



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

EA-22-124

February 16, 2023

Cheryl Gayheart
Regulatory Affairs Director
Southern Nuclear Operating Company, Inc.
3535 Colonnade Parkway
Birmingham, AL 35243

SUBJECT: JOSEPH M. FARLEY NUCLEAR PLANT–NRC INSPECTION REPORT
05000348/2022011

Dear Cheryl Gayheart:

On February 2, 2023, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at Joseph M. Farley Nuclear Plant. On February 2, 2023, the NRC inspectors discussed the results of this inspection with Delson Erb, Site Vice President, and other members of your staff. The results of this inspection are documented in the enclosed report.

Two findings of very low safety significance (Green) are documented in this report. One of these findings 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 Joseph M. Farley Nuclear Plant.

If you disagree with a cross-cutting aspect assignment 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 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 Joseph M. Farley Nuclear 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,



Signed by Jackson, Donna
on 02/16/23

Donna N. Jackson, Acting Chief
Reactor Projects Branch 2
Division of Reactor Projects

Docket Nos. 05000348
License Nos. NPF-2

Enclosure:
As stated

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05000348/2022011 Dated February 16, 2023

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U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Numbers: 05000348

License Numbers: NPF-2

Report Numbers: 05000348/2022011

Enterprise Identifier: I-2022-011-0045

Licensee: Southern Nuclear Operating Company, Inc.

Facility: Joseph M. Farley Nuclear Plant

Location: Columbia, AL

Inspection Dates: October 25, 2022, to February 2, 2023

Inspectors: M. Riley, Senior Project Engineer
C. Scott, Senior Project Engineer
S. Sandal, Senior Reactor Analyst

Approved By: Donna N. Jackson, Acting Chief
Reactor Projects Branch 2
Division of Reactor Projects

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting an NRC inspection at Joseph M. Farley Nuclear 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

Improperly Configured Relay Resulted in a Unit 1 Automatic Reactor Trip			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Initiating Events	Green FIN 05000348/2022011-01 Open/Closed EA-22-124	None (NPP)	71153
A self-revealed Green finding was identified for the licensee's failure to take appropriate action to address the impacts of a setpoint change on relay KC-2 into design-basis documentation in accordance with licensee procedure NMP-ES-039-001, "Calculations – Preparation and Revision," Version 6. As a result, the licensee failed to update drawing A-177048, U1 Main Transformer Switchyard Fault Detector, Version 1, with the correct relay setting, which resulted in an improperly configured relay and unnecessary automatic reactor trip of Unit 1 on August 3, 2022.			

Unit 1 Partial Loss of Offsite Power after Dropped Floor Tile in High Voltage Switch House			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Initiating Events	Green NCV 05000348/2022011-02 Open/Closed	[H.12] - Avoid Complacency	71153
A self-revealed Green finding and associated non-cited violation of 10 CFR 50.65(a)(4) "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified for the licensee's failure to assess and manage the increase in risk that may result from maintenance activities that were performed in the switchyard house. Specifically, the licensee's failure to assess and manage the increase in risk associated with the movement of floor tiles near vibration sensitive relays on August 3, 2022, resulted in a (1) partial loss of offsite power to the '1B' startup transformer (SUT) and (2) absent the KC-2 relay setpoint, the loss of generation (i.e., runback) of approximately 10-percent power.			

Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
LER	05000348/2022-001-00	Joseph M. Farley Nuclear Plant, Unit 1, Outdated Relay Settings Resulted in an Automatic Reactor Trip After a Floor Tile was Dropped in High Voltage Switch House	71153	Closed
URI	05000348/2022050-02	Unit 1 Reactor Trip and Partial Loss of Offsite Power	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.

OTHER ACTIVITIES—BASELINE

71153 - Follow Up of Events and Notices of Enforcement Discretion

Event Report (IP Section 03.02) (1 Sample)

The inspectors reviewed licensee event report (LER) 05000348/2022-001-00, "Outdated Relay Settings Resulted in an Automatic Reactor Trip After a Floor Tile was Dropped in High Voltage Switch House," and unresolved item (URI) 05000348/2022050-02. "Unit 1 Reactor Trip and Partial Loss of Offsite Power" in Inspection Report 05000348/2022050 (ADAMS Accession No. ML22272A557) to determine if a performance deficiency existed for the event that occurred on August 3, 2022, which resulted in a Unit 1 reactor trip and partial loss of offsite power. On August 3, 2022, Alabama Power Company (APC) personnel were performing pre-outage work in the switch house for breaker and relay upgrades associated with the Farley Unit 1 offsite power supply and inadvertently dropped a floor tile near a vibration sensitive relay inside an electrical cabinet, causing the relay to actuate. The relay actuation resulted in the automatic opening of eight circuit breakers in the high voltage switchyard (HVSY) and electrical isolation of the 230 kilovolt (KV) 'Bus 1.' The loss of the 230 KV 'Bus 1' caused a loss of offsite power to the '1B' startup transformer (SUT) and associated safety-related 4KV bus.' Farley Unit 1 experienced an automatic reactor trip, from 100 percent power, due to an incorrect setpoint of main generator protection relay KC-2, which resulted in a loss of power to the 1B unit auxiliary transformer powering the 4KV buses '1B' and '1C.' The licensee evaluated the switchyard activities as low risk.

The inspectors reviewed licensee procedures to determine if the licensee assessed and managed the increase in risk associated with performing work activities near vibration sensitive relays prior to performing the activity and to determine if the licensee had the ability to foresee and correct the technician's decision to move the floor tile next to the electrical cabinet. Additionally, the inspectors reviewed licensee procedures, calculations, and drawings to determine if a performance deficiency existed with the incorrect setpoint of the KC-2 relay.

- (1) LER 05000348/2022-001-00, "Outdated Relay Settings Resulted in an Automatic Reactor Trip After a Floor Tile was Dropped in High Voltage Switch House," (ADAMS Accession No. ML22273A139). The inspection conclusions associated with this LER are documented in this report under Inspection Results Section 71153.

INSPECTION RESULTS

Improperly Configured Relay Resulted in a Unit 1 Automatic Reactor Trip			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Initiating Events	Green FIN 05000348/2022011-01 Open/Closed EA-22-124	None (NPP)	71153
<p>A self-revealed Green finding was identified for the licensee's failure to take appropriate action to address the impacts of a setpoint change on relay KC-2 into design-basis documentation in accordance with licensee procedure NMP-ES-039-001, "Calculations – Preparation and Revision," Version 6. As a result, the licensee failed to update drawing A-177048, U1 Main Transformer Switchyard Fault Detector, Version 1, with the correct relay setting, which resulted in an improperly configured relay and unnecessary automatic reactor trip of Unit 1 on August 3, 2022.</p>			
<p><u>Description:</u> On August 3, 2022, Farley Unit 1 main generator / turbine / reactor unexpectedly tripped from 100 percent rated thermal power. The event was initiated by work in the high voltage switchyard switch house that inadvertently actuated a nonsafety-related protection relay. Assuming all other protective features worked as designed, the unit should not have tripped. The initiating event by itself should have only resulted in a 10 percent runback and partial loss of offsite power. However, a latent error associated with a different nonsafety-related relay resulted in a main generator trip and reactor trip. The error was the failure to address a relay setpoint change identified in engineering calculation SE-01-2445-002, "Main Generator and Main Power Transformer Protection and Coordination," Revision 6, due to updated design inputs for system impedance.</p> <p>Calculation SE-01-2445-002 stated that the purpose of the calculation was to determine the relay settings for the protective relays associated with the main generator and the main power transformer systems. The Unit 1 main generator backup relay protection system circuit design associated with the 230 KV switchyard consists of relays KD-10 and KC-2 in series. When both these relays actuate, it results in a trip of the main generator and a reactor/turbine trip. The purpose of relay KD-10 is to identify whether a fault condition exists in the switchyard using system impedance and, if a fault does not exist, then it would not provide a protective trip to the main generator. Relay KC-2 is designed to supervise relay KD-10 to prevent undesired tripping of the main generator in the event of such a fault condition on the 230 KV Switchyard. This calculation determined that the setting for the main power transformer/system backup relay KC-2 was to be set to 4 Amps (A) for Unit 1.</p> <p>After the event, it was determined that the setting of the KC-2 relay had not been set to 4 A after the system impedance was updated and was still set to the old setting of 3 A contained in Revision 5 of the calculation. This was because the drawing that was used to set the relay, drawing A-177048, "U1 Main Transformer Switchyard Fault Detector," Version 1, was never updated to reflect the change from the calculation, since at least May 2013. Since the relay setpoint was not changed in accordance with the design (lower than designed setpoint), it no longer provided its supervisory function over relay KD-10 and increased the likelihood of upsetting plant stability for faults in the switchyard.</p> <p>Section 3.2 and 3.3 of station procedure NMP-ES-039-001, "Calculations – Preparation and Revision," Version 6, the procedure in effect at the time, stated the licensee was to verify that they had taken appropriate action to address all impacts of the revised calculation with other calculations and design-basis documentation. The inspectors determined that the licensee</p>			

failed to update the KC-2 relay drawing sheet with the correct setpoint from calculation SE-01-2445-002, "Main Generator and Main Power Transformer Protection and Coordination."

Corrective Actions: As an immediate corrective action, if emergent and critical work was required, 100 percent direct oversight by a licensed reactor operator was required in the HVSY relay house. Following a review of the events, the immediate corrective action was downgraded to 100 percent oversight of all activities by a licensee representative. Planned corrective actions include updating the KC-2 relay setting drawing and changing the setpoint during the next outage.

Corrective Action References: CAR 316338

Performance Assessment:

Performance Deficiency: The failure to take appropriate action to address the impacts of a setpoint change on relay KC-2 into design-basis documentation in accordance with licensee procedure NMP-ES-039-001, "Calculations – Preparation and Revision," Version 6, was a performance deficiency (PD). Specifically, the licensee failed to update drawing A-177048, "U1 Main Transformer Switchyard Fault Detector," Version 1, with the correct relay setting, which resulted in an improperly configured relay and unnecessary plant trip.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Design Control attribute of the Initiating Events cornerstone and adversely 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 PD resulted in the relay being in an incorrect state during normal operations and the plant being more susceptible to undesired plant trips in the event of a loss of voltage on the 230 kV bus.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The affected cornerstone was Initiating Events as determined by IMC 0609, Attachment 4, "Initial Characterization of Findings." The inspectors screened the performance deficiency using Exhibit 1 of IMC 0609, Appendix A and determined a detailed risk evaluation was required since the finding would cause a reactor trip coincident with the isolation of the normal offsite power supply to the 1B startup transformer. Additionally, the conditional core damage probability for the reactor trip had the potential to be greater than 1E-06.

A detailed risk evaluation was performed by a regional Senior Reactor Analyst using SAPHIRE Version 8.2.6 and NRC Farley SPAR model Version 8.81. An event analysis was performed to evaluate the risk increase by determining the Incremental Conditional Core Damage Probability (ICCDP) using the guidance described in Section 08.02 of IMC 0308, Attachment 3, "Technical Basis for the Significance Determination Process." The incremental risk increase was estimated by determining the difference between the core damage probability for the conditional case (with offsite power unavailable to the 1B startup transformer) and the baseline risk of a general plant transient. This yielded an estimated ICCDP that was less than 1E-06. The dominant cutsets included an anticipated transient without SCRAM (ATWS) sequence involving common mode failure of the control rods to insert followed by unavailability of the pressurizer Power-Operated Relief Valve flow path. Because the dominant sequences were not associated with large early release risk contributors, the finding did not require additional evaluation for Incremental Conditional

Large Early Release Probability. The analysis determined that the estimated ICCDP was less than 1E-06, representing a finding of very low safety significance (Green).

Cross-Cutting Aspect: Not Present Performance. No cross-cutting aspect was assigned to this finding because the inspectors determined the finding did not reflect present licensee performance.

Enforcement: Inspectors did not identify a violation of regulatory requirements associated with this finding.

This finding closes unresolved item (URI) 05000348/2022050-02, "Unit 1 Reactor Trip and Partial Loss of Offsite Power."

Failure to Assess and Manage Risk of Switchyard House Maintenance Activities			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Initiating Events	Green NCV 05000348/2022011-02 Open/Closed	[H.12] - Avoid Complacency	71153

A self-revealed Green finding and associated non-cited violation of 10 CFR 50.65(a)(4) "Requirements for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," was identified for the licensee's failure to assess and manage the increase in risk that may result from maintenance activities that were performed in the switchyard house. Specifically, the licensee's failure to assess and manage the increase in risk associated with the movement of floor tiles near vibration sensitive relays on August 3, 2022, resulted in a (1) partial loss of offsite power to the '1B' startup transformer (SUT) and (2) absent the KC-2 relay setpoint, the loss of generation (i.e., runback) of approximately 10 percent power.

Description: On August 3, 2022, Alabama Power Company (APC) personnel were performing pre-outage work in the switch house for breaker and relay upgrades associated with the Farley Unit 1 offsite power supply. The APC work order task involved lifting 2x2-foot floor tiles weighing approximately 40 pounds to expose cable trays under the floor. The floor tiles are located all the way up to the electrical cabinets with trip sensitive relays. During the work activity a tile was inadvertently dropped while being moved toward an electrical cabinet (instead of away from the cabinet) and caused a protection relay near the work activity to actuate. The relay actuation resulted in the automatic opening of eight circuit breakers in the high voltage switchyard (HVSY) and electrical isolation of the 230 kilovolt (KV) 'Bus 1.' The loss of the 230 KV 'Bus 1' caused a loss of offsite power to the '1B' SUT and associated safety-related 4KV bus." The loss of the 230KV 'Bus 1' should have only resulted in a decrease of approximately 10 percent power. However, due to an incorrect relay setting, Farley Unit 1 also experienced an automatic reactor trip from 100 percent power, due to a main generator lockout signal and main turbine trip, which resulted in a loss of power to the 1B unit auxiliary transformer powering the 4KV buses '1B' and '1C.

Licensee procedure NMP-DP-001, "Operational Risk Assessment," established the process used to identify, evaluate, and manage the overall risk associated with work activities performed at Southern Nuclear Facilities. NMP-DP-001 applied to risk screening for all maintenance activities for switchyards at Southern Nuclear Facilities and was used in conjunction with NMP-GM-021, Switchyard Access and Maintenance Controls.

NMP-DP-001, "Operational Risk Assessment," Revision 23.0 contained requirements to screen work activities in the switchyard as "Low," "Medium," or "High" risk and identified additional requirements based on the risk level. Work activities identified as "Medium" and "High" risk required documented risk management plans. The objective of the high-risk

management plans was “to ensure a work activity that poses risk to personnel, plant equipment, or the environment is clearly identified, and an appropriate mitigation plan is developed to minimize or eliminate the likelihood of an event.” The procedure contained lists of pre-screened work activities and identified activities that have the potential to “cause vibration near relays or other vibration sensitive equipment that could cause a loss of generation” as a “high risk” activity. The procedure also required that activities where “a single human error or omission could cause a loss of generation” to be screened as “high risk.”

Licensee procedure NMP–GM-021, “Switchyard Access and Maintenance Controls,” Revision 7.0 provided additional requirements for switchyard activities. NMP–GM-021 requires Southern Nuclear oversight and an APC point of contact who has no other concurrent duty than direct oversight of the activity for “high risk” work inside the high voltage switchyard. Per procedure, “Oversight personnel must manage overall risk to the plant by challenging assumptions made during the operations risk assessments by performing additional [Operational Risk Assessments] based on changes to scope, schedule, personnel, or work environment.”

Southern Nuclear screened the work activity performed on August 3, 2022, as low risk. By being low risk, no additional mitigative actions were in place beyond the normal work processes to minimize the potential and consequence of an inadvertent movement in the wrong direction. The APC worker who dropped the tile was working alone and did not have direct oversight during the activity. Also, there were no markings or signs on the relays to highlight the sensitivity and there were no markings indicating 2-foot configuration control areas around the panels as discussed in plant status and configuration control procedures. Based on follow-up interviews, the licensee assumed the low-risk classification was sufficient as the worker was assumed to be at least 2 feet from the relays and similar work was completed many times before with no issues.

The inspectors noted that the dropped floor tile caused vibration near relays that resulted in a loss of generation and a plant event, which was consistent with the licensee's criteria for a “high risk” activity. The inspectors concluded that the licensee should have screened the switchyard activities as “high risk”, documented a risk mitigation plan and implemented risk mitigation actions for the switchyard work activity on August 3, 2022, in accordance with licensee procedures NMP–DP-001 and NMP–GM-021.

Corrective Actions: As an immediate corrective action, if emergent and critical work was required, 100 percent direct oversight by a licensed reactor operator was required in the HVSY relay house. Following a review of the events, the immediate corrective action was downgraded to 100 percent oversight of all activities by a licensee representative. The licensee also established a 2 ft buffer zone around switch house instrumentation panels and updated procedure NMP–GM-021-001 to provide guidance on accessing and work inside the newly established buffer zones.

Corrective Action References: CAR 316338

Performance Assessment:

Performance Deficiency: The failure to assess and manage the increase in risk associated with the movement of floor tiles near vibration sensitive relays that could cause a loss of generation was a performance deficiency.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the Human Performance attribute of the Initiating Events cornerstone and adversely 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 licensee failed to evaluate the potential impact of maintenance in the switchyard which could result in plant upsets or transients. On August 3, 2022, while APC workers were performing maintenance activities in the switchyard, a relay was inadvertently actuated causing a partial loss of an offsite power to a safety-related bus and, absent the inadequate KC-2 relay setpoint, the loss of generation (i.e., runback) of approximately 10 percent power.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix K, "Maintenance Risk Assessment and Risk Management SDP, as determined by IMC 0609, Attachment 4, "Initial Characterization of Findings." The inspectors determined that the failure to assess the risk associated with the work in the high voltage switchyard required additional evaluation. Although the licensee's process to assess and manage the risk associated with the maintenance activity was qualitative, a Region II Senior Reactor Analyst determined that the incremental core damage probability deficit (ICDPD) could be estimated using SAPHIRE Version 8.2.6 and Farley SPAR model Version 8.80. The risk deficit was estimated by determining the difference between the nominal baseline plant risk and the loss of the 230 kV high voltage switchyard supply to startup transformer 1B due to the maintenance activity. This was accomplished by using the 1B startup transformer SPAR model basic event as a surrogate for loss of offsite power feed from the 230 kV high voltage switchyard. The duration of the period of the maintenance activity was then applied which yielded an estimated ICDPD of less than 1E-06. The dominant cutsets included a loss of the A train 4.16 kV bus initiator accompanied by random failure of the B train 4.16 kV bus. Because the dominant sequences were not associated with large early release risk contributors, the finding did not require additional evaluation for incremental large early release probability deficit (ILERPD). The estimated risk deficit was determined to be less than the 1E-06 for ICDPD and 1E-07 for ILERPD values described in Flowchart 1 of Appendix K, and therefore, consistent with a finding of Green risk significance.

Cross-Cutting Aspect: H.12 - Avoid Complacency: Individuals recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Individuals implement appropriate error reduction tools. Specifically, the licensee failed to consider the inherent risk associated with working near vibration sensitive relays and implement appropriate risk mitigation actions to minimize the possibility of a plant transient.

Enforcement:

Violation: 10 CFR 50.65 (a)(4) states, in part, before performing maintenance activities (including but not limited to surveillance, post-maintenance testing, and corrective and preventive maintenance), the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activities.

Contrary to the above, on August 3, 2022, the licensee failed to assess and manage the increase in risk that may result from maintenance activities that were performed in the switchyard house. Specifically, the licensee failed to assess and manage the increase in risk associated with the movement of floor tiles near vibration sensitive relays that could cause a loss of generation. As a result, no specific maintenance-related risk mitigative actions were taken to mitigate the potential for a (1) a partial loss of offsite power to the '1B' startup transformer (SUT) and (2) absent the KC-2 relay setpoint, the loss of generation (i.e., runback) of approximately 10 percent power.

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

This finding closes unresolved item (URI) 05000348/2022050-02, "Unit 1 Reactor Trip and Partial Loss of Offsite Power."

EXIT MEETINGS AND DEBRIEFS

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

- On February 2, 2023, the inspectors presented the NRC inspection results to Delson Erb, Site Vice President, and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71153	Calculations	NMP–ES-039-001	Calculations - Preparation and Revision	Rev. 6.0
71153	Calculations	NMP–ES-039-001	Calculations - Preparation and Revision	Rev. 5
71153	Corrective Action Documents	CAR 316338	U1 Reactor Trip Due to a Turbine Trip Caused by a B train LOSP	8/23/2022
71153	Drawings	A-177048, Sht. 563	KD-10 Relay Setting Sheet	Rev. 1
71153	Drawings	A-177048, Sht. 567	KC-2 Relay Setting Sheet	Rev. 1
71153	Drawings	D-177000	U1 Single Line - Electrical Auxiliary System (Normal - 4160 V & 600 V)	Rev. 33
71153	Procedures	NMP–GM-021-001	Plant Farley Switchyard Access and Maintenance Controls	Rev. 7
71153	Procedures	NMP–GM-047	Plant Status Configuration and Control	Rev. 1.1