



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION I
2100 RENAISSANCE BLVD., SUITE 100
KING OF PRUSSIA, PA 19406-2713

November 28, 2016

EA-16-128

Mr. Bryan Hanson
Senior Vice President, Exelon Generation
President and Chief Nuclear Officer, Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

**SUBJECT: R. E. GINNA NUCLEAR POWER PLANT, LLC – SUPPLEMENTAL
INSPECTION REPORT 05000244/2016010 AND ASSESSMENT FOLLOW-UP
LETTER**

Dear Mr. Hanson:

On November 3, 2016, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure (IP) 95001, "Supplemental Inspection Response to Action Matrix Column 2," at your R.E. Ginna Nuclear Power Plant, LLC (Ginna). On November 3, 2016, the NRC Inspection team and an NRC Region I Branch Chief discussed the inspection results and the implementation of your corrective actions with Mr. J. Pacher, Site Vice President and members of his staff during an inspection exit meeting and Regulatory Performance Meeting.

In accordance with the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was conducted within the Regulatory Response Column of the NRC's Reactor Oversight Process (ROP) Action Matrix because one finding of White significance, associated with the Emergency Preparedness Cornerstone, was identified in the second quarter 2016 integrated inspection report (ML16232A051) dated August 18, 2016. The finding was associated with Exelon's implementation of a revision to the emergency action level (EAL) table for the fission product barrier matrix that was incorrect with respect to the EAL threshold associated with potential loss of containment barrier. This could have resulted in an untimely declaration of a General Emergency or a failure to declare a Site Area Emergency during an actual event. The final significance determination and follow-up assessment letter (ML16262A213) for this finding issued on September 20, 2016, documented that Ginna transitioned to the Regulatory Response Column of the ROP Action Matrix, retroactive to the second quarter of 2016. The NRC staff was informed on October 5, 2016, of your staff's readiness for this supplemental inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and the contributing causes of risk-significant performance issues were understood; (2) the extent of condition and extent of cause of risk-significant performance issues were identified; and (3) corrective actions for risk-significant performance issues are sufficient to address the root and contributing causes and prevent recurrence. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with

the Commission's rules and regulations, and the conditions of your operating license. Based on the results of this inspection, the NRC concluded that, overall, the supplemental inspection objectives were met and no significant weaknesses were identified. Additionally, no findings of significance were identified.

Based on the guidance in IMC 0305, "Operating Reactor Assessment Program," and the results of this inspection, the White finding will be closed effective the date of this report. However, Ginna will remain in the Regulatory Response Cornerstone until four calendar quarters have passed starting in the second quarter 2016.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390 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 Public Document Room or from the Publicly Available Records System component of the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Anthony Dimitriadis, Chief
Reactor Projects Branch 1
Division of Reactor Projects

Docket No. 50-244
License No. DPR-18

Enclosure:
Inspection Report 05000244/2016010
w/Attachment: Supplementary Information

cc w/encl: Distribution via ListServ

Based on the results of this inspection, the NRC concluded that, overall, the supplemental inspection objectives were met and no significant weaknesses were identified. Additionally, no findings of significance were identified.

Based on the guidance in IMC 0305, "Operating Reactor Assessment Program," and the results of this inspection, the White finding will be closed effective the date of this report. However, Ginna will remain in the Regulatory Response Cornerstone until four calendar quarters have passed starting in the second quarter 2016.

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390 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 Public Document Room or from the Publicly Available Records System component of the NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Anthony Dimitriadis, Chief
Reactor Projects Branch 1
Division of Reactor Projects

Docket No. 50-244
License No. DPR-18

Enclosure:
Inspection Report 05000244/2016010
w/Attachment: Supplementary Information

cc w/encl: Distribution via ListServ

DISTRIBUTION w/encl:

DDorman, RA	JYerokun, DRS	MRose, DRP, AA
DLew, DRA	ADimitriadis, DRP	JBowen, RI, OEDO
MScott, DRP	ARosebrook, DRP	RidsNrrPMGinna Res
DPelton, DRP	ASiwy, DRP	RidsNrrDorLpl1-1 Res
RLorson, DRS	NPerry, DRP, SRI	ROPreports Res
	JPetch, DRP, RI	ROPassessment Res

DOCUMENT NAME: G:\DRP\BRANCH1\Ginna\Reports\2016-010 EP NOV 95001\Ginna 95001 2016010 .docx
ADAMS ACCESSION NO. ML16333A024

<input checked="" type="checkbox"/> SUNSI Review		<input checked="" type="checkbox"/> Non-Sensitive <input type="checkbox"/> Sensitive		<input checked="" type="checkbox"/> Publicly Available <input type="checkbox"/> Non-Publicly Available	
OFFICE	RI/DRP	RI/DRP			
NAME	ARosebrook	ADimitriadis			
DATE	11/15/16	11/28/16			

OFFICIAL RECORD COPY

U.S. NUCLEAR REGULATORY COMMISSION**REGION I**

Docket No. 50-244

License No. DPR-18

Report No. 05000244/2016010

Licensee: Exelon Generation Company, LLC (Exelon)

Facility: R. E. Ginna Nuclear Power Plant, LLC (Ginna)

Location: Ontario, New York

Dates: October 31, 2016, through November 3, 2016

Inspectors: A. Rosebrook, Senior Project Engineer, Team Leader
S. Barr, Senior Emergency Preparedness Inspector

Approved by: Anthony Dimitriadis, Chief
Reactor Projects Branch 1
Division of Reactor Projects

Enclosure

SUMMARY

Inspection Report 05000244/2016010; 10/31/2016 – 11/03/2016; R.E. Ginna Nuclear Power Plant, LLC (Ginna); Supplemental Inspection – Inspection Procedure (IP) 95001

A Senior Project Engineer from the Division of Reactor Projects, U.S. Nuclear Regulatory Commission (NRC) Region I and a Senior Emergency Preparedness Inspector from the Division of Reactor Safety, USNRC Region I, performed 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 6.

Cornerstone: Emergency Preparedness

The NRC staff performed this supplemental inspection pursuant to Inspection Procedure (IP) 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," at the R.E. Ginna Nuclear Power Plant, LLC (Ginna), to assess Exelon's root cause evaluation and associated corrective actions taken in response to a finding of low to moderate safety significance (White) associated with the Emergency Preparedness Cornerstone. The finding was identified in the second quarter 2016 integrated inspection report (ML16232A051) dated August 18, 2016. The finding was associated with Exelon's implementation of a revision to the emergency action level (EAL) table for the fission product barrier matrix that was incorrect with respect to the EAL threshold associated with potential loss of containment barrier. This condition could have resulted in an untimely declaration of a General Emergency or a failure to declare a Site Area Emergency during an actual event. The final significance determination, notice of violation (NOV), and follow-up assessment letter (ML16262A213) for this finding issued on September 20, 2016, documented that Ginna transitioned to the Regulatory Response Column of the ROP Action Matrix retroactive to the second quarter of 2016. The NRC staff was informed on October 5, 2016, of Exelon staff's readiness for this inspection.

Based on the results of the inspection, no significant weaknesses or findings were identified. The inspectors concluded that Exelon had adequately performed a root cause analysis of the event, and corrective actions, both completed and planned, were reasonable to address the related issues. Based on the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," dated December 23, 2015, and the results of this inspection, the White finding will be closed. However, Ginna will remain in the Regulatory Response Cornerstone until four calendar quarters have passed from when the finding became effective which will be the end of the first quarter of 2017. (Section 4OA4)

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (IP 95001)

.1 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95001 to assess Exelon's evaluation of a White finding, which affected the Emergency Preparedness cornerstone in the Reactor Safety strategic performance area. The inspection objectives were to:

- provide assurance that the root and contributing causes of risk-significant performance issues were understood;
- provide assurance that the extent of condition and extent of cause of risk-significant performance issues were identified,
- provide assurance that corrective actions for risk-significant performance issues are sufficient to address the root and contributing causes and prevent recurrence.

The NRC staff performed a supplemental inspection pursuant to IP 95001, "Supplemental Inspection Response to Action Matrix Column 2 Inputs," at the R.E. Ginna Nuclear Power Plant, LLC (Ginna), as required by the NRC Reactor Oversight Process. This supplemental inspection was conducted because one finding of low to moderate safety significance (White), associated with the Emergency Preparedness Cornerstone, was identified in the second quarter 2016 integrated inspection report (ML16232A051) dated August 18, 2016. The finding was associated with Exelon's implementation of a revision to the EAL table for the fission product barrier matrix that was incorrect with respect to the EAL threshold associated with potential loss of the containment barrier. This condition could have resulted in an untimely declaration of a General Emergency or a failure to declare a Site Area Emergency during an actual event. The final significance determination and follow-up assessment letter (ML16262A213) for this finding issued on September 20, 2016, documented that Ginna transitioned to the Regulatory Response Column of the ROP Action Matrix retroactive to the second quarter of 2016.

Exelon staff informed the NRC staff on October 5, 2016, of their readiness for the supplemental inspection. Upon identification, Exelon conducted prompt communications with all emergency response organization (ERO) personnel and issued Operations Department Standing Order 2016-006 which clarified the EAL criteria. Exelon subsequently took the following actions: (a) completed a root cause evaluation (RCE) issue report (IR) 02659732, to identify and correct the root and contributing causes for the incorrect revision; (b) revised procedure EP-AA-1002 Addendum 3, "R.E. Ginna Nuclear Power Plant Emergency Action Levels," to correct the EAL table; and (c) conducted extent of cause and extent of condition reviews. Exelon submitted, Reply to a Notice of Violation: EA-16-128 dated October 18, 2016, (ML16294A555) which documented the reason for the violation, corrective actions and corrective actions to prevent repetition planned and completed, and stated the full compliance had been restored on September 16, 2016.

The White finding had a cross-cutting aspect in the area of Human Performance, Change Management, because Exelon did not use a systematic process for evaluating and implementing change so that nuclear safety remains the overriding priority. Specifically, Exelon did not maintain a clear focus on nuclear safety when implementing changes to the EALs resulting in a significant unintended consequence, the potential to make an untimely emergency declaration.

The inspectors reviewed the causal evaluations, procedures, standing orders, and documents referenced above, in addition to other documents listed in the Attachment, which supported Exelon's actions to address the White finding. The inspectors reviewed corrective actions, both completed and planned, to address the identified causes, extent of condition, and extent of cause. The inspectors also interviewed Exelon personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood; and corrective actions taken or planned were appropriate to address the causes and prevent recurrence. Interviews were conducted with both onsite personnel and Exelon corporate emergency preparedness specialists. Lastly, the inspectors conducted in-plant walkdowns, which included independent inspections of the containment spray system and the main control room.

.2 Evaluation of the Inspection Requirements

02.01 Problem Identification

- a. IP 95001 requires that the inspection staff determine that Exelon's evaluation of the issue documents who identified the issue (i.e., licensee-identified, self-revealing, or NRC-identified) and under what conditions the issue was identified.

Exelon's Root Cause Analysis Report (RCAR) and IR 02659732 documented that this issue was identified by a Shift Manager during an emergency preparedness exercise scenario review and validation on April 22, 2016. Since this review is a normal part of Exelon's exercise review process, the issue is considered licensee-identified.

- b. IP 95001 requires that the inspection staff determine that Exelon's evaluation of the issue documents how long the issue existed and prior opportunities for identification.

Exelon's RCAR documents that the issue existed from December 23, 2013, when EAL Table Revision 4900 and EAL Technical Basis Revision 4900 were implemented, until April 22, 2016, when the issue was identified and Operations Department Standing Order 2016-006 was issued.

The RCAR also identified that there were opportunities to identify the issue previously, most notably in June 2014 when an emergency drill scenario was developed and performed which included making a declaration based upon the degraded EAL criteria. Additional missed opportunities included, an extent of condition review conducted as part of IR 02476668 for overly conservative protective action recommendation guidance, licensed operator requalification and initial licensing classes, corporate program audits conducted after the transfer of the operating license from Constellation to Exelon in 2015, and annual nuclear oversight emergency preparedness program audits.

- c. IP 95001 requires that the inspection staff determine that Exelon's evaluation documents the plant specific risk consequences, as applicable, and compliance concerns associated with the issue.

Exelon's RCAR accurately classified the safety significance and potential risk consequences of this issue. Due to this error a potential loss of the containment barrier may not have been declared in a timely matter, resulting in an untimely General Emergency declaration and associated protective action recommendation (PAR) or the failure to make a Site Area Emergency declaration under certain accident conditions. Exelon's RCAR also accurately identified the compliance concerns associated with the issue.

d. Findings

No findings of significance were identified.

02.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

- a. IP 95001 requires that the inspection staff determine that Exelon evaluated the problem using a systematic methodology to identify the root and contributing causes.

The inspectors determined that Exelon evaluated the White finding using a systematic methodology to identify root and contributing causes. The inspectors verified that Exelon staff implemented PI-AA-125-1001, Revision 2, "Root Cause Analysis," as well as the guidance in PI-AA-125, Revision 0, "Corrective Action Program (CAP) Procedure," in the conduct of the station's causal analyses to identify the root and contributing causes. The station utilized the following systematic methods to complete the RCAR:

- data gathering through interviews and document review;
- comparative timeline;
- root cause trees;
- WHY staircase; and
- hazard-barrier-target analysis.

The inspectors verified these methods were completed by reviewing the RCAR and its attachments. The inspectors also verified that the root and contributing causal conclusions were consistently understood and supported by Exelon staff through the conduct of interviews, and review of third party reports.

- b. IP 95001 requires that the inspection staff determine that Exelon's RCAR was conducted to a level of detail commensurate with the significance of the problem.

The inspectors determined that Exelon's RCAR was conducted to a level of detail commensurate with the significance of the White finding. In accordance with PI-AA-125-1001, Revision 2, "Root Cause Analysis," as well as PI-AA-125, Revision 0, "Corrective Action Program (CAP) Procedure," Exelon conducted an RCAR that identified the root and contributing causes associated with the inaccurate revision to the EAL table identified on April 22, 2016.

The root cause was, "station ownership of Emergency Preparedness program changes lacked the necessary vision and strategy to achieve excellence." Two contributing causes were also identified. First, Emergency Preparedness leadership did not establish appropriate standards for rigor in reviews of program changes for cross-discipline reviews. Second, the Plant Operations Review Committee (PORC) did not perform an adequate review of changes to an emergency action threshold.

The inspectors noted that two other factors identified may have also been contributing causes. First, the inspectors noted that NEI 99-01, Revision 5 has a convention where individual criteria are clearly delineated by a Line Break and a bold, capitalized "AND" or "OR." The criteria in question had two criteria: Greater than or equal to 28 psig in containment AND one full train of containment depressurization equipment available. Station staff requested that the second term be defined in plant specific terminology to avoid confusion. One full train of containment depressurization equipment consists of the combination of at least two Containment Recirculation Fan Cooler (CRFC) units and one Containment Spray (CS) pump. When the wall chart was revised to meet this request the convention separating the criteria was not followed and the two criteria were in the same line and non-capitalized or bolded "ands" were used. Thus it could now be read that there were three criteria vice two criteria. This error was made in August of 2010 and was carried forward until December 2013. Thus this was a contributing cause which was later compounded.

The second factor was the December 2013, PORC, which reviewed and approved changes suggested during the initial training for the EAL table changes. The changes added a less than sign in front of the CS pumps to make it clear the less than in front of the CRFC units applied to both the CRFC units and the CS pumps. The change also attempted to restore the convention discussed above and capitalizing and bolding both ANDs and separating it into three criteria vice the original two. Although this change was presented to PORC and a 10 CFR 50.54 (q) evaluation was completed discussing the change, the change was only partially incorporated in the EAL Table itself. Specifically, the less than symbol was added, but the change restoring the convention delineating each criteria was not. PORC approved the change as described in the 10 CFR 50.54(q) evaluation. However, both PORC and the station failed to recognize the EAL table did not contain the full change as discussed. The new table was implemented on December 23, 2013. This factor also contributed to the amount of time it took to identify the error since having three distinct criteria would clearly have not been consistent with both NEI 99-01 Rev 5 and the EAL Technical basis document.

Exelon's RCAR did identify both these concerns as causal factors; however, specific corrective actions are not required for causal factors per PI-AA-125-1001, Revision 2. Although specific corrective actions were not created the corrective actions for the two contributing causes did appear to address these causal factors as well. Therefore, this inspection objective is considered to be met. Exelon documented the team's observation as IR 02741463.

- c. IP 95001 requires that the inspection staff determine that Exelon's RCAR included a consideration of prior occurrences of the problem and knowledge of operational experience.

Exelon's RCAR appropriately considered both internal and external operating experience during their review of this issue. Exelon reviewed previous emergency preparedness violations from Ginna, Calvert Cliffs, Prairie Island, and Susquehanna. The Exelon team used information from these prior issues to establish the contributing cause and aid in developing corrective actions.

- d. IP 95001 requires that the inspection staff determine that Exelon's RCAR addressed the extent of condition and extent of cause of the problem.

The inspectors determined that Exelon's evaluations appropriately addressed the extent of condition and extent of cause of the issue. The inspectors determined these extent of

condition actions were appropriate to the circumstances, based on Exelon's knowledge of the issue when the actions were created.

IR 02659732 Action 5 was to conduct an extent of cause review. The review included a review of program changes since December 2013 including changes affecting the Respiratory Protection Program, Improved Technical Specifications, Technical Requirements Manual, Offsite Dose Calculation Manual, Update Final Safety Analysis Report, and National Fire Protection Code 805 transition. No current significant issues were identified during the review but it did identify that similar causes had been identified in previous RCARs and Apparent Cause Evaluations. IR 02696733 was created to evaluate, document, and address the issues identified during the review.

IR 02659732 Action 22 was to conduct an Extent of Condition Review. This review included all changes to the EALs that occurred after the NRC's approval of the Ginna Licensee Amendment Request to update the Ginna EALs to NEI 99-01, Revision 5. Several discrepancies were noted which required additional evaluation. IR 02713354 was written to document six differences between the EALs and NEI 99-01, Revision 5. As a result two operations standing orders were issued while the issues were evaluated further. However, none of these issues identified resulted in a reduction in effectiveness of the Ginna Emergency Plan.

- e. IP 95001 requires the inspection staff to determine that Exelon's root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture traits in NUREG-2165, "Safety Culture Common Language," referenced in IMC 0310, "Aspects Within Cross-Cutting Areas."

The inspectors determined that Exelon's RCAR did consider the safety culture components as described in IMC 0305. The inspectors noted that Exelon performed the evaluation of the safety culture components in accordance with station procedures. Overall, the inspectors noted that Exelon appropriately identified station performance gaps in the cross-cutting areas of human performance and problem identification and resolution. Finally, the inspectors noted that Exelon's corrective actions were adequate to address the performance gaps. Attachment 4 of the RCAR specifically documented the safety culture review and observations.

f. Findings

No findings of significance.

02.03 Corrective Actions Taken and Planned

- a. IP 95001 requires the inspection staff to determine that Exelon: (1) specified appropriate corrective actions for each root and/or contributing cause; or (2) had an adequate evaluation for why no corrective actions are necessary.

Overall, the inspectors found that Exelon specified appropriate corrective actions for each root cause, contributing causes, extent of condition, and extent of cause for the White finding. Exelon's corrective actions to address the root and contributing causes were assigned in accordance with station procedure PI-AA-125-1001, Revision 2, "Root Cause Analysis," as well as the guidance in PI-AA-125, Revision 0, "Corrective Action Program (CAP) Procedure,":

RCA 02659732 Corrective Actions included:

- Corrective Action to Preclude Recurrence for the Root Cause: Establishment of an Emergency Preparedness Advisory Sub Committee (EPAC) for Excellence in Emergency Preparedness.
- Corrective Actions for Contributing Cause #1: 1) Revise EP-AA-1012 Addendum 3, R.E. Ginna Nuclear Power Plant Emergency Action Levels. 2) Site Emergency Preparedness Manager reinforce and train staff on the roles and responsibilities and the requirements to ensure cross disciplinary reviews are completed for all program changes.
- Corrective Action for Contributing Cause #2: Regulatory Assurance Manager to reinforce the roles and responsibilities and train PORC members to include expectations for conduct of an independent review and ensuring appropriate cross discipline reviews have occurred.

- b. IP 95001 requires that the inspection staff determine that corrective actions were prioritized by Exelon with consideration of risk significance and regulatory compliance.

The inspectors determined that Exelon prioritized corrective actions appropriately. Immediate corrective actions to communicate the issue to all operating crews and issue a standing order to aid operators in properly determining the EAL criteria were completed the same day the issue was discovered and the EP-AA-1012 Addendum 3, Revision 3 was issued and implemented on June 17, 2016.

- c. IP 95001 requires that the inspection staff determine that corrective actions taken to address and preclude repetition of significant performance issues are prompt and effective.

Immediate corrective actions including communications with all emergency directors and the issuance of Operations Standing Order 2016-006 were completed on the day of discovery of the issue and Revision 3 of when EP-AA-1012 Addendum 3, Revision 3 was issued and implemented on June 17, 2016. These actions were determined to be prompt and effective in eliminating the performance deficiency and precluding recurrence. Other corrective actions to preclude recurrence for the root cause of the issue, described above, were considered to be timely and effective in addressing the organizational weaknesses which led to this performance deficiency. These actions were completed by the time of the inspection and effectiveness reviews are scheduled for February 2017.

- d. IP 95001 requires that the inspection staff determine that Exelon developed quantitative and/or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

Exelon scheduled an effectiveness review to be completed in February 2017. Originally the effectiveness review was scheduled to be conducted the week of November 16, 2016, but was rescheduled to ensure enough time would pass to adequately evaluate the CAPR effectiveness. The effectiveness review will be conducted in accordance with Exelon procedure PI-AA-125-1004, Rev-001, "Effectiveness Review Manual."

- e. IP 95001 requires that the inspection staff determine that Exelon's planned or taken corrective actions adequately address each NOV that was the basis for the supplemental inspection.

The inspectors determined that Exelon's planned and completed corrective actions adequately, restored compliance with the NOV of 10 CFR 50.54 (q)(2), the issue was properly evaluated for root, contributing causes and an extent of cause and extent of condition review was completed and corrective actions developed and implemented including corrective actions to preclude repetition.

Partial compliance was restored on April 22, 2016, when operations standing order 2016-006 was issued, and full compliance restored when EP-AA-1012 Addendum 3, Revision 3 was implemented on June 17, 2016.

f. Findings

No findings were identified.

02.05 Evaluation of IMC 0305 Criteria for Treatment of Old Design Issues

Exelon did not request credit for self-identification of an old design issue; therefore, the risk-significant issue was not evaluated against the IMC 0305 criteria for treatment of an old design issue.

40A6 Exit Meeting and Regulatory Performance Meeting

On November 3, 2016, the inspectors presented the inspection results to Mr. J. Pacher, Site Vice President, and other members of his staff, who acknowledged the inspection results. The inspectors verified that no proprietary information provided during the inspection was retained by the inspectors or documented in this report..

Upon completion of the exit meeting, the Region I Chief, Reactor Projects Branch 1, Mr. Anthony Dimitriadis, conducted a Regulatory Performance Meeting, in accordance with IMC 0305 Section 10.01 (a), with Mr. J. Pacher, Site Vice President, and other members of his staff. The purpose of the meeting was to discuss Exelon's corrective actions in response to the White finding and NOV and to provide a forum in which to develop a shared understanding of performance issues. Based on the guidance in IMC 0305, "Operating Reactor Assessment Program," and the results of this inspection, the White finding will be closed effective the date of this report. However, Ginna will remain in the Regulatory Response Cornerstone until four calendar quarters have passed starting in the second quarter 2016.

ATTACHMENT: SUPPLEMENTARY INFORMATION

SUPPLEMENTARY INFORMATION**KEY POINTS OF CONTACT**Licensee Personnel

J. Pacher – Site Vice President
 D. Blankenship – Director Site Operations
 T. Edwards - Manager Site Chemistry, Environmental, & Radwaste
 E. Fischer – Site Regulatory Assurance
 K. Garnish – Manager Operations Support and Services
 T. Harding – Site Regulatory Assurance Manager
 J. Jackson – Manager Emergency Preparedness
 P. Ledain - Operations CAP Coordinator
 R. Reissner – Manager Operations Services
 P. Swift - Director Site Work Management

LIST OF ITEMS OPENED, CLOSED AND DISCUSSEDClosed

05000244/2016002-01 NOV Incorrect Emergency Action Level Table

LIST OF DOCUMENTS REVIEWEDProcedures

CENG-EP-1.01-1013 R0000, Emergency Classification and PAR
 EP-AA-1002 Addendum 3, Revisions 1-3, R.E. Ginna Nuclear Power Plant Emergency Action Levels
 EP-AA-120-1004, Revision-002, Emergency Preparedness Advisory Committee
 EPG-EPAC, Revision-000, EPAC Subcommittee
 EPIP-1-0, Revision 48 and 49, Ginna Station Event Evaluation and Classification
 PI-AA-125, Revision 0, Corrective Action Program (CAP) Procedure
 PI-AA-125-1001, Revision 002, Root Cause Analysis Manual
 PI-AA-125-1004, Revision-001 Effectiveness Review Manual

Condition Reports (*means CR written as a result of this inspection)

01902660	02476668	02659732
01935410	02502359	02696733
01960543	02515393	02713354
01960650	02515980	02715246
02449963	02609057	02741463*

Miscellaneous

EAL FASA Plan and Report
 ECP-16-00708-309-101-01, Clarify Basis of 4 hour release duration specified in EAL Table R-1
 Exelon Standing Order 2016-006
 Ginna Regulatory Performance Meeting Notes
 List of Items Identified during Ginna EP Deep Dive review
 PORC meeting 013-0029 minutes
 PORC package for 2013-0029

LIST OF ACRONYMS USED

ACE	Apparent Cause Evaluation
ADAMS	Agencywide Documents Access and Management System
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CRFC	Containment Recirculation Fan Cooler
CS	Containment Spray
EAL	Emergency Action Level
EPAC	Emergency Preparedness Advisory Committee
ERO	Emergency Response Organization
Exelon	Exelon Generation Company, LLC
Ginna	Ginna Nuclear Power Plant, LLC
IP	Inspection Procedure
IMC	Inspection Manual Chapter
IR	Issue Report
LER	Licensee Event Report
MRC	Management Review Committee
NEI	Nuclear Energy Institute
NOV	Notice of Violation
NRC	U. S. Nuclear Regulatory Commission
OE	Operating Experience
PAR	Protective Action Recommendation
PM	Preventive Maintenance
PORC	Plant Operations Review Committee
RCAR	Root Cause Analysis Report
RCE	Root Cause Evaluation
ROP	Reactor Oversight Process