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

January 19, 2012

Mr. Vito Kaminskas
Site Vice President
FirstEnergy Nuclear Operating Company
Perry Nuclear Power Plant
P. O. Box 97, 10 Center Road, A-PY-A290
Perry, OH 44081-0097

SUBJECT: PERRY NUCLEAR POWER PLANT – NRC REVIEW OF LICENSEE ACTIONS TO ADDRESS IDENTIFIED SUBSTANTIVE CROSS-CUTTING ISSUES IN HUMAN PERFORMANCE - INSPECTION REPORT 05000440/2011012

Dear Mr. Kaminskas:

On December 9, 2011, the U. S. Nuclear Regulatory Commission (NRC) completed an Inspection Procedure 92702 team inspection to review licensee actions to address identified substantive cross-cutting issues in human performance with cross-cutting themes in the components of Work Planning (H.3(a)) and Resources (H.2(c)) at your Perry Nuclear Power Plant (PNPP). The enclosed report documents the inspection results, which were discussed on December 9, 2011, with you and other members of your staff.

A human performance area substantive cross-cutting issue was first opened in our March 3, 2008, end-of-cycle assessment letter [ADAMS Ref. ML 080600303]. In our 2010 end-of-cycle assessment letter [ADAMS ML110620306] dated March 4, 2011, we advised you of our intent to perform Inspection Procedure 92702, "Followup on Corrective Actions for Violations and Deviations," to evaluate whether adequate corrective actions have been implemented for the human performance substantive cross-cutting issue(s); to verify that the root causes of these issues have been identified; to determine that generic implications have been addressed; and to determine that your programs and practices have been appropriately enhanced to prevent recurrence. On June 7, 2011, you advised us that you needed additional time to prepare for this inspection and requested rescheduling until later in 2011. As a result, we asked you to provide us a written statement of your readiness for this inspection by October 1, 2011.

Your September 30, 2011, letter to us stated that PNPP was ready for our inspection of the effectiveness of corrective actions taken to address the long-standing human performance substantive cross-cutting issues at the PNPP. Our plan was to perform our inspection during November 2011. Our final plan, which was coordinated with members of your staff, was to conduct the onsite portion of the inspection during the week of December 5, 2011. This time shift was to permit your staff additional time to complete in-progress cause evaluations. However, during the onsite inspection, the inspectors were informed that the root cause evaluation addressing the licensee's inability to effectively close long-standing substantive cross-cutting issues was not complete. In addition, focused root causes for H.2(c) and H.1(b) [conservative decision making] were still ongoing. A focused root cause evaluation on H.3(a) had been completed and corrective actions had been taken.

Based on the results of this inspection and the data reviewed, no findings were identified. However, the inspectors could not complete all of their inspection objectives, because needed cause evaluations, germane to the areas being inspected, were not completed. The inspectors could not conclude that your current actions would address the underlying causes of the human performance issues as related to findings in H.2(c); and potentially in H.1(b). Follow on inspection will be required by the NRC. The specifics will be discussed in a separate letter.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and 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 (PARS) component of NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

John B. Giessner, Chief
Branch 4
Division of Reactor Projects

Docket Nos. 50-440
License Nos. NPF-58

Enclosure: Inspection Report 05000440/2011012
w/Attachment: Supplemental Information

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-440
License No:	NPF-58
Report No:	05000440/2011012
Licensee:	FirstEnergy Nuclear Operating Company (FENOC)
Facility:	Perry Nuclear Power Plant, Unit 1
Location:	Perry, Ohio
Dates:	December 5 – 9, 2011
Inspectors:	J. Rutkowski, Project Engineer, Team Lead T. Briley, Reactor Engineer
Approved by:	J. Giessner, Chief Branch 4 Division of Reactor Projects

Enclosure

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SUMMARY OF FINDINGS

Inspection Report 05000440/2011012; 12/05/2011 - 12/09/2011; Perry Nuclear Power Plant, Unit 1; Followup on Licensee Actions to Address Identified Substantive Cross-Cutting Issues in Work Planning H.3(a) and Documentation/Procedures H.2(c).

This inspection was performed by two NRC regional inspectors. No findings of significance were identified by the inspectors. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Human Performance

During the onsite inspection, the inspectors were informed that the root cause assessment addressing the licensee's inability to effectively close long-standing substantive cross-cutting issues was not complete. In addition, a focused root cause for addressing human performance aspects H.2(c) [documentation/procedures] and one for H.1(b) [conservative decision making] were still ongoing. A focused root cause evaluation on H.3(a) [work planning] had been completed and corrective actions had been taken. The inspection did not identify any issues with licensee corrective actions and conclusions with respect to addressing issues specifically associated with H.3(a). However, because cause evaluations germane to the areas being inspected were on-going during the onsite portion of the inspection, the inspectors could not complete all of their inspection objectives. Additionally, with the number of human performance issues identified by the NRC and licensee, the inspectors could not conclude that the licensee actions taken at the time of the inspection would address the underlying causes of the human performance issues as related to findings with H.2(c) [documentation/procedures] and potentially H.1(b) [conservative decision making] aspects.

A. NRC-Identified and Self-Revealed Findings

No findings were identified.

B. Licensee-Identified Violations

No violations of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA5 Review Of Licensee Actions To Address Identified Substantive Cross-Cutting Issues

.1 Background

A human performance area substantive cross-cutting issue was first opened in our March 3, 2008, end-of-cycle assessment letter [ADAMS Ref. ML 080600303]. In our end-of-cycle assessment letter [ADAMS ML110620306] dated March 4, 2011, we documented a continuing substantive cross-cutting issue (SCCI) in the area of human performance with cross-cutting themes of work planning, (H.3(a)) and documentation/procedures, (H.2(c)). The licensee was advised that the human performance substantive cross-cutting issue would remain open until the number of findings with H.2(c) and H.3(a) aspects were reduced and the licensee demonstrated the implementation of effective corrective actions that result in sustained performance improvement in the human performance area. We also stated that the NRC would perform Inspection Procedure 92702, "Followup on Corrective Actions for Violations and Deviations," to evaluate whether adequate corrective actions have been implemented for the human performance substantive cross-cutting issue; verify that the root causes of these issues have been identified; that their generic implications have been addressed; and that Perry Nuclear Power Plant (PNPP) programs and practices have been appropriately enhanced to prevent recurrence.

On June 7, 2011, PNPP advised us that additional time was needed to prepare for followup inspection and requested rescheduling until later in 2011. As a result, PNPP was asked to provide a written statement of their readiness for the followup inspection by October 1, 2011. On August 10, 2011, the NRC completed its mid-cycle performance review of the Perry Nuclear Power Plant [ADAMS ML112440084]. That review concluded that performance at the Perry Nuclear Power Plant during the assessment period continued to exhibit weaknesses in the area of human performance. Additionally, we stated that each theme identified in our end-of-cycle assessment letter would now be classified as a separate substantive cross-cutting issue. Inspection Manual Chapter (IMC) 0305 was recently revised to represent multiple substantive cross-cutting issues in the same cross-cutting area individually and not combined into one overall SCCI for that cross-cutting area.

By letter dated September 30, 2011, the licensee stated that PNPP was ready for the NRC inspection of the effectiveness of corrective actions taken to address the long-standing human performance substantive cross-cutting issues at the PNPP. The NRC inspection plan was to perform an inspection the week of November 14, 2011. Our final plan, which was coordinated with members of your staff, was to conduct the onsite portion of the inspection during the week of December 5, 2011. This time shift was to permit your staff additional time to complete in-progress cause evaluations.

.2 Overall Inspection Scope

To evaluate whether corrective actions have been implemented for the human performance substantive cross-cutting issues; verify that the root causes of these issues

have been identified; that their generic implications have been addressed; and that the licensee's programs and practices have been appropriately enhanced to prevent recurrence. Specifically:

a. Corrective Actions. Determine whether:

- Licensee management has assigned responsibility for implementing corrective actions, including any necessary changes in procedures and practices.
- Corrective actions have been fully implemented.
- Followup actions were initiated for deviations noted in any recent Quality Assurance (QA) audits (or self-assessments) conducted by the licensee of the inspection area.

b. Root Cause Analysis. Review the adequacy of the licensee's analysis.

c. Generic Implications Analysis. Review the adequacy of the licensee's analysis.

.3 Findings and Observations

.a Overall Assessment of the Corrective Action Program Effectiveness for Addressing Human Performance Issues

The substantive cross-cutting issues associated with NRC aspect H.2(c) [documentation/procedures] and H.3(a) [work planning] are part of the cross-cutting area of human performance and have been recurring themes at PNPP. Also identified by the licensee and the inspectors was a recent trend in issues over the last four quarters associated with NRC aspect H.1(b) [conservative assumptions in decision making]. The licensee advised the inspectors that steps were taken to improve station and individual performance accountability and human performance. The plant has about 30 people to act as human performance advocates; several of whom talked to the inspectors, and displayed enthusiasm for improving human performance. The inspectors were also informed that plant management had recently asked people to 're-commit'/re-affirm commitment to improving station performance. One element of the overall effort was to encourage additional coaching, peer-to-peer and others, to workers. Part of that effort was using the Keep Improving Performance (KIP) process.

In discussions with the inspectors, plant personnel consistently stated that they saw a need for performance improvement, had seen improvements, but also said that they and the station were not where they wanted to be. Several groups, however, expressed a reluctance to document their coaching in a database that would or could be viewed by management. Additionally, several individuals expressed a concern with overall alignment on the process and the need for improvement. One individual expressed the concern that straight line alignment did not exist from top management to the working level. Another individual stated that the top management believed in the need for improvement along with the craft personnel, but questioned if people between those levels were aligned with the need.

The inspectors determined that the licensee was implementing actions to improve overall human performance, but results seen at the time of inspection were not sufficient for the inspectors to conclude that actions would be sufficient to address recurring human performance issues. Report sections below address items specifically reviewed

for the currently identified substantive cross-cutting issues identified by NRC and documented most recently in the August 10, 2011, NRC 2011 mid-cycle performance review of the PNPP.

.b Assessment of the Corrective Action Program Effectiveness for Addressing Substantive Cross-Cutting issues

(1) Work Control Aspect H.3(a)

Work Control aspect H.3(a), is defined in IMC 0310, "Components Within the Cross-Cutting Areas," as the licensee plans and coordinates work activities, consistent with nuclear safety. Specifically (as applicable) the licensee appropriately plans work activities by incorporating: risk insights; job site conditions, including environmental conditions which may impact human performance; plant structures, systems, and components; human-system interface; or radiological safety; and the need for planned contingencies, compensatory actions, and abort criteria.

a. Inspection Scope

The inspectors reviewed licensee root cause evaluations Condition Report (CR) 08-32972; CR 09-58110; and CR 09-55801 and other documents that identified various work control weaknesses at both an organizational and individual level. Those reviews and discussions with licensee personnel were to evaluate whether adequate corrective actions have been implemented for the H.3(a) substantive cross-cutting issue; verify that the root causes of these issues have been identified; that their generic implications have been addressed; and that the licensee's programs and practices have been appropriately enhanced to prevent recurrence.

Documents reviewed are listed in the Attachment to this report.

b. Assessment

Weaknesses were identified by the licensee with regard to less than adequate management monitoring of the use of human performance error prevention tools, providing feedback to ensure expectations are met, and establishing individual and site accountability for improving human performance. As a whole, PNPP had lacked a strategic approach to reduce the frequency of human error events and to reduce the severity of the events by providing adequate defense-in-depth. Additional weaknesses were identified in risk perception and mitigation. In particular, the use of pre-job briefs, effectively using jumpers and cables, and planning outage work activities with appropriate risk insights were less than adequate and were tolerated as such. The NRC determined the weaknesses identified by the licensee were consistent with the NRC's assessment.

Various corrective actions have been implemented to address the root cause evaluation results and the H.3(a) substantive cross-cutting issue in work control. Clearer expectations for pre-job brief conduct and management expectations on the use of human error-prevention tools have been established. Interviews with site personnel, in particular radiological protection, indicated that more thorough and reverse-style briefings were common and that high-intensity training focusing on human performance has been beneficial in preventing and/or identifying human error traps before they occur. Approximately 30 human performance advocates representing each department at the

working level have re-emphasized the use of error-prevention tools during work preparation and work performance, and were providing valuable feedback in addition to enhancing cross-disciple human performance alignment.

Personnel interviewed by the NRC from Chemistry, Operations, Maintenance Mechanical, Maintenance Electrical, Instrumentation and Control, Radiological Protection, and Security, all indicated that peer-to-peer coaching was encouraged and actively used; although not all of the staff formally documented their observations in the KIP program intended to track and document actual observations and coaching out in the field. The protected equipment process has been revised to strengthen controls, access requirements, and limitations for work being performed on protected equipment. Efforts have been made to identify, prioritize, and implement engineered solutions in order to eliminate the use of difficult jumpers, lifted leads, and other maintenance and test equipment connections. Personnel interviewed from electrical maintenance, instrumentation and control, and mechanical maintenance expressed relatively positive feedback on the revised protected equipment controls and the relocation of difficult test equipment connections for easier access. Moving forward, corrective actions and monitoring/response mechanisms were put in place to ensure that improved performance continues through the changes made to site procedures, training, and management oversight techniques.

In general, the corrective actions that resulted from the licensee root cause evaluations indicate that there has been a trend of continued improvement in H.3(a). In particular, the number of NRC findings with cross-cutting aspects in H.3(a) has decreased each quarter since second quarter 2010. The last NRC finding with a H.3(a) cross-cutting aspect was assigned in third quarter 2010 and has since remained at zero. Additionally, licensee cross-cutting aspect precursors (XCAP), which track cross-cutting aspects at a lower threshold than the level of an NRC finding, indicate only three NRC-identified or self-revealed items over the period of November 2010 to October 2011. This number is a continued decrease from the eight H.3(a) XCAP precursors in 2009 and four H.3(a) XCAP precursors in 2010. Overall, for H.3(a) the inspectors did not identify any areas that would contradict the licensee's root cause analyses and the corrective actions taken appear to be appropriate.

c. Findings

No findings were identified.

(2) Resources Aspect H.2(c) Documentation/Procedures

Resources aspect H.2(c) is defined in IMC 0310, "Components Within the Cross-Cutting Areas," as the licensee ensures that personnel, equipment, procedures, and other resources are available and adequate to assure nuclear safety. Specifically, those necessary for complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components.

a. Inspection Scope

The inspectors reviewed CR 2011-89187, "NRC Cross-Cutting Theme for Human Performance Aspect H.2.c Resources", Snapshot Assessment SN-SA-11-229, "Cross-Cutting Aspects of NRC Inspection Report Findings," and various documents that either mentioned those documents or documents that supported information within

the aforementioned documents. The inspectors also reviewed select CRs that directly addressed some of the specific events where documentation (H.2(c)) was identified as associated with the issue. Those reviews and discussions with licensee personnel were to evaluate whether corrective actions have been implemented for the H.2(c) substantive cross-cutting issue; verify that the root causes of these issues have been identified; that their generic implications have been addressed; and that licensee's programs and practices have been appropriately enhanced to prevent recurrence.

Documents reviewed are listed in the Attachment to this report.

b. Assessment

Condition Report 2011-89187 focused on the quality of procedures attributing many of the issues with procedure quality to lack of commitment to working down backlogs and inferring that a part of the problem was that the last time that training was really conducted for procedure writers was 5 years ago. The CR also implied that there were no issues with work order packages, because there was continuing training for work planners. The CR also documented the recommendations from an INPO assist visit to improve procedure quality.

Inspectors' discussions with licensee work groups did show that work groups were prioritizing their procedure backlogs and were slowly working down the backlogs. However, there was no consensus from those discussions that a lack of training contributed to having continuing issues with underlying causes of poor or inadequate documentation. The inspectors were told that many procedure writers had attended various training classes, but that it was not documented in the station database because the training was not officially recognized in an accredited training program. Also, several people stated that they thought there were issues with work order packages, although there was no data presented to us to specifically support that statement. Condition Report 2011-89187 seemed to address specific issues but did not, in the inspector's view, look into the why the conditions were allowed to develop at the station. The station had a H.2(c) substantive cross-cutting issue identified in the first quarter of 2009 through the first quarter of 2010. This current substantive cross-cutting issue was again identified in the first quarter of 2011 from the NRC's 2010 end-of-cycle assessment.

Assessment SN-SA-11-229 questioned if the licensee totally understood the reasons for the continuation of findings with H.2(c) aspects and if corrective actions had been developed that would minimize further findings with H.2(c) aspects. That assessment was scheduled to be completed by June 2011 but the assessment results were not approved until November 2011. The inspectors were advised that the statements within the assessment were basically correct and for that reason other CRs and evaluations were being undertaken. These CRs and evaluations were to investigate the reasons for the findings and why it was taking the licensee so long to close the substantive cross-cutting issue in H.2(c). Those assessments and evaluations were not available at the conclusion the NRC inspection.

The inspectors did note that the licensee currently had three (one from a recently completed team inspection) NRC findings with a cross-cutting aspect of H.2(c) and also three NRC findings with a cross-cutting of H.1(b) [conservative assumptions in decision making]. Also, the licensee's "cross-cutting aspect precursors" performance indicator,

for the period of November 1, 2010, through October 31, 2011, showed nine NRC-identified or self-revealed and eight licensee identified H.2(c) items.

The licensee provided the inspectors a document in which the licensee concluded that current station performance, to the date of the inspection, showed improvement in the area of Resources/Documentation H.2(c); that moving forward other corrective actions would focus on improving the procedure quality and reducing backlogs of procedure document change requests; and that there were additional root cause evaluations in process to understand and address organization issues associated with the station's inability to permanently address substantive cross-cutting issues in a timely manner.

The inspectors found that the licensee had programs and processes to slowly reduce procedure backlogs, and have other actions in place, such as the renewed/re-invigorated commitment to human performance, to address human performance issues. The inspectors could not conclude, however, that the actions taken by the licensee will correct the underlying causes of the human performance issues as related to NRC findings in H.2(c) based on the continued issues with human performance associated with documents; and the need, as identified by the licensee, for further evaluation. Also, from the inspector's assessment, and licensee identified precursors, it appeared that the underlying causes had not been addressed nor had actions been in place long enough to bring about the desired effects. Thus, while some corrective actions might be effective, the inspectors found no evidence to show that these corrective actions would be effective in reducing H.2(c) human performance issues and sustaining that reduction.

c. Findings

No findings were identified.

4OA6 Management Meetings

Exit Meeting Summary

On December 9, 2011, the inspectors presented the inspection results to Mr. Kaminskas 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.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

V. Kaminskas, Site Vice-President
R. Coad, Manager, Regulatory Compliance
J. Grabner, Site Operations Director
M. Stevens, Maintenance Director
L. Zerr; Response Team

Nuclear Regulatory Commission

M. Marshfield, Senior Resident Inspector, Perry Nuclear Power Plant

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened/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 of 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

Number	Description or Title	Revision
NOP-LP-2001	Corrective Action Program	29
NOBP-CC-1006-01	FENOC Engineering Brief Card	0
NOBP-CC-1007	Engineering Human Performance Team Charter	1
NOBP-LP-2001	FENOC Self-Assessment/Benchmarking	18
NOBP-LP-2008	FENOC Corrective Action Review Board	10
NOBP-LP-2011	FENOC Cause Analysis	13
NOBP-LP-4015	Cross-Cutting Aspects of Inspection Findings	2
PYBP-POS-0030	Transient Strategies and Mitigating Actions	0

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

Number	Description or Title
08-32972	Cross-Cutting Theme for Human Performance Aspect H.3.a, Work Control
08-42164	NRC Questions on Protected Train Postings and Risk Assessment
09-55801	Dose for the ADHR Project Exceeds 2nd 100% Estimate
09-58110	Loss of Shutdown Cooling
09-63793	Independent Common Cause Analysis of Recent Human Performance Events at the Perry Nuclear Plant
09-64398	Cross-Cutting Theme for Human Performance Aspect H.3.a Work Control, NRC
10-85222	Perry Substantive Cross-Cutting Issue in H.3(a) Appropriate Work Planning
11-89187	NRC cross-cutting theme for human performance aspect h.2.c resources
11-89870-001	Corrective Action for Procedure Review and Approval
11-03181	Fleet Oversight Missed Opportunity Identified During the Review September Condition Reports
11-06246	Additional Casual Analysis for Human Performance Cross-Cutting Issues in H.2(c)

AUDITS, ASSESSMENTS AND SELF-ASSESSMENTS

Number	Description or Title	Date or Revision
SN-SA-11-229	Cross-Cutting Aspects of NRC Inspection Report Findings	11/04/11
IP-SA-11-262	Integrated Performance Assessment and Trending, Station/Site Performance, 1st Half 2011	

OTHER DOCUMENTS

Number	Description or Title	Date or Revision
	Human Performance Action Plan	9/26/11
Performance Indicator	Licensee Cross-Cutting Aspect Precursors	Feb 2008 through Oct 2011
Performance Indicator	Perry NRC Cross-Cutting Issue Analysis and Trending Rolling 12 Month Ending 3Q 2008 – 2Q 2011	Undated
Summary Document	NRC Cross-Cutting Aspect H.3(a) Summary/Corrective Actions	Undated
Summary Document	NRC Cross-Cutting Aspect H.2(c) Summary/Corrective Actions	Undated
Summary Document	NRC Cross-Cutting Aspect H.1(b) Summary/Corrective Actions	Undated
Miscellaneous	Various Documented KIP Observations	Various
	Maintenance PCR Backlog Reduction Performance Indicator	Jan 2011 through Dec 2011
	Maintenance DCR Backlog Performance Indicator	Oct 2011 through Nov 2011
	Operations PCR Backlog Reduction Performance Indicator	Jan 2011 through Dec 2011
	Operations DCR Backlog Performance Indicator	Oct 2011 through Nov 2011
	PNPP Planning Rework Performance Indicator	Sep 2011 through Nov 2011
J. Grabnar Memo	Human Performance Re-Commitment	Nov 11, 2011
P-SPO-04A	Precursor Errors and Precursor Error Rate	May 2011 through Oct 2011

LIST OF ACRONYMS USED

ADAMS	Agencywide Documents Access and Management System
CR	Condition Report
IMC	Inspection Manual Chapter
KIP	Keep Improving Performance
NRC	Nuclear Regulatory Commission
PNPP	Perry Nuclear Power Plant
SCCI	Substantive Cross-Cutting Issue
XCAP	Cross-Cutting Aspect Precursor

Based on the results of this inspection and the data reviewed, no findings were identified. However, the inspectors could not complete all of their inspection objectives, because needed cause evaluations, germane to the areas being inspected, were not completed. The inspectors could not conclude that your current actions would address the underlying causes of the human performance issues as related to findings in H.2(c); and potentially in H.1(b). Follow on inspection will be required by the NRC. The specifics will be discussed in a separate letter.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, and 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 (PARS) component of NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html (the Public Electronic Reading Room).

Sincerely,

/RA/

John B. Giessner, Chief
Branch 4
Division of Reactor Projects

Docket Nos. 50-440
License Nos. NPF-58

Enclosure: Inspection Report 05000440/2011012
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Letter to V. Kaminskas from J. Giessner dated January 19, 2012.

SUBJECT: PERRY NUCLEAR POWER PLANT – NRC REVIEW OF LICENSEE ACTIONS TO ADDRESS IDENTIFIED SUBSTANTIVE CROSS-CUTTING ISSUES IN HUMAN PERFORMANCE - INSPECTION REPORT 05000440/2011012

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