



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
245 PEACHTREE CENTER AVENUE N.E., SUITE 1200
ATLANTA, GEORGIA 30303-1200

December 2, 2020

Ms. Kim Maza
Site Vice President
Duke Energy Progress, LLC
5413 Shearon Harris Road
Mail Code HNP01
New Hill, NC 27562

**SUBJECT: SHEARON HARRIS NUCLEAR POWER PLANT – BIENNIAL PROBLEM
IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000400/2020011**

Dear Ms. Maza:

On October 22, 2020, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your Shearon Harris Nuclear Power Plant and discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's corrective action program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

Finally, the team reviewed the station's programs to establish and maintain a safety-conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available. Based on the team's observations and the results of these interviews the team, in general, found no evidence of challenges to your organization's safety-conscious work environment with the exception discussed below. Specifically, the team did find evidence of potential challenges to the safety-conscious work environment in the radiation protection department.

One finding of very low safety significance (Green) is documented in this report. This finding involved a violation of NRC requirements. We are treating this violation as a non-cited violation (NCV) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violation or the significance or severity of the violation documented in this inspection 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 II; the Director, Office of Enforcement; and the NRC Resident Inspector at Shearon Harris Nuclear Power Plant.

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 II; and the NRC Resident Inspector at Shearon Harris Nuclear Power 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 Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

/RA/

Stewart N. Bailey, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket No. 05000400
License No. NPF-63

Enclosure:
As stated

cc w/ encl: Distribution via LISTSERV®

SUBJECT: SHEARON HARRIS NUCLEAR POWER PLANT – BIENNIAL PROBLEM
IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000400/2020011 Dated December 2, 2020

DISTRIBUTION:

M. Kowal
S. Price
L. Gibson
RIDSNRRDRO
PUBLIC
RidsNrrPmShearonHarris Resource

ADAMS ACCESSION NUMBER: ML20337A201

OFFICE	RII: DRP	RII: DRP	RII: DRP	RII: DRP	RII: DRP
NAME	EHilton	DJackson	LPressley	JSteward	SBailey
DATE	11/24/2020	11/24/2020	11/23/2020	11/24/2020	12/2/2020

OFFICIAL RECORD COPY

**U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report**

Docket Number: 05000400

License Number: NPF-63

Report Number: 05000400/2020011

Enterprise Identifier: I-2020-011-0031

Licensee: Duke Energy Progress, LLC

Facility: Shearon Harris Nuclear Power Plant

Location: New Hill, NC 27562

Inspection Dates: October 05, 2020 to October 23, 2020

Inspectors: E. Hilton, Resident Inspector, V. C. Summer
D. Jackson, Project Engineer (Team Lead)
L. Pressley, Senior Project Engineer
J. Steward, Resident Inspector, Brunswick

Approved By: Stewart N. Bailey, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee’s performance by conducting a biennial problem identification and resolution inspection at Shearon Harris Nuclear Power Plant, in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC’s program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

List of Findings and Violations

Failure to Identify and Correct a Condition Adverse to Quality Associated with a Source Range Nuclear Instrument			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Barrier Integrity	Green NCV 05000400/2020011-01 Open/Closed	[P.1] - Identification	71153
A self-revealed Green finding and associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” was identified for the licensee's failure to promptly identify and correct a condition adverse to quality associated with a nuclear instrumentation well following a lower cavity overfill event. Specifically, the licensee failed to promptly identify via the corrective action program (CAP), that the equipment in the NI well had been wetted, or adequately evaluate the impact of the overfill event on equipment in the well. This resulted in the degradation and inoperability of source range (SR) nuclear instrument (NI)-31.			

Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
LER	05000400/2019-003-00	Both Source Range Nuclear Instruments Inoperable	71153	Closed

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards. Starting on March 20, 2020, in response to the National Emergency declared by the President of the United States on the public health risks of the coronavirus (COVID-19), inspectors were directed to begin telework. In addition, regional baseline inspections were evaluated to determine if all or portion of the objectives and requirements stated in the IP could be performed remotely. If the inspections could be performed remotely, they were conducted per the applicable IP. In some cases, portions of an IP were completed remotely and on site. The inspections documented below met the objectives and requirements for completion of the IP.

OTHER ACTIVITIES – BASELINE

71152B - Problem Identification and Resolution

Biennial Team Inspection (IP Section 02.04) (1 Sample)

- (1) The inspectors performed a biennial assessment of the licensee's corrective action program, use of operating experience, self-assessments and audits, and safety conscious work environment.
 - Corrective Action Program Effectiveness: The inspectors assessed the corrective action program's effectiveness in identifying, prioritizing, evaluating, and correcting problems. The inspectors also conducted a five-year review of equipment aging management issues.
 - Operating Experience: The inspectors assessed the effectiveness of the licensee's processes for the use of operating experience.
 - Self-Assessments and Audits: The inspectors assessed the effectiveness of the licensee's self-assessments and audits.
 - Safety Conscious Work Environment: The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety-conscious work environment.

71153 - Followup of Events and Notices of Enforcement Discretion

Event Report (IP Section 03.02) (1 Sample)

The inspectors evaluated the following licensee event report (LER):

- (1) LER 05000400/2019003-00, Both Source Range Nuclear Instruments Inoperable (ADAMS Accession No. ML19346D060). The inspection conclusions associated with this LER are documented in this report in Inspection Results Section 71153. This LER is closed.

INSPECTION RESULTS

Assessment	71152B
<p>1. Corrective Action Program Effectiveness</p> <p>Based on the samples reviewed, the team determined that the licensee’s corrective action program (CAP) complied with regulatory requirements and self-imposed standards. The licensee’s implementation of the CAP adequately supported nuclear safety.</p> <p><u>Problem Identification:</u> The inspectors determined that the licensee was effective in identifying problems and entering them into the CAP and there was a low threshold for entering issues into the CAP. This conclusion was based on a review of the requirements for initiating condition reports (CRs) as described in licensee procedure, AD-PI-ALL-0100, “Corrective Action Program.” Additionally, 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 selected systems, the inspectors determined that generally, deficiencies were being identified and placed in the CAP.</p> <p>However, an example of the licensee’s failure to adequately identify and consequently, evaluate a condition adverse to quality is documented in Section 71153, associated with LER 2019003-00.</p> <p><u>Prioritization and Evaluation of Issues:</u> Based on the review of CRs sampled by the inspection team during the inspection period, the inspectors concluded that problems were generally prioritized and evaluated in accordance with the applicable procedures. The inspectors determined that, in general, adequate consideration was given to system or component operability and associated plant risk. The inspectors determined that plant personnel had conducted root cause and other types of cause analyses in accordance with the licensee’s CAP procedures. The cause determinations were considered appropriate and addressed the significance of the issues being evaluated. A variety of formal causal-analysis techniques were used to evaluate CRs depending on the type and complexity of the issue consistent with the applicable cause evaluation procedures.</p> <p><u>Corrective Actions:</u> 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. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence. The inspectors reviewed performance indicators, CRs, and effectiveness reviews, as applicable, to verify that the significant conditions adverse to quality had not recurred. Effectiveness reviews for corrective actions to preclude repetition were sufficient to ensure corrective actions were properly implemented and were effective.</p> <p>2. Use of Operating Experience</p> <p>The inspectors reviewed the licensee’s program for obtaining and using industry operating</p>	

experience. This included review of procedure AD-PI-ALL-0400, "Operating Experience," selected corrective program action requests, and the licensee's operating experience (OE) database to assess the effectiveness of how external and internal OE data was handled at the plant. Additionally, the inspectors selected OE documents such as NRC generic communications, licensee event reports, vendor notifications, and plant internal OE items to verify whether the licensee had appropriately evaluated each notification for applicability to Harris, and whether issues identified through these reviews were entered into the CAP.

The team determined that station's processes for the use of industry and NRC operating experience information were effective and complied with regulatory requirements and licensee standards. The implementation of these programs adequately supported nuclear safety. The team concluded that operating experience was adequately evaluated for applicability and that appropriate actions were implemented in accordance with applicable procedures.

3. Self-Assessments and Audits

The inspectors reviewed the licensee's self-assessments and audit programs. This included a review of licensee procedure AD-PI-ALL-0300, "Self-Assessments and Benchmarks," and other relevant procedures and licensee documents.

The inspectors determined that in general, the licensee was effective at performing self-assessments and audits to identify issues at a low level, properly evaluated those issues, and resolved them commensurate with their safety significance.

4. Safety-Conscious Work Environment

The inspectors reviewed the licensee's safety conscious work environment. This included a review of relevant procedures and documents, recent safety culture assessments and pulse survey results, and interviews with a sample of licensee personnel.

Employees interviewed appeared willing to raise nuclear safety concerns through at least one of the several means available. Based on interviews with plant staff and reviews of the latest safety culture survey results, in general, the team found no evidence of challenges to a safety conscious work environment, with one exception as noted below.

Based on interviews with approximately 40 percent of the radiation protection (RP) staff, the inspectors determined there were indications of issues that would represent challenges to the free flow of information and underlying factors that could produce a reluctance to raise nuclear safety concerns. Specifically, the RP staff interviewed indicated they would not or would be hesitant to initiate a CR because 1) they felt that supervisors and managers filtered/alterd the content and 2) that issues initiated via CRs were not adequately resolved. Additionally, the RP staff interviewed indicated they would not raise issues with the Employee Concerns Program because they felt the issues would not be adequately resolved. However, the RP staff indicated that they would initiate work orders or work requests for applicable concerns (e.g., equipment issues). They also stated they would report issues up their chain of command or to the NRC if it were a significant safety issue. Based on inspection insights obtained from interviews, the inspectors concluded that conditions in the RP department were not conducive to a healthy SCWE. The licensee initiated CR 2355203 to address the assessment conclusion.

Failure to Identify and Correct a Condition Adverse to Quality Associated with a Source Range Nuclear Instrument			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Barrier Integrity	Green NCV 05000400/2020011-01 Open/Closed	[P.1] - Identification	71153
<p>A self-revealed Green finding and associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," was identified for the licensee's failure to promptly identify and correct a condition adverse to quality associated with a nuclear instrumentation well following a lower cavity overflow event. Specifically, the licensee failed to promptly identify via the corrective action program (CAP), that the equipment in the NI well had been wetted, or adequately evaluate the impact of the overflow event on equipment in the well. This resulted in the degradation and inoperability of source range (SR) nuclear instrument (NI)-31.</p> <p><u>Description:</u> On April 22, 2018, during the spring 2018 outage, water level in the lower cavity slowly raised unknowingly, until it overflowed onto the upper cavity floor. At the time of the overflow event, the hatch to the well containing SR NI-31 was open for maintenance activities. CR 2200424 initiated on April 23, 2018, for the overflow event did not identify that the detectors had been wetted. Initially, the outage logs noted that no equipment was impacted by the overflow event and referenced the above CR. However, it was later noted in the logs that licensee personnel identified water on the nuclear instrumentation, an assessment was performed (no details listed), and no further actions were identified. The CR was not updated with this information, nor was a new CR or work request initiated for the wetted detectors.</p> <p>Approximately 18 months later, the licensee began a reactor shutdown for the fall 2019 outage. On October 12, 2019, SR NI-31 began to exhibit a slow drift and invalid increase in count rate. On October 14, 2019, at about 0500, NI-31 failed to pass a channel check. This condition was not identified by the licensee until October 15, 2019, at 0653 during a main control board walkdown. The licensee had previously (and erroneously) declared wide range NI-61 inoperable on October 14, at 0908, before it was determined that it was actually SR NI-31 that did not pass the channel check. The licensee identified the cause of the SR NI-31 failure as degradation impacting the flux detector due to borated water intrusion into the well from the April 2018 overflow event (CR 02302938). SR NI-31 was declared operable following repairs on November 19, 2019 (approximately one month later).</p> <p>The licensee subsequently determined that both SR instruments NI-31 and N-32 were inoperable simultaneously on several occasions for approximately 29 hours total:</p> <ol style="list-style-type: none"> 1) October 14 from 0500 to 1716, while NI-32 was out for planned surveillances between October 12 @ 1403 and October 14 @1716; 2) October 14 from 1809 to 1846, while NI-32 was inoperable a second time to adjust the high flux at shutdown alarm; and 3) November 9 from 0635 to 2256, while NI-32 was inoperable due to an unrelated equipment issue. <p>Two SR nuclear instruments were required in Modes 5 and 6 per two separate technical specifications (TSs). In Mode 5, with both instruments inoperable, TS 3.3.1 required opening</p>			

the RPS breakers and suspending positive reactivity changes, as well as validating adequate shutdown margin. In Mode 6 with both instruments inoperable, TS 3.9.2 required core alterations and positive reactivity changes to be ceased, and additional monitoring of boron concentrations. The licensee determined they had met all TS actions associated with both TSs. TS 3.9.2 allowed for use of a single train of the wide range neutron flux monitors in place of a single train of SR nuclear instruments (e.g., to allow core alterations). However, the use of the wide range monitors did not constitute a redundant train, because the wide range monitors lacked audible indication within containment and the control room. Additionally, the TS did not permit substitution of the wide range monitors for both SR instruments. Once discovered, the licensee submitted LER 2019003-00 for a condition that could have prevented the fulfillment of the safety function of structures or systems that were needed to shut down the reactor and maintain it in a safe shutdown condition. During that time, no audible indication was available to containment or the control room to alert licensee personnel in the case of an inadvertent dilution event.

Corrective Actions: The licensee restored NI-31 to operable by replacing the flux detector. Additionally, although the licensee indicated that all other detectors functioned properly during the time in question, all detectors located in the same well were replaced after the licensee confirmed indications of water intrusion.

Corrective Action References: NCRs 02354895, 2302938, 2297036, and 2200424

Performance Assessment:

Performance Deficiency: The licensee's failure to promptly identify and correct a condition adverse to quality that resulted in the degradation and inoperability of SR NI-31 was a performance deficiency. Specifically, the licensee failed to adequately identify the equipment in the NI well had been wetted, or adequately evaluate the impact of the overfill event to the NI well.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Configuration Control attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, the failure to adequately identify and correct the condition adverse to quality led to SR NI-31 being inoperable.

Significance: The inspectors assessed the significance of the finding using Inspection Manual Chapter 0609 Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process, Phase 1 Initial Screening And Characterization of Findings," because the finding pertained to operations, an event, or a degraded condition while the plant was shut down. The finding screened to Green because all questions in Exhibit 4 – Barrier Integrity Screening Questions, were answered no.

Cross-Cutting Aspect: P.1 - Identification: The organization implements a corrective action program with a low threshold for identifying issues. Individuals identify issues completely, accurately, and in a timely manner in accordance with the program. Specifically, the licensee did not thoroughly (via corrective action program) identify the detectors had become wetted, nor identify or evaluate the potential latent effects of the wetted detectors.

Enforcement:

Violation: Appendix B to 10 CFR Part 50, Criterion XVI, "Corrective Action," required, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above, from approximately April 22, 2018, to October 15, 2019, the licensee failed to promptly identify and correct a condition adverse to quality involving an overfill condition during the spring 2018 outage which wetted the NI well. This resulted in the latent degradation and eventual inoperability of SR NI-31. Specifically, the licensee initiated a CR for the overfill event, but did not identify/document in the CR (or a work request) that the nuclear instruments in the well were wetted and any potential degradation.

Enforcement Action: This violation is being treated as a non-cited violation, consistent with Section 2.3.2 of the Enforcement Policy.

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On October 22, 2020, the inspectors presented the biennial problem identification and resolution inspection results to Ms. Kim Maza and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Corrective Action Documents	637670 717550 741147 2045531 2070270 2092122 2177014 2269085 2272647 2277107 2281819 2284910 2286887 2287050 2287052 2291122 2291729 2292561 2293715 2294070 2294377 2294592 2296588 2299095 2300487 2301522 2303349 2305989 2308559 2308620 2311457 2311938		

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		2313544 2315299 2315684 2315725 2315727 2316234 2317161 2317511 2320227 2322967 2323421 2326566 2329150 2331982 2335012 2336997 2338560 2338772 2339156 2341740 2341797 20064961 20154105 20160836 20168298 20168840 20176495 20177690 20364615		
71152B	Corrective Action Documents Resulting from Inspection	Work Request (WR) 20185621	3BR-E012, Plaster Material Degraded on top of tank	
WR 20185624		3BR-E013, Plaster Material Degraded on top of tank		
WR 20185691		1B31-SB Loose Screw on Back of Column 12		
WR 20185692		1A-2 125 VDC Panel is missing screws		

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		WR 20185698	1B2-SB-3B, FDR Brk to 1B2-SB, Missing charging handle chain	
		NCR 2351994	ASI Squib Valves past the tagged Do Not Use dates	
		NCR 2352485	DSDG Stored FO Analysis Not in Accordance with MPT-M0115	
		NCR 2354131	Scaffold Clearance Deviation on Safety Related Component	
		NCR 2355203	PI&R Inspection 2020011 Observation [SCWE]	
		AR 2354390	[PI&R Inspection 2020011 Observation - Performance Trending]	
71152B	Drawings	2165-G-0871	Flow Diagram Alternate Seal Injection System Unit 1	1
		2165-S-1371	Simplified Flow Diagram Alternate Seal Injection System Unit 1	1
		CPL-2166-S-4011	Reactor Auxiliary Building EL. 286 Cable Tray Covers	7
		CPL-2166-S-4100 S23	Cable Tray Cover Installation Notes and Details	3
71152B	Miscellaneous	DBD-320	Alternate Seal Injection System (ASI-System 2007)	4
		HNP-F/PSA-0065 Appendix 24	Alternate Seal Injection, Dedicated Shutdown Diesel Generator (T) and Flex Notebook	8
		Maintenance Rule (a)(1) Evaluations, CRs: 2269085-11, 2301522		
		Maintenance Rule EVAL-2019-HNP-5015-00002129	Turbine Protection	
		Maintenance Rule EVAL-2020-HNP-4085-00002154	4085 Train "B" ESCW	
		Maintenance Rule EVAL-2020-HNP-5015-00002157	EHC System Plant Level	
		MPT-M0115	Dedicated Shutdown Diesel Generator Engine Operational Inspection	6

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		Reportability Evaluation Worksheet 2070270		
		Root Cause Evaluations 2177014, 2269085, 2321895		
71152B	Procedures	AD-EG-ALL-1207	Plant Health Process	Revision 9
		AD-EG-ALL-1209	System Health Reports and Notebooks	Revision 8
		AD-EG-ALL-1210	Maintenance Rule Program	Revision 2
		AD-EG-ALL-1650	License Renewal Aging Management	Revision 3
		AD-EP-ALL-0100	Emergency Response Organization	Revision 4
		AD-MN-ALL-0015	Nuclear Station Scaffold Erection, Tracking, and Dismantling	Revision 16
		AD-NO-ALL-0202	Employee Concerns Program	Revision 2
		AD-PI-ALL-0100	Corrective Action Program	Revision 23
		AD-PI-ALL-0200	Performance Trending	Revision 10
		AD-PI-ALL-0300	Self-Assessment and Benchmark Programs	Revision 5
		AD-PI-ALL-0400	Operating Experience Program	Revision 7
		AD-PI-ALL-1000	Conduct of Performance Improvement	Revision 9
		AD-WC-ALL-0210	Work Request Initiation, Screening, Prioritization and Classification	Revision 13
		AD-WC-ALL-0250	Work Implementation and Completion	Revision 12
		MST-E0010	1E Battery Pilot Cell Test Surveillance, Volume 4 Part 7	Revision 19
		MST-E0013	1E Battery Performance Test	Revision 022
		MST-E0027	1E Battery Cell Connection Resistance and Service Test	Revision 022
		OP-185	Alternate Seal Injection	Revision 12
		PLP-717	Equipment Important to Emergency Response	Revision 31
		TE-MN-ALL-0015	Nuclear Station Long Term and Non-Maintenance Scaffold Control	Revision 2
71152B	Self-Assessments	2248369 2271575		

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		2274784 2289985 2233404-05 2247498-05 2249778-05 2270288-05 2292914-05 2295316-02 2306906-05 2308099-05 2308100-05 2308107-05 2308128-05 2308924-05 2309096-05 2312460-21 2320933-05 2339796-05 2340613-05		
71152B	Work Orders	20057820 20228585 20351667 20420467		
71153	Corrective Action Documents	2200424 2296857 2297036 2301501 2302938 2304487 2304487 2317908		
	Corrective Action Documents Resulting from	2354895	PI&R Inspection Green NCV: 10 CFR 50 App B Cri 16	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
	Inspection			
71153	Procedures	AD-LS-ALL-0006	Notification/Reportability Evaluation	Revision 3
71153	Work Orders	13314158 20155821 20158192 20358727		