



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION II
245 PEACHTREE CENTER AVENUE NE, SUITE 1200
ATLANTA, GEORGIA 30303-1257

May 7, 2015

Mr. Brian K. Taber
Vice President - Vogtle
Southern Nuclear Operating Company, Inc.
Vogtle Electric Generating Plant
7821 River Road
Waynesboro, GA 30830

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC PROBLEM IDENTIFICATION
AND RESOLUTION INSPECTION REPORT 05000424/2015008 AND
05000425/2015008

Dear Mr. Taber:

On April 2, 2015, the U. S. Nuclear Regulatory Commission (NRC) completed an inspection at your Vogtle Electric Generating Plant Units 1 and 2. The enclosed report documents the inspection findings, which were discussed on April 2, 2015, with Mr. G. Saxon and other members of your staff.

On the basis of the samples selected for review, the inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. In reviewing your corrective action program, the inspectors assessed how well your staff identified problems at a low threshold, your staff's implementation of the station's process for prioritizing and evaluating these problems, and the effectiveness of corrective actions taken by the station to resolve these problems. In each of these areas, the inspectors determined that your staff's performance was adequate to support nuclear safety.

The inspectors also evaluated other processes your staff used to identify issues for resolution. These included your use of audits and self-assessments to identify latent problems and your incorporation of lessons learned from industry operating experience into station programs, processes, and procedures. The inspectors determined that your station's performance in each of these areas supported nuclear safety.

Finally, the inspectors determined that your station's management maintains a safety-conscious work environment adequate to support nuclear safety. Based on the inspectors' observations, your employees are willing to raise concerns related to nuclear safety through at least one of the several means available.

B. Taber

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Sincerely,

/RA By Reinaldo Rodriguez For/

Anthony D. Masters, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Docket Nos. 50-424, 50-425
License Nos. NPF-68, NPF-81

Enclosure:
IR 05000424/2015008, 05000425/2015008
w/Attachment: Supplementary Information

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B. Taber

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Letter to Brian K. Taber from Anthony D. Masters dated May 7, 2015.

SUBJECT: VOGTLE ELECTRIC GENERATING PLANT - NRC PROBLEM IDENTIFICATION
AND RESOLUTION INSPECTION REPORT 05000424/2015008 AND
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U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket Nos.: 50-424, 50-425

License Nos.: NPF-68, NPF-81

Report Nos.: 05000424/2015008 and 05000425/2015008

Licensee: Southern Nuclear Operating Company, Inc. (SNC)

Facility: Vogtle Electric Generating Plant, Units 1 and 2

Location: Waynesboro, GA 30830

Dates: March 16 – April 2, 2015

Inspectors: Wesley Deschaine, Resident Inspector Sequoyah (Team Leader)
Shani Lewis, Project Engineer
Natasha Childs, Resident Inspector Oconee
Ryan Taylor, Senior Project Inspector

Approved by: Anthony D. Masters, Chief
Reactor Projects Branch 7
Division of Reactor Projects

Enclosure

SUMMARY

IR 05000424/2015008 and 05000425/2015008; March 16 – April 2, 2015; Vogtle Electric Generating Plant, Units 1 and 2; Biennial Inspection of the Problem Identification and Resolution Program.

The inspection was conducted by two resident inspectors, a senior project inspector, and a project engineer. No findings were identified. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 5.

Identification and Resolution of Problems

The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution, as evidenced by the relatively few number of deficiencies identified by external organizations (including the NRC) that had not been previously identified by the licensee, during the review period. Generally, prioritization and evaluation of issues were adequate, formal root cause evaluations for significant problems were adequate, and corrective actions specified for problems were acceptable. Overall, corrective actions developed and implemented for issues were generally effective and implemented in a timely manner.

The inspectors determined that overall, audits and self-assessments were adequate in identifying deficiencies and areas for improvement in the CAP, and appropriate corrective actions were developed to address the issues identified. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work and plant operations.

Based on discussions and interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve those concerns.

REPORT DETAILS

4OA2 Problem Identification and Resolution

1. Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's CAP procedures which described the administrative process for initiating and resolving problems primarily through the use of condition reports (CRs). To verify that problems were being properly identified, appropriately characterized, and entered into the CAP, the inspectors reviewed CRs that had been issued between February 2013 and February 2015, including a detailed review of selected CRs associated with the following risk-significant systems: Emergency Diesel Generators (EDGs), Nuclear Service Cooling Water (NSCW), 125VDC Electrical, and 4160V Electrical systems. Where possible, the inspectors independently verified that the corrective actions were implemented as intended. The inspectors also reviewed selected common causes and generic concerns associated with root cause evaluations (RCE) to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones of safety identified in the Reactor Oversight Process (ROP), the inspectors selected a representative number of CRs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, health physics, chemistry, emergency preparedness, and security. These CRs were reviewed to assess each department's threshold for identifying and documenting plant problems, thoroughness of evaluations, and adequacy of corrective actions. The inspectors reviewed selected CRs, verified corrective actions were implemented, and attended meetings where CRs were evaluated for significance to determine whether the licensee was identifying, accurately characterizing, and entering problems into the CAP at an appropriate threshold.

Plant walkdowns of equipment within the selected systems listed above and other plant areas were conducted by inspectors to assess the material condition and to identify deficiencies that had not been previously entered into the CAP. The inspectors reviewed CRs, maintenance history, corrective actions (CAs), completed work orders (WOs) for the systems, and reviewed associated system health reports. These reviews were performed to verify that problems were being properly identified, appropriately characterized, and entered into the CAP. Items reviewed generally covered a two-year period of time; however, in accordance with the inspection procedure, a five-year review was performed for selected systems for age-related issues.

Control Room walk-downs were also performed to assess the main control room (MCR) deficiency list and to ascertain if deficiencies were entered into the CAP and tracked to resolution. Operator workarounds (OWA) and operator burden screenings were reviewed, and the inspectors verified compensatory measures for deficient equipment which were being implemented in the field.

The inspectors conducted a detailed review of selected CRs to assess the adequacy of the root cause and apparent cause evaluations of the problems identified. The inspectors reviewed these evaluations against the descriptions of the problem described in the CRs and the guidance in licensee procedure NMP-GM-002-GL03, "Cause Analysis and Corrective Actions Guideline." The inspectors assessed if the licensee had adequately determined the cause(s) of identified problems, and had adequately addressed operability, reportability, common cause, generic concerns, extent-of-condition, and extent-of-cause. The review also assessed if the licensee had appropriately identified and prioritized corrective actions to prevent recurrence.

The inspectors reviewed selected industry operating experience (OE) items, including NRC generic communications, to verify that they had been appropriately evaluated for applicability and that issues identified through these reviews had been entered into the CAP.

The inspectors reviewed site trend reports, to determine if the licensee effectively trended identified issues and initiated appropriate corrective actions when adverse trends were identified.

The inspectors reviewed licensee audits and self-assessments, including those which focused on problem identification and resolution programs and processes, to verify that findings were entered into the CAP and to verify that these audits and assessments were consistent with the NRC's assessment of the licensee's CAP.

The inspectors attended various plant meetings to observe management oversight functions of the corrective action process. These included CR screening meetings and Management Review Committee (MRC) meetings.

Documents reviewed are listed in the Attachment.

b. Assessment

Problem Identification

The inspectors determined that the licensee was generally effective in identifying problems and entering them into the CAP and there was an appropriately low threshold for entering issues into the CAP. This conclusion was based on a review of the requirements for initiating CRs as described in licensee procedure NMP-GM-002-001, "Corrective Action Program Instructions," management's expectation that employees were encouraged to initiate CRs for any reason. Trending was generally effective in monitoring equipment performance. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues. Based on reviews and walkdowns of accessible portions of the selected systems, the inspectors determined that system deficiencies were being identified and placed in the CAP.

A performance deficiency was identified during the inspection associated with the site's failure to identify and correct the condition adverse to quality discovered during the failure analysis for the 2B EDG bridge transfer switch. Specifically, the failure analysis report concluded that the bridge transfer switch failed due to hardened and degraded grease not being properly removed during preventative maintenance (PM). The report also concludes that the PM procedure may be inadequate to remove the older grease and should be updated to mitigate future failures. The site has entered this issue into the CAP as CRs 10041480 and 10043156. However, because this performance deficiency did not adversely affect any ROP cornerstone objectives, the inspectors determined the issue was of minor significance and not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Problem Prioritization and Evaluation

Based on the review of CRs sampled by the inspection team during the onsite period, the inspectors concluded that problems were generally prioritized and evaluated in accordance with the licensee's CAP procedures as described in the CR severity level determination guidance in NMP-GM-002-001. Each CR was assigned a priority level at the CAP coordinator (CAPCO) meeting, and adequate consideration was given to system or component operability and associated plant risk.

The inspectors determined that station personnel had conducted root cause and apparent cause analyses in compliance with the licensee's CAP procedures and assigned cause determinations were appropriate, considering the significance of the issues being evaluated. A variety of formal causal-analysis techniques were used depending on the type and complexity of the issue consistent with NMP-GM-002-GL03.

The inspectors identified three performance deficiencies associated with the licensee's prioritization and evaluation of issues. These issues were screened in accordance with Manual Chapter 0612, "Issue Screening," and were determined to be of minor significance and not subject to enforcement action in accordance with the NRC's Enforcement Policy.

- The inspectors reviewed Corrective Action Report (CAR) 210971 associated with a NRC non-cited violation (NCV), and identified the following issues with the Apparent Cause Determination (ACD):
 - Technical Evaluation (TE) 860480 was a corrective action for Operations training to perform a Gap Analysis to address potential knowledge gaps identified by the apparent cause team. This action was one of several actions to resolve apparent cause #1 (AC1) and contributing cause #1 (CC1) of the ACD. The priority level of TE 860480 was downgraded from a level 2 to level 3 without following the process as outlined in section 4.6 of NMP-GM-002-001. Additionally, the apparent cause analysts did not follow the process outlined in NMP-GM-002-GL03 when initially assigning the corrective action. The licensee has entered these issues into the CAP as CRs 10047594 and 10047596.

- TE 853634 was a corrective action for the Chemistry department to perform a department stand down to discuss upcoming procedure changes as a result of the event. The action was one of several actions to resolve AC1 and CC1 of the ACD. The action due date was extended without following NMP-GM-002-001. There was no assessment of the potential impact of the extension and the appropriate level of management approval was not received. The licensee has entered this issue into the CAP as CR 100475594.
- The inspectors reviewed CAR 211142 associated with an NRC NCV and identified the following issue with the Apparent Cause Determination:
 - The ACD report listed seven corrective actions to address AC1; none of the seven actions were assigned a priority level 2, which is not in accordance with NMP-GM-002-001. This procedure states that corrective actions assigned to address an apparent cause should be assigned a level 2 priority. The potential weakness in assigning the incorrect priority level is that the action could potentially be revised and/or receive due date extensions without receiving the appropriate levels of review appropriate for the significance. The licensee has entered this issue into the CAP as CR 10049368.

Corrective Actions

Based on a review of corrective action documents, interviews with licensee staff, and verification of completed corrective actions, the inspectors determined that overall, corrective actions were timely, commensurate with the safety significance of the issues, and effective, in that conditions adverse to quality were corrected and non-recurring. For significant conditions adverse to quality, the corrective actions directly addressed the cause and effectively prevented recurrence in that a review of performance indicators, CRs, and effectiveness reviews demonstrated that the significant conditions adverse to quality had not recurred. Effectiveness reviews for corrective actions to prevent recurrence (CAPRs) were sufficient to ensure corrective actions were properly implemented and were effective.

c. Findings

No findings were identified.

2. Use of Operating Experience

a. Inspection Scope

The inspectors examined the licensee's use of industry OE to assess the effectiveness of how external and internal operating experience information was used to prevent similar or recurring problems at the plant. In addition, the inspectors selected operating experience documents (e.g., NRC generic communications, 10 CFR Part 21 reports, licensee event reports, vendor notifications, and plant internal operating experience items, etc.), which had been issued since February 2013, to verify whether the licensee

had appropriately evaluated each notification for applicability to the Vogtle Electric Generating Plant, Units 1 and 2, and whether issues identified through these reviews were entered into the CAP.

b. Assessment

Based on a review of selected documentation related to operating experience issues, the inspectors determined that the licensee was generally effective in screening operating experience for applicability to the plant. Industry OE was evaluated at either the corporate or plant level depending on the source and type of the document. Relevant information was then forwarded to the applicable department for further action or informational purposes. OE issues requiring action were entered into the CAP for tracking and closure. In addition, operating experience was included in all apparent cause and root cause evaluations in accordance with licensee procedure NMP-GM-002-GL03.

c. Findings

No findings were identified.

3. Self-Assessments and Audits

a. Inspection Scope

The inspectors reviewed audit reports and self-assessment reports, including those which focused on problem identification and resolution, to assess the thoroughness and self-criticism of the licensee's audits and self-assessments, and to verify that problems identified through those activities were appropriately prioritized and entered into the CAP for resolution in accordance with licensee procedure NMP-GM-003, "Self-Assessment and Benchmark Procedure."

b. Assessment

The inspectors determined that the scopes of assessments and audits were adequate. Self-assessments were generally detailed and critical, as evidenced by findings consistent with the inspector's independent review. The inspectors verified that CRs were created to document areas for improvement and findings resulting from the self-assessments, and verified that actions had been completed consistent with those recommendations. Generally, the licensee performed evaluations that were technically accurate.

c. Findings

No findings were identified.

4. Safety-Conscious Work Environment

a. Inspection Scope

During the course of the inspection, the inspectors assessed the station's safety-conscious work environment (SCWE) through review of the station's Employee Concerns Program (ECP) and interviews with various departmental personnel. The inspectors reviewed a sample of ECP issues to verify that concerns were being properly reviewed and identified deficiencies were being resolved and entered into the CAP when appropriate.

b. Assessment

Based on the interviews conducted and the CRs reviewed, the inspectors determined that licensee management emphasized the need for all employees to identify and report problems using the appropriate methods established within the administrative programs, including the CAP and ECP. These methods were readily accessible to all employees. Based on discussions conducted with a sample of plant employees from various departments, the inspectors determined that employees felt free to raise issues, and that management encouraged employees to place issues into the CAP for resolution. The inspectors did not identify any reluctance on the part of the licensee staff to report safety concerns.

c. Findings

No findings were identified.

4OA6 Exit

Exit Meeting Summary

On April 2, 2015, the inspectors presented the inspection results to Mr. G. Saxon and other members of the site staff. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTARY INFORMATION

SUPPLEMENTARY INFORMATION

KEY POINTS OF CONTACT

Licensee personnel:

G. Saxon, Plant Manager
G. Gunn, Regulatory Affairs Manager
J. Wade, Site Design Engineering Manager
K. Morrow, Licensing Engineer
K. Walden, Licensing Engineer
M. Carstensen, Engineer
M. Cline, Site CAPCO
N. Koteel, Fleet PI Manager
T. Thompson, Site System Engineering Manager
T. Simmons, PI Manager
T. Moorer, Director EHS

NRC personnel:

A. Alen, Resident Inspector
M. Cain, Senior Resident Inspector

LIST OF REPORT ITEMS

Opened and Closed

None

Closed

None

Discussed

None

LIST OF DOCUMENTS REVIEWED

Procedures

NMP-GM-003-001, Self-Assessment Instructions for Focused Area Self-Assessment (FASA), Version 4.0
 NMP-GM-003, Self-Assessment and Benchmark Procedure, Version 21.1
 NMP-GM-002-005, Corrective Action Program Trending, Version 2.0
 NMP-GM-002-002, Effectiveness Review Instructions, Version 4.2
 83308-C, Testing of Safety Related NSCW System Coolers, Version 31.3
 NMP-AD-012, Operability Determinations and Functionality Assessments, Version 12.4
 NMP-ES-002, System Monitoring and Health Reporting, Version 17.0
 NMP-ES-002-005, System Monitoring, Version 45.0
 NMP-GM-002, Corrective Action Program, Versions 13, 13.1, 17, 21, 29, 30.1, and 33
 NMP-GM-002-001, Corrective Action Program Instructions, Versions 30.1 and 33.1
 NMP-GM-002-F42, Fleet Keywords for the Corrective Action Program, Version 6.0
 NMP-GM-002-GL03, Cause Analysis and Corrective Actions Guideline, Version 25.0
 NMP-GM-008, Operating Experience Program, Version 16.0
 NMP-OS-006, Operations Performance Indicators, Version 16.1
 NMP-OS-006-002, Aggregate Operator Impact Review Instruction, Version 2.0
 NMP-ES-035-007, Fleet Fire Watch Instruction, Version 2.0
 NMP-ES-035-007, Fleet Fire Watch Instruction, Version 1.0
 13145A-1, Diesel Generator Train A, Version 6.3
 NMP-ES-005, Scoping and Importance Determination for Equipment Reliability, Version 13.0
 NMP-ES-005-001, Scoping and Importance Determination for Equipment Reliability – Single Point Vulnerability, Version 7.0

Condition Reports

666516	751415	847696	10015985
666519	753454	847715	10017123
879125	755107	853151	10017506
886738	756528	854169	10019402
787908	757218	854169	10028619
736458	758675	854171	10033287
736457	768834	865135	10035756
10009629	783161	885259	10039801
10022663	800397	886940	10002493
10005548	802927	887102	445343
10013422	802929	897154	459265
10005644	818370	900250	794843
138108	818742	1026761	617317
152044	830348	10003891	825470
164740	835222	10003897	10041480
538849	836212	10011167	10041025
597467	837899	10013699	829822
750553	838044	10014081	766880
	838871	10014381	
	842803	10015498	

Technical Evaluations

906704	849687	858202	882477
910486	853634	858202	882479
798369	853638	858717	882482
908394	853645	860480	882482
337844	853645	860480	909344
908404	853687	860488	909356
668572	858192	865927	909668
668563	858193	868157	911975
737677	858193	868157	835105
737675	858201	882472	675693
836852	858201	882477	

Corrective Action Reports

212916	213052	210112	213395
249529	256024	210971	255666
249304	208164	211089	255857
210270	195060	211142	

Work Orders

SNC586376	SNC631008	SNC589884	SNC624767
SNC586566	SNC631027	SNC589884	SNC646897
SNC567223	SNC632292	SNC619778	SNC640825
SNC567222	SNC632880	SNC624725	SNC564818
SNC602033	SNC637929	SNC624726	SNC638913
SNC621555	SNC642581	SNC624738	SNC528990
SNC629405	SNC619779	SNC524759	

Self-Assessments

Nuclear Oversight (NOS) audit of the CAP, Fleet-CAP-2014, April 7, 2014
 Nuclear Oversight Special CAP audit, Fleet-Special CAP-2015
 FASA Self-Assessment, Implementation of Interim Cyber Security Milestones 1-7, 5/13/2013

Drawings

1X4DB133-1, Nuclear Service Cooling Water System P&ID, Version 54.0
 1X4DB133-2, Nuclear Service Cooling Water System P&ID, Version 60.0
 1X4DB134, Nuclear Service Cooling Water System P&ID, Version 31.0
 1X3D-AA-G01A, Main one line Class 1E 125V DC and 120V vital AC systems, version 10.0
 1X3D-AA-H01A, One line Class 1E 125V DC Train A, version 17.0

Other Documents

Failure Analysis of Square D Tap Switch Class 9831, 2B EDG, Date 11/24/2014
 MRC package for 3-18-2015
 CAPCO (CR daily screening) meeting package for 2/26/2015
 CAPCO (CR daily screening) meeting package for 3/18/2015
 FP LCO Package, LCO Number: 1-14-026
 FP LCO Package, LCO Number: 2-13-169
 DC-1806, Design Bases for Class 1E dc system, Version 13
 System Health Report – Unit 1 1804 - 4160 Volt Alternating Current System
 System Health Report – Unit 2 1804 - 4160 Volt Alternating Current System
 DC-1202, Nuclear Service Cooling Water (NSCW) System Design Bases, Version 13

DC-1202A, Nuclear Service Cooling Towers Design Bases, Revision 11
 DC-2105, NSCW Cooling Towers and Warehouses Design Bases, Version 7
 ELV-01212, Vogtle Electric Generating Plant Response to Generic Letter 89-13, dated January 25, 1990
 FSAR Chapter 9, Section 9.2.1, Nuclear Service Cooling Water System
 LCV-0716-C, Correspondence from CK McCoy to USNRC, Vogtle Electric Generating Plant Revised Reply to a Notice of Violation, dated April 1, 1996
 NL-04-1762, Correspondence from Don Grissette to USNRC regarding additional information concerning generic letter 96-06, dated November 5, 2004
 System Health Reports, Unit 1 NSCW, Q1-2013 through Q4-2014
 System Health Reports, Unit 2 NSCW, Q1-2013 through Q4-2014
 VEGP-LR-IMP-12, Vogtle Electric Generating Plant - Units 1&2, Generic Letter 89-13 Program License Renewal Implementation Package, dated May 15, 2009
 V-LO-TX-06101, Operations Lesson Plan - Nuclear Service Cooling Water System, Revision 7.1
 X4C1202V43, Flow Calculation for the Unit 2 NSCW System, Revision 7

CRs Generated

10042617, Tunnel 2T2A incandescent lighting out - three fixtures
 10042633, NSCW Electrical Receptacle deficiency - open-hot
 10043020, Loose Penetration Labels
 10043156, Vogtle Failure Analysis Report tracking
 10043415, 1R18 Work Order SNC564478 is work complete but in schedule status in MAXIMO
 10043439, IRT closure documents do not capture all actions that are outstanding.
 10043450, PI&R inspection finding on work orders were not cancelled per NMP-GM-006-GL01
 10043501, Log-keeping practices need improvement
 10047591, CA TE extended without following NMP-GM-002-001
 10047594, Failure to follow NMP-GM-002-GL03 for training corrective action
 10047596, CA downgraded without following NMP-GM-002-001, section 4.6
 10048988, Corrective action priority inconsistency from causal analysis