

Salem 1

1Q/2014 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Online Risk Assessment for an Adverse Change in Grid Conditions

The inspectors identified a Green NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65(a)(4) when PSEG inadequately assessed risk during a period of adverse grid conditions. On January 7, 2014, the regional transmission organization declared a Maximum Emergency Generation Action, a condition that PSEG was procedurally required to consider a high risk evolution (HRE) for a loss of offsite power (LOOP). Specifically, PSEG was to elevate online risk to a Yellow condition; however, PSEG did not assess risk as Yellow. PSEG subsequently elevated their risk condition, protected equipment, took other risk management actions (RMAs), and entered the issue in their CAP.

The issue was more than minor since it was associated with the Protection Against External Factors attribute of the Initiating Events cornerstone and adversely affected its 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 extreme cold weather conditions indirectly were affecting grid stability and required risk assessment and management. Additionally, it was similar to IMC 0612, Appendix E, example 7.e, in that an inadequate risk assessment is not minor if the overall plant risk would put the plant into a higher licensee-established risk category. In this case, plant risk was reclassified from Green to Yellow when properly assessed. Specifically, the extreme cold weather conditions indirectly were affecting grid stability. The inspectors evaluated the finding using IMC 0612, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process." Since the incremental core damage probability deficit was less than 1 E-6 and the incremental large early release probability deficit was less than 1 E-7, this finding was determined to be of very low safety significance (Green). The finding was determined to have a cross-cutting aspect in the area of Human Performance, Teamwork, in that individuals and work groups communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety is maintained. Specifically, PSEG staff in the Electric System Operations Center (ESOC), Salem control room, and Hope Creek control room did not appropriately communicate across organizational boundaries to ensure that risk was appropriately assessed.

Inspection Report# : [2014002](#) (*pdf*)

Significance:  Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to establish appropriate MR performance goals

A self-revealing Green FIN was identified against PSEG procedure MA-AA-716-009, "Use of Maintenance Procedures," Revision 5, when PSEG staff did not follow "the rules of usage for Maintenance Department procedures" as applied to work on a Unit 2 isolated phase bus cooling fan. Specifically, PSEG staff did not perform inspection and testing as required. Subsequently, the 2B fan belts broke causing high temperatures in the bus enclosure, control room alarms, and an unplanned reduction to 51 percent reactor thermal power. As interim corrective actions, PSEG entered this in their corrective action program (CAP), initiated a prompt investigation,

installed fan belts and swapped operations to the 2A motor, and established weekly readings to monitor drive belt conditions.

The issue was more than minor since it was associated with the Equipment Performance attribute of the Initiating Events cornerstone and adversely impacted its 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 failure of the drive belts resulted in an unplanned downpower. The finding was evaluated in accordance with IMC 0609, Attachment 4, and Appendix A where it screened as very low safety significance (Green) as a support system initiator. Specifically, the finding did contribute to the likelihood of, or cause, both an initiating event and affect mitigation equipment. The finding had a cross-cutting aspect in the area of Human Performance, Teamwork, in that individuals and work groups communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety is maintained. Specifically, PSEG operations, maintenance, and engineering staff did not coordinate to ensure that inspections and testing were completed appropriately or that decisions not to complete steps as required were reviewed by the appropriate departments.

Inspection Report# : [2014002](#) (pdf)

Significance:  Sep 30, 2013

Identified By: NRC

Item Type: FIN Finding

Inadequate Maintenance Procedure to Reconsolidate Pressurizer Spray Valve Packing

The inspectors identified a self-revealing Green finding when PSEG did not provide appropriate air-operated valve program setpoint control, and ensure adequate packing consolidation of the Unit 1 pressurizer spray valve (1PS1) in accordance with station procedure, ER-AA-410, "Air Operated Valve Program Implementing Procedure," Revision 4. This resulted in a packing leak in excess of the Technical Specification (TS) allowable unidentified reactor coolant system (RCS) leak rate on August 22, 2013, and subsequently required an unplanned Unit shutdown. PSEG isolated the leak and entered this issue in the corrective action program (CAP) via Notifications 20618913 and 20618915.

This finding was more than minor because it was associated with the equipment performance attribute of the Initiating Events cornerstone, and adversely affected the associated cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Using IMC 0609, the inspectors determined that this finding was of very low safety significance (Green) using Exhibit 1 – "Initiating Events Screening Questions." Specifically, after a reasonable assessment of degradation, the inspectors determined the finding would not exceed the RCS leak rate for a small loss-of-coolant accident (LOCA), and the finding would not have affected other systems used to mitigate a LOCA. The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance, Operating Experience (OE), because PSEG did not implement vendor recommendations through changes to station processes and procedures. [P.2(b)] (Section 4OA3)

Inspection Report# : [2013004](#) (pdf)

Significance:  Aug 01, 2013

Identified By: NRC

Item Type: FIN Finding

Failure to Evaluate Performance Deficiency for FIN 2011004-02

The inspectors identified a Green finding (FIN) for PSEG's failure to evaluate the performance deficiency documented for FIN 2011004-02 in accordance with procedure LSAA-1003, "NRC Inspection Preparation and Response." Specifically, PSEG failed to initiate a notification to review FIN 2011004-02 and develop appropriate corrective actions. The original finding, FIN 201100402, was associated with untimely corrective actions for degraded reactor coolant pump motor cables. In addition to not addressing the performance deficiency, the failure to initiate a notification creates the potential for future untimely

corrective actions in similar cases. This issue was entered into PSEG's corrective action program as notification 20616485.

This finding is more than minor because if left uncorrected the issue has the potential to lead to a more significant safety concern. Specifically, PSEG has not corrected the performance deficiency which resulted in untimely corrective actions with regards to FIN 2011004-02. If similar untimely corrective actions were taken on a safety system this could result in a more significant safety concern. In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 2 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, this finding is of very low safety significance (Green) because it did not involve the complete or partial loss of a support system that contributes to the likelihood of, or cause, an initiating event and did not affect mitigation equipment. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Corrective Action Program, because PSEG did not completely and accurately identify the issue for FIN 2011004-02. Specifically, PSEG did not initiate a notification to review FIN 2011004-02 to ensure corrective actions properly address the finding. [P.1(a)]

Inspection Report# : [2013008](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow the Loss of Main Condenser Vacuum Procedure

A self revealing NCV of Technical Specification (TS) 6.8.1 "Procedure and Programs," resulted from operators' failure to implement the Loss of Condenser Vacuum procedure. Specifically, operators failed to follow S1.OP-AB.COND-0001, "Loss of Main Condenser Vacuum," which directed closure of the main steam isolation valves (MSIVs). This resulted in the inability to potentially recover the condenser as a heat sink, after the loss of circulating water (CW) pumps initiator was recovered, due to the actuation of the 11 low pressure (LP) turbine shell rupture disk. Corrective actions from the cause evaluation include developing additional abnormal operating procedure guidance to address a loss of all CW pumps, and designing simulator training scenarios to focus on secondary plant stabilization following reactor and turbine trips.

The performance deficiency (PD) was determined to be more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was considered associated with the initiating events cornerstone since it occurred during recovery actions after the reactor trip. The finding was determined to be of very low safety significance (Green) per IMC 0609, "Significance Determination Process," Appendix A, Exhibit 1 "Initiating Events", Section B "Transient Initiators," because the PD did not cause both a reactor trip and the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. Specifically, the PD occurred after the reactor trip and resulted in the loss of one system (main condenser) of a number of available mitigation systems used to transition the plant to a stable shutdown condition. The PD did not cause the initiating event of a loss of condenser heat sink, but instead it only affected the ability to potentially recover the heat sink after circulating water was restored. This finding has a cross-cutting aspect in the area of Human Performance, Resources, in that PSEG did not ensure that the crew was skilled in secondary plant stabilization and recovery. Specifically, PSEG did not ensure that the training program previously focused on the secondary plant stabilization and / or recovery post trip. [H.2(b)] (Section 40A3

Inspection Report# : [2013003](#) (*pdf*)

Mitigating Systems

Significance:  Mar 31, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Follow Fire Protection Test Procedure Resulted in Fuel Oil Spill

The inspectors determined there was a Green, self-revealing violation of Technical Specification (TS) 6.8.1, "Procedures and Programs," as described in Regulatory Guide 1.33, Revision 2, February 1978, when PSEG failed to adequately implement procedure steps associated with fire protection hose flow verification testing on March 6, 2014. Consequently, a fuel oil day tank was overfilled, resulting in approximately 3000 gallons of fuel oil on the pump house roof, leaks through the roof onto the fire pumps, and Salem fire water suppression system unavailability for approximately two days. PSEG stopped the leak, entered this issue in their CAP, and completed a Prompt Investigation.

The inspectors determined that the performance deficiency was more than minor because it was associated with the Protection Against External Factors attribute of the Mitigating System cornerstone and adversely its cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events (fire) to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance (Green) because it did not impact the ability of Salem Units 1 or 2 to achieve and maintain safe shutdown. The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because PSEG fire protection operators did not recognize and plan for the possibly of mistakes, latent issues, and inherent risk, even while expecting successful outcomes of procedure steps to refill the fuel oil day tank. Further, they did not implement appropriate error reduction tools.

Inspection Report# : [2014002](#) (*pdf*)

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: FIN Finding

Failure to take adequate corrective actions following a PDP failure to couple-on-demand event.

The inspectors identified a Green FIN associated with Unit 1 for PSEG's failure to take adequate corrective actions in accordance with procedure LS-AA-125, "Corrective Action Program," Attachment 1 guidance following a PDP failure to couple-on-demand event, and to preclude subsequent failures during other couple-on-demand events and additional unplanned PDP unavailability. PSEG entered this issue into their CAP, implemented a compensatory measure, and initiated actions to correct the condition causing the failure to couple events.

The performance deficiency was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and affected its objective to ensure the availability and reliability of systems (safe shutdown charging cross-connect) that respond to initiating events (fire) to prevent undesirable consequences (i.e., core damage). The inspectors determined that the finding was very low safety significance as the Unit 2 reactor would have been able to reach and maintain safe shutdown. This finding has a cross-cutting aspect in the area of Problem Identification and Resolution, Resolution, in that PSEG did not take effective corrective actions to address issues in a timely manner commensurate with their safety significance. Specifically, PSEG did not take adequate corrective actions in response to a PDP failure-on-demand event in February 2013 to preclude several additional unexpected PDP failure-on-demand events which resulted in additional unplanned unavailability.

Inspection Report# : [2014002](#) (*pdf*)

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate HELB Barrier Controls

The inspectors identified a Green NCV of TS 6.8.1, "Procedures and Programs", as described in Regulatory Guide (RG) 1.33, Revision 2, when PSEG did not properly implement high energy line break (HELB) barrier controls in accordance with CC-AA-201, Plant Barrier Control, during maintenance activities that affected the performance of safety-related equipment on October 1, 2 and 17, 2013. PSEG entered the issue into the CAP under notifications 20623371 and 20633614.

This finding was more than minor because it was associated with the configuration control attribute of the Mitigating System cornerstone, and adversely affected its objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, improper barrier controls could potentially affect the operating equipment in the case of a HELB. This performance deficiency required a detailed risk evaluation (DRE) in accordance with IMC 0609, Appendix A, screening questions in Exhibits 2, "Mitigating Systems," because of an assumed loss of the AFW system decay heat removal safety function. The inspectors and a Region I Senior Reactor Analyst (SRA) conducted a bounding DRE and determined this finding to be of very low safety significance (Green). This finding had a cross-cutting aspect in the area of Human Performance, Work Control, in that licensees plan and coordinate work activities by incorporating the need for planned contingencies, compensatory actions, and abort criteria. Specifically, PSEG did not properly plan and coordinate compensatory actions via station procedures for HELB barrier impairments. [H.3(a)] (Section 1R18)
Inspection Report# : [2013005](#) (*pdf*)

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Significance: Aug 01, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

13 Switchgear and penetration Area Ventilation Supply Fan Motor Bearing Failure due to Deletion of Preventative Maintenance Requirement

A self-revealing Green NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified because PSEG did not complete a change to a preventative maintenance requirement for the Switchgear and Penetration Area Ventilation (SPAV) fan motors in accordance with PSEG procedure MA-AA-716-210-1005, "Predefine Change Processing." PSEG failed to perform an adequate engineering review of the Preventative Maintenance Change Request (PMCR) when bearing replacements were deleted from the SPAV fan motor maintenance plans in September, 2009. This resulted in the bearing not being lubricated and subsequent failure of the 13 SPAV supply fan motor on February 4, 2013. PSEG entered the issue into the corrective action program as notification 20594424.

The inspectors determined that the performance deficiency was more than minor because it was associated with the design control attribute of the Mitigating Systems cornerstone, and it adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, because PSEG failed to investigate a difference in bearing type documented in a 1998 NRC commitment letter and the SPAV fan motor material master, they did not resolve conflicting information on the type of bearing installed in the SPAV fan motors before a preventive maintenance change to delete periodic bearing replacements took effect. This resulted in bearing and fan motor failure. The inspectors evaluated the finding in accordance with IMC 0609, Appendix A, "Determining the Significance of Reactor Inspection Findings for At-Power Situations" (IMC 0609A). The inspectors determined that the finding was of very low safety significance (Green) because the deficiency did not affect the design or qualification; did not represent a loss of system safety function; did not screen

as potentially risk significant due to external initiating events; and SPAV fans are not designated as high safety-significance in the licensee's maintenance rule program. There is no cross-cutting aspect assigned because the performance deficiency is not indicative of current performance. Specifically, the performance deficiency involves an issue that occurred greater than three years ago and is not indicative of current performance.

Inspection Report# : [2013008](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Scaffold Installed with Insufficient Separation to Safety-Related Equipment

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Procedures," because PSEG did not ensure adequate separation was maintained between temporary scaffolding and safety-related equipment. Specifically, the inspectors identified numerous scaffolds installed in the plant with less than the minimum standoff distance to safety-related equipment specified in PSEG procedures and no engineering evaluation to support these deviations. Following inspector identification of the issue, PSEG performed independent walkdowns of all scaffolding and entered all discrepancies into their CAP. All discrepancies were corrected and assessed for any potential impact to the operability or functionality of the system and PSEG determined that there was no loss or degradation of equipment or function specifically designed to mitigate a seismic event. PSEG also initiated an apparent cause evaluation (ACE 70152874) on numerous scaffolding issues identified by the inspectors and PSEG Nuclear Oversight (NOS) personnel.

This PD was considered more than minor because it affected the protection against external factors attribute of the mitigating systems cornerstone and its objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, PSEG routinely did not evaluate scaffold installations when insufficient separation to safety-related equipment was provided. Additionally, it was similar to example 4.a in IMC 0612, Appendix E, "Examples of Minor Issues," which states that the issue of failing to appropriately evaluate scaffold installation as required by procedures is more than minor if the licensee routinely failed to perform engineering evaluations. The issue was evaluated in accordance with IMC 0609, Appendix A, "The SDP for Findings At-Power," and determined to be of very low safety significance (Green) since it did not involve the loss or degradation of equipment or function specifically designed to mitigate a seismic event. This finding has a cross-cutting aspect in the area of Human Performance, Work Practices, because PSEG did not ensure that personnel work practices support human performance. Specifically, PSEG personnel did not follow scaffold installation procedures when they routinely installed scaffold within the allowable clearance of safety-related equipment without an engineering evaluation. [H.4(b)] (Section 1R20)

Inspection Report# : [2013003](#) (*pdf*)

Barrier Integrity

Significance:  Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Corrective Actions to Address an Adverse Trend in the 2R1B-2 Radiation Monitor

The inspectors identified an NCV of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” associated with PSEG failing to adequately trend an adverse condition and initiate effective corrective actions to address declining performance. Specifically, PSEG did not take adequate corrective actions to address an adverse trend in radiation monitor channel spiking caused by defective detector foil. As a result of these ineffective corrective actions, on April 20, 2013, a spike of the 2RIB channel 2 radiation monitor (2RIB-2) unintentionally resulted in an unanalyzed post-accident dose analysis condition for the Salem common control room (CR). PSEG has entered this issue into their CAP as Notification 70154084.

The PD was determined to be more than minor because it affected the Human Performance attribute of the barrier integrity cornerstone to maintain the radiological barrier functionality of the CR post-accident. The PD was also similar to IMC 0612, Appendix E, example 3.i, in that, the CR post-accident dose analysis calculation was required to be re-performed by PSEG to assure the post-accident dose analysis limits were not exceeded. The finding is of very low safety significance (Green) per IMC 0609, Attachment 4, “Phase 1, Appendix A, Exhibit 3 – Barrier Integrity Screening Questions,” because it only represented a degradation of the radiological barrier function provided for the control room. The finding had a cross-cutting aspect in the area of Problem Identification and Resolution (PI&R), CAP, because PSEG did not adequately trend and assess information from the CAP to identify programmatic and common cause problems. Specifically, PSEG did not take adequate corrective actions to address an adverse trend in the 2RIB-2 detector foil replacement and as a result of these ineffective corrective actions, on April 20, 2013, a spike of the radiation monitor unintentionally resulted in an unanalyzed post-accident dose analysis condition for the Salem common CR. [P.1(b)] (Section 1R04)

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Jun 30, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Incorrect Component Installed for Containment Closure

A self-revealing NCV of Unit 1 of 10 CFR Part 50, Appendix B, Criterion VIII, “Identification and Control of Materials, Parts, and Components,” because PSEG did not prevent the installation and use of incorrect components. Specifically, PSEG installed an incorrect bladder that was being used as a substitution component for establishing adequate containment closure during refueling operations. On May 2, 2013, while serving as a credited containment boundary, the installed bladder failed, causing Unit 1 to suspend fuel movements during refueling operations and enter TS 3.9.4 for “Containment Building Penetrations.”

The PD was determined to be more than minor because it affected the configuration control attribute of the barrier integrity cornerstone to provide reasonable assurance that physical design barriers, containment boundaries, are preserved and protect the public from radionuclide releases caused by accidents or events. This finding is also similar to IMC 0612, Appendix E, example 5.c, in that, an incorrect and inadequate part was installed and placed in service for establishing containment closure during refueling operations. The finding is of very low safety significance (Green) per 0609 Appendix G, “Shutdown Operations SDP,” Figure 1 and Attachment 1, Checklist 4, “Pressurized Water Reactor (PWR) Refueling Operation: RCS Level >23’ or PWR Shutdown Operation with Time to Boil >2 hours and Inventory in the Pressurizer,” because it did not require a qualitative assessment and although this issue created a direct pathway from the containment atmosphere to the mechanical penetration area, invalidating PSEG’s credited containment closure boundaries during refueling operations, it did not increase the likelihood of a loss of reactor coolant system inventory or degrade the licensee’s ability to terminate a leak path or recover decay heat removal once it is lost. The finding had a cross-cutting aspect in the area of Human Performance, Resources, in that, PSEG did not ensure that complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components. Specifically, PSEG failed to prevent the installation and use of incorrect components credited for containment closure during refueling operations because the incorrect part number was used in the procurement process and work order(WO). [H.2(c)] (Section 1R13)

Inspection Report# : [2013003](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Mar 31, 2009

Identified By: NRC

Item Type: AV Apparent Violation

Apparent Violation for Exelon Plants - 1 (2009 Findings)

For apparent violation #1:

Contrary to the above, on March 31, 2009 Exelon Generation Company, LLC (Exelon) provided incomplete and inaccurate information on the status of its decommissioning funding, as required by 10 CFR 50.75 when it submitted the decommissioning funding status report. Specifically, the March 31, 2009, decommissioning funding status (DFS) report contained inaccurate and incomplete information regarding Exelon's compliance with the requirements of 10 CFR 50.75. The report stated that the amount listed for each of the reactors was determined in accordance with 10 CFR 50.75(b) and the applicable formulas of 10 CFR 50.75(c). However, for each of the 23 reactors, the amount reported was a discounted value that was less than the minimum required amount specified by 10 CFR 50.75(b) and (c). The report was material to the NRC because Exelon under-reported its certified decommissioning amounts by approximately \$4 billion, and the NRC staff evaluated the status of Exelon's decommissioning funds based on the inaccurate reports. After identifying the inaccurate information, the NRC required parent company guarantees before the staff could make its determination that there was reasonable assurance that funds will be available for the decommissioning process.

Inspection Report# : [2012012](#) (*pdf*)

Inspection Report# : [2013201](#) (*pdf*)

Significance: N/A Mar 31, 2009

Identified By: NRC

Item Type: AV Apparent Violation

Apparent Violation for Exelon Plants - 2 (2009 Findings)

For apparent violation #2:

Contrary to the above, on March 31, 2007, and March 31, 2005, Exelon Generation Company, LLC (Exelon) provided incomplete and inaccurate information on the status of its decommissioning funding, as required by 10 CFR 50.75 when it submitted the decommissioning funding status reports. Specifically, the March 31, 2007, and March 31, 2005, decommissioning funding status (DFS) reports contained inaccurate and incomplete information regarding Exelon's compliance with the requirements of 10 CFR 50.75. The reports stated that the amount listed for each of the reactors was determined in accordance with 10 CFR 50.75(b) and the applicable formulas of 10 CFR 50.75(c). However, in multiple instances, the amount reported was a discounted value that was less than the minimum required amount specified by 10 CFR 50.75(b) and (c). The reports were material to the NRC because Exelon under-reported its certified decommissioning amounts, and the NRC staff evaluated the status of Exelon's decommissioning funds based on the inaccurate reports. After identifying the inaccurate information, the NRC required parent company guarantees before the staff could make its determination that there was reasonable assurance that funds will be available for the decommissioning process.

Inspection Report# : [2012012](#) (*pdf*)

Inspection Report# : [2013201](#) (*pdf*)

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