspection and the additional information you provided at the regulatory conference, the NRC has concluded that the finding is appropriately characterized as Green, or very low safety significance. The NRC has also determined that the failure to: (1) implement inspection instructions to examine the emergency transformer bus insulation for discoloration and repair the associated components; and (2) maintain adequate instructions for performing high potential testing of the emergency transformer bus bars, constitute violations of Technical Specification 5.4.1.a. Accordingly, the

NRC is documenting two findings of very low safety significance (Green) in the enclosed report, both of which involved violations of NRC requirements. The NRC is treating these two violations as non-cited violations (NCVs) consistent with Section 2.3.2.a of the Enforcement Policy.

If you contest the violations or significance of these NCVs, 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 IV; the Director, Office of Enforcement; and the NRC resident inspector at the Cooper Nuclear Station.

If you disagree with a cross-cutting aspect assignment 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 U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region IV; and the NRC resident inspector at the Cooper Nuclear Station.

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/

Troy W. Pruett, Director
Division of Reactor Projects

Docket No. 50-298
License No. DPR-46

Enclosure:
Inspection Report 05000298/2017012
w/ Attachment: Supplemental Information

U.S. NUCLEAR REGULATORY COMMISSION

REGION IV

Docket: 05000298

License: DPR-46

Report: 05000298/2017012

Licensee: Nebraska Public Power District

Facility: Cooper Nuclear Station

Location: 72676 648A Ave
Brownville, NE

Dates: August 14 through December 18, 2017

Inspectors: P. Voss, Senior Resident Inspector
R. Deese, Senior Reactor Analyst
C. Young, Senior Project Engineer
S. Graves, Senior Reactor Inspector
C. Smith, Reactor Inspector

Approved By: Jason Kozal
Chief, Project Branch C
Division of Reactor Projects

Enclosure

SUMMARY

IR 05000298/2017012; 08/14/2017 – 12/18/2017; Cooper Nuclear Station; Other Activities.

The inspection activities described in this report were performed between August 14 and December 18, 2017, by the resident inspectors at Cooper Nuclear Station and inspectors from the NRC's Region IV office. Two findings of very low safety significance (Green) are documented in this report. Both of these findings involved violations of NRC requirements. The significance of inspection findings is indicated by their color (i.e., Green, greater than Green, White, Yellow, or Red), determined using Inspection Manual Chapter 0609, "Significance Determination Process," dated April 29, 2015. Their cross-cutting aspects are determined using Inspection Manual Chapter 0310, "Aspects within the Cross-Cutting Areas," dated December 4, 2014. Violations of NRC requirements are dispositioned in accordance with the NRC Enforcement Policy. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," dated July 2016.

Cornerstone: Initiating Events

- Green. The inspectors reviewed a self-revealed, non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to implement Maintenance Procedure 7.3.41, "Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment," Revision 10, during inspection of the emergency station service transformer 4160 V bus bars. Specifically, the inspectors identified a violation of Technical Specification 5.4.1.a for the licensee's failure to implement inspection instructions to examine the emergency transformer bus insulation for discoloration and to repair the associated components on March 23, 2015. As a result, the licensee did not properly assess corona-related degradation on the emergency transformer bus, which resulted in an emergency transformer bus fault and a loss of the emergency transformer and the supplemental diesel generator on January 17, 2017. Immediate corrective actions to restore compliance included replacement of the faulted portions of the emergency transformer bus, and extent of condition inspection and cleaning of the remainder of the emergency transformer bus bars. The long term corrective action is replacement of the emergency transformer bus insulation. The licensee entered this issue into the corrective action program as Condition Report CR-CNS-2017-00223.

The licensee's failure to implement Maintenance Procedure 7.3.41 to properly assess degradation of the emergency station service transformer bus, in violation of Technical Specification 5.4.1.a, was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Initiating Events Cornerstone, and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown, as well as, power operations. Specifically, the finding resulted in the licensee's failure to identify and repair indications of corona-related degradation on the emergency station service transformer bus, which resulted in an emergency station service transformer bus fault, and a loss of the emergency station service transformer and supplemental diesel generator on January 17, 2017. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, the inspectors determined that the finding required a detailed risk evaluation because it involved the partial loss of a support system that contributes to the likelihood of, or causes, an initiating event (loss-of-offsite power) and

the finding affected mitigation equipment (supplemental diesel generator). A senior reactor analyst performed a detailed risk evaluation in accordance with Inspection Manual Chapter 0609, Appendix A, Section 6.0, "Detailed Risk Evaluation." The analyst concluded that the finding is of very low safety significance (Green).

The performance deficiency had a cross-cutting aspect in the area of problem identification and resolution, associated with evaluation because the licensee failed to thoroughly evaluate emergency station service transformer bus discoloration and high potential test failures to ensure that resolutions addressed the causes and extent of conditions commensurate with their safety significance. Specifically, the licensee failed to thoroughly evaluate emergency station service transformer bus discoloration identified during the 2015 inspection, the hipot testing failures that followed the inspection, and the extent of condition of the 2015 testing and inspection deficiencies [P.2]. (Section 4OA5)

- Green. The inspectors identified a non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to maintain Maintenance Procedure 7.3.41, "Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment," Revision 10, to contain adequate instructions for testing of the emergency station service transformer 4160 V bus. Specifically, the inspectors identified a violation of Technical Specification 5.4.1.a for the licensee's failure to maintain adequate instructions for performing high potential testing of the emergency transformer bus bars between March 23, 2015, and April 18, 2017. As a result, the licensee did not properly assess corona-related degradation on the emergency transformer bus, which resulted in an emergency transformer bus fault and a loss of the emergency transformer and the supplemental diesel generator on January 17, 2017. Immediate corrective actions to restore compliance included replacement of the faulted portions of the emergency transformer bus, and extent of condition inspection and cleaning of the remainder of the emergency transformer bus bars. Long term corrective actions include replacement of the emergency transformer bus insulation and revision of high potential testing procedure instructions. The licensee entered this issue into the corrective action program as Condition Report CR-CNS-2017-02164.

The licensee's failure to maintain Maintenance Procedure 7.3.41 to properly assess degradation of the emergency station service transformer bus, in violation of Technical Specification 5.4.1.a, was a performance deficiency. The performance deficiency was determined to be more than minor, and therefore a finding, because it was associated with the equipment performance attribute of the Initiating Events Cornerstone, and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown, as well as, power operations. Specifically, the finding resulted in the licensee's failure to identify and repair indications of corona-related degradation on the emergency station service transformer bus, which resulted in an emergency station service transformer bus fault, and a loss of the emergency station service transformer and the supplemental diesel generator on January 17, 2017. Using Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power," dated June 19, 2012, the inspectors determined that the finding required a detailed risk evaluation because it involved the partial loss of a support system that contributes to the likelihood of, or causes, an initiating event (loss-of-offsite power) and the finding affected mitigation equipment (supplemental diesel generator). A senior reactor analyst performed a detailed risk evaluation in accordance with Inspection Manual Chapter 0609, Appendix A, Section 6.0, "Detailed Risk Evaluation." The analyst concluded that the finding is of very low safety significance (Green).

The performance deficiency had a cross-cutting aspect in the area of human performance, associated with change management, because the licensee failed to use a systematic process for evaluating and implementing a change so that nuclear safety remained the overriding priority. Specifically, on March 23, 2015, the licensee changed the Maintenance Procedure 7.3.41 bus testing method from performance of a megger test to performance of a high potential test, but failed to use a systematic process to evaluate the change to ensure that the new test had instructions that were adequate and consistent with industry Institute of Electrical and Electronics Engineers standards [H.3]. (Section 4OA5)

REPORT DETAILS

4. OTHER ACTIVITIES

Cornerstone: Initiating Events

40A5 Other Activities

AV 05000298/2017011-01, "Emergency Transformer Bus Failure due to Inadequate Inspection and Testing Activities"

a. Summary

A finding with preliminary White (low-to-moderate) safety significance with two associated apparent violations was documented in NRC Inspection Report 05000298/2017011 (ADAMS Accession No. ML17223A459) dated August 14, 2017. The inspectors reviewed the licensee's corrective actions to address the identified deficiencies, as well as the licensee's actions taken to evaluate the safety significance of the finding, as discussed at a Regulatory Conference on November 7, 2017. The NRC concluded that the safety significance was most appropriately characterized as Green, or very low safety significance. Further details of the NRC's evaluation are provided in Section 40A5.b below. The NRC identified two Green, non-cited violations, as discussed below. This apparent violation is closed.

The inspectors reviewed a self-revealed, Green, non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to implement Maintenance Procedure 7.3.41, "Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment," Revision 10, during inspection of the emergency station service transformer (ESST) 4160 V bus bars. Specifically, the licensee failed to implement inspection instructions to examine the ESST bus insulation for discoloration and to repair the associated components on March 23, 2015.

Additionally, the inspectors identified a Green, non-cited violation of Technical Specification 5.4.1.a for the licensee's failure to maintain Maintenance Procedure 7.3.41, "Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment," Revision 10, to contain adequate instructions for testing of the ESST 4160 V bus. Specifically, the licensee failed to maintain adequate instructions for performing high potential testing of the ESST bus bars between March 23, 2015, and April 18, 2017.

As a result of these issues, the licensee did not properly assess corona-related degradation on the ESST bus, which resulted in an ESST bus fault and a loss of the ESST and the supplemental diesel generator (SDG) on January 17, 2017. A full description of the circumstances surrounding these issues was included in NRC Inspection Report 05000298/2017011 (ADAMS Accession No. ML17223A459) dated August 14, 2017.

b. Final Significance Determination

A senior reactor analyst performed a preliminary detailed risk evaluation in accordance with Inspection Manual Chapter 0609, Appendix A, Section 6.0, "Detailed Risk Evaluation." The calculated increase in core damage frequency was dominated by

station blackout initiators. The results of the preliminary detailed risk evaluation were included in Attachment 2 of NRC Inspection Report 05000298/2017011 (ADAMS Accession No. ML17223A459) dated August 14, 2017. The staff reviewed the information presented by the licensee at the November 7, 2017, regulatory conference. Three key points: (1) the probability that a safety relief valve could stick open during an event; (2) the probability that plant operators would fail to vent containment during an event; and (3) the extent that a fault on the emergency station service transformer (ESST) bus could cause consequential failure of the startup station service transformer X-tap (SSST-X) bus, were evaluated, and corresponding adjustments were incorporated in the risk evaluation. These adjustments resulted in a revised estimate of the increase in core damage frequency of $9.3E-7$ /year. Other points, described below, that were discussed with the licensee during the regulatory conference, if incorporated, would only serve to further reduce this final estimate of the increase in core damage frequency. The staff qualitatively considered these inputs to determine that the finding was of very low safety significance (Green).

The licensee proposed that the failure probability for one safety relief valve sticking open in the NRC Standardized Plant Assessment Risk (SPAR) model for Cooper was conservatively high with a value of $9.6E-2$. The SPAR model's value was obtained from NUREG/CR-4550, "Analysis of Core Damage Frequency from Internal Events," which would not reflect recent operating experience. The licensee suggested a better value would be $8.1E-3$, which included Cooper specific data. The staff consulted with Idaho National Laboratory to evaluate the licensee's point. From this, the staff used the methodology from NUREG/CR-7037, "Industry Performance of Relief Valves at U.S. Commercial Nuclear Power Plants through 2007," combined with updated industry data to estimate the failure probability for a stuck open safety relief valve to be $8.4E-3$. The staff then input this new value into the Cooper SPAR model that was used to arrive at the preliminary significance determination.

Additionally, the licensee proposed that the probability of plant operators failing to vent containment during postulated potential core damage events was too high in the Cooper SPAR model, which quantified the failure probability as $1.2E-1$. The licensee proposed a failure probability of $1.0E-3$. The staff, in consultation with Idaho National Laboratory, reassessed the basis of the value in the Cooper SPAR model in light of the licensee's modifications to the containment venting system to comply with NRC Order EA-13-109, "Issuance of Order to Modify Licenses with Regard to Reliable Hardened Containment Vents Capable of Operation Under Severe Accident Conditions," dated June 6, 2013. Also, corresponding site specific operating procedures and thermal hydraulic analyses were assessed to arrive at a more appropriate failure rate of $6.0E-3$. The staff adjusted the failure probability to this new value in the Cooper SPAR model that was used to arrive at the preliminary significance determination.

The licensee also proposed that the SSST-X bus would never sustain damage as a result of a fault on the ESST bus. The staff disagreed and continued to apply, in part, the information and the associated responses to the Frequently Asked Questions associated with the zone of influence determination in Appendix M, "Appendix for Chapter 11, High Energy Arcing Faults," of NUREG/CR-6850, "Fire Probabilistic Risk Assessment Methodology for Nuclear Power Facilities, Final Report." In support of their conclusion, the licensee described that they had conducted both bounding analysis and experimental testing. The NRC staff reviewed the analysis and were unable to reach the same conclusion. Although the analysis performed did include some conservative

aspects, the NRC staff found that it was not conclusive due to concerns with other aspects of the analysis such as assumptions, boundary conditions, decoupling of the blast and thermal effects, and general simplifications within the analysis. Based on these discrepancies, the staff did not regard the analysis as evidence that the SSST-X bus would be unaffected. To address the licensee's testing, the staff observed the testing which the licensee performed at KEMA Laboratory from October 2-4, 2017. The NRC determined that the two tests the licensee conducted did not provide a statistically sound basis to assume the SSST-X bus would never be adversely affected. The tests did provide some information as to the durability of the SSST-X duct within approximately 2 feet of a 14,000-amp, 1-second arc fault. The staff used this information to analyze the entire length of the ESST duct, taking into account the specific configurations and features of the ESST and SSST-X buses. From this analysis, the staff reassessed the consequential failure probability of the SSST-X bus to be 6 percent, down from an initial value of 25 percent that was estimated in the preliminary significance determination. The staff then applied this value to further revise the estimate of the overall increase in core damage frequency.

In applying the above three adjustments to the estimate, the staff arrived at a revised increase in core damage frequency of $9.3E-7$ /year. Other information, such as reduced exposure time for the loss of both ducts, additional credit for FLEX strategies, enhanced credit for fire water injection, lowered importance of reactor recirculation pump seal failure events, and the possibility of backfeeding offsite power through the normal station service transformer, was presented by the licensee. If any of these effects were adopted in part or whole, they would only serve to further lower the estimate of core damage frequency and further reinforce that the finding was of very low safety significance. The staff did not quantitatively evaluate these licensee propositions and concluded that the final estimate of the increase in core damage frequency was determined to be no greater than $9.3E-7$ /year, or of very low safety significance (Green).

c. Inadequate Inspection Activities for Emergency Transformer Bus

The licensee's failure to implement and Maintenance Procedure 7.3.41 to properly assess degradation of the ESST bus, in violation of Technical Specification 5.4.1.a, was a performance deficiency. The performance deficiency had a cross-cutting aspect in the area of problem identification and resolution, associated with evaluation, because the licensee failed to thoroughly evaluate ESST bus discoloration and hipot test failures to ensure that resolutions addressed the causes and extent of conditions commensurate with their safety significance. Specifically, the licensee failed to thoroughly evaluate ESST bus discoloration identified during the 2015 inspection, the hipot testing failures that followed the inspection, and the extent of condition of the 2015 testing and inspection deficiencies [P.2].

Technical Specification 5.4.1.a requires, in part, that procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Section 9 of Appendix A to Regulatory Guide 1.33, Revision 2, requires, "Procedures for Performing Maintenance." The licensee established Maintenance Procedure 7.3.41, "Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment," Revision 10, to meet the Regulatory Guide 1.33 requirement. Step 5.9 of Procedure 7.3.41 requires maintenance personnel to, "Examine non-segregated bus insulations for discoloration. IF insulation discoloration is present, THEN clean as necessary. Remove bus bar supports, if

necessary, to clean insulation.” Contrary to the above, between March 23 and 29, 2015, maintenance personnel failed to fully examine nonsegregated bus insulations for discoloration; and when insulation discoloration was present, did not clean as necessary. Specifically, during inspection and testing of the ESST nonsegregated bus, the licensee failed to implement inspection instructions to examine the bus insulations for evidence of corona deposits and repair the associated components. As a result, the licensee did not properly assess corona-related degradation on the ESST bus, which resulted in a bus fault and a loss of the ESST and SDG on January 17, 2017. Immediate corrective actions to restore compliance included replacement of the faulted portions of the ESST bus, extent of condition inspection and cleaning of the remainder of the ESST bus bars. The long-term corrective action is to replace all of the ESST bus insulation. Because this violation was of very low safety significance (Green) and was entered into the licensee’s corrective action program as Condition Report CR-CNS-2017-00223, this violation is being treated as a non-cited violation (NCV) in accordance with Section 2.3.2.a of the NRC Enforcement Policy. (NCV 05000298/2017012-01, “Inadequate Inspection Activities for Emergency Transformer Bus”)

d. Inadequate Testing Activities for Emergency Transformer Bus

The licensee’s failure to maintain Maintenance Procedure 7.3.41 to properly assess degradation of the ESST bus, in violation of Technical Specification 5.4.1.a, was a performance deficiency. The performance deficiency had a cross-cutting aspect in the area of human performance, associated with change management, because the licensee failed to use a systematic process for evaluating and implementing a change so that nuclear safety remained the overriding priority. Specifically, on March 23, 2015, the licensee changed the Maintenance Procedure 7.3.41 bus testing method from performance of a megger test to performance of a high potential test, but failed to use a systematic process to evaluate the change to ensure that the new test had instructions that were adequate and consistent with industry Institute of Electrical and Electronics Engineers (IEEE) standards [H.3].

Technical Specification 5.4.1.a requires, in part, that procedures shall be established, implemented, and maintained covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Section 9 of Appendix A to Regulatory Guide 1.33, Revision 2, requires, “Procedures for Performing Maintenance.” The licensee established Maintenance Procedure 7.3.41, “Examination and High Pot Testing of Non-Segregated Buses and Associated Equipment,” Revision 10, to meet the Regulatory Guide 1.33 requirement. Contrary to the above, between March 23, 2015, and April 18, 2017, the licensee failed to maintain adequate written procedures covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2. Specifically, the licensee failed to maintain Procedure 7.3.41 with adequate instructions for performing hipot testing of the ESST bus bars to ensure that the buses were appropriately tested for phase-to-phase degradation in addition to phase-to-ground degradation. In particular, the test instructions did not ensure that test voltages were applied between each phase individually and ground, with the other phases and the enclosure grounded, so that the phase-to-phase degradation that resulted in the ESST bus fault could be identified. As a result, the licensee did not properly assess corona-related degradation on the ESST bus, which resulted in a bus fault and a loss of the ESST and SDG on January 17, 2017. Immediate corrective actions to restore compliance included replacement of the faulted portions of the ESST bus, and extent of condition inspection and cleaning of the remainder of the ESST bus bars. Long term

corrective actions include replacement of the emergency transformer bus insulation and revision of high potential testing procedure instructions. Because this violation was of very low safety significance (Green) and was entered into the licensee's corrective action program as Condition Report CR-CNS-2017-02164, this violation is being treated as a non-cited violation (NCV) in accordance with Section 2.3.2.a of the NRC Enforcement Policy. (NCV 05000298/2017012-02, "Inadequate Testing Activities for Emergency Transformer Bus")

4OA6 Meetings, Including Exit

Exit Meeting Summary

On December 18, 2017, the inspectors presented the inspection results to Mr. J. Kalamaja, General Manager Plant Operations, and other members of the licensee staff. The licensee acknowledged the issues presented. The licensee confirmed that any proprietary information reviewed by the inspectors had been returned or destroyed.

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee Personnel

M. Bakker, System Engineer
T. Barker, Manager, Engineering Program and Components
D. Buman, Director, Nuclear Safety Assurance
B. Chapin, Manager, Maintenance
J. Dent, Vice President, Chief Nuclear Officer
L. Dewhirst, Manager, Corrective Action and Assessment
K. Dia, Director, Engineering
J. Ehlers, Supervisor, System Engineering
T. Forland, Engineer, Licensing
G. Gardner, Manager, Engineering Design
D. Goodman, Manager, Operations
K. Higginbotham, Former Vice President, Chief Nuclear Officer
J. Kalamaja, General Manager Plant Operations
J. Reimers, Manager, System Engineering
J. Shaw, Manager, Licensing

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed

05000298/2017012-01	NCV	Inadequate Inspection Activities for Emergency Transformer Bus (Section 4OA5)
05000298/2017012-02	NCV	Inadequate Testing Activities for Emergency Transformer Bus (Section 4OA5)

Closed

05000298/2017011-01	AV	Emergency Transformer Bus Failure due to Inadequate Inspection and Testing Activities (Section 4OA5)
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COOPER NUCLEAR STATION – FINAL SIGNIFICANCE DETERMINATION OF GREEN FINDINGS; NRC BASELINE INSPECTION REPORT 05000298/2017012 – DECEMBER 20, 2017

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