



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**

REGION III  
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LISLE, ILLINOIS 60532-4352

September 30, 2019

Mr. Paul Fessler, Senior VP  
and Chief Nuclear Officer  
DTE Energy Company  
Fermi 2 – 260 TAC  
6400 North Dixie Highway  
Newport, MI 48166

SUBJECT: FERMI POWER PLANT, UNIT 2—BIENNIAL PROBLEM IDENTIFICATION AND  
RESOLUTION INSPECTION REPORT 05000341/2019010

Dear Mr. Fessler:

On August 16, 2019, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at your Fermi Power Plant, Unit 2 and discussed the results of this inspection with you and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's corrective action program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the sample reviewed, the team determined that the station had a low threshold for identifying issues and entering them into the Corrective Action Program. A risk-based approach was used to determine the significance of the issues and priority for issue evaluation and resolution. Corrective actions were usually implemented in a timely manner, commensurate with their safety significance. However, the team identified examples of weaknesses in evaluating problems, and in the timeliness of corrective actions taken to resolve those problems.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, operating experience was generally entered into the Corrective Action Program when appropriate and evaluated in accordance with Corrective Action Program implementing procedures. The use of operating experience was integrated into daily activities and found to be generally effective in preventing similar issues at the plant. In addition, self-assessments and audits were conducted at appropriate frequencies with sufficient depth for most departments based on the documents the team reviewed. Most of the self-assessments reviewed were found to be effective in identifying site performance deficiencies, programmatic concerns, and improvement opportunities. However, the team identified some weaknesses in your audits and self-assessments, and some inadequacies in your evaluation of industry and NRC operating experience.

Finally the team reviewed the station's programs to establish and maintain a safety conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Based on our review of your recent safety culture assessments and the results of the

interviews we conducted, the team did not identify any impediment to the establishment of a safety conscious work environment. Your staff was aware of and generally familiar with the Corrective Action Program and other station processes, including the Employee Concerns Program, through which concerns could be raised.

The NRC inspectors did not identify any finding or violation of more than minor significance.

Based on the samples reviewed, and although a finding or violation was not identified during this inspection, the range and number of identified deficiencies and weaknesses in the Corrective Action Program and supporting processes led the team to conclude that your overall implementation of the Corrective Action Program at Fermi was marginally effective.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with 10 CFR 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

**/RA/**

Eric R. Duncan, Chief  
Branch 4  
Division of Reactor Projects

Docket No. 05000341  
License No. NPF-43

Enclosure:  
As stated

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Letter to Paul Fessler from Eric Duncan dated September 30, 2019

SUBJECT: FERMI POWER PLANT, UNIT 2—BIENNIAL PROBLEM IDENTIFICATION AND  
RESOLUTION INSPECTION REPORT 05000341/2019010

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**U.S. NUCLEAR REGULATORY COMMISSION**  
**Inspection Report**

Docket Number: 05000341

License Number: NPF-43

Report Number: 05000341/2019010

Enterprise Identifier: I-2019-010-0047

Licensee: DTE Electric Company

Facility: Fermi Power Plant, Unit 2

Location: Newport, MI

Inspection Dates: July 29, 2019 to August 16, 2019

Inspectors: V. Meghani, Reactor Inspector  
R. Ng, Project Engineer  
J. Rutkowski, Project Engineer  
A. Shaikh, Senior Reactor Inspector  
T. Taylor, Resident Inspector

Approved By: Eric R. Duncan, Chief  
Branch 4  
Division of Reactor Projects

Enclosure

## **SUMMARY**

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a biennial problem identification and resolution inspection at Fermi Power Plant, Unit 2 in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

### **List of Findings and Violations**

No findings or violations of more than minor significance were identified.

### **Additional Tracking Items**

None.

## INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

## OTHER ACTIVITIES – BASELINE

### 71152B - Problem Identification and Resolution

#### Biennial Team Inspection (IP Section 02.04) (1 Sample)

- (1) The inspectors performed a biennial assessment of the licensee's corrective action program, use of operating experience, self-assessments and audits, and safety conscious work environment.
  - Corrective Action Program Effectiveness: The inspectors assessed the corrective action program's effectiveness in identifying, prioritizing, evaluating, and correcting problems.
  - Operating Experience, Self-Assessments and Audits: The inspectors assessed the effectiveness of the station's processes for use of operating experience, audits, and self-assessments.
  - Safety Conscious Work Environment: The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety conscious work environment.

## INSPECTION RESULTS

Assessment	71152B
Based on the samples reviewed, and the range and number of deficiencies and weaknesses in the licensee's Corrective Action Program and supporting processes that were identified through these samples, the team concluded that the licensee's implementation of the Corrective Action Program was marginally effective.	
<u>Effectiveness of Problem Identification:</u>	
Based on the samples reviewed, the team concluded that the licensee continued to identify issues at a low threshold and appropriately entered these issues into the Corrective Action Program. The team determined that problems were usually entered into the Corrective Action Program in a complete and accurate manner.	

The team also noted that some deficiencies were identified by external organizations, including the NRC, that had not been previously identified by licensee staff and were subsequently entered into the Corrective Action Program. These externally-identified deficiencies represented missed opportunities by licensee staff to identify issues to be addressed through the Corrective Action Program.

The team found that the licensee utilized a number of Corrective Action Program support processes to identify problems, including the self-assessment and audit process and the Operating Experience Program. The licensee generally performed adequate department self-assessments and quality assurance audits to identify issues in station processes. Similarly, the licensee generally screened issues from both NRC and industry operating experience and entered them into the Corrective Action Program when they were applicable to the station. However, the team identified several issues related to the self-assessment process and the Operating Experience Program. Details of these issues are discussed in the Observation section of this report.

The team determined that the licensee was generally effective at trending low level issues and taking appropriate corrective actions to prevent more significant issues from developing. The licensee used the Corrective Action Program to document instances in which previous corrective actions were ineffective or were inappropriately closed.

The team performed a 5-year review of emergency diesel generator leakage. As part of this review, the team interviewed the emergency diesel generator system engineer, reviewed corrective action resolution documents (CARDs), plant health reports, and condition evaluations. In addition, the team performed a system walkdown to assess the material condition of the emergency diesel generator system and surrounding areas. The team concluded that emergency diesel generator leakage concerns were identified and entered into the Corrective Action Program at a low threshold, and concerns were resolved in a timely manner commensurate with their safety significance. For the areas walked down, the team did not identify any additional issues.

#### Effectiveness of Prioritization and Evaluation of Issues:

Based on the samples reviewed, the team determined that licensee performance was adequate with opportunities for improvement at prioritizing and evaluating issues commensurate with the safety significance of the identified problem. The Ownership Screening Committee and the Management Review Committee meetings were generally thorough and intrusive in reviewing issues and prioritizing actions. The team observed a productive dialogue between the members of these committees and the members challenged each other when dispositioning CARDs.

In general, once a degraded or non-conforming condition was identified, the Corrective Action Program directed that an equipment operability or functionality review be performed. The majority of the samples reviewed were evaluated in a timely manner. However, the team identified an issue with the technical rigor of some of these evaluations. Additional details of this issue are discussed in the Observation section of this report.

The team identified several issues related to the untimely screening and inadequate evaluation of operating experience. Additional details of these issues are described in Observation section of this report.

Effectiveness of Corrective Actions:

Based on the samples reviewed, the team determined that the licensee was adequate with opportunities for improvement in corrective action implementation. In general, corrective actions for deficiencies that were safety significant were implemented in an adequate and timely manner. Problems identified using a root cause or other cause methodologies were, in general, resolved in accordance with Corrective Action Program requirements. The corrective actions assignments that were sampled by the team for selected NRC documented violations and for licensee event reports (LERs) were generally effective and timely. However, the team identified a relatively high number of systems that were categorized as Maintenance Rule (a)(1). The team reviewed selected Maintenance Rule (a)(1) systems and their corrective action plans and concluded there was a weakness in the licensee's equipment reliability program. Additional details of this weakness are discussed in the Observation section of this report.

The team also identified that corrective actions from Self-Assessments and Nuclear Quality Assurance (NQA) audits were not always implemented in a timely manner. Additional details of these issues are described in Observation section of this report.

Assessment	71152B
Based on the samples reviewed, the team determined that licensee performance in the use of operating experience was adequate with some opportunities for improvement. The licensee screened industry and NRC operating experience information for station applicability. Based on these initial screenings, the licensee initiated actions in the Corrective Action Program to fully evaluate the impact, if any, to the station. When applicable, actions were developed and implemented to prevent similar issues from occurring. Operating experience lessons learned were communicated and incorporated into plant operations. The team observed the information being used in daily activities, such as pre-job briefs, as well as CARD reviews and investigations. However, the team identified a number of issues regarding the timeliness of the screening and technical rigor of Operating Experience evaluations. These issues are further discussed in the Observation section of this report.	

Assessment	71152B
Based on the samples reviewed, the team determined that the licensee's performance of self-assessments and audits was adequate with some opportunities for improvement. The licensee performed department self-assessments and quality assurance audits throughout the organization on a periodic basis. These self-assessments and audits were generally effective at identifying issues and enhancement opportunities at an appropriate threshold. The self-assessments and audits reviewed by the team identified issues that were not previously known, including issues within the Corrective Action Program itself. Nuclear Quality Assurance (NQA) identified deficiencies with the licensee's processes and those issues were addressed by the station through the Corrective Action Program. However, the team identified several weaknesses between department self-assessments and NQA audits. These weaknesses were related to the ability of the self-assessment and audit programs to cause timely, lasting change and prevent more significant issues from occurring. Additional details are discussed in the Observation section of this report.	

Assessment	71152B
Based on a review of documents and interviews with licensee staff, the team did not identify any impediment to the establishment of a safety conscious work environment.	



The team reviewed the results from the 2018 Nuclear Safety Culture Assessment (NSCA) performed by the licensee, the subsequent root cause evaluation that was completed as prescribed by CARD 19-23612, "Station Leaders Have Allowed a Culture of Rationalizing and Tolerating Unacceptable Performance," and Nuclear Safety Culture Monitoring Panel meeting minutes. The team also conducted focus group meetings and one-on-one interviews with more than 50 licensee staff concerning the effectiveness of the Corrective Action Program, the ability to raise issues, and the freedom from potential retaliation for raising issues.

In general, the licensee's staff was aware of and familiar with the Corrective Action Program and other processes, such as the Employee Concerns Program, to raise nuclear safety concerns. Licensee staff indicated they could raise safety concerns without a fear of retaliation. Through the interviews and document reviews, the team was not provided or identified any examples of retaliation for raising nuclear safety concerns. Although some work groups felt that the Corrective Action Program was not effective for addressing low level issues, the staff interviewed believed that operational issues and issues with high safety significance were being appropriately addressed in a timely manner.

Observation: Evaluation Technical Rigor Weaknesses	71152B
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During this inspection, the team identified a number of examples in which the licensee's evaluations lacked technical rigor. In several cases, incorrect assumptions were used in decision-making processes such that the significance of the issue was marginalized, or the corrective actions were delayed.

For example, during the review of a Nuclear Quality Assurance (NQA) audit finding documented in CARD 19-20869, "Inadequate Control of Safety-Related Fuses Maintained and Installed by Operators," the team identified that the shift manager relied on the successful operation of safety-related systems following fuse replacements and continued satisfactory performance of surveillances as an indicator of the safety-related pedigree of the newly installed fuses. The shift manager concluded that no nonsafety-related fuses had been installed in safety-related systems. Since satisfactory performance of post-maintenance testing and surveillances was not necessarily indicative of fuse performance at designed fault or over-current conditions, the team questioned the licensee's operability conclusion. The licensee then provided an alternate basis for operability, which included operator interviews following the NQA audit finding and the procedure requirements to verify and document that correct fuses were being installed for use. However, the team noted that the NQA audit finding specifically stated that operators were not documenting the fuse replacement information and that safety-related and nonsafety-related fuses were stored in the same lockers. The licensee subsequently performed a cross-verification of safety-related and nonsafety-related fuses located in the same locker and determined that safety-related fuses did not have corresponding nonsafety-related fuses in the same locker boxes based on examining the procurement master material list. The licensee entered this issue into their Corrective Action Program as CARD 19-25794.

During the review of CARD 08-26828, "Non-Qualified Support System to Ensure Adequate Post-LOCA [Loss-Of-Coolant-Accident] Emergency Depressurization," the team noted that this issue had been identified more than 10 years ago, but had not yet been resolved. This issue was associated with the qualification of equipment relied on to mitigate a design basis small break LOCA. The licensee classified this issue as a condition adverse to quality, but considered the emergency core cooling system fully operable. Following discussions with Engineering and Operations staff, the team determined that the staff in these departments did

not have a common understanding of the issue. Operations staff stated they would follow the subject emergency operating procedure and restore the air system to containment when required to emergency depressurize the reactor pressure vessel. Engineering staff, however, understood that the air system may be available, but could not be relied upon for design basis accident mitigation because the equipment was not safety-related. This information was not shared between the two groups. It was unclear why Operations staff did not obtain that information from Engineering staff, even after the team posed the question. Therefore, the team concluded that a lack of technical rigor in the licensee's operability determination for CARD 08-26828 led to an incorrect conclusion. The licensee entered this issue into their Corrective Action Program as CARD 19-26112 and 19-26154. At the end of the inspection, no additional compensatory actions were required since the licensee had recently verified that adequate trapped air inside the drywell piping had always been available to support emergency depressurization. As a result, the team did not identify a finding or violation of more than minor significance.

Both examples highlighted a lack of technical rigor in the licensee's evaluation. As a result, incorrect assumptions were relied upon in the licensee's decision-making process. At the end of the inspection, the licensee planned to evaluate this identified weakness through the CARDS identified above.

Observation: Equipment Reliability Program Weaknesses	71152B
<p>At the time of this inspection, 14 systems were in a Maintenance Rule (a)(1) status; which was unusually high, particularly for a single unit site. The team reviewed the Maintenance Rule (a)(1) system performance recovery plans for selected systems and interviewed the station's Maintenance Rule Program coordinator. As associated with these Maintenance Rule (a)(1) systems, the team also reviewed all Tier 1 system health reports and several Tier 2 and Tier 3 system Corrective Action Program documents. The licensee utilized system health reports as a trending tool for Tier 1 systems.</p> <p>The team determined that the performance recovery plans were detailed and listed requirements and actions to return the systems to a Maintenance Rule (a)(2) status. The team concluded that the licensee had appropriately documented equipment issues that led to a Maintenance Rule (a)(1) status in the Corrective Action Program. Given that system health reports were generated only for Tier 1 systems and not considered in the Maintenance Rule review process, it was unclear if the licensee's equipment trending practices could have identified an issue and taken actions prior to reaching a Maintenance Rule (a)(1) status. The team considered this a weakness in the licensee's equipment reliability program.</p> <p>The licensee completely revised procedure FBP-41, "Equipment Reliability Program," in March 2019. This revised procedure described, "a risk informed approach that extended beyond reliability initiatives to ensure emphasis of condition-based maintenance to minimize unavailability while maximizing reliability. It included activities that were essential for effective life cycle management, by ensuring proper prioritization, scheduling, and integration into site long range plans. This process supported a zero tolerance for unplanned failures on critical equipment." The procedure provided a uniform prioritization process for a proposed change or issue. The resultant ranking provided a means to determine the projects and/or initiatives that should be funded and implemented. As a result, the licensee developed a list of modifications and changes, along with schedules for the completion of required actions. The team concluded that, if properly implemented, this new process, over time, could potentially improve equipment reliability.</p>	

Observation: Operating Experience Review Inadequacies	71152B
<p>While the licensee generally addressed Operating Experience identified by external organizations appropriately, the team identified several instances where the licensee's reviews of NRC and industry operating experience were inadequate.</p> <p>Information Notice (IN) 2017-04, "High Energy Arcing Faults (HEAF) in Electrical Equipment Containing Aluminum Components," was issued by the NRC in August 2017. The issue was entered into the licensee's Corrective Action Program as CARD 18-21869 in March 2018. However, the corrective action to investigate the use of aluminum components as documented in the CARD was still open at the time of this inspection. Upon questioning by the team, the licensee determined that the concern of aluminum increasing the effects of a HEAF were limited since the electrical design specifications and the plant's Support Engineering Practice Standards only allowed a limited use of aluminum in the electrical design of the plant. Given that the plant was designed with the separation of safety-related trains and fire areas, the licensee determined that there was reasonable assurance that the electrical systems would meet their design functions during any fault on a nonsafety-related system or a single failure of a safety-related system. The licensee entered the timeliness concern identified by the inspectors into their Corrective Action Program as CARD 19-26081.</p> <p>Information Notice 2017-06, "Battery and Battery Charger Short-Circuit Current Contributions to a Fault on the Direct Current Distribution System," was issued by the NRC in September 2017. Although the IN was subsequently entered into the licensee's database to be screened, the issue was not entered into the Corrective Action Program until March 2018. It was also noted that the evaluation performed for the IN was later found to be inadequate by an NRC inspection team in early 2019. As a result, a new evaluation was performed through CARD 19-23651, which identified an operable-but-nonconforming condition that required plant modifications. The licensee entered the timeliness concern identified by the inspectors into their Corrective Action Program as CARD 19-26102.</p> <p>Further, the inspectors identified two examples where industry operating experience did not result in an engineering evaluation, despite their potential applicability to the main steam isolation valves (MSIVs). In the first example, Licensee Event Report (LER) 2017-002 described MSIV pilot valve binding due to potential foreign material. A second example associated with LER 2018-002 described slow MSIV closure times due to foreign material introduced by the vendor during manufacturing. For the 2018 LER, the site screened the issue as not applicable to Fermi. In the case of the 2017 LER, the station had not considered the operating experience at all. After the inspectors reviewed the operating experience and questioned the site regarding their applicability, the licensee issued CARD 19-26074 to evaluate applicability since Fermi used the same vendor for the refurbishment of their equipment.</p> <p>Although the team did not identify any violations of NRC requirements, these issues represented inadequacies in the licensee's screening and evaluation of operating experience in a timely manner such that potential issues with safety-related equipment might go unnoticed. Specifically, the licensee failed to ensure that all available avenues for Operating Experience were reviewed for applicability as LERs often described issues that could pertain to other sites, especially when associated with the same vendor or with parts issues. Additionally, the licensee did not ensure that personnel with an appropriate level of expertise were reviewing issued Operating Experience, especially when specific sites were not specifically identified in the operating experience documents that were received.</p>	

Observation: Self-Assessment and Audit Weaknesses	71152B
<p>The team reviewed several department self-assessments regarding the storage and staging of material. These assessments were conducted in April 2017, October 2017, and April 2018. In April 2017, the results of a department self-assessment documented that all critical attributes concerning material storage areas and staged material were met. However, in May 2017, NQA performed an audit in the same area and identified a number of findings and, “multiple barrier failures and programmatic breakdowns,” regarding the storage and staging of material. Similarly, a department self-assessment performed in October 2017 and April 2018 documented that all critical attributes were met. However, in March 2019, NQA issued an elevation letter citing numerous issues in the storage and staging of material, and the fact that previous NQA findings had not been resolved. The team determined that this apparent disparity between the department self-assessment conclusions and the NQA findings throughout the period called into question the quality of the department reviews.</p> <p>In another example, the team reviewed a common cause analysis performed in November 2017 regarding the control of measurement and test equipment (M&amp;TE). While the common-cause analysis highlighted weaknesses in the program and instituted corrective actions that ultimately reduced the number of current issues, the team noted a history of similar M&amp;TE control issues that dated back to at least early 2015. Specifically, in January 2015, NQA performed an audit that identified issues in the control of M&amp;TE after use and in the trending of M&amp;TE deficiencies. In May 2015, a department self-assessment identified that M&amp;TE users did not understand their responsibilities for controlling M&amp;TE. In January 2016, the site identified an emerging trend in M&amp;TE that was assumed to have failed or had been lost. In June 2017, an NQA audit prompted an apparent cause analysis to address multiple gaps in the M&amp;TE calibration program and the process for the control and issuance of M&amp;TE. Finally, in October 2017, another adverse trend in the same area was identified, which led to the common cause analysis.</p> <p>The examples above demonstrated that the licensee's self-assessments and audits did not always identify performance gaps. Further, when performance issues were identified by self-assessments and audits, they sometimes recurred before being effectively addressed.</p> <p>The team also reviewed NRC finding 05000341/2018004-01 regarding a valve stem and disc that was dropped during a lifting and rigging evolution in 2018, and a subsequent formal self-assessment on lifting and rigging. This assessment identified that the previous self-assessment in lifting and rigging performed in February 2016 was not adequate. Specifically, in 2016, a lifting and rigging department self-assessment failed to identify gaps in Fermi procedures relative to industry standards. That self-assessment also failed to identify gaps in the first line supervisor's ability to monitor lifting and rigging evolutions.</p> <p>In addition to the licensee-identified issues with the 2016 assessment, the team determined that the licensee had missed an opportunity to determine whether worker behavior contributed to the 2018 stem and disc drop event. For instance, the various analyses that were performed by the licensee in response to the 2018 stem and disc drop event referred to a culture of “taking short cuts,” “having a can-do attitude that leads to poor decision-making and substandard performance,” and a failure to conduct an adequate pre-job brief. While the 2016 self-assessment included a critical attribute associated with fundamental behaviors, the focus of this assessment did not include human performance, but rather on recommended qualifications, training, and the definition of roles among crew members.</p> <p>In the three examples listed above, the team noted there were no corrective actions</p>	

developed to explore why self-assessments and audits were either inadequate or not timely in addressing problems. The team concluded that while self-assessments and audits were performed in accordance with licensee procedures, performance gaps went unnoticed or uncorrected. The team concluded that this indicated a lack of intrusiveness in the licensee's assessment and a lack of vigilance in correcting performance issues.

## **EXIT MEETINGS AND DEBRIEFS**

The inspectors verified no proprietary information was retained or documented in this report.

- On August 16, 2019, the inspectors presented the biennial problem identification and resolution inspection results to Mr. P. Fessler and other members of the licensee staff.

## DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Corrective Action Documents	05-24876	Blown Scram Pilot Fuse	08/22/2005
		07-22140	Reactor Recirculation Pump Driver Mount Drain Lines Potentially Direct Unidentified Leak Sources into the Identified Leak Path	04/19/2007
		07-23630	CDBI - UFSAR Anti-Vortex Methodology Non-Conservative	06/28/2007
		08-26828	Non-Qualified Support System to Ensure Adequate Post-LOCA Emergency Depressurization	10/15/2008
		08-27506	DC-0501 Vol 1 HPCI Key Calculation Review Results	11/11/2008
		09-26761	Key Calculation Review of DC-5490 Vol. I, Ventilation Air Quality for EDG Switchgear Room	09/01/2009
		10-28090	Reactor Building Superstructure Re-Analysis	09/14/2010
		11-29120	DC-0919 Recommended Setting Changes	10/06/2011
		11-29284	Legacy Circuit Design Associated with the RHR 4.16kV Load Shed Scheme	10/12/2011
		12-21134	Evaluate OE35219 (Preliminary – Automatic Reactor Trip and Loss of Offsite Power Due to Failed Switchyard Insulator) for Applicability to Fermi	02/10/2012
		12-23735	Main Steam Line Radiation Monitor F Cage Broken Bolts	04/24/2012
		12-24521	Review BWROG SC05-03 Analysis	05/16/2012
		12-29077	Reactor Scram Due to H2 In-Leakage to Stator Water	11/07/2012
		13-10103	Main Steam Piping Support Exceeds Design Load	06/07/2013
		13-22663	EDP - Setpoint Change is Required for the TSC Upstream HEPA Filter DP Switch	04/15/2013
		13-24841	EDG Steady State Voltage and Frequency Technical Specification Ranges	07/10/2013
		14-21857	Configuration Control Discrepancy: Drawing M-3184-1 Doesn't Reflect the Plant Configuration of the Division 2 RHRSW Piping	03/01/2014
		14-22610	Repetitive Failures of RPS Relay K17B	03/20/2014
		14-22612	EDG 11 Manually Tripped During Surveillance Test Due to Fire from Turbocharger Lagging	03/20/2014
		14-22646	EDG 11 Jacket Coolant Leak at Standby Heater Control	03/21/2014

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Switch	
		14-23829	Lube Oil Leak from Body of R3000F111B During EDG 13 Governor Vent Run	05/02/2014
		14-25670	EDG Lockwire Gauge is Inconsistent	07/11/2014
		14-27839	Warehouse Cannot Properly Store Spare MSIV Actuators	10/06/2014
		15-20167	NQA Recommendation - Benchmark and Develop Performance Metrics for M&TE Program	01/08/2015
		15-20168	NQA Recommendation - Formalize How M&TE is Turned Over After Use	01/08/2015
		15-21132	Calculation (DC-4931) Damper Minimum Air Pressure Calculation Identified Margin Issue	02/12/2015
		15-21952	Replacement CRD Pump Not Stored IAW Vendor Manual	03/17/2015
		15-22182	Warehouse Documentation Did Not Match ASME Tube Plug Heat Codes for Drywell Cooler #2	03/25/2015
		15-22883	NRC Identified Issue: EDG-14 Oil Leak	04/22/2015
		15-22949	Review and Revise SAM Program Section 3.2	04/24/2015
		15-23047	Crankcase Vacuum Tubing Cracked at Fitting	04/28/2015
		15-23171	Excessive Smoke from EDG 14 During SOP Run	05/02/2015
		15-23277	RHRSW Return from RHR HX High Temperature Alarm Setpoints Above Piping Design Temperature	05/07/2015
		15-23290	Leaking Bypass Valve	05/07/2015
		15-23679	M&TE Users Do Not Understand Responsibilities	05/27/2015
		15-24444	Jet Pump Failure AOP May be Non-Conservative	06/26/2015
		15-25177	Recommend Spare Parts for RHRSW Pump/Motor	07/27/2015
		15-26907	29.ESP.03 EOP Support Tool Box Damaged	09/27/2015
		15-27998	Discrepancy Identified in Replacement Coupling and Installed Coupling For CRD Pump Replacement	10/19/2015
		16-20417	Emerging Trend - CARDS on Assumed Failures of M&TE	01/15/2016
		16-21485	NRC Resident Question Regarding AOV T4600F406	02/17/2016
		16-21963	Switch Calibration Drift	03/02/2016
		16-23673	Independent RHRSW Inspection - Piping Calculation is Inconsistent with Drawing	05/04/2016
		16-24088	Fuel Oil Leak on EDG 11 Fuel Oil Transfer Pump B	05/18/2016

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		16-24244	Starting Air Leak Inside EDG 14 Starting Air Compressor Air Dryer	05/21/2016
		16-25611	2016 EQ Program Self Assessment Deficiency	07/14/2016
		16-25666	Lube Oil Leak on EDG 12 Flex Coupling	07/17/2016
		16-26533	2016 CDBI Issue: Non-Conformance to Licensing Bases for Evaluation of Degraded Voltage	08/17/2016
		16-26814	Inclement Weather Results in Unplanned LCO Entry, EOP Entry, and 8 Hour Report to NRC	08/27/2016
		16-27087	Additional Support Not Evaluated in Pipe Stress Calculation	09/06/2016
		16-28543	Single Rod Scram of CR 26-07	10/26/2016
		16-29549	New Spider Bearing 0.010" Larger than Previous One Installed on RHR Service Water Pump	11/29/2016
		16-29936	Siren Performance - 200 Amp Fuses	12/14/2016
		17-00469	EDG 13 Fuel Tank Room	12/23/2017
		17-20141	SPF Failed Test of Shut Down Relay from Overspeed Simulation Per WO 43631018 PM 1291	01/05/2017
		17-20163	Use of RPS Test Box May Cause Loss of RPS Function	01/06/2017
		17-21316	CCA: Steam Leaks on High Pressure Turbine 1st Stage Pressure Instrument Lines	05/16/2017
		17-21382	RERP Drill 02/14/17: Failure of Follow-Up Notifications Objective	02/17/2017
		17-21385	Common Cause Evaluation: Negative Trend Seen in Follow-Up Notifications Performance	05/11/2017
		17-22078	Evaluate the Impact on EAL Threshold Values EP-101 Based on OCDM Revision	03/15/2017
		17-22236	CCA: Trend in Radiation Protection TPE Failures	05/10/2017
		17-23685	Common Cause Evaluation: Emerging Trend - Mispositionings in Operations	06/02/2017
		17-23736	Adverse Trend - Foreign Material Exclusion	04/20/2017
		17-24655	EACE: Failure of E1150F068B, Division 2 RHRSW HX Outlet FCV to Open	2
		17-24758	NQA Audit Finding - Repeat Finding on Improper Controls of Safety-Related (QA1) and Non-Safety (NQ) Material	05/23/2017
		17-24845	Several DevonWay Operating Experience Evaluations are	05/25/2017



Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Overdue	
		17-25157	Division 2 RHRSW is Exceeding Maintenance Rule Performance Criteria	06/08/2017
		17-25383	NQA Audit 17-0107 Finding - Procedures for M&TE Calibration Methods Not Properly Approved and Controlled in Accordance with QA Program	06/16/2017
		17-25480	NRC Information Notice 2017-03	06/21/2017
		17-25545	10 CFR Part 21 for NUMAC PRNM 386SX Computer Module and ASP Module	06/23/2017
		17-26069	E1150F068B Monitoring and Inspection WOs Needed	07/19/2017
		17-26338	NQA Audit 17-0110 Deficiency - Radioactive Material (RAM) Control Gaps and Inconsistencies	07/27/2017
		17-26340	NQA Audit 17-0110 Deficiency - Poor Housekeeping Inside Contaminated Areas	07/27/2017
		17-26351	Received 17D41 For Division 2 DW Temperature High	07/27/2017
		17-26708	Division 1 CCHVAC Supply Fan Vibration Trend	08/09/2017
		17-26894	NRC Identified Issue with Firearms Instructor Qualification	08/16/2017
		17-27148	2017 NRC FP Triennial: Review FPPEE-16-0001 to Determine if the Addition of Steps to 20.000.18 Have an Impact on Time Critical Operator Actions	08/25/2017
		17-27225	Elevated Dose Rates Observed Coming From the FPCCU Precoat Tank	08/29/2017
		17-28757	Cognitive Trend in Maintenance - Assumed Failures of M&TE	10/26/2017
		17-29262	NRC RIS 2017-05: Administration of 10 CFR Part 72 Certificate of Compliance	11/16/2017
		18-00690	EDG 11 Engine Room	08/22/2018
		18-00983	Standby Heating Discharge Control Temperature Switch is Leaking for EDG 14	11/28/2018
		18-20628	NRC Issues Regulatory Issue Summary 2018-01 on 10 CFR Part 37 Issues	01/24/2018
		18-20786	NRC ENS Phone Not Communicating Correctly	01/29/2018
		18-21062	Continuing Vibration Trend Division 1 CCHVAC Supply Fan Motor	02/07/2018
		18-21062-01	Complete MPFF Evaluation on Division 1 CCHVAC	02/27/2018

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		18-21869	(OE 2017-0395) NRC Information Notice 2017-04 - High Energy Arcing Faults in Electrical Equipment Containing Electrical Components	03/06/2018
		18-22371	Leak Identified on R3001C006	03/21/2018
		18-22931	Dry Cask Noble Fission Gas Release Response Strategy	04/11/2018
		18-24354	Oil Leak from Flange Supplying EDG #11 LO Filter	06/01/2018
		18-24437	EACE: EDG 11 Lube Oil Leak	08/23/2018
		18-25713	Equipment Cause Evaluation: Recirc Pump Seal Purge Relief Valve B3100F015B Repetitive Failures	08/24/2018
		18-27810	Increased Dose Rates Experienced During RF19	10/04/2018
		18-28008	Organizational Effectiveness Evaluation: Unexpected Dose Rate Conditions After Opening the G3352F001	10/08/2018
		18-29027	Root Cause Evaluation Report: E1150F068B Did Not Close as Expected	01/16/2019
		18-29102	2018 NSCA Results - Trait CO.2 Basis for Decisions	11/07/2018
		18-29367	Part 21 for ITT Conoflow for GT25 Current to Pressure Transducers	11/19/2018
		18-29568	New Replacement Stem and Disc Dropped from Rigging with Personnel Injury	11/29/2018
		18-29620	2018 LIR Reactor Recirculation - Seal Purge Relief Valves	11/30/2018
		18-29672	EDG 14 Air Coolant Hx Leaking Coolant	12/02/2018
		18-29775	Clogged Drain Lines Resulting in Multiple Leaks	12/07/2017
		18-29870	Reactor Building to Suppression Chamber Vacuum Breaker UFSAR Nonconformance	12/08/2018
		18-30322	EDG 13 JCS STBY Circulating Pump Seal Leaking	12/21/2018
		18-30330	Adverse Trend in Lifting and Rigging Practices	12/21/2018
		18-30400	NQA – Valve R3000F118B (Lube Oil Source Valve for R30NA11B) Has Slight Weeping	12/27/2018
		19-00209	130 DPM Leak from EDG 11 Coolant Standby Heating - Low Temp SW Elec	04/08/2019
		19-20549	EDG 13 Standby Lube Oil Pump Leak	01/24/2019
		19-20652	Provide Additional Training/Information Regarding the Purpose and Value of the Site Corrective Action Process	01/29/2019
		19-20869	NQA Audit 19-0101 Finding: Inadequate Control of Safety-	02/06/2019

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Related Fuses Maintained and Installed by Operations	
		19-21169	NRC Finding - Inadequate Lifting and Rigging Practices Result in Damage to Division 2 Residual Heat Removal Structures and Components	02/15/2019
		19-21335	Operations Department Reset for Unacceptable Performance	02/20/2019
		19-21397	#1 and #9 Cylinder Liner Indicator Valve Adapter O-Rings Found Leaking During Hydrostatic Test	02/22/2019
		19-21433	NRC Violation - Inadequate Work Instructions for Maintenance on EDG 14	02/25/2019
		19-21685	NQA Elevation-Leaders Actions Have Been Insufficient in Correcting Fundamental Worker Behaviors for the Control and Traceability of Safety-Related Material, Parts, and Components	03/05/2019
		19-21969	Strategic Engineering Identified Part 21 Issue on Safety-Related 4160V-480 Dry Transformers	03/13/2019
		19-22077	EDG 13 Strategic Engineering Walkdown	03/18/2019
		19-22412	SLC Ignition Continuity Loss Squib A	03/28/2019
		19-22895	Evaluate Impact of Part 21 on SF-1154 Hydraulic Fluid Used in Power Piping Snubbers	04/16/2019
		19-23227	Recommend Review of Site Response to Open CARD 07-23630	04/26/2019
		19-23602	2019 AFI Station Leaders Have Not Corrected Worker Behaviors Affecting Plant Status Control	05/09/2019
		19-23612	Root Cause Evaluation of Culture that Allowed Rationalizing and Tolerating Unacceptable Worker and Plant Performance	05/09/2019
		19-23651	2019 DBAI: Information Notice IN 17-06 - Battery Chargers (Ametek Chargers) May Contribute up to 10 Times their Rating for a Short Period	05/10/2019
		19-23897	No Tie-Down and/or Securing Devices Within the Off-Site RET Team Van to Safely Secure Cargo	05/20/2019
		19-24015	INPO Operating Experience Report for Exporting Radioactive Material RIS 19-01 Clarification	05/24/2019
		19-24107	Secondary Containment Doors Open at the Same Time	05/30/2019
		19-24316	Tagouts/Protection Putting Operators at Risk	06/05/2019

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		19-24655	DevonWay Errors Preventing Operating Experience Evaluations from Being Properly Closed Out	06/20/2019
		19-25978	2019 PI&R NRC Inspection Observation: CARD 19-24107 AI #4 Closure	08/07/2019
		19-25988	2019 PI&R Inspection NRC Observations: Maintenance Programs	08/07/2019
		19-25989	2019 PI&R Inspection NRC Observations: Potential Missed Opportunities to Address Maintenance Behavioral Gaps	08/07/2019
		19-26074	2019 PIR - Evaluate Monticello MSIV OE	08/12/2019
		19-26080	OE Review in DevonWay is Past Due	08/12/2019
	Corrective Action Documents Resulting from Inspection	19-25794	2019 PI&R Inspection - CARD 19-20869 Quality Less Than Adequate to Support Conclusion of Reasonable Assurance	08/01/2019
		19-25794	2019 PI&R Inspection - CARD 19-20869 Quality Less Than Adequate to Support Conclusion of Reasonable Assurance	08/01/2019
		19-25840	2019 NRC PI&R Inspection: NRC Identified Hanging Oil Drops on EDG 11 Upper Air Start Distributor	08/02/2019
		19-25840	NRC Identified Oil Drops on EDG 11 Upper Air Start Distributor	08/02/2019
		19-25933	Spec 3071-128-EJ Identified with a Deficiency	08/06/2019
		19-25978	2019 PI&R NRC Inspection (Observation) - CARD 19-24107 AI #4 Closure	08/07/2019
		19-25978	CARD 19-24107 AI #4 Closure	08/07/2019
		19-25988	Maintenance Programs	08/07/2019
		19-25988	2019 PI&R Inspection NRC Observations: Maintenance Programs	08/07/2019
		19-25989	2019 PI&R Inspection NRC Observations: Potential Missed Opportunities to Address Maintenance Behavioral Gaps	08/07/2019
		19-25989	Potential Missed Opportunities to Address Maintenance Behavioral Gaps	08/07/2019
		19-25993	2019 PI&R - Disposition of Paragon Labs Failure Analysis Report TR1801449-01-0 Recommendations	08/08/2019
		19-26074	2019 PI&R - Evaluate Monticello MSIV OE	08/12/2019
		19-26074	Evaluate Monticello OE	08/12/2019
		19-26081	2019 PI&R: Review of IN 2017-04 Has Not Been Completed	08/12/2019

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			in a Timely Manner	
		19-26102	2019 PI&R: IN 2017-06 Not Reviewed in a Timely Manner	08/13/2019
		19-26103	2019 PI&R	08/13/2019
		19-26112	2019 PI&R - RFI-083: Discuss CARD 08-26828 Assurance of Operability	08/13/2019
		19-26139	2019 PI&R Inspection Insight on Part 21 Screening Practices	08/15/2019
		19-26140	2019 PI&R Inspection - Insight on Evaluating Effectiveness of Previous Self Assessments	08/15/2019
		19-26141	2019 PI&R NRC Inspection (Observation) – Confidence in CAP	08/15/2019
		19-26143	2019 PI&R NRC Inspection (Observation) - Personnel Associating SCWE with Industrial Safety Not Nuclear Safety	08/15/2019
		19-26154	2019 PI&R Inspection - NRC Team Observation Related to Older Open CARDS	08/15/2019
		19-26179	2019 PI&R Inspection Concluded Fermi's Corrective Action Program is Marginally Effective	08/16/2019
	Drawings	6I721N-2578-06	Relaying & Metering Diagram Diesel Generator #11 Unit 2	X
		6M721-5007	Diagram Primary Containment Pneumatic Supply System	Z
		6M721-5988	Operator Time Critical Actions and Design Basis Sheet 1	E
	Engineering Changes	EDP-70032	Replacement of Bussmann MIN-3 Fuses with Bussmann BBS-3 Fuses at C71P002B, D, F	0
		TSR-36584	Re-Classify Auxiliary Building Superstructure as Seismic II/I	0
		TSR-37859	Reconciled Design Loads	0
	Engineering Evaluations	17-22857	Apparent Cause Evaluation: Degraded Reactor Building Pressure Due to OPDRVs	05/16/2017
		18-23026	Root Cause Evaluation: Reactor Scram Due to Loss of 64 Transformer	04/16/2018
	Miscellaneous		2019 CARD Backlog - July	
			Compensatory Monitoring Plan - 3D11 SLC Ignition Continuity Loss/Circuit A Continuity Light is Off	03/29/2019
			2017 CARD Backlog End of Year	
			D&Z Safety Conscious Work Environment Survey Results	05/29/2019
			USA NSCA Survey Organization Level and Department Statistics	08/10/2018

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Spring 2019 Fermi Employee Engagement Overview	05/06/2019
			Listing of Systems in Maintenance Rule (a)(1) Status	07/15/2019
			2018 CARD Backlog End of Year	
		16-0262	50.59 Screening - Revision to Programming of T41R800A/B Recorder	0
		ECP-19-001 (0801.26)	2019 First Quarter Report - Employee Concerns Program	04/30/2019
		LER 17-22425	NRC 1 Hour-Reportable Physical Security (10 CFR 73.71)	03/23/2017
		LER 17-24655	Division 2 RHR HX SW Outlet FCV Failed to Open	05/22/2017
		LER 18-20257	Reactor Building Pressure > -0.125" During a Planned Swap of Two Train to Single Train RBHVAC	01/11/2018
		LER 18-28457	RHR Pump "C" Tripped After Auto Start During 24.307.02	10/18/2018
		LER 19-21227	AB5-RB5 Interlock Switch Needs Adjustment	02/16/2019
		Monticello Nuclear Generating Plant LER 2017-002-00	Main Steam Isolation Valve Closure Time Outside of Technical Specification Requirements	00
		Monticello Nuclear Generating Plant LER 2018-002-00	C Outboard Main Steam Line Isolation Valve Delayed Closure Due to Foreign Material in the Air Valve	00
		NAPI-18-0016	2018 Nuclear Safety Culture Assessment Report	11/01/2018
		NQA 17-0114	Nuclear Quality Assurance Audit Report, Nuclear Quality Assurance Audit of the Corrective Action and Operating Experience Programs	11/06/2017 - 11/17/2017
		NQA 18-0113	Nuclear Quality Assurance Audit Report, Quality Assurance Audit of the Corrective Action and Operating Experience Programs	11/05/2018 - 11/16/2018
		OE 2018-0012	RIS17-08, Process for Scheduling and Allocating Resources	01/08/2018
		SCR-37770	Revision to Programming of T41R800A/B Recorders	0
	Procedures	24.307.14	Emergency Diesel Generator 11 - Start and Load Test	55
		24.307.30	Emergency Diesel Generator No. 11 - 24 Hour Run Followed by Hot Fast Restart	38
		24.307.47	Emergency Diesel Generator 13 - Fast Start Followed by	13

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Load Reject	
		29.100.01 Sh 1	RPV Control	17
		29.100.01 Sh 3	RPV Flooding, & Emergency Depressurization	13
		29.100.01 Sh 4	RPV Alternative Level/Pressure Control	12
		35.000.224	Alignment and Tension Adjustment of V-Belt Driven Equipment	39
		42.307.02	Logic System Functional Test of Division 2 EDG ECCS Emergency Start Circuits and Automatic Trip/Bypass Circuits	34
		ARP 1D30	RHR HX A Cooling H2O Discharge Temperature High	5
		ARP 2D35	RHR HX B Cooling H2O Discharge Temperature High	7
		FBP-41	Equipment Reliability Program	34
		MMR Appendix D	Guidelines for Determining Functional Failures and Maintenance Preventable Functional Failures	20
		MMR Appendix F	Maintenance Rule Performance Criteria	22
		MMR02	Maintenance Rule Program Description	6A
		MMR06	Establishing Performance Criteria	8
		MMR09	Establishment of Get Well Plans	17A
		MQA11	Corrective Action Program	47
		MQA11-200	Condition Initiation	1A
		MQA11-300	Screening and Assignment	2
		MQA11-400	Corrective Action Program Condition Disposition	1
		MQA11-500	Non-Corrective Action Program Condition Dispositions	1
		MQA11-500	Quality Assurance Conduct Manual Implementing Procedure Non-Corrective Action Program Condition Disposition	1
		MQA15	Quality Assurance Conduct Manual, Apparent Cause Evaluations	19
	Self-Assessments	17-0113	Quality Assurance Audit of the Equipment Reliability Program	10/31/2017
		17-0114	Nuclear Quality Assurance Audit Report - Corrective Action and Operating Experience Programs	12/18/2017
		18-0110	Nuclear Quality Assurance Audit of the Radiological Effluents, Radiological Material Transfer and Disposal, and Radiation Protection Programs	08/27/2018
		18-0113	Nuclear Quality Assurance Audit Report - Corrective Action &	12/14/2018

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			Operating Experience Programs	
		2019Q1	Maintenance Continuous Learning Report	03/31/2019
		NAPI-18-0014	Quick Hit Self-Assessment - CARD Closure Quality	09/28/2018
		NAPI-19-0006	Focused Self-Assessment - Corrective Action Program	03/29/2019
		NAQA-15-0001	NQA Special Oversight - M&TE	01/08/2015
		NARP-17-0230	NRC Performance Indicator Comparative Analysis	05/03/2017
		NARP-18-0155	Simulator Notifications Performance Assessment	05/15/2018
		NPMA-16-0028	Focused Self-Assessment Report: Rigging, Lifting, and Material Handling	02/22/2016
		NPMA-19-0023	Focused Self-Assessment Report: Lifting and Rigging Program	04/17/2019
		NPOP-17-0066	Review of B.5.b Strategies	08/10/2017
		NPOP-18-0466	Effectiveness Review for CARD 17-27545	05/22/2018
		NPRP-18-0039	Quick Hit Self Assessment: Occupational ALARA Planning and Controls	03/29/2018
		NSSC-17-0006	Quick Hit Self-Assessment: Material Storage and Staging	04/27/2017
		NSSC-17-0019	Quick Hit Self-Assessment: Material Storage and Staging	10/31/2017
		NSSC-18-0002	Quick-Hit Self Assessment: Material Storage and Staging	04/16/2018
		TMPE-18-0084	Quick Hit Self Assessment: Configuration Management and Temporary Alterations	06/15/2018
	Work Orders	25971306	Replace Scram Pilot Solenoid Fuses in C71P002F Per EDP-70032	11/28/2018
		25971310	Replace Scram Pilot Solenoid Fuses in C71P002B Per EDP-70032	11/28/2018
		26809154	Replace Scram Pilot Solenoid Fuses in C71P002D Per EDP-70032	11/28/2018
		37662340	Implement Mounting Configuration Change for EDG 14 Emergency Overspeed Switch	04/23/2015
		46561773	Division 1 Reactor Building Differential Pressure Recorder Response	12/23/2016
		46671775	Implement a Software Change Request for T41R800B	12/23/2016