



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION III
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LISLE, IL 60532-4352

May 31, 2016

Mr. Bryan C. Hanson
Senior VP, Exelon Generation Company, LLC
President and CNO, Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: DRESDEN NUCLEAR POWER STATION, UNITS 2 AND 3 – NRC PROBLEM
IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000237/2016007;
05000249/2016007

Dear Mr. Hanson:

On April 29, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution biennial inspection at your Dresden Nuclear Power Station, Units 2 and 3. The NRC inspection team discussed the results of this inspection with Mr. P. Karaba and other members of your staff. The inspection team documented the results of this inspection in the enclosed inspection report.

Based on the inspection sample, the inspection team determined that your staff's implementation of the corrective action program supported nuclear safety. In reviewing your corrective action program, the team 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 team determined that your staff's performance was adequate to support nuclear safety.

The team 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 team determined that your station's performance in each of these areas supported nuclear safety. Discussed in the enclosed report is an identified weakness associated with the quality of some of your self-assessments.

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

B. Hanson

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In accordance with Title 10 of the *Code of Federal Regulations* 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Jamnes Cameron, Chief
Branch 4
Division of Reactor Projects

Docket Nos. 50-237; 50-249
License Nos. DPR-19; DPR-25

Enclosure:
IR 05000237/2016007; 05000249/2016007

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-237; 50-249

License Nos: DPR-19; DPR-25

Report No: 05000237/2016007; 05000249/2016007

Licensee: Exelon Generation Company, LLC

Facility: Dresden Nuclear Power Station, Units 2 and 3

Location: Morris, IL

Dates: April 11 through April 29, 2016

Inspectors: J. Rutkowski, Project Engineer and Team Leader
G. Hausman, Senior Reactor Inspector
G. O'Dwyer, Reactor Engineer
C. Phillips, Project Engineer
M. Porfiro, Resident Inspector, Illinois Emergency
Management Agency

Approved by: J. Cameron, Chief
Projects Branch 4
Division of Reactor Projects

Enclosure

SUMMARY

Inspection Report 05000237/2016007; 05000249/2016007; 04/11/2016 – 04/29/2016;
Dresden Nuclear Power Station, Units 2 and 3; Biennial Problem Identification and Resolution
Inspection Report

This inspection was performed by four NRC regional inspectors and the site Illinois Emergency Management Agency inspector. No findings of significance or violations of NRC requirements were identified during this inspection. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 5, dated February 2014.

Problem Identification and Resolution

On the basis of the sample selected for review, the team determined that implementation of the corrective action (CA) program at the Dresden Nuclear Power Station, Units 2 and 3, was generally good. The licensee demonstrated a low threshold for identifying problems and entering them in the CA program. Items entered into the CA program were screened and prioritized in a timely manner using established criteria; were properly evaluated commensurate with their safety significance; and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies although weaknesses with self-assessments were identified in one department. On the basis of interviews conducted during the inspection, workers at the site expressed freedom to enter safety concerns directly into the CA program or through their supervisors but some non-supervisory personnel questioned the value of identifying concerns for what they perceived as low-level issues.

NRC-Identified and Self-Revealed Findings

None

Licensee-Identified Violations

None

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution (71152B)

The activities documented in Sections .1 through .4 constituted one biennial sample of problem identification and resolution as defined in IP 71152.

.1 Assessment of the Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's corrective action (CA) program implementing procedures and attended CA program meetings to assess the implementation of the CA program by site personnel.

The inspectors reviewed risk and safety significant issues in the licensee's CA program since the last NRC Problem Identification and Resolution (PI&R) inspection completed in March 2014. The selection of issues ensured an adequate review of issues across NRC cornerstones. The inspectors used issues identified through NRC generic communications, department self-assessments, licensee audits, operating experience reports, and NRC documented findings as sources to select issues. Additionally, the inspectors reviewed action requests/issue reports (ARs) generated as a result of facility personnel's daily plant activities. The inspectors also reviewed a selection of work orders (WOs), performance indicator reports, system health reports, and completed investigations from the licensee's various investigation methods, which included root cause evaluations (RCE) and apparent cause evaluations (ACE).

The inspectors selected electronic board components used in safety-related equipment to review in detail. The inspectors' review was to determine whether the licensee staff were properly monitoring and evaluating the performance of these and associated components through effective implementation of station monitoring programs. A five year review of the electronic component was undertaken to assess the licensee staff's efforts in monitoring for system degradation due to aging aspects. The inspectors also performed a partial system walkdown of emergency diesel generators and equipment associated with a station battery room ventilation to review if conditions of the equipment was appropriately represented in plant health reports, work orders, and the CA program.

During the reviews, the inspectors determined whether the licensee staff's actions were in compliance with the facility's CA program and 10 CFR Part 50, Appendix B requirements. Specifically, the inspectors determined whether licensee personnel were identifying station issues at the proper threshold, entering the station issues into the station's CA program in a timely manner, and assigning the appropriate prioritization for resolution of the issues. The inspectors also determined whether the licensee staff assigned the appropriate investigation method to ensure the proper determination of root, apparent, and contributing causes. The inspectors also evaluated the timeliness and effectiveness of corrective actions for selected issue reports, completed investigations, and eight NRC previously identified findings that included principally non-cited violations.

The inspectors also reviewed corrective actions from licensee's ARs 01513452, "NRC Preliminary White Finding--Flood Mitigation Procedure," 02445040, "NRC Report 2014-005 Preliminary White Finding for ERV," and 02437067, "FWLC 2-0640-33 Failed; Resulting in Loss of Baily FWLC SYS" which were not completed by the licensee as of closeout inspections for the associated violations.

Documents reviewed are listed in the Attachment to this report.

b. Assessment

(1) Effectiveness of Problem Identification

Based on the information reviewed, including initiation rates of ARs and information from interviews, the inspectors determined that the licensee has a low threshold for initiating ARs, and from the ARs reviewed, the threshold was appropriate and that all station departments were active in generating ARs. The inspectors did not identify any safety significant item that was not entered into the CA program. Some personnel stated that they might not document low-level issues, due to the perception that those issues would not be effectively addressed through the CA program. The inspectors also determined that the station was generally effective at trending low level issues to prevent larger issues from developing. The inspectors assessed the effectiveness of problem identification as adequate to support nuclear safety.

Observations

The inspectors found that issues were being identified and captured in the licensee's CA program. The licensee initiated approximately 13,000 ARs in calendar year 2015. The licensee identified that approximately 1727 ARs were in the approved status (reviewed) but assigned action was not complete. There were also approximately 795 issue reports in an approved status that were categorized as a condition not required to be in the formal CA program (categorized as an "NCAP"). The inspectors noted that licensee's procedures allowed for closing some low-level ARs to the work order system. The inspectors noted that at the time of the inspection there were approximately 2403 open work orders (WOs) with the majority of the orders classified as not critical. The inspectors concluded that the number of open ARs and WOs appeared consistent with industry averages.

The inspectors reviewed open corrective WOs, open corrective action items, and system health reports for the last five years for electronic component history. The inspectors also discussed the licensee's aging management program for those components with system engineers and physically verified the apparent physical conditions of some equipment containing those components with a system engineer. The inspectors did not identify any major conflicts between actual system conditions and the condition of the systems as represented in WOs, system health reports, and CA program documents. Additional details are provided in Section .1b.(2).

Findings

No findings were identified.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors concluded that the licensee's overall performance in the prioritization and evaluation of issues was generally appropriate. In particular, the inspectors observed that while the majority of issues identified were at a low level of significance, those issues and issues of more significance were assigned a review and action level appropriate for the identified condition evaluation and in accordance with governing procedures. Issues were appropriately screened by the originating departments, the Station Ownership Committee (SOC), Management Review Committee, and Operations shift management for items potentially impacting equipment operability. Evaluations in apparent cause and root cause reports reviewed by the inspectors were appropriate to support nuclear safety; however, the inspectors noted numerous examples in which it was not clear whether specified corrective actions had been completed from the review of completed ARs. Also the inspectors found some corrective actions were rescheduled beyond the initial scheduled completion dates and some developed actions were rescheduled several times.

Observations

The inspectors identified no items in the backlogs of the CA program or maintenance WO system that were risk significant, either individually or collectively, although the inspectors noted several instances of multiple extensions for actions. The inspectors also noted several instances where they questioned whether actions classified as an Action Tracking Item (ACIT) should have been specified as CAs. The inspectors questioned the ease of an ACIT being changed or cancelled with minimal or no review; the inspectors did not identify any examples of where an ACIT actions would have changed if it had been categorized as a CA. The inspectors reviewed the licensee's WO backlog and associated performance metric data and concluded that equipment issues were generally being addressed appropriately.

The inspectors had difficulty in following the activities in several ARs to final completion due to the lack of documented results and only references to other document numbers. Some examples were:

- AR 01239089, "Failed Equipment Is Obsolete - Engineering Required for Eval," showed status as complete and the SOC in the Action Request Details stated "WR [work request] generated to replace 2-3241-98," however, only one AR assignment was identified and the in-progress notes did not identify the WR number or the results of the engineering evaluation. The In-Progress Notes did state "EC 385199 generated on 7/13/11 to replace 2-3241-98," but there was no reference to the results of the engineering evaluation or when a replacement was installed.
- AR 01398536, "U3 MPT Protective Relay Obsolete with No Replacement," showed the AR status as complete and the SOC in the Action Request Details stated "OAD have 3 relays that can be refurb/repared" and "Stores has been notified of the relays on hand. Closed to actions taken." The AR did not indicate any assignments that scheduled actions to address and track the issue to resolution. With no In-Progress Notes available to determine what action the licensee took, the completion status of any required actions could not be determined.

- AR1493744 was written to address obsolete meteorological tower wind sensors. The AR was closed with a statement that a contract to obtain new sensors was initiated, but did not state the final outcome and whether parts were delivered.
- AR2602903 identified that the station lift pump transformer TR-41 was obsolete, but did not clearly state how the issue would be addressed.

The licensee satisfactorily answered the inspectors' questions and provided documentation that the issues had been resolved. However, as stated, these conclusions could not be reached based on a review of the CA program entries alone.

5 Year Review for Obsolescence and Age Degradation

The inspectors performed a review of the licensee's CA Program and associated documents focusing on electronic components to determine whether any obsolescence and aging issues existed for the last five years. The inspectors' review and evaluation were focused on obsolescence and aging issues to ensure corrective actions were: complete, accurate, and timely; considered extent of condition; provided appropriate classification and prioritization; provided identification of root and contributing causes; appropriately focused actions taken that resulted in the correction of the identified problem; identified negative trends; operating experience was adequately evaluated for applicability; and applicable lessons learned were communicated to appropriate organizations. The inspectors determined that the licensee established an Obsolescence Steering Committee (OSC) in accordance with Procedure ER-AA-550, "Equipment Obsolescence Process," Revision 2, which requires quarterly meetings to discuss, maintain and resolve a Top Ten List of obsolescence components. In addition, the OSC presents the obsolescence Top Ten List to the Plant Health Committee (PHC) on a semi-annual frequency. No findings were identified.

The inspector's review concentrated on the last five years of CA program actions associated with obsolescence and aging issues of the Unit 2 and Unit 3 Containment Oxygen Analyzer and the actions associated with the Control Room Habitability Calculations.

Through interviews and reviews of CA program documents, the inspectors found that during the time period between April 10, 2011, and April 29, 2016, the Unit 2 and Unit 3 Primary Containment Oxygen Analyzers were out-of-service for 374 days and 140 days, respectively. Unit 3 continued to remain out-of-service as of April 29, 2016. The inspectors observed that at one time Unit 2 and Unit 3 were out-of-service for 200 and 62 consecutive days, respectively. The Primary Containment Oxygen Analyzers are required to be operational per technical specification (TS) 3.6.3.1. If the Primary Containment Oxygen Analyzers are not operational, a manual sample must be taken every 7 days to verify the primary containment oxygen is within limits. This requires chemistry and radiation protection technicians to obtain the sample. The sample takes 4 man-hours to complete. As a result, a conservative 54 samples (i.e., 216 man-hours) and 20 samples (i.e., 80 man-hours) were required to maintain Unit 2 and Unit 3 TS requirements, respectively.

Findings

No findings were identified.

(3) Effectiveness of Corrective Actions

On the basis of the corrective action documents reviewed, the inspectors concluded that the CAs appeared generally appropriate for the identified issues. Those CAs addressing selected NRC documented violations were also determined to be generally effective and usually timely. The inspectors' review of Corrective Actions to Prevent Reoccurrence (CAPRs) did not identify subsequent recurrence of the addressed issues. The inspectors' review of the previous five years of the licensee's efforts to address issues with electronic components did not identify any recent negative trends or inability by the licensee to address long-term issues.

Observations

A maintenance fundamentals self-assessment (AR 2502328) completed in July 2015 listed two deficiencies. Maintenance workers and first line supervisors were not consistently applying all of the maintenance fundamentals. This conclusion was based on a series of ARs and observations made by the assessors. The sole action from these two deficiencies was to present a single slide at the beginning of the maintenance cycle training in April 2016 which was almost a year after the assessment was completed.

The Nuclear Oversight (NOS) assessments of maintenance in 2012, 2014, and 2016 all identified issues with the control of quality parts. Although these conditions adverse to quality were addressed on an individual basis the trend was not addressed effectively which resulted in the recurring deficiency.

Corrective Actions Associated with Root Cause Evaluations for White NRC Findings associated with Flood Mitigation Procedure, and Failed Electromagnetic Relief Valve

At the NRC closeout of inspections associated with cited violations, not all of the corrective actions that the licensee had developed were completed. However, the actions that were completed were deemed sufficient to close the violations. However, the NRC requires that those actions not completed also require eventual inspection. During this inspection the inspectors reviewed:

- AR 01513452, "NRC: Preliminary White Finding – Flood Mitigation Procedure." Corrective actions reviewed were deemed acceptable. The following items/assignments in the AR remained opened at the time of this inspection and remain to be reviewed in a subsequent inspection: 41 and 42.
- AR 2445040, "NRC Report 2014–005 "Preliminary White Finding for ERV." Corrective actions reviewed were deemed acceptable. The following items/assignments in the report remained opened at the time of this inspection and remain to be reviewed in a subsequent inspection: 25, 28, 35, and 36.

Findings

No findings were identified.

.2 Assessment of the Use of Operating Experience

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the facility's Operating Experience (OE) program. Specifically, the inspectors reviewed implementing OE program procedures, attended CAP meetings to observe the use of OE information, completed evaluations of OE issues and events, and selected monthly assessments of the OE composite performance indicators. The inspectors' review was to determine whether the licensee was effectively integrating operating experience into the performance of daily activities, whether evaluations of issues were proper and conducted by qualified personnel, whether the licensee's program was sufficient to prevent future occurrences of previous industry events, and whether the licensee effectively used the information in developing departmental assessments and facility audits. The inspectors also assessed whether corrective actions, as a result of OE, were identified, and effectively and timely implemented.

In addition, the inspectors review included a sample portion of OE driven corrective actions resulting from 10 CFR Part 21 reports. The inspectors verified the licensee adequately evaluated the vendor's issues for applicability to the station. The inspectors also confirmed the licensee correctly justified whether programmatic controls were in place that would prevent similar issues at the site. In addition, the inspectors verified that the licensee initiated actions to detect, prevent, monitor and correct conditions to prevent future occurrences related to the vendor's report.

Assessment

In general, OE was effectively used at the station. The inspectors observed that OE was discussed as part of the daily station and pre-job briefings. Industry OE was effectively disseminated across the various plant departments and no issues were identified during the inspectors' review of licensee OE evaluations. During interviews, several licensee personnel commented favorably on the use of OE in their daily activities.

Observations

The team noted that root and apparent cause evaluations were required to evaluate whether internal or external operating experience was available associated with the event or failure being examined, and whether the evaluation and actions to address those items had been effective. Additionally, all root cause evaluations reviewed included an assessment as to whether the issue being evaluated had potential application to other similar components or plants.

The inspectors had one observation in the area of OE. AR 2578767, "10 CFR 21 Notifications Not Reviewed At Dresden," discussed that during the performance of the biennial OE program review performed in 2015, the licensee identified that three 10 CFR Part 21 reports from 2014, that did not specifically identify Dresden Station as being impacted by the report, were not evaluated for applicability to the station by the licensee. The inspectors reviewed 10 CFR Part 21 report number 2016-009 from the NRC public web site on April 27, 2016. This 10 CFR Part 21 report did not state that it was specifically applicable to Dresden Station. The inspectors selected this report because of its potential applicability to Dresden Station. Exelon internally generates a Daily

Industry Events Report (DIER) that compiles all industry OE every week day. The station was notified of this 10 CFR Part 21 report (2016-009) via the DIER on March 18, 2016. At the time the inspectors reviewed this report on April 27, 2016, the licensee had not yet assigned an action to review the report for applicability, a period of about 40 days. The licensee's procedure PI-AA-115-1003, "Processing of Level 3 OPEX Evaluations," Revision 2, Step 4.2.1 had a requirement to assign an action to review 10 CFR Part 21 reports for applicability with a completion date goal within 30 days of the time the action was assigned. There was, however, no time period specified for the assignment to review the Part 21 report after the receipt of the report. The licensee acknowledged this as an issue at the exit meeting on April 29, 2016. However, the issue was not placed into the CA program until May 9, 2016, when questioned by the inspectors.

b. Findings

No findings were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors assessed the licensee staff's ability to identify and enter issues into the CA program, prioritize and evaluate issues, and implement effective corrective actions, through efforts from departmental assessments and audits.

Assessment

The inspectors concluded that most self-assessments and audits were typically accurate, thorough, and effective at identifying issues and enhancement opportunities at an appropriate threshold with some exceptions in one department. The inspectors concluded that personnel involved in audits and self-assessments were knowledgeable in the subject area they audited or assessed. In many cases, self-assessments and audits identified issues that were not previously recognized by the licensee.

Observations

The inspectors reviewed three radiation protection (RP) department self-assessments. Of the three RP assessments there was only one deficiency identified. One of these assessments was a review of all the areas the NRC planned to inspect over the next year (AR 1613009). No deficiencies were identified. The inspectors also reviewed AR 2614410 which identified that corporate RP had performed four assessments in the past year. Three of those assessments had no strengths, recommendations, or deficiencies. The fourth discussed a recommendation but no assignment to address that recommendation was put into the CA Program. The assessments performed by NOS in the RP area in 2015, however, had found seven deficiencies that were addressed (AR 2422723). Based on these observations, the inspectors concluded that the self-assessments performed by the station and corporate RP staff of the station's RP department were not effective.

b. Findings

No findings were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors assessed the licensee's safety conscious work environment (SCWE) through the reviews of the facility's employee concerns program (ECP) implementing procedures, discussions with the coordinator of the ECP, interviews with personnel from various departments, and reviews of issue reports. The inspectors also reviewed the results from 2012 and 2014 organization effectiveness surveys and meeting minutes of the Safety Culture Monitoring Panel.

As part of the overall inspection effort, inspectors discussed department and station programs with a variety of people. In addition, the inspectors held scheduled interviews with 59 non-supervisory individuals, in groups of four to eleven people, from various departments to assess their willingness to raise nuclear safety issues. Additionally other personnel were randomly asked their views of the effectiveness of the CA program.

The individuals for the scheduled interviews were randomly selected to provide a distribution across the various departments at the site. In addition to assessing individuals' willingness to raise nuclear safety issues, the interviews included discussion on any changes in the plant environment over the last 12 months. Other items discussed included:

- knowledge and understanding of the CA program;
- effectiveness and efficiency of the CA program;
- willingness to use the CA program; and
- knowledge and understanding of ECP.

The inspectors also discussed the functioning of the ECP with the program coordinator; reviewed program logs from 2014 and 2015; and reviewed two case files.

Assessment

The inspectors did not identify any issues of concern regarding the licensee's SCWE. Information obtained during the interviews indicated that an environment was established where the majority of licensee personnel felt free to raise nuclear safety issues without fear of retaliation. Licensee personnel were aware of and generally familiar with the CA program and other processes, including the ECP and the NRC's allegation process, through which concerns could be raised; and safety significant issues could be freely communicated to supervision. The inspectors did not observe and were not provided any examples where there was retaliation for the raising of nuclear safety issues. Documents provided to the inspectors regarding surveys and monitoring of the safety culture and SCWE generally supported the conclusions from the interviews even with 2014 survey issues identifying conditions that potentially might act to inhibit discussion of items.

Observations

Non-supervisory personnel in the interviewed groups stated that at their level there were no issues with working with and communicating with workers in other groups. Several of the groups interviewed expressed concerns with their supervisors' qualifications or a lack of support from their department managers.

All interviewees indicated that they could and would bring up safety issues with supervision, management, or through the CA program. Several of the groups stated the view that the CA program was ineffective for addressing low-level issues. None of the interviewed personnel stated that there was intimidation or retaliation when they brought up issues. Those same interviewees predominantly said they would use the ECP but saw no need to have to resort to the ECP for issue reporting.

b. Findings

No findings were identified.

4OA6 Management Meetings

.1 Exit Meeting Summary

On April 29, 2016, the inspectors presented the inspection results to the Site Vice President, Mr. P. Karaba, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary and that all material considered proprietary by the licensee was returned to the licensee.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

P. Karaba, Site Vice President
J. Washko, Station Plant Manager
G. Baxa, Senior Regulatory Engineer
F. Gogliotti, Director, Site Engineering
G. Morrow, Operations Director
S. Matzke, Corrective Action Program Manager
D. Walker, Regulatory Assurance – NRC Coordinator

Nuclear Regulatory Commission

J. Cameron, Chief, Division of Reactor Projects, Branch 4
G. Roach, Senior Resident Inspector

IEMA

M. Porfirio, Resident Inspector, Illinois Emergency Management Agency

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

None

LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety, but rather, that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

PLANT PROCEDURES

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
DAP 14-19	Oversight of Project/Modification Testing	0
ER-AA-550	Equipment Obsolescence Process	2
ER-AA-310-1005	Maintenance Rule – Dispositioning Between (A)(1) and (A)(2)	7
PI-AA-125-1001	Root Cause Analysis Manual	2
LS-AA-104-1000	Exelon 50.59 Resource Manual	9
PI-AA-125-1003	Apparent Cause Evaluation Manual	2
PI-AA-115	Operating Experience Program	1
PI-AA-115	Operating Experience Program	1
PI-AA-115-1003	Processing of Level 3 Opex Evaluations	2
PI-AA-125	Corrective Action Program (Cap) Procedure	3
PI-AA-125-1001	Root Cause Analysis Manual	2
PI-AA-125-1003	Apparent Cause Evaluation Manual	10
PI-AA-125-1004	Effectiveness Review Manual	1
MA-AA-716-001	Quality Material/Components Control And Identification/Segregation of Non-Conforming Items	8
DIS 6600-08	Unit 3 Diesel Generator Pressure Switches and Pressure Indicators Calibration	1
DIS 6600-08	Unit 3 Diesel Generator Pressure Switches and Pressure Indicators Calibration	2
ER-AA-440	Emergency Diesel Generator (EDG) Reliability Program	1
DOP 1300-02	Automatic Operation of Isolation Condenser	23
DOP 1300-02	Automatic Operation of Isolation Condenser	24
DOP 1300-02	Automatic Operation of Isolation Condenser	26
DOP 1300-02	Automatic Operation of Isolation Condenser	27
AD-AA-3000	Nuclear Risk Management Process	1
CC-AA-309	Control of Design Analyses	11
CC-AA-309-1001	Guidelines for Preparation and Processing of Design Analyses	8
CC-AA-311-1001	Controlled Document Prioritization	8

PLANT PROCEDURES

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
DOS 7000-26	Local Leak Rate Testing of Unit 2(3) Feedwater System Valves [2(3)-220-58A(B), [2(3)-220-62A(B)]	7
ER-AA-200	Preventative Maintenance Program	2
ER-AA-200-1001	Equipment Classification	1
ER-AA-310-1003	Maintenance Rule – Performance Criteria Selection	5
ER-AA-550	Equipment Obsolescence Process	2
MA-AA-733-1001	Guidance for Check Valve General Visual Inspection	7
MA-DR-MM-4- 3201	Feedwater Check Valve Maintenance	3
PI-AA-120	Issue Identification and Screening Process	3
PI-AA-127	Passport Action Tracking Management Procedure	2

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
291401	3 8540 5, U3 Primary Containment O2 Analyzer Failed	01/17/05
519376	O2 Analyzer not Functioning	08/13/06
861036	Analyzer Flow not High Enough	12/29/08
917864	U3 O2 Monitor Having Erratic Indication Over 24 Hours	05/10/09
939142	Adverse Trend Identified on U3 DW O ₂ Analyzer	07/06/09
961281	Request a WO to Replace Following Components for U3 DW O ₂	09/03/09
1187682	2-2301-51 Check Valve is Obsolete	03/15/11
1204088	Control Room HVAC FASA Deficiency has no Tracking Mechanism	04/18/11
1204088-17	Provide Status CR Habitability Calculations	06/14/12
1210549	Contingency Relay is Obsolete w/ no Direct Replacement	05/02/11
1213989	CR Habitability Calculations Need Revision	12/12/13
1224866	U3 Drywell O ₂ Analyzer Flow Lo Alarm (923-5A B-3)	06/05/11
1230101	Inst Air Regulators Failed for 3-8501-3B and 3-8501-5B	06/17/11
1239089	Failed Equipment is Obsolete - Engineering Required for Eval	07/12/11
1296084	2/3-1740-203 Obsolete and Parts no Longer Available	11/30/11
1305676	Material Requested in DIS 0700-13 is Obsolete	12/21/11
1327169	NOS ID: Uncontrolled Quality Part Found in MMD and EMD Shops	02/15/12
1344929	FASA Identifies Eng MCR Habitabl Calcs are Obsolete/Need Rev	03/23/12

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
1374428	U2 EDGCWP Failed to Start	06/05/12
1393901–13	Procedure Change Tracking due to Spare Parts Evaluation	10/18/13
1398536	U3 MPT Protective Relay Obsolete with no Replacement	08/08/12
1434927	U3 Battery Room HVAC Needs Mrule a(1) Determination	11/02/12
1493744	Met Wind Sensors are Obsolete and Requires Replacement	03/28/13
1513452	NRC: Preliminary White Finding – Flood Mitigation Procedure	05/13/13
1590535	2–3902 MOV Failed to Open	11/27/13
1617579	Zones Unable to Test	02/05/14
1618987	As Left Zero not within Tolerance	02/10/14
1622805	Root Cause Report Requested for SGI Classification	02/18/14
1626267	NOS ID: Corrective Action not Assigned & Completed	02/20/14
1626461	ACE Requested on 3 HU Events	02/26/14
1626461	Security Requests ACE on 3 HU Events	02/26/14
1626985	NOS ID: Safety Related Parts not Traceable to Work Orders	02/27/14
1636137	NRC Issued Green NCV for SGI Issue	03/14/14
1644740	NRC Questions Why 2–3902 Valve Failure not MRFF	04/08/14
1650033	Mrule A1 Determination Needed for MRFF Z39–1	05/10/14
1658449	Security - CCTV OSS	05/10/14
1662096	Issues with Procedure Revisions Identified	05/20/14
1670444	NRC Questions Regarding Iso Cond MOV 2–1301–3	06/11/14
1854476	MOV 2–1301–3 Stroke Length Found Longer than Expected	09/06/14
2404375	Level IV Green Finding 3rd Quarter NRC Exit	10/31/14
2411760	Stud Cleaning Refuel CAM Alarm	11/14/14
2414608	3–1601–60 Failed to Operate from MCR	11/19/14
2431672	U3 DW %O ₂ Slow Trend Up	01/01/15
2437067	FWLC 2–0640–33 Failed; Resulting in Loss of Bailey FWLC Sys	01/14/15
2445040	Corrective Actions – NRC Report 2014–005 Preliminary White Finding for ERV	01/30/15
2470558	Hittman Driver Released Without RP Approval	03/18/15
2478121	AFI EN.1.1, Engineering Fundamentals	04/01/15
2486872	Temp Shield SSP 2013–006 and –011 Need to be Made Permanent	04/17/15
2490022	Found FME In U2 D/G Main Bearing Low Oil Press (MB1) PS	04/23/15
2490584	Trng. Thorough Surrounding Written Exam Administration	04/24/15

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
2490696	IR to Document Possible Degradation of U2 DW O ₂ Sample PP	04/24/15
2502176	U2 Drywell O ₂ Analyzer System Issue	05/18/15
2502695	Mispositioned Test Switch During Performance of DIS 1500-05	05/19/15
2506613	NOS ID: NIRB Results – RCR on FWLC Reactor Scrams	05/28/15
2506847	PMC – U2 and U3 Main Condenser Fouling	05/28/15
2518096	Water/Oil on U3 TB 517' Floor	06/23/15
2518113	Severe Weather Safeguards Suspension	06/22/15
2518113	Security - Severe Weather Safeguards Suspension	06/22/15
2518254	What Good are Flood Barriers if Wtr Comes in thru Floor Drains	06/23/15
2519394	NOS ID: Resolution of A 2013 RP Audit Def. not Effective	06/25/15
2521704	Corrective Actions – FASA (RA): ERV 95001 Preps	06/30/15
2527516	U3 SBO Secondary Exhaust Damper will not Full Open	07/13/15
2527598	FASA ID: Deficiency In Maintenance Fundamentals	07/13/15
2527602	FASA ID: Deficiency In Maintenance Fundamentals	07/13/15
2532555	UHS Insp – Calc for DGCW Pumps Based at 501 Elevation	07/24/15
2548876	SPC Closure and Needs ACE	08/31/15
2549747	Dreambox Failure	09/01/15
2549747	Dreambox 02 Failure	09/01/15
2551306	Rx Bldg. / Turb. 569' Elev. Interlock Door Bypassed	09/04/15
2557390	Clean Floor Drains are Backing Up	09/18/15
2559581	Clean Floor Drains Backed Up While Flushing Temporary Demin	09/23/15
2560103	U3 SBO Inverter Transformer Failure	09/24/15
2561006	U3 SBO PLC not in Run	09/26/15
2564768	Disengagement of Filters Unit 2 Spent Fuel Pool	10/02/15
2565610	Ejector Pit Heaters Submerged	10/05/15
2567011	ACE 2548876 Rejected by MRC	10/07/15
2570579	MRule: U3 SBO Requires MR (A)(1) Determination	10/14/15
2574338	REMP Missed Samples	10/21/15
2578767	10 CFR 21 Notifications not Reviewed at Dresden	10/29/15
2583258	D2R24 LLRT FW CK 220-58B Exceeded Admin Alarm Limit	11/06/15
2583264	D2R24 LLRT FW CK 220-58B Exceeded Admin Alarm Limit	11/06/15
2583276	D2R24 FW CK 0220-62B LLRT Exceeded Admin Alarm Limit	11/06/15
2587167	Level 1 PCE While Removing Bladder From 62B FW Check Valve	11/13/15
2591977	NOS ID: CA Closure Documentation not Stand Alone	11/24/15

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
2592330	REMP Sampling Issues –Detached Wire	11/25/15
2593333	Lane 1 AVB Loose	11/30/15
2593333	Security-Lane 1 AVB Loose	11/30/15
2596243	Unit 3 Drywell O ₂ Analyzer Appears to be out of Calibration	12/05/15
2601715	FASA (EN): Emergency Diesel Reliability	12/17/15
2602903	TR-41 is Obsolete and Should be Replaced	12/20/15
2605048	REMP Sampling Issues	12/28/15
2605164	U2 517' Clean Side Floor Drains Clogged	12/28/15
2611686	U3 Ejector Pit is Frozen, Backup Up Drains in the Plant	01/13/16
2614410	RP Self-Assessment Gaps Identified	01/15/16
2621750	DG FASA: Obsolete Equipment Noted	02/04/16
2633374	Quarterly SC Meeting Summary of February 2016	02/26/16
2633687	NOS Maintenance Audit	02/19/16
2640695	NRC FOF Inspection Presentation	03/15/16
2640695	NRC FOF Inspection Presentation	03/15/16
2640697	NRC FOF Inspection Presentation	03/15/16
2640697	NRC FOF Inspection Presentation	03/15/16
2644583	IR to Document Possible Degradation of U3 DW O ₂ Sample PP	03/23/16
2645113	Abnormal Trend on Unit 2 DW O ₂ Analyzer	03/24/16
2652873	IEMA Inspector Inquiry For SWC Issue	04/08/16
2652902	NOS ID Work Package Issue	04/07/16
2653121	MOV Limitorque Motors	04/08/16
2653188	2A Recirc Motor Temps Erratic	04/09/16
2653534	3A CCSW Pump Discharge Vavle Could not be Closed	04/10/16
2653730	EMD Planning Discretionary Crew Clock Reset	04/01/16
2653764	Hose Was Found Disconnected And Split On LIC 3-3541-10A	04/09/16
2658154	Alarm 923-5A A-4, U2 Drywell O ₂ Content High	04/20/16
2660515	Calculation DRE15-0013 Error Identified	04/25/16

OPERATING EXPERIENCE

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
1620074	OPEX: Monticello Event Requires Possible Actions at Dresden	02/12/14
1620462	Braidwood OPEX Potential Applicability (NER BW-14-004)	02/12/14
1672727	PMC – Braidwood OPEX Review for Applicability (ICES #310905)	06/18/14

1689112	Proactive Action to Ensure NPDES Sampling Performed	08/04/14
2385995	ERVR Vulnerability from ASD Power Cell PM Strategy	09/25/14
2388710	Dresden Susceptible to Similar NRC Violation Issued to Fermi	09/30/14
2478177	Evaluation Needed to Determine Proper Response of HPCI AOP	04/01/15
2506698	Need OPEX Review of Quad IR 2506106	05/28/15
2572426	Review of ICES 317634 Determines Dresden Vulnerability	10/17/05
2611812	L2 IER 15-34 – DOA 0202-01 Gap Identified	01/13/16
2016–009–00	Loss of High Pressure Coolant Injection System Function as a Result of Failed Flow Controller Signal Converter (a 50.73 Report)	02/26/16
ICES Rpt 249702	Failure of Regulator In Containment Environmental Monitoring Sys. Integrator/Computational Module Computational Module 3-8541-19 (Containment Oxygen Analyzer)	06/17/11
ICES Rpt 307946	Rod Block Monitor Failed Quarterly Calibration Surveillance	07/17/13
ICES Rpt 310242	Drywell and Torus Oxygen Analyzer	02/10/14
ICES Rpt 312505	Reactor Building Floor Drain Sump Control Relay Failure	07/15/14
ICES Rpt 314317	Intermediate Range Monitor Drive Motor Fuse Blown	11/16/14
ICES Rpt 314426	Maintenance Rule Condition Monitoring Criteria Exceeded for Intermediate Range Monitor	12/08/14
ICES Rpt 314742	Manual Reactor Scram Due to Transient Caused By Feed Water Level Control System Failure	01/13/15
ICES Rpt 315154	Automatic Reactor Scram Due to Loss of Feedwater	02/06/15
ICES Rpt 319999	High Radiation Sampling System Heat Trace Relay Chatter Caused by Worn Relay Contact Parts	08/29/15
	Must Know Operating Experience	08/26/14

AUDITS, ASSESSMENTS AND SELF-ASSESSMENTS

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
1589739	Check-In Self-Assessment Dresden System Engineering Practices and Expectations	02/27/14
1589739	Dresden System Engineering Practices/Expectations	02/27/14
	Maintenance Audit Report NOSA–DRE–14–01	03/05/14
	Check-In Self-Assessment Plant Engineering Support of Work Control E-Meetings	05/05/14
1612032	Plant Engineering Support of Work Control E-Meetings	05/05/14

2409231	Dresden Maintenance and Test Equipment (M&TE) Process	07/31/15
	Biennial Self-Assessment & Benchmark Program	03/31/15
	Level 3 Operating Experience Utilization	10/30/15
2453271	NRC Inspection 71124.08, Radioactive Solid Waste Processing and Radioactive Material Handling, Storage, and Transportation Assessment	04/15/15
2478599	Engineering Safety Check-In Self-Assessment	05/15/15
2488514	Dresden FLS Program Check-In	09/11/15
	Assessing Maintenance Fundamentals	07/17/15
2575235	FASA: Pre-NRC PI&R	02/11/16
2575547	Pre-NRC 71111.11 FASA	02/25/16
	Exelon Emergency Diesel Generator Reliability	03/15/16
2601715	FASA Exelon EDG Reliability	03/08/16
	Maintenance Audit Report NOSA-DRE-16-01	03/02/16
02521704-06	Performa FASA Results Measurement Review	02/09/16
	IMD Work Practices	06/25/15
2521704-06	Perform a FASA Results Measurement Review	02/09/16
NOSA-DRE-14-05	Engineering Programs and Station Blackout Audit Report	04/07/14
NOSA-DRE-15-05	Engineering Design Control Audit Report	08/10/15
NOSA-DRE-15-12	Engineering Programs and Station Blackout Increased Frequency Audit Report	11/04/15
	Dresden Station T-6 Assessment	No date

DRAWINGS

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
12E-2848G	Wiring Diagram Drywell O ₂ Analyzer System Panel 923-5A	AK
12E-2848M	Wiring Diagram Drywell O ₂ Analyzer System Panel 923-5A	B
12E-3848A	Schematic Diagram Containment O ₂ Sample Selector	D
12E-3848A, Sh2	Schematic Diagram Containment O ₂ Sample Selector	A
12E-3848B	Internal Wiring Diagram Containment O ₂ Sample Selector	B
B-111	Turbine Bldg Plumbing Floor Plan EL 517-06 Unit 2	T
B-541	Turbine Bldg Plumbing Floor Plan, EL 517-06 Unit 3	F

CONDITION REPORTS GENERATED DURING INSPECTION

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
2654883	Discrepancy Noted Between ICES # 249702 and ATI 01230101-03	04/13/16
2655164	Reference PowerLabs Report Number is Incorrect in EACE	04/13/16
2656097	PI&R NRC Identified Issues	04/15/16
2656290	NRC Questioning U2 Recirc Dissolved O2 Indication	04/15/16
2659453	Clarification To ACE 2479781-02 Previous Events Section	04/22/16
2661053	NRC PI&R – LPCI Hx Tube Scaling Impact on DBA	04/26/16
2661809	PI&R: ACIT 1204088-07 has Inaccuracy	04/27/16
2662353	NRC PI&R Questioned CAP Assignments Tracking REMP Deviations	04/28/16
2667267	10 CFR Part 21 Item not Reviewed at Dresden	05/09/16

ROOT CAUSES AND APPARENT CAUSES REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
1331916-06	AEER AHU Belts Came off the Sheaves	02/25/12
	Apparent Cause Investigation Report (Equipment): 2A IAC Trip on High Element 2 Outlet Temp	05/17/14
1662068	Air Intrusion Into MPC #343 - RCE	05/19/14
	MOV 2-1301-3 Stroke Length Found Longer than Expected - WGE	09/16/14
1854476	D3R23 Work Stopped on Refuel Floor After CAM Alarmed	11/14/14
2411760	- ACE	
	Unit 2 Turbine Trip Due to Moisture Separator Hi-Hi Level (AC)	02/06/15
2431208	Two Reactor Scrams From A Feedwater Level Control System Failure with a Reactor Recirc Pump Runback (RC)	03/13/15
2437067	Degraded Lug Identified For TP J-18 In 902-8 PNL - ACE	04/04/15
2479781	U2 EDG Failure To Start – EACE	05/19/15
2488474	U3 EDG Failure To Start – EACE	09/11/15
2541257	Unit 3 B Reactor Building Vent Radiation Monitor Fuse Failure (AC)	10/28/15
2562930		
2608781	Potential Low-Level HU Trend in MMD - ACE	11/06/2015
2629853	RPS EPA Breakers Failed to Trip (AC)	03/21/16
	Root Cause Investigation Report: Dresden Unit 2-2B Recirculation Pump Trip due to Inadequate	08/08/14

ROOT CAUSES AND APPARENT CAUSES REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
	Ownership/Oversight during Implementation of ASD Project	
1622805-02	Security Document Classification (RCE)	03/24/14
1626461-02	Security Identified 3 HU Events (ACE)	02/26/14
2411760-02	Stud Cleaning Refuel CAM Alarm (ACE)	12/11/14
2523462-02	LORT Requal Results (AC)	08/04/15
2502695-4	Mispositioned Test Switch During Performance of DIS 1500-05 (AC)	06/18/15
2548876-02	U2 and U3 Main Condenser Fouling (ACE)	09/11/15

WORK ORDERS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
01484189-01	Degraded Recorder Causing Alarm	10/26/11
1434927	Unit 3 5712-1 Battery and Battery Charger Room HVAC a(1) Action Plan	09/21/15
1462291	3-0203-3E ERV and 3-0203-4C MSSV a(1) Action Plan	03/27/16
1650033	2-3902, U2 Standby Coolant Supply MOV a(1) Action Plan	07/09/14
1710196	Clean U2 Main Condenser South Tubes with Plastic Condenser Cleaner Plugs	11/11/15
	Clean Floor Drains Backing Up	03/10/16
2419701	AEER HVAC a(1) Action Plan	02/29/15
	Unit 0 49-1 – Miscellaneous Sumps and Drains a(1) Action Plan	01/08/16
2553500	Unit 3 SBO EDG 103-1 a(1) Action Plan	01/08/16
01719343 – 01	D2 30M/RFL TS LLRT VLV 0220-57B & 0220-58B FW INBD CHK VLV	10/13/15
01719344 – 01	D2 30M/RFL TS LLRT VLV 0220-57B & 0220-62B FW OTBD CHK VLV	10/13/15
01775920 – 01	Need Contingency Repair Work Order For 2-0220-62B	07/28/15
01775920 – 02	Need Contingency Repair Work Order For 2-0220-62B	04/02/15
01775920 – 05	Need Contingency Repair Work Order For 2-0220-62B	11/17/15
01775920 – 06	Need Contingency Repair Work Order For 2-0220-62B	10/13/15
01775920 – 07	Need Contingency Repair Work Order For 2-0220-62B	12/11/14
01775923 – 01	Need Contingency Repair Work Order For 2-0220-58B	07/28/15
01775923 – 06	Need Contingency Repair Work Order For 2-0220-58B	07/28/15
01775923 – 07	Need Contingency Repair Work Order For 2-0220-58B	07/28/15
01775923 – 08	Need Contingency Repair Work Order For 2-0220-58B	10/13/15
01775923 – 09	Need Contingency Repair Work Order For 2-0220-58B	01/30/15

WORK ORDERS REVIEWED

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
01775923 – 10	Need Contingency Repair Work Order For 2–0220–58B Replace PS 3–6641–526 U3 D/G Main Bearing Low Oil	12/11/14
01826415–01	Press (MB1) 570 TB to RXB Interlock Door Circuit Logic	
01868032 – 01	Reconfiguration	12/08/15

OTHER

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
1434927	Unit 3 5712-1 Battery and Battery Charger Room HVAC a(1) Action Plan	09/21/15
1462291	3–0203–3E ERV and 3–0203–4C MSSV a(1) Action Plan	03/27/16
1650033	2–3902, U2 Standby Coolant Supply MOV a(1) Action Plan	07/09/14
2419701	AEER HVAC a(1) Action Plan	02/29/15
2553500	Unit 0 49–1 – Miscellaneous Sumps and Drains a(1) Action Plan	01/08/16
2570579	Unit 3 SBO EDG 103–1 a(1) Action Plan	01/08/16
2014–007	ECP Case File	
2015–001	ECP Case File	
AP–913	INPO Equipment Reliability Process Description	01/04/00
DRE–41511	Failure Analysis of Element, Filter, 5 Micron, for Parker P3NF Series	02/26/16
DRE–48700	Failure Analysis of a GE Circuit Breaker and GE Voltage Regulator Card	06/16/11
Dresden OE 1	QRT Indicator	02/01/16
Dresden PE 2	Request for Engineering Changes	02/01/16
Dresden PE 3	Engineering Changes in Development	02/01/16
Dresden PE 4	Engineering Changes in Implementation	02/01/16
Dresden PE 5	Engineering Change Closeout	02/01/16
Dresden PE 6	Engineering Change Incorporation	02/01/16
Dresden PE 6	Engineering Change Incorporation	03/01/16
EC 385199	Replace Obsolete/Failed U2 FW DO Analyzer 2–3241–98	01/00/00
EC 398606	Move HVAC Calculations to Supersede Status	01/00/00
Function 103–1 (U3)	Maintenance Rule Database: Station Blackout Diesel Generator	
Function 49–1 (U0)	Miscellaneous Sumps and Drains	
LS–AA–1012	Semi-Annual Safety Culture Review	
TS 3.6.3.1	Primary Containment Oxygen Concentration Amendment 237/230	
UFSAR 9.3.2.6	Primary Containment Oxygen Sampling System	01A
WR00216398	U3 Prim Containment Oxygen Analyzer	08/13/06
WR00290978	Analyzer Flow Not High Enough	12/30/08

OTHER

<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
WR00303847	U3 O2 Monitor Having Erratic Indication Over 24 Hours	05/11/09
WR00313503	Request a WO to Replace Following Components for U3 DW O2	09/04/09
WR00371883	(ASSY) U3 DW Air Sample Sys Return to Torus Upstrm FCV	06/21/11
	Meeting Minutes-Safety Culture Monitoring Panel-1st Quarter 2014	
	Meeting Minutes-Safety Culture Monitoring Panel-3rdt Quarter 2015	
	Organizational Effectiveness Survey Results	
	Meeting Minutes-Safety Culture Monitoring Panel-4th Quarter 2015	
	ECP Logs, 2014, 2015, 2016	
	Equipment Reliability Excellence Plan	
	Training Department Human Performance Improvement Plan, 1st Quarter 2016	
	Training Department Human Performance Improvement Plan, 4tht Quarter 2016	
		4th Quarter 2015
	System Health Report Unit 2 EDG	4th Quarter 2015
		4th Quarter 2015
	System Health Report Unit 2/3 EDG	4th Quarter 2015
		4th Quarter 2015
	System Health Report Unit 3 EDG	4th Quarter 2015
		4th Quarter 2015
	System Health Report Unit 2 SBO Diesel	4th Quarter 2015
		4th Quarter 2015
	System Health Report Unit 3 SBO Diesel	4th Quarter 2015

LIST OF ACRONYMS USED

AC	Alternating Current
ACE	Apparent Cause Evaluation
ACIT	Action Tracking Item
ADAMS	Agencywide Document Access Management System
AR	Action Request/Issue Report
CA	Corrective Action
CAPR	Corrective Action to Prevent Recurrence
CFR	Code of Federal Regulations
ECP	Employee Concerns Program
GE	General Electric
HPCI	High Pressure Coolant Injection
IMC	Inspection Manual Chapter
IMEA	Illinois Emergency Management Agency
IP	Inspection Procedure
IR	Inspection Report
NCAP	Identified Documented Condition not Required to be in the CA Program
NCV	Non-Cited Violation
NOS	Nuclear Oversight
NRC	Nuclear Regulatory Commission
OAD	Action Request Details
OE	Operating Experience
OSC	Obsolesce Steering Committee
PARS	Publicly Available Records
PHC	Plant Health Committee
PI&R	Problem Identification and Resolution
RCE	Root Cause Evaluation
RP	Radiation Protection
SCWE	Safety Conscious Work Environment
SOC	Station Ownership Committee
WO	Work Order
WR	Work Request

B. Hanson

-2-

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Sincerely,

/RA/

Jamnes Cameron, Chief
Branch 4
Division of Reactor Projects

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