March 5, 2001

Mr. Oliver D. Kingsley President, Nuclear Generation Group Commonwealth Edison Company ATTN: Regulatory Services Executive Towers West III 1400 Opus Place, Suite 500 Downers Grove, IL 60515

SUBJECT: DRESDEN INSPECTION REPORT 50-237/01-003(DRP); 50-249/01-003(DRP)

Dear Mr. Kingsley:

On February 11, 2001, the NRC completed an inspection at Dresden Units 2 and 3. The enclosed report documents the inspection findings which were discussed on February 8, 2001, with Mr. Fisher and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to safety and to compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified one issue of very low safety significance (GREEN). This issue concerned the discovery of a situation where the actuation logic for the automatic depressurization system was rendered inoperable for one pump in the low pressure coolant injection system due to a configuration control problem. This issue was determined to involve a violation of NRC requirements. However, because the issue was of very low safety significance and was entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response, with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-001; and the NRC Resident Inspector at the Dresden facility.

O. Kingsley

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PAR) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (The Public Electronic Reading Room).

Sincerely,

/RA/

Mark Ring, Chief Reactor Projects Branch 1

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

- Enclosure: Inspection Report 50-237/01-003(DRP); 50-249/01-003(DRP)
- cc w/encl: D. Helwig, Senior Vice President, Nuclear Services C. Crane, Senior Vice President, Nuclear Operations H. Stanley, Vice President, Nuclear Operations R. Krich, Vice President, Regulatory Services DCD - Licensing P. Swafford, Site Vice President R. Fisher, Station Manager D. Ambler, Regulatory Assurance Manager M. Aguilar, Assistant Attorney General State Liaison Officer Chairman, Illinois Commerce Commission

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*See previous concurrence

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O. Kingsley

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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: License Nos:	50-237; 50-249 DRP-19; DRP-25
Report No:	50-237/01-003(DRP); 50-249/01-003(DRP)
Licensee:	Commonwealth Edison Company (ComEd)
Facility:	Dresden Nuclear Power Station, Units 2 and 3
Location:	6500 North Dresden Road Morris, IL 60450
Dates:	January 1, 2001 through February 11, 2000
Inspectors:	 D. Smith, Senior Resident Inspector B. Dickson, Resident Inspector E. Duncan, Senior Resident Inspector, LaSalle County Station T. Madeda, Security Inspector P. Pelke, Reactor Engineer R. Zuffa, Illinois Department of Nuclear Safety
Approved by:	Mark Ring, Chief Reactor Projects Branch 1 Division of Reactor Projects

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety

Radiation Safety

Occupational

Safeguards

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Public

Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: <u>http://www.nrc.gov/NRR/OVERSIGHT/index.html</u>.

SUMMARY OF FINDINGS

IR 05000237-01-03, IR 05000249-01-03; on 01/01 - 02/11/2001; Commonwealth Edison Company; Dresden Nuclear Power Plant; Units 2 and 3. Personnel Performance During Nonroutine Plant Evolutions and Events.

The inspection covered a 6-week period of resident inspection and one regional specialist. The inspection identified one green issue which was a non-cited violation. The significance of the issue is indicated by its color (GREEN, WHITE, YELLOW, RED) and was determined by the Significance Determination Process in Inspection Manual Chapter 0609.

Reactor Safety

Mitigating Systems

GREEN
 On March 24, 2000, during the performance of surveillance testing, the licensee identified that an instrument header root valve which isolates the 100 psi permissive pressure switches for the automatic depressurization system was closed. As a result, the automatic depressurization system permissive interlock associated with the 3C low pressure coolant injection pump was rendered inoperable. The licensee did not restore operability to the automatic depressurization trip system within the allowed outage time of Technical Specification 3.2.B, "Emergency Core Cooling System Actuation." Failure to meet the requirements of Technical Specification 3.2.B was a non-cited violation.

The inspectors reviewed this issue using the significance determination process and concluded that the event had very low safety significance since the automatic depressurization system permissive switches associated with the remaining five emergency core cooling system pumps were un-isolated and operable. (Section 1R14).

Report Details

Summary of Plant Status

Unit 2 began the period at full power operations. On January 14, 2001, operators reduced load to 725 MWe to performed weekly surveillance activities. The unit was returned to full power operations (842 MWe) the following day. On January 17, 2001, the operators reduced load to 700 MWe to swap reactor feed pumps. The reactor feed pump swap was completed to facilitate the repair of a failed solenoid on the 2B reactor feed pump minimum flow valve. The A reactor feed pump was started and the B reactor feed pump was secured. The unit was returned to full power later that day.

Unit 3 began the period at full power operations. The unit remained at full power for the inspection period except for planned weekly surveillance tests.

1. **REACTOR SAFETY**

Cornerstone: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

1R01 Adverse Weather (71111.01)

a. Inspection Scope

The inspectors assessed the licensee's cold weather preparations and response to adverse snow and icing conditions. The review included an inspection of the lift station and the security diesel building.

b. Issues and Findings

No findings of significance were identified.

1R04 Equipment Alignments (71111.04)

a. Inspection Scope

The inspectors selected a redundant or backup system (listed below) to an out-of-service or degraded train, reviewed documents to determine correct system lineup, and verified critical portions of the system configuration. Instrumentation valve configurations and appropriate meter indications were also observed. The inspectors observed various support system parameters to determine the operational status. Control room switch positions for the systems were observed. Other conditions, such as adequacy of housekeeping, the absence of ignition sources, and proper labeling, were also evaluated.

Mitigating System Cornerstone

Semi-annual walk-down of the Unit 2/3 Emergency Diesel Generator

b. Issues and Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

a. Inspection Scope

The inspectors toured plant areas important to safety to assess the material condition, operational lineup, and operational effectiveness of fire protection systems and features. The review included control of transient combustibles and ignition sources, fire detection systems, fire suppression systems, manual fire fighting equipment and capability, passive fire protection features (including fire doors), and compensatory measures. The tours included the following areas:

Mitigating System Cornerstone

Unit 2 Control Rod Drive Pump and Containment Cooling Service Water Pump Floor	Fire Zone 8.2.2.A
Unit 2 Reactor Building Southwest Corner Room	Fire Zone 11.2.1
Unit 2 Reactor Building Southeast Corner Room	Fire Zone 11.2.2
Unit 2 Standby Liquid Control Area	Fire Zone 1.1.2.5.D
Unit 3 Standby Liquid Control Area	Fire Zone 1.1.1.5.D

Documents reviewed included the fire hazard analysis, Dresden Safe Shutdown Procedure 0100-E, Revision 16, "Hot Shutdown Procedure - Path E," and Chapter 9 of the Dresden Updated Final Safety Analysis Report.

b. Issues and Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors assessed the licensee's implementation of the maintenance rule by determining if systems were properly scoped within the maintenance rule. The inspectors also assessed the licensee's characterization of the failed structures, systems, and components and determined whether goal setting and performance monitoring was adequate.

The following systems were reviewed during the inspection period:

Initiating Events Cornerstone

Unit 2 Feedwater System Unit 2 Main Steam System Unit 2 Reactor Recirculation System Unit 3 Turbine Building Closed Cooling Water System Unit 3 Reactor Building Closed Cooling Water System Unit 3 Main Steam System

Mitigating System Cornerstone

Unit 3 Local Power Range Monitoring Unit 2 Reactor Protection System Unit 3 Primary Containment Isolation System Unit 2/3 Main Control Room Heating Ventilation and Air Conditioning System Unit 2 120/240V Alternating Current Instrument Bus Unit 3 120/240V Alternating Current Instrument Bus

b. Issues and Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation (71111.13)

a. Inspection Scope

The inspectors evaluated the effectiveness of the risk assessments performed before maintenance activities were conducted on structures, systems, and components and verified how the licensee managed the risk. The inspectors evaluated whether the licensee had taken the necessary steps to plan and control emergent work activities. The inspectors also evaluated the 12-week work window process and attended work-week management meetings.

The following risk significant work request (WR) activities were evaluated:

Initiating Events Cornerstone

WR 990117008	345 KV Switchyard Breaker 2-7 Preventive Maintenance Activities
Mitigating Systems Co	prnerstone
WR 990070696-01	Unit 3 Acoustic Monitor System Power Supply Replacement
WR 990250925-01	Unit 2 A and C Reactor Building Equipment Drain System, Troubleshooting and Repair

WR 990250103-01 Unit 2 Emergency Diesel 125 VDC Grounds, Troubleshooting and Repair

b. Issues and Findings

No findings of significance were identified.

1R14 Personnel Performance During Non-routine Plant Evolutions and Events (71111.14)

a. Inspection Scope

The inspectors reviewed licensee event reports to ensure that issues documented in these reports were adequately addressed in the licensee's corrective action program. The inspectors also interviewed plant personnel and reviewed operating and maintenance procedures to ensure that generic issues were captured appropriately.

The inspector reviewed operating logs, the Updated Final Safety Analysis Report, and other documents to verify the statements contained in the LER.

- b. Issues and Findings
- .1 <u>(Closed) LER 50-237/1998-005-00</u>: High Pressure Coolant Injection (HPCI) System Inoperable Due To Turbine Stop Valve Trip Failure Caused By Inadequate Preventative Maintenance.

The inspectors reviewed the subject LER which documented that during surveillance testing on April 17, 1998, the HPCI turbine stop valve did not trip closed when the control room "Remote Turbine Trip" push-button was depressed. The safety significance of this event was minimal since the HPCI turbine, although incapable of being tripped from the control room, would have responded to an accident initiation signal. Additionally, all other emergency core cooling systems were available during the time that the HPCI system was inoperable. No findings of significance were identified. This issue was entered into the licensee's corrective action program as LER 50-237/1998-005.

.2 (Closed) Licensee Event Report (LER) 50-249/2000-001-00: Instrument Root Valve Found Closed During Unit 3 Low Pressure Coolant Injection System Pump Testing.

On March 24, 2000, during the performance of surveillance testing, the licensee identified that instrument header root valve 3-1554C-HV for the Unit 3 "C" low pressure coolant injection pump automatic depressurization system 100 pounds per square inch (psi) permissive pressure switches (PS) 3-1554H and 3-1554C were closed. As a result, the automatic depressurization system (ADS) permissive interlock associated with the 3C low pressure coolant injection pump was rendered inoperable. There are six low pressure emergency core cooling system (ECCS) pumps. Each pump has two automatic depressurization system 100 psi pressure switches located downstream of the discharge of the emergency core injection pump. Each automatic depressurization system 100 psi permissive pressure switch inputs to both Division I and Division II automatic depressurization system logic. The automatic depressurization system logic is two-out-of-two taken once, which can be satisfied by any one low pressure emergency

core cooling system pump running. The licensee entered Technical Specification 3.2.B due to the condition of both automatic depressurization system permissive switches being inoperable. Root valve 3-1554C-HV was subsequently re-opened and TS 3.2.B was exited within the time limits of the TS action statement.

The licensee conducted a root cause investigation and determined that the header root valve was closed sometime between September 28, 1999 and December 28, 1999, and was not re-opened until the problem was identified on March 24, 2000. The exact time or group responsible for this loss of configuration control could not be determined.

The inspectors reviewed LER 50-249/2000-001, and discussed the event with licensee personnel.

The inspectors concluded that a credible impact on safety existed since the permissive switches for the 3C low pressure coolant injection pump were rendered inoperable, which impacted an automatic depressurization system interlock. However, this impact was relatively minor since the automatic depressurization system permissive switches associated with the remaining five emergency core cooling system pumps were operable. Since the operability of the automatic depressurization system, a mitigating system, was impacted, a Phase 2 Significance Determination Process evaluation was performed. This evaluation resulted in a Green finding based on the fact that no other mitigating systems were inoperable when the condition was identified.

Technical Specification 3.2.B, "Emergency Core Cooling System Actuation," requires that ECCS actuation instrumentation channels shown in Table 3.2.B-1 shall be operable. Table 3.2.B-1, Section 5, for the Automatic Depressurization System Trip System 'B', specifies that LPCI pump discharge pressure-high (permissive) be operable with a minimum number of channels per pump or take the action required. Closing root valve 3-1551C-NV from September 28 to December 28, 1999 exceeded the allowed outage time for the 3C LPCI pump ADS permissive instrumentation and was a violation of TS 3.2.B. However, this violation is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A.1 of the NRC Enforcement Policy (NCV 50-249/01-003-01(DRP)). This issue was entered the licensee's corrective action

(NCV 50-249/01-003-01(DRP)). This issue was entered the licensee's corrective action program as LER 50-249/2000-001.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the operability evaluations (OEs) listed below to ensure that operability was properly justified and the component or system remained available, such that no unrecognized increase in risk occurred.

Mitigating Systems Cornerstone

OE 00-066 Unit 2, 2B Drywell Radiation Monitor Failure

OE 00-059	Unit 2/3 Main Control Room Refrigeration Condenser, Containment Cooling Service Water Emergency Flow Below Surveillance Requirements
OE 00-054	Unit 2/3 Main Control Room Toxic Gas Analyzer
OE 00-064	Unit 2 and Unit 3 Environmental Qualification of Solenoid Valves for Safety-related Air-Operated Valves
OE 00-031	Unit 2 and Unit 3 Technical Specification 4.8.D - Control Room Emergency Ventilation System

b. Issues and Findings

No findings of significance were identified.

1R16 Operator Work-Arounds (71111.16)

a. Inspection Scope

The inspectors reviewed the following operator work-arounds (OWA) and operator challenges to assess any potential effect on the functionality of mitigating systems to determine whether functional capability of the system or human reliability to initiating events was affected. The inspectors also determined if operator's ability to implement abnormal or emergency operating procedures were impacted.

Mitigating Systems Cornerstone

OWA 2-00-01	Unit 2 Shutdown Cooling System High Temperature Isolation
OWA 2-0B-21	Unit 2 Reactor Building Floor Drain Surge Tank

b. Issues and Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed the following post-maintenance test results to confirm that the tests were adequate for the scope of the maintenance being performed, that the test data met the acceptance criteria. The inspectors also determined that the test resolved the operational readiness consistent with the design and licensing basis documents.

Mitigating Systems Cornerstone

WR 970131266 01 Unit 3 Low Pressure Coolant Injection Loop C Pump Minimum Flow Bypass Check Valve Replacement

WR 990028455 01	Unit 2 Station Blackout Diesel Primary Ventilation Damper Hydra-motors Replacement
WR 990189835 01	Unit 2 High Pressure Coolant Injection Turbine Steam Inlet Pressure Loop Power Supply Repair
WR 990239600 01	Unit 2, 2B Reactor Protection System Motor Generator Set Voltage Regulator Replacement
WR 990089755 01	Unit 2, 2A Core Spray Pump Discharge Minimum Flow Bypass Flow Instrument Switch 2-1771-A C25 Inspection/Replacement
Barrier Cornerstone	
WR 990124637-01	Unit 2 East Drywell Cooler Intake Louver Air Sample Upstream Flow Control Valve (2-9206A) Solenoid Replacement
Initiating Event Corner	stone

WR 990238470 01 Unit 3 Replace Reactor Core Flow/Jet Pump No. 5 Square Root Converter

b. Issues and Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed surveillance testing on risk-significant equipment. The inspectors assessed whether the selected plant equipment could perform its intended safety function and satisfy the requirement contained in the Technical Specifications. Following the completion of the test, the inspectors determined that the test equipment was removed and the equipment returned to a condition in which it could perform its intended safety function.

Mitigating System Cornerstone

WR 990242688-01	Unit 2 Acoustic Monitor/Temperature Detector Instrument (Channel) Check, DOS 0250-06
WR 990087679	Unit 2/3 Diesel Generator Endurance and Margin/Full Load Rejection/Emergency Core Cooling System Hot Restart, DOS 6600-12, Revision 20
WR 990034912-01	Unit 2/3 Standby Gas Treatment System Monthly Surveillance, DOS 7500-07

WR 990229463-01	Unit 3 Condenser Pit High and High-High Water Level Switch Functional Check, DIS 4400-01
WR 990231625-01	Unit 2 Quarterly Technical Specification Main Steam Isolation Valve Scram Functional Test

b. Issues and Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors screened active temporary modifications on systems ranked high in risk and assessed the effect of temporary modifications on safety-related systems. The inspectors also determined that the installations were consistent with systems design.

Mitigating System Cornerstone

Temporary Modification/Design Change No. 9900711, "Disable Isolation Condenser Valve 3-1301-1 Off-Normal Alarm Circuit"

Barrier Integrity Cornerstone

Temporary Shielding Permits 1999-184 and 1999-185 for Drywell Penetration X-143 and X-145.

b. Issues and Findings

No findings of significance were identified.

3. SAFEGUARDS

Cornerstone: Physical Protection

3PP4 Security Plan Changes (71130.04)

a. Inspection Scope

The inspector reviewed Revision 63 to the Dresden Nuclear Station Security Plan to verify that the changes did not decrease the effectiveness of the submitted document. The referenced revision was submitted in accordance with regulatory requirements by a licensee letter dated December 22, 2000.

b. Issues and Findings

No findings of significance were identified.

4. OTHER ACTIVITIES (OA)

40A2 Identification and Resolution of Problems

Unresolved Items

(Closed) Unresolved Item (50-237; 249/00-16-04)(DRS)): The unresolved item involved two changes in security plan language of Revision 62 that required additional clarification to adequately define bullet resistant structures and supervisory review of personnel access authorization to vital areas. Those issues were closed based on our review of Revision 63 of the licensee's security plan (See Section 3PP4).

4OA6 Management Meetings

The inspectors presented the inspection results to Mr. Fisher and other members of licensee management at the conclusion of the inspection on February 8, 2001. The licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

<u>Licensee</u>

- D. Ambler, Regulatory Assurance Manager
- G. Bockholdt, Instrument Maintenance Superintendent
- K. Bowman, Operations Manager
- S. Butterfield, NRC Coordinator
- R. Fisher, Plant Manager
- T. Fisk, Chemistry Manager
- D. Goble, Self Assessment Coordinator
- B. Hanson, Work Management Manager
- L. Licata, Engineering Administration Supervisor
- M. Molaei, Acting Design Engineering Manager
- J. Moser, Radiation Protection Manager
- R. Whalen, Acting Engineering Manager
- T. Wojkiewicz, Nuclear Oversight
- D. Zehrung, Acting Training Manager
- V. Gengler, Station Security Administrator

<u>NRC</u>

- B. Dickson, Dresden Resident Inspector
- M. Ring, Branch Chief
- D. Smith, Dresden Senior Resident Inspector

<u>IDNS</u>

R. Zuffa, Illinois Department of Nuclear Safety

ITEMS OPENED, CLOSED, AND DISCUSSED

<u>Opened</u>

50-237/01-003-01	NCV	The failure to shut down within 12 hours following the isolation of root valve 3-1554C-HV which rendered both ADS trip systems inoperable.
<u>Closed</u> 50-237/01-003-01	NCV	The failure to shut down within 12 hours following the isolation of root valve which rendered both automatic depressurization System trip systems inoperable.
50-237/1998-005-00	LER	High Pressure Coolant Injection (HPCI) System Inoperable Due To Turbine Stop Valve Trip Failure Caused By Inadequate Preventative Maintenance.
50-249/2001-001	LER	Instrument Root Valve Found Closed During Unit 3 Low Pressure Coolant Injection (LPCI) System Pump Testing.
50-237; 249/00-16-04	URI	Changes in security plan language required additional clarification to adequately define bullet resistant structures and supervisory review of personnel access authorization to vital areas.

LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

	Inspection Procedure	Report
Number	<u>Title</u>	Section
71111-01	Adverse Weather Preparations	1R01
71111-04	Equipment Alignment	1R04
71111-05	Fire Protection	1R05
71111-12	Maintenance Rule Implementation	1R12
71111-13	Maintenance Risk and Emergency Work	1R13
71111-14	Nonroutine Evolutions	1R14
71111-15	Operability Evaluations	1R15
71111-16	Operator Work-Arounds	1R16
71111-19	Post Maintenance Testing	1R19
71111-22	Surveillance Testing	1R22
71111-23	Temporary Modifications	1R23
71130-04	Security Plan Changes	3PP4
(none)	Identification and Resolution of Problems	40A2
(none)	Management Meetings	4OA6

LIST OF ACRONYMS AND INITIALISMS USED

- ADS Automatic Depressurization System
- ECCS Emergency Core Cooling System
- HPCI High Pressure Coolant Injection
- IDNS Illinois Department of Nuclear Safety
- LPCI Low Pressure Coolant Injection
- LER Licensee Event Report
- NCV Non-Cited Violation
- OE Operability Evaluation
- OWA Operator Work-Arounds
- PS Pressure Switch
- PSI Pounds Per Square Inch
- WR Work Request