UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
1600 EAST LAMAR BOULEVARD
ARLINGTON, TEXAS 76011-4511

May 06, 2024

Kimberly A. Harshaw, Acting President
Chief Executive Officer and Chief of Nuclear Officer
STP Nuclear Operating Company
P.O. Box 289
Wadsworth, TX 77483

SUBJECT: SOUTH TEXAS PROJECT ELECTRIC GENERATING STATION, UNITS 1 AND 2 – INTEGRATED INSPECTION REPORT 05000498/2024001 AND 05000499/2024001

Dear Kimberly A. Harshaw:

On March 31, 2024, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at South Texas Project Electric Generating Station, Units 1 and 2. On April 24, 2024, the NRC inspectors discussed the results of this inspection with Christopher Georgeson, General Manager of Engineering and other members of your staff. The results of this inspection are documented in the enclosed report.

Three findings of very low safety significance (Green) are documented in this report. Each of these findings involved violations of NRC requirements. We are treating these violations as non-cited violations (NCVs) consistent with Section 2.3.2 of the Enforcement Policy.

If you contest the violations or the significance or severity of the violations 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 IV; the Director, Office of Enforcement; and the NRC Resident Inspector at South Texas Project Electric Generating Station, Units 1 and 2.

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 South Texas Project Electric Generating Station, Units 1 and 2.

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 Vossmar, Patricia
on 05/06/24

Patricia J. Vossmar, Chief
Reactor Projects Branch A
Division of Operating Reactor Safety

Docket Nos. 05000498, 05000499
License Nos. NPF-76, NPF-80

Enclosure:
As stated

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SOUTH TEXAS PROJECT ELECTRIC GENERATING STATION, UNITS 1 AND 2 – INTEGRATED INSPECTION REPORT 05000498/2024001 AND 05000499/2024001 DATED MAY 06, 2024

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ADAMS ACCESSION NUMBER: **ML24123A073**

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U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report

Docket Numbers: 05000498 and 05000499

License Numbers: NPF-76 and NPF-80

Report Numbers: 05000498/2024001 and 05000499/2024001

Enterprise Identifier: I-2024-001-0003

Licensee: STP Nuclear Operating Company

Facility: South Texas Project Electric Generating Station, Units 1 and 2

Location: Wadsworth, TX 77483

Inspection Dates: January 01, 2024, to March 31, 2024

Inspectors: L. Flores, Resident Inspector
A. Saunders, Reactor Inspector
J. Vera, Senior Resident Inspector

Approved By: Patricia J. Vossmar, Chief
Reactor Projects Branch A
Division of Operating Reactor Safety

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting an integrated inspection at South Texas Project Electric Generating Station, Units 1 and 2, 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 Maintain Minimum On-Shift Emergency Response Staffing Levels			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Emergency Preparedness	Green NCV 05000498,05000499/2024001-01 Open/Closed	[H.12] - Avoid Complacency	71152A
The inspectors identified a Green finding and associated non-cited violation of 10 CFR Part 50.47(b)(2) for the licensee's failure to maintain the effectiveness of its emergency plan, when on more than one occasion, the number of control room operators fell below minimum staffing as required by EP0001.001, "STPEGS Emergency Plan."			

Failure to Provide Adequate Work Instructions Results in Inoperable Essential Chiller			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000498/2024001-02 Open/Closed	[P.2] - Evaluation	71153
The inspectors identified a Green finding and associated non-cited violation of Technical Specification 6.8.1.a for the licensee's failure to provide adequate work instructions appropriate to the circumstances for essential chillers as required by Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operation)," revision 2, appendix A, section 9, "Procedures for Performing Maintenance." Specifically, the licensee failed to provide adequate work instructions to reassemble the essential chiller condenser water box covers during maintenance. As a result, the Unit 1 train C essential chiller (essential chiller 12C) was inoperable for greater than the technical specification allowed outage time.			

Failure to Promptly Identify and Correct a Condition Adverse to Quality Resulting in Repeated Steam Generator Power-Operated Relief Valve Inoperability			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000498/2024001-03 Open/Closed	[P.2] - Evaluation	71153
The inspectors identified a Green finding and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the licensee's failure to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to identify and correct a condition that caused a failure of steam generator power-operated relief valve 1C during a forced outage in January 2024. As a result, a second failure of the same valve occurred during a second forced outage in March 2024.			

Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
LER	05000498/2024-001-00	Two Steam Generator Power Operated Relief Valves (PORVs) Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function	71153	Closed
LER	05000498/2023-004-00	Condition Prohibited by Technical Specifications Due to Inoperable Train of Essential Chilled Water	71153	Closed
LER	05000499/2023-001-00	Two Essential Chilled Water Trains Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function	71153	Closed

PLANT STATUS

Unit 1 began the inspection period at rated thermal power. On January 20, 2024, the licensee down powered the unit to approximately 75 percent rated thermal power to perform repairs on a turbine governor valve, returning to full power on January 21, 2024. On January 21, 2024, the licensee down powered and shut down the unit, entering forced outage 1F2401 to perform repairs on turbine governor valve electrohydraulic control (EHC) fluid lines. The licensee commenced reactor startup and the reactor was made critical on January 25, 2024, however, the licensee determined that EHC cleanup efforts had not been sufficient, and the unit was shut down again on January 26, 2024. After further EHC cleanup activities, reactor startup was performed and the unit went critical on January 30, 2024, with the unit resuming full power operations on January 31, 2024. On February 29, 2024, the licensee down powered and shut down the unit, entering forced outage 1F2402 to replace a cracked spring on a steam generator safety relief valve. Reactor startup was performed, and the unit went critical on March 4, 2024, with the unit resuming full power operations on March 5, 2024. The unit remained at full power for the remainder of the inspection period.

Unit 2 began the inspection period at rated thermal power and commenced a reactor shutdown on March 22, 2024, to begin refueling outage 2RE23.

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 performed activities described in IMC 2515, Appendix D, “Plant Status,” observed risk significant activities, and completed on-site portions of IPs. 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.

REACTOR SAFETY

71111.01 - Adverse Weather Protection

Impending Severe Weather Sample (IP Section 03.02) (1 Sample)

(1) The inspectors evaluated the adequacy of the overall preparations to protect risk-significant systems from impending severe weather extreme cold temperatures for Units 1 and 2 on January 16, 2024.

71111.04 - Equipment Alignment

Partial Walkdown Sample (IP Section 03.01) (3 Samples)

The inspectors evaluated system configurations during partial walkdowns of the following systems/trains:

(1) Unit 2, train D auxiliary feedwater system on February 1, 2024
(2) Unit 2, 480 VAC class 1E MCC and distribution breaker lineup on February 16, 2024
(3) Unit 2, train C essential cooling water system on March 1, 2024

Complete Walkdown Sample (IP Section 03.02) (1 Sample)

(1) The inspectors evaluated system configurations during a complete walkdown of the Unit 1 essential chilled water system on March 1, 2024

71111.05 - Fire Protection

Fire Area Walkdown and Inspection Sample (IP Section 03.01) (3 Samples)

The inspectors evaluated the implementation of the fire protection program by conducting a walkdown and performing a review to verify program compliance, equipment functionality, material condition, and operational readiness of the following fire areas:

(1) Unit 1, mechanical auxiliary building, fire area 3, fire zone Z147 on January 12, 2024
(2) Unit 1, ESF switchgear room train B, fire area 3, fire zone Z042 on February 13, 2024
(3) Unit 2, containment on March 28, 2024

71111.11Q - Licensed Operator Requalification Program and Licensed Operator Performance

Licensed Operator Performance in the Actual Plant/Main Control Room (IP Section 03.01) (1 Sample)

(1) The inspectors observed and evaluated licensed operator performance in the control room during Unit 1 down power to 75 percent and power ascension due to governor valve GV-1 oscillations on January 20, 2024.

Licensed Operator Requalification Training/Examinations (IP Section 03.02) (1 Sample)

(1) The inspectors observed and evaluated a licensed operator requalification exam at the simulator on February 29, 2024.

71111.13 - Maintenance Risk Assessments and Emergent Work Control

Risk Assessment and Management Sample (IP Section 03.01) (5 Samples)

The inspectors evaluated the accuracy and completeness of risk assessments for the following planned and emergent work activities to ensure configuration changes and appropriate work controls were addressed:

(1) Unit 1, repairs on governor valve (GV) 1 while at reduced power to address valve oscillations on January 21, 2024
(2) Unit 2, yellow risk the weeks of February 19 and February 26, 2024
(3) Unit 2, white risk the week of March 4, 2024
(4) Unit 1, essential cooling water train C leakage on March 9, 2024
(5) Unit 1, white risk the week of March 11, 2024

71111.15 - Operability Determinations and Functionality Assessments

Operability Determination or Functionality Assessment (IP Section 03.01) (5 Samples)

The inspectors evaluated the licensee's justifications and actions associated with the following operability determinations and functionality assessments:

(1) Unit 1, train C emergency diesel generator annunciator failed to reset on February 2, 2024
(2) Unit 2, train C essential cooling water self-cleaning strainer stuffing gland bolt corrosion on February 21, 2024
(3) Unit 1, train A steam generator power operated relief valve inoperable during forced outage on February 23, 2024
(4) Unit 1, train C steam generator power operated relief valve failure to stroke on February 24, 2024
(5) Unit 1, pressurizer power operated relief valve failure to operate on February 28, 2024

71111.18 - Plant Modifications

Temporary Modifications and/or Permanent Modifications (IP Section 03.01 and/or 03.02) (1 Sample)

The inspectors evaluated the following temporary or permanent modifications:

(1) Unit 2, EC 12-21926-381-replacement of class 1E switchgear E2C circuit breakers during 2RE23 outage

71111.20 - Refueling and Other Outage Activities

Refueling/Other Outage Sample (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated the forced outage due to a cracked spring in steam generator B safety relief valve activities from February 29 to March 4, 2024.

71111.24 - Testing and Maintenance of Equipment Important to Risk

The inspectors evaluated the following testing and maintenance activities to verify system operability and/or functionality:

Post-Maintenance Testing (PMT) (IP Section 03.01) (5 Samples)

(1) Unit 1, train C auxiliary feedwater pump after planned maintenance on January 16, 2024
(2) Unit 1, train C essential chiller 12C on January 18, 2024
(3) Unit 1, control room HVAC after actuator rebuild/replace on February 6, 2024
(4) Unit 2, essential cooling water system following planned equipment outage on February 28, 2024
(5) Unit 2, train C emergency diesel generator following planned equipment outage on February 29, 2024

Surveillance Testing (IP Section 03.01) (3 Samples)

(1) Unit 2, train C emergency diesel generator on January 17, 2024
(2) Unit 1, 125 VDC class 1E system on February 15, 2024
(3) Unit 1, train B essential cooling water pump on March 9, 2024

Inservice Testing (IST) (IP Section 03.01) (2 Samples)

(1) Unit 2, train B essential cooling water system pressure test on January 10, 2024
(2) Unit 1, train D auxiliary feedwater pump on March 14, 2024

OTHER ACTIVITIES – BASELINE

71151 - Performance Indicator Verification

The inspectors verified licensee performance indicators submittals listed below:

IE01: Unplanned Scrams per 7000 Critical Hours Sample (IP Section 02.01) (2 Samples)

(1) Unit 1 (January 1, 2023, through December 31, 2023)
(2) Unit 2 (January 1, 2023, through December 31, 2023)

IE03: Unplanned Power Changes per 7000 Critical Hours Sample (IP Section 02.02) (2 Samples)

(1) Unit 1 (January 1, 2023, through December 31, 2023)
(2) Unit 2 (January 1, 2023, through December 31, 2023)

IE04: Unplanned Scrams with Complications (USwC) Sample (IP Section 02.03) (2 Samples)

(1) Unit 1 (January 1, 2023, through December 31, 2023)
(2) Unit 2 (January 1, 2023, through December 31, 2023)

71152A - Annual Follow-up Problem Identification and Resolution

Annual Follow-up of Selected Issues (Section 03.03) (1 Sample)

The inspectors reviewed the licensee's implementation of its corrective action program related to the following issues:

(1)
- actions taken associated with Emergency Response Organization (ERO) on-shift staffing levels falling below minimum allowed by emergency plan.

71153 - Follow Up of Events and Notices of Enforcement Discretion

Event Follow up (IP Section 03.01) (1 Sample)

(1) The inspectors evaluated Unit 1 EHC leak on GV-2 and resultant forced outage and the licensee's response on January 21, 2024.

Event Report (IP Section 03.02) (3 Samples)

The inspectors evaluated the following licensee event reports (LERs):

(1) LER 05000499/2023-001-00, Two Essential Chilled Water Trains Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function " (ADAMS Accession No. ML24015A002). The inspectors determined that the cause of the condition described in the LER was not reasonably within the licensee's ability to foresee and correct, and therefore was not reasonably preventable. No performance deficiency nor violation of NRC requirements was identified.
(2) LER 05000498/2023-004-00, "Unit 1, Condition Prohibited by Technical Specifications Due to Inoperable Train of Essential Chilled Water" (ADAMS Accession No. ML24036A352). The inspection conclusions associated with this LER and an associated non-cited violation are documented in this report under the inspection results section.
(3) LER 05000498/2024-001-00, “Two Steam Generator Power Operated Relief Valves (PORVs) Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function" (ADAMS Accession No. ML24092A190). The inspection conclusions associated with this LER and an associated non-cited violation are documented in this report under the inspection results section.

INSPECTION RESULTS

Failure to Maintain Minimum On-Shift Emergency Response Staffing Levels			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Emergency Preparedness	Green NCV 05000498,05000499/2024001-01 Open/Closed	[H.12] - Avoid Complacency	71152A
The inspectors identified a Green finding and associated non-cited violation of 10 CFR Part 50.47(b)(2) for the licensee’s failure to maintain the effectiveness of its emergency plan, when on more than one occasion, the number of control room operators fell below minimum staffing as required by EP0001.001, “STPEGS Emergency Plan.”			
Description: During a review of corrective action program documents, the inspectors identified that during the period of December 15, 2023, through February 15, 2024, there were two instances of the licensee failing to meet emergency plan (E-Plan) minimum staffing requirements for on-shift staffing. On December 17, 2023, and February 3, 2024, E-Plan minimum staffing was not met due to the station not having a senior reactor operator (SRO) who is shift manager (SM) trained on-shift. The South Texas Project E-Plan requires staffing three emergency response organization (ERO) functions: command and control, classification advisor, and engineering. These functions are staffed by three on-shift SROs covering four positions: one SRO (SM) as the emergency director under the command-and-control function; one SRO (SM trained) also serving the command and control function and collaterally serving as a classification advisor; and one SRO (shift technical advisor (STA)) for engineering. The licensee initially documented that implementation of the E-plan was not impeded due to having one SM to perform the emergency director role. However, the inspectors determined that this was contrary to the licensee’s E-Plan. Specifically, when the SRO (SM trained) left the site, two			

required E-Plan roles became unstaffed – the second command and control SRO (SM trained) position and the classification advisor position. Neither of these roles were allowed to be taken on by the onsite SROs as collateral duties.

The inspectors questioned whether there was a process in place to address occasions where on-shift minimum staffing was not met. The licensee stated that callouts are made to off shift personnel if needed; however, there is not a documented process that is used, nor does the E-Plan have an allowed time for on-shift minimum staffing to fall below requirements to re-staff positions. The E-Plan only outlines response times of either 60 or 90 minutes for augmenting ERO staff to respond.

On December 17, 2023, the SRO required by the E-Plan arrived after 2 hours and 45 minutes. On February 3, 2023, the SRO required by the E-Plan arrived after 5 hours and 40 minutes. The inspectors determined that the licensee failed to recognize that E-Plan staffing requirements must be met regardless of whether licensed operator staffing levels, as required by Technical Specifications, were met. On the occasions identified above, the technical specification unit staff requirements were met.

Corrective Actions: The licensee entered the issue into their corrective action program and initiated an action in condition report (CR) 24-1162 to identify and document the process to follow when E-Plan minimum staffing requirements are not met and clarify the differences in E-Plan and technical specification SRO roles.

Corrective Action References: CR 2023-11255, 2024-1162

Performance Assessment:

Performance Deficiency: The licensee's process for maintaining minimum emergency response staffing failed to ensure that on-shift emergency response responsibilities are staffed and assigned, and that the process for timely augmentation of on-shift staff is established and maintained.

Screening: The inspectors determined the performance deficiency was more than minor because it was associated with the ERO Performance attribute of the Emergency Preparedness cornerstone and adversely affected the cornerstone objective to ensure that the licensee can implement adequate measures to protect the health and safety of the public in the event of a radiological emergency. Specifically, the failure to maintain required emergency response staffing levels reduced the licensee's capabilities to respond to an emergency.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix B, "Emergency Preparedness SDP." The inspectors determined that this finding is of very low safety significance (Green), consistent with table 5.2-1 – significance examples for 50.47(b)(2) and is an example of a staffing process that would permit a shift to go below E-Plan minimum staffing requirements. Specifically, the inspectors determined that the licensee's process failed to ensure on-shift staffing met the E-Plan minimum staffing requirement on December 17, 2023, and February 3, 2024.

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 documented that not meeting E-Plan minimum staffing requirements for a period on two

occasions did not impede the implementation of the E-plan and the licensee did not have a process in place to address the gaps.

Enforcement:

Violation: Title 10 CFR 50.54(q)(2) requires that a holder of a nuclear power plant operating license follow and maintain the effectiveness of an emergency plan that meets the requirements of Appendix E of this part and the planning standards of 10 CFR 50.47(b). Further, 10 CFR 50.47(b)(2) requires, in part, that adequate staffing to provide initial facility accident response in key functional areas is maintained at all times, and that timely augmentation of response capabilities is available.

Contrary to the above, on December 17, 2023, and February 3, 2024, the licensee failed to maintain the effectiveness of their emergency plan when they did not ensure that adequate staffing to provide initial facility accident response in key functional areas was maintained at all times. Specifically, on more than one occasion, the number of control room operators fell below minimum staffing as required by EP0001.001, "STPEGS Emergency Plan."

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

Failure to Provide Adequate Work Instructions Results in Inoperable Essential Chiller			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000498/2024001-02 Open/Closed	[P.2] - Evaluation	71153

The inspectors identified a Green finding and associated non-cited violation of Technical Specification 6.8.1.a for the licensee's failure to provide adequate work instructions appropriate to the circumstances for essential chillers as required by Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operation)," revision 2, appendix A, section 9, "Procedures for Performing Maintenance." Specifically, the licensee failed to provide adequate work instructions to reassemble the essential chiller condenser water box covers during maintenance. As a result, the Unit 1 train C essential chiller (essential chiller 12C) was inoperable for greater than the technical specification allowed outage time.

Description: The essential chilled water system provides chilled water to safety-related air handling units (AHU) to provide a suitable environment for personnel and class 1E equipment located in the electrical auxiliaries building, mechanical auxiliaries building and the fuel handling building. It is a closed system designed to remain functional during and following design basis accidents and plant safe shutdown. It consists of three, 50-percent-heat-removal-capacity redundant and independent trains. Each train has an allowable design basis leakage rate of 1 gallon per day (gpd), or 52 drops per minute (dpm) for the chiller to be operable. The 1 gpd leakage rate is established to account for leakage and ensure the chiller operates for 15 days without needing to add water during a design basis event. Each essential chilled water train also has an expansion tank which allows for the volume expansion of water due to increases in temperature. Two chillers are required to be always operating, and the chillers are regularly rotated to support plant operations and maintenance.

On November 10, essential chiller 12C was declared inoperable due to high compressor discharge pressure. The licensee replaced the compressor mechanical seal and started the chiller for testing on November 19, 2023. After the chiller was started, the licensee discovered

chilled water leakage from the east and west end condenser water box covers totaling 178 dpm and documented the leakage in condition reports (CR) 23-10571 and 23-10577. On November 20, the licensee checked the torque value on the condenser water box cover bolts at 52-ft-lbs and increased torque by 10 percent to 57-ft-lbs to stop the leakage. The leakage decreased to 21 dpm, and the chiller was declared operable. On November 21, the licensee noted a significant increase in leakage, calculated the leakage to be approximately 15-20 gpd and declared essential chiller 12C inoperable. The licensee performed walkdowns of the chilled water system piping and AHUs but did not identify any other leaks.

The inspectors questioned the licensee on the justification to increase torque by 10 percent and reviewed the recent work history on essential chiller 12C. On July 23, 2023, essential chiller 12C was returned to operable status after preventive maintenance and post maintenance testing was completed under work authorization number (WAN) 667883. This maintenance included, in part, removing, inspecting, and recoating the essential chiller condenser water box covers and reinstalling the covers with new gaskets.

Work instructions written under WAN 667883 directed the condenser water box covers to be installed with new gaskets and the cover bolts torqued to 26-ft-lbs in accordance with vendor drawing 4310-0021YD. Maintenance was completed on July 22, 2023, and the chiller was started for post-maintenance testing. The licensee noted leakage at the 26-ft-lb torque value and increased torque to 52-ft-lbs. per step 3.8.3 of WAN 667883. Step 3.8.3 states, “if inlet and/or return water box cover(s) leaks, increase torque the water box cover fasteners 52-ft-lb. +/- 10 percent IAW, page 13A, in VTD-Y018-0001 to stop leakage.” Page 13A of vendor manual VTD-Y018-0001, “Open Turbopak Centrifugal Liquid Chilling Units Instruction Operating and Maintenance,” revision 3, directs increasing torque on the condenser water box covers only if there is leakage when the tube sheet is warped or bowed, and only after an additional rubber gasket has been installed. WAN 667883 added a step that allowed increasing torque to 52-ft-lb without tube sheet deformation and without adding a second gasket to the condenser water box cover, contrary to the vendor manual.

On October 22, 2023, the licensee documented in CR 23-9850 that the chilled water expansion tank unexpectedly lowered several times over the preceding three months to the low-level alarm setpoint. No engineering evaluation was performed at that time. The inspectors reviewed control room and operator logs from January 1, until November 21, 2023, and noted that from July 22, until November 11, 2023, the train C essential chiller was running for a total of 84 days. The chilled water expansion tank was filled 7 times over that period, and a total of approximately 128 gallons of water were added to the system. The inspectors calculated that for each period that the train C essential chiller was operating, the leakage rates were between 1.05 and 1.92 gpd, exceeding the design basis limit of 1 gpd.

- From July 22, 2023 – August 11, 2023, 38.4 gallons of water were added with a calculated loss of 1.92 gpd.
- From August 24, 2023 – September 16, 2023, 31.1 gallons of water were added with a calculated loss of 1.35 gpd.
- From September 21, 2023 – October 7, 2023, 16.8 gallons of water were added with a calculated loss of 1.05 gpd.
- From October 19, 2023 – November 11, 2023, 42.3 gallons of water were added with a calculated loss of 1.69 gpd.

On November 27, WAN 698806 was issued to correct the excessive leakage identified on November 19, 2023. Upon removal and inspection of the condenser water box covers, the

licensee noted that each gasket on both end bells of the chiller installed in the July 2023 maintenance window were installed backwards. The work instructions in WAN 667883 did not contain steps detailing installation of the gaskets and did not reference vendor drawings 4310-00202YD and 4310-0100216YD, which detail how to install the gaskets.

Corrective Actions: The licensee cleaned the surfaces of the water box covers, replaced the gaskets in accordance with vendor drawings, reassembled the condenser water box covers and torqued the cover bolts to 26-ft-lbs in accordance with the vendor manual. The chiller was tested and declared operable on December 3, 2023.

Corrective Action References: CRs 2023-10571, 2023-10577, 2023-9850, 2023-10624

Performance Assessment:

Performance Deficiency: The failure to provide adequate work instructions to reassemble the essential chiller condenser water box covers during maintenance was a performance deficiency. Specifically, the licensee failed to establish work instructions in accordance with vendor documentation.

Screening: The inspectors determined 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. Specifically, essential chiller 12C had leakage more than the design basis limit of 1 gpd from July 23, 2023, until it was corrected and returned to operable status on December 3, 2023.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix A, “The Significance Determination Process (SDP) for Findings At-Power.” The inspectors determined that, from July 23, 2023, until November 20, 2023, while the chilled water leakage rate for essential chiller 12C was more than the design basis limit and TS operability was lost, it did not represent a loss of the PRA function of one train of a multi-train system for greater than its TS allowed outage time. However, from November 21, 2023, until December 3, 2023, the finding did require a detailed risk evaluation because essential chiller 12C chilled water leakage represented a loss of PRA function for one train of a multi-train system for greater than its TS allowed outage time when leakage increased to 15-20 gpd.

A senior reactor analyst performed a detailed risk evaluation. The analyst assumed that the performance deficiency resulted in the Unit 1 essential chiller 12C being in a condition where it would have been unable to perform its required function due to excessive system leakage. During this exposure period, the safety functions that are supported by this affected train of essential chilled water, including the corresponding trains of the high-pressure injection and residual heat removal functions, were assumed to be non-functional. The analyst considered that this affected train of essential chilled water could have remained capable of functioning to some degree and for some amount of time with this degraded condition present; therefore, the assumptions reflected in this analysis approach constitute a bounding analysis for purposes of bounding the potential safety significance of the degraded condition that resulted from this performance deficiency. The analyst assumed that the Unit 1 essential chiller 12C was unavailable to perform its required function due to increased system leakage during the time from 1530 on November 20, 2023, until corrective maintenance was completed at 2254 on December 3, 2023. The analyst did not apply recovery credit for the affected PRA

functions associated with this condition. This assumption was also consistent with a bounding approach to determine significance.

The South Texas Project SPAR Model version 8.82 along with SAPHIRE software version 8.2.9 were used for the evaluation. The analyst determined that this condition would be most appropriately modeled by setting the basic event CHW-CHL-FR-300TC (300-Ton Chiller C Fails) to TRUE in the Events and Conditions Assessment (ECA) workspace for an exposure time of 13 days and 7 hours. The analyst included credit for the use of Diverse and Flexible Coping (FLEX) Strategies Flex by adjusting the basic event FLX-XHE-XE-ELAP (Operators Fail to Declare ELAP When Beneficial) probability to 1.0E-2. The analyst quantified the SPAR model according to the assumptions described above to obtain a result of 5.32E-7/year for an increase in average annual core damage frequency (delta-CDF) associated with internal events. The dominant sequences involved loss of all feedwater with failure of the feed-and-bleed function, as well as small and medium loss of coolant accident sequences with failure of the low pressure and high pressure recirculation functions.

The increase in risk associated with external events attributable to this degraded condition was also evaluated. Using the SPAR model, the analyst obtained a result of 1.04E-7/year for a delta-CDF associated with the external events of hurricane, straight line high winds, tornado, and seismic events. Since the SPAR model did not include modeling of fire events, the analyst determined that best available information associated with the risk attributable to fire events would be obtained from the licensee's fire PRA model. The analyst obtained and reviewed the results of the licensee's fire PRA modeling of the impact of this condition and concluded that the increase in risk for this condition associated with fire events was best estimated to be a delta-CDF of 1.33E-7/year.

The risk significance of the finding was also evaluated for impact on large early release frequency (LERF). The analyst evaluated the increase in LERF using Inspection Manual Chapter 0609, appendix H, "Containment Integrity Significance Determination Process." The finding was treated as a Type A finding because it could influence the likelihood of accidents leading to core damage as well as being a contributor to LERF. The analyst reviewed all sequences contributing to CDF for any elements affecting LERF and screened out all sequences except those associated with a steam generator tube rupture (SGTR) event. For the SGTR sequence, the analyst applied the applicable assessment factor of 1.0 from table 6.2, phase 2 Assessment Factors – Type A Findings at Power. This resulted in an increase in LERF from internal and external events (minus fire events) of 1.81E-8/year. From a review of the licensee's fire risk analysis, the analyst determined the best estimate of increase in LERF due to fire events was 1.46E-9/year.

The analyst performed an uncertainty analysis using the Monte Carlo method with 3,675 runs on the internal and external events (minus fire events) results in SAPHIRE. The mean value result was 6.45E-7/year, and the 5^{th} and 95^{th} percentile results were 8.83E-8/year and 2.03E-6/year, respectively, with 96.8 percent of the results falling within the range of less than 1.0E-6/year. The analyst considered that the uncertainty distribution associated with the overall/total result (i.e., with the addition of the fire event results of 1.33E-7/year) would be shifted upward with a dominant portion of the results remaining below the 1.0E-6/year significance threshold.

The analyst reviewed the licensee's risk significance evaluation, which yielded results of 6.20E-7/year and 1.74E-8/year for delta-CDF and delta-LERF, respectively, for all internal and external hazards.

Based on best estimates of 7.69E-7/year for total delta-CDF and 1.96E-8/year for total delta-LERF, the analyst concluded that the risk significance of the finding was determined to be very low safety significance (Green).

Cross-Cutting Aspect: P.2 - Evaluation: The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, Essential Chiller 12C showed signs of excessive leakage beginning July 23, 2023, but the condition was not adequately evaluated by the licensee until leakage increased significantly to 15-20 gpd on November 21, 2023.

Enforcement:

Violation: Technical Specification (TS) 6.8.1.a requires, in part, that written procedures shall be established, implemented, and maintained in accordance with appendix A of Regulatory Guide 1.33, revision 2, appendix A, section 9, "Procedures for Performing Maintenance," requires, in part, that maintenance that can affect the performance of safety-related equipment should be properly pre-planned and performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances.

Technical Specification 3.7.14, “Essential Chilled Water System,” requires, in part, that at least three independent essential chilled water system loops shall be operable in modes 1, 2, 3, and 4. TS 3.7.14 action statement (a) requires, in part, that with only two essential chilled water system loops operable, within 7 days restore at least three loops to operable status or apply the requirements of the configuration risk management program (CRMP), or be in at least hot standby within the next 6 hours and in cold shutdown within the following 30 hours.

Contrary to the above, from July 23, until December 3, 2023, the licensee failed to properly pre-plan and perform maintenance activities that could affect the performance of safety-related equipment in accordance with documented instructions appropriate to the circumstances. Specifically, the licensee failed to provide adequate work instructions to reassemble the essential chiller condenser water box covers during maintenance, resulting in leakage exceeding the design basis limit while the chiller was operating. As a result, essential chiller 12C was inoperable for greater than the TS allowed outage time permitted by TS 3.7.14 action (a) for only two essential chilled water system loops operable, and the unit was not placed in hot standby within the following 6 hours.

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

Failure to Promptly Identify and Correct A Condition Adverse to Quality Resulting in Repeated Steam Generator Power-Operated Relief Valve Inoperability			
Cornerstone	Significance	Cross-Cutting Aspect	Report Section
Mitigating Systems	Green NCV 05000498/2024001-03 Open/Closed	[P.2] - Evaluation	71153
The inspectors identified a Green finding and associated non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, for the licensee’s failure to promptly identify and correct a condition adverse to quality. Specifically, the licensee failed to identify and correct a condition that caused a failure of steam generator power-operated relief valve 1C during a forced			

outage in January 2024. As a result, a second failure of the same valve occurred during a second forced outage in March 2024.

Description: The atmospheric steam relief valves, also known as steam generator power-operated relief valves (PORVs), are required by Technical Specification (TS) 3.7.1.6 to be operable and are provided for reactor coolant system cooldown and decay heat removal. Operation of the atmospheric steam relief valves is assumed in accident analyses for mitigation of a small break loss of coolant accident, feedwater line break, loss of normal feedwater, and loss-of-offsite power. Technical Specification 3.7.1.6 requires at least four atmospheric steam relief valves to be operable in Modes 1 through 3, and in Mode 4 when steam generators are used for decay heat removal.

On January 23, 2024, with the unit in Mode 3, operators attempted to open PORV 1C, but it did not stroke. A blown fuse in the corresponding servo amplifier was replaced, but the replacement fuse also blew. The station conducted minimal troubleshooting and causal evaluation. However, station personnel judged the most likely cause of the issue was the servo amplifier, and this component was replaced. The valve was declared operable after these replacements following satisfactory post-maintenance testing. The unit returned to mode 1 on January 30, and resumed full power operation on January 31, 2024.

On March 1, 2024, the station entered a forced outage to replace a steam generator safety relief valve spring. With the unit in Mode 4, after closing PORV 1C earlier in the day, operators attempted to open PORV 1C, but it did not stroke. The operators observed that the demand signal did not change on the controller. The licensee declared the valve inoperable and investigated the conditions in the field. The licensee found the same fuse blown again, and an intermittent electrical failure on one of the A/B solenoid coils required to operate PORV 1C. The licensee replaced the A/B solenoid and PORV 1C was declared operable following post-maintenance testing.

The inspectors noted that the March 1, 2024, failure was the third atmospheric relief valve failure in 3 months, and the second for PORV 1C. The inspectors reviewed the condition report and work orders associated with the January 23, 2024, and March 1, 2024, failures and noted that neither included causal products that would lead to a determination of causes for the failures.

The inspectors reviewed the troubleshooting work instructions for the January 23, 2024 failure, and noted that the work instructions were limited to replacement of the servo amplifier board and terminal boards, calibration of the new servo amplifier board, and return to service. Diagnostic steps were minimal. The inspectors noted that the licensee's Prompt Equipment Performance Checklist highlighted the fact that after replacement of the initial blown fuse, the replacement fuse also blew; however, there was no subsequent effort to determine the cause. The corrective action was limited to replacing the fuse again, as well as the servo amplifier. The licensee's basis, stated in the Prompt Equipment Performance Checklist, was: "…it appeared that there had been an intermittent condition within the servo amp[lifier] cause the blown fuses and not an external device. In conclusion the intermittent condition identified with the servo amp[lifier] was the reason for the failure and the servo amp[lifier] was replaced as a result." The Prompt Equipment Performance Checklist is the licensee's lowest level of causal product. The inspectors concluded that a lack of thorough investigation of the January 2024 PORV 1C failure led to licensee's failure to identify the deficient condition within the electrical circuit and resulted in the second valve failure in March 2024.

The inspectors reviewed condition report 24-2042, associated with the March 1, 2024,

PORV 1C failure, and noted that a Prompt Equipment Performance Checklist was not performed for the March 1, 2024, PORV 1C failure, even though the licensee's procedure CAP-0003 "Condition Report Screening," revision 6, prescribes this level of evaluation for equipment failures resulting in unplanned entries into TS.

Corrective Actions: The licensee replaced the A/B solenoid on the affected circuit and tested and declared operable PORV 1C on March 2, 2024.

Corrective Action References: CRs 2024-806, 2024-2042

Performance Assessment:

Performance Deficiency: The failure to identify and correct the condition adverse to quality that led to the failure of steam generator PORV 1C during forced outages in January and March 2024 was a performance deficiency. Specifically, the licensee failed to identify the condition that caused the failure during the January 2024 outage, having performed only limited troubleshooting and causal evaluation. This led to a second failure of the same valve on March 1, 2024.

Screening: The inspectors determined 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. Specifically, corrective actions taken for the PORV 1C failure to operate on January 23, 2024, did not address the condition and led to a subsequent failure of PORV 1C on March 1, 2024.

Significance: The inspectors assessed the significance of the finding using IMC 0609 Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." The inspectors determined that this finding required a detailed risk evaluation because the degraded condition resulted in the loss of PRA function of one train of a multiple train TS system for greater than the TS allowed outage time. A senior reactor analyst performed a detailed risk evaluation. In performing the detailed risk evaluation, the analyst assumed that the exposure time was 38 days, spanning from January 23, 2024, when steam generator atmospheric steam relief valve 1C 7431 did not stroke until March 2, 2024, when the valve was declared operable. To model the failure, the analyst set basic event MSS-ARV-CC-7431, Failure of SG 1 ARV-7431, to TRUE. The analyst noted that the exposure time contained approximately 8 days with the plant shutdown in the hot standby mode, during which time the reactor decay heat load was lower than during full power operations. Because of these lower decay heat loads, operators would have had more time available to diagnose and initiate the feed and bleed decay heat removal strategy. For these 8 days, the analyst adjusted human performance event HPI-XHE-XM-FAB, Operator Fails to Initiate Feed and Bleed Cooling, by changing available time from barely adequate to nominal time. The analyst applied the baseline probability for HPI-XHE-XM-FAB for the remaining 29 days of the exposure time.

The analyst ran these inputs on the South Texas Project SPAR model, Version 8.80, ran on SAPHIRE, revision 8.2.9, to obtain an estimate in the increase of core damage frequency of 9.0E-7/year. The analyst considered this estimate to be qualitatively high because steam generator atmospheric steam relief valve 1C 7431 functioned on its first operated attempt on March 1, 2024. The analyst also ran this failure as a decreased reliability case and changed the failure rate of steam generator atmospheric steam relief valve 1C 7431 to 5.0E-1, to represent the observed conditions on March 1, 2024. This sensitivity run produced an

estimate of the increase in core damage frequency of 9.0E-9/year.

For external events the analyst noted that the SPAR model did not produce significant risk estimates for high winds, tornadoes, hurricanes, seismic, or flooding scenarios. The analyst estimated fire risk using licensee fire modeling information to obtain an increase in the core damage frequency due to fires of 2.0E-8/year. This produced a combined conservative risk estimate of the total risk increase in core damage frequency of 9.2E-7/year, making the issue of very low safety significance (Green). The analyst used Manual Chapter 0609, Appendix H, "Integrity Significance Determination Process," to determine that the increase in large early release frequency was not risk significant. The dominating sequences were steam generator tube ruptures losses of condenser heat sinks which were mitigated by the primary pilot operated relief valves and the emergency feed water system.

Cross-Cutting Aspect: P.2 - Evaluation: The organization thoroughly evaluates issues to ensure that resolutions address causes and extent of conditions commensurate with their safety significance. Specifically, for the failure of PORV 1C, the licensee replaced a servo amplifier designated as a likely cause based on previous experience, instead of thoroughly evaluating the condition to find and address the actual cause.

Enforcement:

Violation: 10 CFR Part 50, appendix B, criterion XVI requires, 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 nonconformance's are promptly identified and corrected.

Contrary to the above, from January 23, until March 1, 2024, the licensee failed to assure that conditions adverse to quality were promptly identified and corrected. Specifically, the licensee failed to identify the condition adverse to quality that caused the PORV 1C servo amplifier fuse to blow, rendering the valve inoperable. As a result, on March 1, 2024, when attempting to operate PORV 1C, the servo amplifier fuse blew, rendering the valve inoperable again.

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 April 24, 2024, the inspectors presented the integrated inspection results to Christopher Georgeson, General Manager of Engineering and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71111.01	Procedures	0PGP03-ZV-0001	Severe Weather Plan	25
71111.01	Procedures	0PGP03-ZV-0004	Winter Readiness Program	13
71111.01	Procedures	0POP01-ZO-0004	Extreme Cold Weather Guidelines	44
71111.04	Drawings	3V119V10002#1	Piping & Instrument Diagram - HVAC Essential Chilled Water System	13
71111.04	Drawings	3V119V10003#1	Piping & Instrument Diagram - HVAC Essential Chilled Water System	18
71111.04	Drawings	3V119V10004#1	Piping & Instrument Diagram - HVAC Essential Chilled Water System	9
71111.04	Drawings	5V119V10001#1	Piping & Instrument Diagram - HVAC Essential Chilled Water System	35
71111.04	Procedures	0POP02-AE-0001	AC Electrical Distribution Breaker Lineup	Rev. 36
71111.04	Procedures	0POP02-AF-0001	Auxiliary Feedwater	Rev. 60
71111.04	Procedures	0POP02-CH-0001	Essential Chilled Water System	59
71111.04	Procedures	0POP02-EW-0001	Essential Cooling Water Operations	86
71111.05	Fire Plans	0EAB03-FP-0042	Fire Preplan Electrical Auxiliary Building ESF Switchgear Room Train B	3
71111.05	Fire Plans	0MAB03-FP-0147	Fire Preplan Mechanical Auxiliary Building Locker Rooms and Clothing Issue	8
71111.05	Miscellaneous	FHAR	STP Fire Hazards Analysis Report	Amendment 27
71111.05	Procedures	0RCB63-FP-0201	Fire Preplan Reactor Containment Building Elevator No. 3	4
71111.05	Procedures	0RCB63-FP-0202	Fire Preplan Reactor Containment Building Central Reactor Area (Upper)	5
71111.05	Procedures	0RCB63-FP-0203	Fire Preplan Reactor Containment Building SW Peripheral Area	4
71111.05	Procedures	0RCB63-FP-0204	Fire Preplan Reactor Containment Building NW Peripheral Area	4
71111.05	Procedures	0RCB63-FP-0215	Fire Preplan Reactor Containment Building SW Peripheral Area	4
71111.05	Procedures	0RCB63-FP-0216	Fire Preplan Reactor Containment Building NW Peripheral	4

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Area	
71111.05	Procedures	0RCB63-FP-0217	Fire Preplan Reactor Containment Building NE Peripheral Area	4
71111.05	Procedures	0RCB63-FP-0219	Fire Preplan Reactor Containment Building Central Reactor Area (Lower)	5
71111.11Q	Procedures	0PGP03-ZT-0142	Shift Technical Advisor Training and Qualification Program	10
71111.11Q	Procedures	0PNT01-TQ-1001	Examination Security	11
71111.11Q	Procedures	0PNT01-ZT-0300	LOR Training Program	2
71111.11Q	Procedures	0PNT01-ZT-0301	LOR Annual and Biennial Evaluation	4
71111.11Q	Procedures	0POP03-ZG-0001	Plant Heatup	Rev. 84
71111.11Q	Procedures	0POP03-ZG-0005	Plant Startup To 100%	Rev.124
71111.13	Corrective Action Documents	CR-YYYY-NNNN	2024-655	
71111.13	Procedures	0PGP01-ZA-0304	Probabilistic Risk Assessment Risk Ranking	Rev. 12
71111.13	Procedures	0PGP02-ZA-0003	Comprehensive Risk Management Program	16
71111.13	Procedures	0PGP03-ZO-0055	Protected Components	18
71111.13	Procedures	0PGP04-ZA-0604	Probabilistic Risk Assessment Program	Rev. 9
71111.13	Procedures	0POP01-Z0-0006	Risk Management Actions - RMAs	29
71111.15	Corrective Action Documents	CR-YYYY-NNNN	2024-1682, 2024-1738, 2024-1891, 2024-2042, 2024-0537, 2024-0750, 2024-0806, 2024-2037	
71111.15	Drawings	PD 88082	Schematic Diagram Servo Amplifier "B"	Rev. C
71111.15	Procedures	0POP01-ZO-0011	Operability, Functionality, and Reportability Guidance	18
71111.15	Procedures	0POP09-AN-0106	Annunciator Lampbox 1(2)-106 Response Instructions	Rev. 19
71111.15	Work Orders	Work Authorization Number	635587, 701742, 416247, 652784, 609061, 615485	
71111.18	Calculations	EC-5008	Class 1EDC system Scenario, Battery/Charger/Inverter Sizing & system Voltage Calculation	16
71111.18	Engineering Changes	DCN 2300065	Design Change notice	
71111.18	Engineering Changes	DCP 12-31926-43 Supp. 00	Class 1E 4.16 KV Circuit Breaker Replacements	A
71111.18	Miscellaneous	5A050GAPK01	4.16KV AC Class 1E Power System Risk Significance Basis	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Document	
71111.20	Procedures	0POP03-ZG-0004	Reactor Startup	52
71111.20	Procedures	0POP03-ZG-0005	Plant Startup to 100%	123
71111.20	Procedures	0POP03-ZG-0006	Plant Shutdown from 100% to Hot Standby	82
71111.24	Procedures	0PEP06-ZE-0001	MOV Diagnostic Testing Error Analysis and Acceptance Criteria	14
71111.24	Procedures	0PMP05-ZE-0312	Limitorque MOV Actuator Lubrication	28
71111.24	Procedures	0PMP05-ZE-0425	MOV Diagnostic Testing (VOTES) - Rising Stem Valves	3
71111.24	Procedures	0PSP03-AF-0007	Auxiliary Feedwater Pump 14(24) Inservice Test	64
71111.24	Procedures	0PSP03-DG-0003	Standby Diesel 13(23) Operability Test	66
71111.24	Procedures	0PSP06-DJ-0001	125 Volt Class 1E Battery Monthly Surveillance Test	39
71111.24	Procedures	0PSP15-EW-0001	Essential Cooling Water System Pressure Test	13
71111.24	Work Orders	Work Authorization Number	624860, 66302, 667339, 669192, 670404, 671708, 673061, 674857, 676275, 653911, 693715, 645444, 675131, 675133, 683405, 641678, 641679	
71152A	Corrective Action Documents	CR-YYYY-NNNN	2023-11255, 2023-11254, 2024-1162	
71152A	Procedures	EP-0001.001	STPEGS Emergency Plan	1
71153	Calculations	MC05234	Expansion Tank Sizing for the Essential Chilled Water System	3
71153	Corrective Action Documents	CR-YYYY-NNNN	2023-9850, 2023-10571, 2023-10577, 23-10624, 2023-10770, 2023-10538	
71153	Drawings	4310--00201YD	Cooler & Cond. 58X14 YCLN/YCLB OTK5	02/08/1984
71153	Drawings	4310--00202AYD	Cooler & Cond 58X14 YCLN/YCLB OTK5	02/08/1984
71153	Miscellaneous	5V369VB00120	Design Basis Document - Chilled Water System	10
71153	Miscellaneous	LER 2023-001-00	Two Essential Chilled Water Trains Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function	
71153	Miscellaneous	LER 2023-004-00	Condition Prohibited by Technical Specifications Due to Inoperable Train of Essential Chilled Water	
71153	Miscellaneous	LER 2024-001-00	Two Steam Generator Power Operated Relief Valves (PORVs) Inoperable Resulting in a Condition That Could Have Prevented Fulfillment of a Safety Function	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71153	Miscellaneous	VTD-Y018-0001	Open Turbopak Centrifugal Liquid Chilling Units Instructions Operating and Maintenance Models OT A1 Thru OT K3 E3 90-650 Tons	3
71153	Work Orders	Work Authorization Number	667883, 698806	