December 7, 2001

Mr. John T. Conway
Site Vice President
Nine Mile Point Nuclear Station, L.L.C.
P.O. Box 63
Lycoming, NY 13093

SUBJECT: NINE MILE POINT NUCLEAR STATION - NRC INSPECTION REPORT 50-220/01-09, 50-410/01-09

Dear Mr. Conway :

On November 9, 2001, the NRC completed a team inspection at the Nine Mile Units 1 and 2 Nuclear facilities. The enclosed report presents the results of that inspection. The preliminary results of this inspection were discussed on November 9, 2001, with you and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, the team concluded that the overall implementation of the corrective action program at Nine Mile Point Units 1 and 2 was adequate. Problems were generally properly identified, evaluated and corrected. However, the team identified some instances where the evaluation and prioritization of some lower level problems have not been effective in resolving the problems in a timely manner.

There was one Green finding identified regarding a recurrent problem with the torus to drywell vacuum breaker position indication limit switches. This green finding was determined to be a violation of NRC requirements. Based on its very low safety significance and because the issue is being addressed within your corrective action process, 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, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspector at Nine Mile Point facility.

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Sincerely,

/RA/

David C. Lew, Chief
Performance Evaluation Branch
Division of Reactor Safety

Docket Nos. 50-220
50-410
License Nos. DPR-63
NPF-69

Enclosure: Inspection Report 50-220/01-09, 50-410/01-09

cc w/encl:
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U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Docket Nos:	50-220 50-410
License Nos:	DPR-63 NPF-69
Report No:	50-220/01-09 50-410/01-09
Licensee:	Nine Mile Point Nuclear Station, LLC
Facility:	Nine Mile Point Nuclear Station Units 1&2
Location:	P. O. Box 63 Lycoming, NY 13093
Dates:	October 22, 2001 - November 9, 2001
Inspectors:	Laura Dudes, Team Leader Mel Gray, Reactor Engineer Rick Fernandes, Resident Inspector
Approved by:	David C. Lew, Chief Performance Evaluation Branch Division of Reactor Safety

Summary of Findings

IR 05000220/01-09, IR 05000410/01-09, on 10/22-11/09/2001;Constellation Nuclear; Nine Mile Point, Units 1 & 2; annual baseline inspection of identification and resolution of problems. A violation was identified regarding a problem evaluation.

The inspection was conducted by two resident inspectors and one region-based inspector. One Green finding of very low safety significance was identified during this inspection and was classified as a non-cited violation. The issue was evaluated using the significance determination process. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation.

Identification and Resolution of Problems

The team concluded that, based on the samples reviewed, the overall implementation of the corrective action program at Nine Mile Point was adequate. In general, problems were properly identified, evaluated and corrected. The licensee entered problems into the corrective action program at an appropriate threshold and generally prioritized and evaluated issues in a timely fashion. The team concluded the licensee's evaluations generally were of adequate depth to identify the causes and appropriately broad in considering the extent of the problem. The team further concluded the licensee tracked corrective actions to completion and appropriately managed the backlog of issues. However, the team identified some instances where the licensee's evaluation and prioritization of lower level problems have not been effective in resolving the problems in a timely manner. One of these instances was determined to be a finding of very low safety significance (Green).

A. Inspector Identified Findings

Cornerstone: Mitigating Systems

- Green. A non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, regarding the failure to determine the cause and take corrective actions to preclude the recurrent setpoint drift of some torus to drywell vacuum breaker position indication limit switches. The setpoint drift beyond technical specification requirements each operating cycle was considered to be a significant condition adverse to quality since the alarms ensure the torus is configured in accordance with design assumptions.

  The finding was determined to be of very low safety significance (Green) since vacuum breaker leak rate tests and surveillance test inspections conducted during each refueling outage did not identify a condition where vacuum breakers were not seating in accordance with their design.

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems

.1 Effectiveness of Problem Identification

a. Inspection Scope

The team reviewed items selected from various licensee processes and activities to determine if the licensee was properly identifying, characterizing and entering problems into the corrective action program for evaluation and resolution. The team noted that the corrective action program was the licensee's primary process for identifying and resolving problems. Problems were entered into this program as Deviation/Event Reports (DERs). The team reviewed the DERs listed in Attachment 1 to determine the licensee's threshold for identifying problems and entering them into the corrective action process.

The team also reviewed items from the licensee's operating, maintenance and quality assessment processes to determine if personnel appropriately initiated DERs when problems were identified via these processes. Specifically the team reviewed a sample of Action Requests (ACRs), Work Orders (WOs), Plant Change Requests (PCRs), self assessments, nuclear safety assessment department reports, control room deficiency lists, operator logs, design modifications, and system health reports. To verify that the licensee was properly classifying deficiencies in accordance with station procedures, the team reviewed all the ACRs generated for which there was no associated DERs. The inspectors also walked down selected plant areas and interviewed plant personnel to identify other processes that may exist where problems and issues could be identified.

b. Issues and Findings

The team determined that, in general, the licensee was identifying problems and entering them into the corrective action program at an appropriate threshold. The team also determined that when licensee personnel identified issues through other processes, they initiated DERs at a proper threshold to document and evaluate the problem. However, several minor issues were identified involving the lack of DERs for equipment deficiencies documented in ACRs. The team identified 18 ACRs in the licensee's work control process, which appeared to meet the threshold for a DER; however, no DER had been initiated. The licensee reviewed these ACRs and reached a similar conclusion that the problems identified in these ACRs met the threshold for a DER. The licensee documented the issue in DER NM-2001-5257. The deviations were minor in nature and required lower level DERs, which did not need a root cause determination or which were for trending only.

.2 Prioritization and Evaluation of Issues

a. Inspection Scope

The team reviewed the DERs listed in Attachment 1 to determine whether the licensee was adequately prioritizing and evaluating issues within their corrective action program. The team considered risk insights from the Nine Mile Point Unit 1 and Unit 2 Individual Plant Examinations (IPE) in selecting DERs. A sample of DERs associated with Non-Cited Violations (NCVs) and Licensee Event Reports (LERs) was also selected. The team assessed the licensee's priority in evaluating these issues, the technical adequacy and depth of the evaluations, the licensee's assessment for reportability and operability, and the completeness of the licensee's cause determinations.

b. Issues and Findings

Overall, the licensee's evaluation of problems was appropriately broad to identify the causes and provide for corrective actions to prevent recurrence of the conditions that led to the problems. The evaluations of significant problems (Category 1 and 2 DERs) were of appropriate detail to identify likely apparent or root causes, and the circumstances contributing to the problem. The scope of the problem, including the applicability of the other Nine Mile Unit, was addressed. Additionally, the team observed that the licensee's corrective action review board (CARB) provided additional oversight of evaluations associated with more significant problems to ensure effective root cause analyses. The licensee's evaluation of less significant problems generally were evaluated in adequate detail.

Notwithstanding, the team identified one instance where the licensee did not evaluate a problem concerning torus to drywell vacuum breaker position indication. The team also identified some instances where the licensee's evaluation and prioritization of some lower level problems have not been effective in resolving the problems. These problems were in regard to the rod worth minimizer, the diesel driven fire pumps and operating experience reviews. These were minor problems when characterized using the group 1 and 2 questions (Appendix B of NRC Manual Chapter 0610*) and therefore the SDP was not applied. However, these examples provide insight into the licensee's corrective action program performance and are being documented to support the team's assessment in the area of problem evaluation and prioritization.

- NMP Unit 1 Torus to Drywell Vacuum Breaker Position Indication

Green. A non-cited violation of 10 CFR 50 Appendix B, Criterion XVI was identified regarding the failure to determine the cause and take corrective action to preclude recurrence of a repetitive condition where torus to drywell vacuum breaker position limit switches were found not to meet technical specification setpoint requirements.

During a refueling outage in March 2001, the licensee completed technical specification surveillance tests to calibrate and functionally test the position indication limit switches mounted on the four NMP Unit 1 torus to drywell vacuum breaker valves. Each vacuum breaker has four limit switches designed to operate control room position indication lights and alarms associated with each valve. The technical specifications require the

vacuum breaker position alarm system to annunciate when any vacuum breaker is open greater than 0.06 inches from its valve seat.

The results of surveillance testing in March 2001 indicated that three of four limit switches associated with vacuum breaker 68-02 were out of the calibration tolerance in the non-conservative, open direction. The licensee re-calibrated the limit switches to within required tolerances and initiated DER 2001-1133 to enter the problem in their corrective action program. This DER was categorized as a significance level 4 and closed out to trend the problem. The licensee's corrective action program does not require a cause evaluation to be completed for issues associated with significance level 4 DERs.

The team reviewed the surveillance test results prior to the March 2001 refueling outage. The surveillance test results from the refueling outage in May 1999 indicated that fifteen of the sixteen torus to drywell vacuum breaker limit switches did not actuate within technical specification requirements. At that time the licensee re-calibrated the limit switches to within specification, but did not initiate a DER to evaluate the problem. Prior surveillance test results indicated that two to four limit switches were typically found out of tolerance each refueling outage.

The team concluded that the 1999 and 2001 refueling outage surveillance test results indicated an adverse trend in the performance of vacuum breaker limit switches. However, the licensee did not evaluate the cause of the problem to identify corrective action to prevent recurrence. During this inspection, the licensee initiated DER 2001-5107 to reassess the process for assigning DER significance levels. The licensee also initiated DER 2001-5193 to evaluate the repetitive problem with some torus to drywell vacuum breaker position limit switches drifting out of specification during each operating cycle.

This issue is more than minor since the condition could have a credible impact on safety. The torus to drywell vacuum breaker position alarms help maintain the validity of assumptions in the torus design. The torus design assumes the torus to drywell vacuum breakers are closed and seated to within .060 inches to limit the steam bypass flow from the drywell back to the torus atmospheric space during a steam blowdown condition. The position alarms ensure operators are aware if vacuum breakers are not seated within this tolerance to prompt actions in accordance with technical specification requirements. This issue affects the containment barrier integrity cornerstone since the reliability of the torus to drywell vacuum breaker position alarms help maintain the capability of the torus to quench and contain the contents of the reactor coolant system during a postulated loss of coolant accident event.

However, the failure to determine the cause of the torus to drywell vacuum breaker position limit switches out of tolerance repetitive condition was considered to have a very low safety significance in accordance with the Phase 1 SDP screening because there was no actual open pathway or reduction of atmospheric pressure control of the reactor containment. This issue is of very low safety significance (Green) since vacuum breaker leak rate test and surveillance test inspections conducted during each refueling outage did not identify a condition where vacuum breakers were not seating in accordance with

their design. Consequently, there was no actual loss of the vacuum breaker safety function to remain closed within design limits.

10 CFR 50 Appendix B, Criterion XVI, requires that, in the case of significant conditions adverse to quality, measures shall assure the cause of the condition is determined and corrective action taken to preclude repetition. The recurrent setpoint drift of some torus to drywell vacuum breaker position indication limit switches beyond technical specification requirements each operating cycle was considered to be a significant condition adverse to quality since the alarms ensure the torus is configured in accordance with design assumptions. Contrary to this requirement, the licensee failed to determine the cause of the repetitive drifting of torus to drywell vacuum breaker position limit switches and ensure corrective actions are taken to preclude recurrence. However, because of the very low safety significance and because the issue is in the licensee's corrective action program (DER 2001-5193), it is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (**NCV 50-220/01-09-01**).

- NMP Unit 2 Diesel Driven Fire Pump

  In October 2000 the licensee attempted to calibrate the overspeed mechanism on the NMP Unit 2 diesel driven fire pump engine. However, during this work the licensee ran the diesel engine uncoupled from the fire pump for approximately ten minutes, which resulted in loss of cooling to the engine. This occurred since the pump outlet flow is used to cool the engine. The licensee initiated DER 2000-3505 to evaluate the problem. The inspectors reviewed the licensee's evaluation and concluded it addressed the causes for running the pump improperly and its subsequent repair. However, the evaluation did not consider a previously identified deficiency in the alarm design that prevented personnel from identifying the loss of cooling condition earlier.

  The licensee's evaluation indicated the loss of cooling was discovered when personnel observed that a local cooling water temperature gage indicated at its maximum position of 250°F. The evaluation did not discuss the functioning of the fire pump diesel engine trouble alarm in the control room. The team determined the licensee had previously identified a design deficiency where the trouble alarm annunciates whenever the diesel engine operates. This trouble alarm is designed to annunciate for a number of abnormal engine operating conditions, including on loss of battery charger voltage and high cooling water temperature greater than 205°F. The alarm annunciates on engine start due to a sensed loss of battery charger output caused by the alternator supplying charging current at a higher voltage than the normal battery charger during engine operation. As a result, when the engine was run without cooling in October 2000, the control room trouble alarm annunciation on high cooling water temperature was masked by the annunciation on apparent loss of battery charger voltage.

  Control room alarm response procedure and the pump surveillance testing procedure had been revised to indicate this alarm was to be expected. DERs had been initiated in 1996 and 2000, but the condition was judged to be a nuisance alarm, and a plant change request to address this condition was given a low priority. The team concluded the licensee's evaluation was incomplete in that it did not identify this design deficiency

as a contributing cause and did not reassess the priority assigned to correcting this problem.

- NMP Unit 2 Rod Worth Minimizer

  A review of DER 2-97-1645 pertaining to a Rod Worth Minimizer erroneous response immediately following a reactor scram revealed less than thorough corrective actions by the licensee. The 1997 DER indicates that the Rod Worth Minimizer did not function as an immediate indication of a shutdown reactor although it was referenced as a tool for operators to use in their scram procedure. The team noted that the licensee incorporated the long standing equipment deficiency associated with the rod worth minimizer into Special Operating Procedure N2-SOP-101C, "Reactor Scram." The team reviewed the post scram review reports for the years 2000 and 2001. All of these reports list the failure of the Rod Worth Minimizer to confirm the reactor was shutdown until several minutes following the scram.

  The team did note that some modification work was performed on the system to resolve the 1997 DER, however, no followup verification was performed to determine if the work performed during the summer of 2001 resolved the deficiency. The team reviewed post scram 01-05, for the reactor scram that occurred on October 15, 2001 and interviewed operations personnel regarding the performance of the Rod Worth Minimizer. There were no indications as to the status of the equipment and therefore the effectiveness of the work performed in summer 2001 wasn't verified.

- Emergency Diesel Generator Fuel System Operating Experience

  The team identified two examples of operating experience DERs with less than thorough evaluations. DER C-2000-2964, "OE-Engine Over-Speed at Surry Following Output Breaker Opening", identified that significant wear on a trip pawl hinge pin and actuation spring resulted in an unintentional trip of the output breaker. The licensee determined that the information was relevant to both units and concluded that the trip device was adequately inspected every outage in accordance with their maintenance procedures. However, the team determined that the procedures do not address inspection of the over speed device but, instead, address testing the device. The second example, DER 2-2000-2963, "OE-Duplex Filter Assembly Incorrectly Manufactured", identified that an improperly installed filter selection switch had the potential to affect the operability of the fuel system. The team determined that the maintenance procedures did not reflect this information or specifically verify proper orientation of the filter selector switch. These minor deficiencies were entered into the licensee's corrective action program as DER NM-2001-5244.

.3 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed the corrective actions associated with the DERs and other documents listed in Attachment 1 to determine whether the corrective actions addressed the identified causes and were scheduled or completed in a timely fashion. The inspectors also reviewed the backlog of corrective actions to determine if there were items that individually or collectively represented an adverse effect on plant risk or an adverse trend in the implementation of the corrective action program.

b. Issues and Findings

The inspectors determined that the licensee specified corrective actions to address each of the causes of problems identified in their evaluations. The inspectors determined that the licensee appropriately scheduled and tracked these corrective actions to completion. The inspectors did not identify combinations of corrective actions in the licensee corrective action process that represented an adverse effect on plant risk. However, the team noted some minor instances were the licensee was not fully effective in addressing long standing equipment deficiencies. One of the deficiencies was excessive flow control valve leakage in the Unit 2 feedwater system. Based on the team's review of multiple DERs and post scram review reports, this deficiency existed since 1997 and has challenged operators during plant transients. While the licensee has incorporated this deficiency into procedures, as well as the plant's simulator model, the licensee has not fully addressed the degraded equipment condition. Another of these deficiencies was the intermittent open indication of the torus to drywell vacuum breakers due to vibration. While the licensee has taken corrective actions, these corrective actions were not fully effective in eliminating the intermittent alarms.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The team interviewed plant personnel to determine if personnel were hesitant to identify safety issues.

b. Issues and Findings

No issues or findings were identified.

4OA6 Meetings, Including Exit

.1 Exit Meeting Summary

On November 9, 2001, the NRC inspectors presented the inspection results to Mr. John Conway and other members of the Nine Mile Point staff. The licensee acknowledged the results of the inspection. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT 1

SUPPLEMENTAL INFORMATION

Key Points of Contact

J.R. Cole, Radiation Protection Manager, U2
J. Conway, Site Vice President
G. Doyle, Director, Assessment and Corrective Actions
K. Embry, Licensing Engineer
P. Mazzaferro, Manager, Technical Support, Unit 1
D. Sandwick, Manager, Technical Programs
A. Shiever, Unit 2 Operations Support Supervisor
D. Willis, Manager, Maintenance Unit 2
B. Yaeger, Manager, Engineering Services

List of Items Opened, Closed, and Discussed

Opened and Closed

50-220/01-09-01	A non-cited violation of 10 CFR 50 Appendix B, Criterion XVI was identified regarding the failure to determine the cause and take corrective action to preclude recurrence of a repetitive condition where torus to drywell vacuum breaker position limit switches were found not to meet technical specification setpoint requirements.

List of Acronyms

ADS	Automatic Depressurization System
ACR	Action Request
CFR	Code of Federal Regulations
DDC	Design Document Change
DER	Deficiency/Event Report
GE	General Electric
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
NCV	Non-cited violation
NMPC	Niagara Mohawk Power Corporation
NRC	Nuclear Regulatory Commission
PCR	Plant Change Request
PMT	Post Maintenance Test
SDP	Significance Determination Process
SSC	Structures, Systems, and Components
TS	Technical Specifications
UFSAR	Updated Final Safety Analysis Report
Unit 1	Nine Mile Point Unit 1
Unit 2	Nine Mile Point Unit 2
WO	Work Order

DOCUMENTS REVIEWED

Procedures

NDD-ECA, Revision 11, “Evaluation and Corrective Action”
NIP-ECA-01, Revision 23, “Deviation/Event Report”
NIP-ECA-02, Revision 4, “Root Cause Evaluations”
NIP-ECA-05, Revision 4, “Focused Self Assessment and Bench Marking”
NIP-ECA-04, Revision 4, “Employee Concerns Program”
QAP-ASU-18.10, Revision 12, “Nuclear Audit Program”
N2-EPM-GEN-W665 DC Weekly Checks
N2-ESP-BYS-W675 Rev. 07, 125V DC Weekly Battery Surveillance
N2-ESP-BYS-Q676, Quarterly Battery Surveillance Test
N2-EPM-FPW-Q679 Rev. 02, Quarterly Diesel Driven Fire Pump Bat Test
N2-EPM-BWS-Q667 Rev. 05, Neutron Monitoring DC PWR 24V DC 12 cells BAT1
N2-EPM-GEN-V628 Rev. 02, Battery Equalizing Charge for 2FAW-BAT1B & 2FPW-BAT1B
N2-ESP-BYS-Q676 Rev. 06, Quarterly Battery Surveillance Test
N1-EPM-SB-265 Rev. 05, DC Batteries Pilot Cell Test (4 each)
N1-ESP-SB-276 Rev. 05, 125V DC Pilot Cell Surveillance (3 each)
N1-EPM-GEN-233 Rev. 02, Inspection of Station Reactor Recirculation, Amplidyne MG Sets and miscellaneous diesel generator equipment (5 each)
N1-ESP-SB-275, 125V DC Battery Cell Surveillance
N1-S-IPM-MET-001 Rev. 00, Meteorological Monitoring System Equip Check
N1-ISP-201-047 Rev. 02, Containment Atmosphere H_2 & O_2 Monitors Instrument Channel Test and Calibration
N1-ISP-201-045 Rev. 00, Torus Temperature Monitoring System Inst. Channel Test
N1-IPM-209-006 Rev. 01, Seismic Recording System Monthly Status Check
EPMP-EPP-05, Emergency Preparedness Program Self Assessment
EPMP-EPP-06, Rev 08, Emergency Response Organization Notification Maintenance and Surveillance.

Quality Assurance Audit Reports and Station Self Assessments

Audit Report 01014 “Corrective Action Program”
Audit Report 00015 “Corrective Action Program”
NMP Unit 2 Forced Outage Critique, December 12, 2000
NMP1 Surveillance and Test Program Effectiveness, December 28, 2000
NMP1 Operations Simulator Critique, July 2000

Station Operations Review Committee, Meeting Minutes
Unit 2, August 14, 2001,
Unit 2, May 21, 2001
Unit 2, July 3, 2001
Unit 2, June 5, 2001
Unit 1, September 18, 2001
Unit 1, September 4, 2001
Unit 1, June 5, 2001
Unit 1, March 9, 2001

Safety Review and Audit Board Meeting Minutes
September 4-5, 2001
July 9-10, 2001
May 8-9, 2001
March 26-27, 2001
January 9-10, 2001
November 27-28, 2000
September 12-13, 2000

Independent Safety Engineering Group Reports

June 2001
July 2001

Other

Procedure Change Evaluation for N2-OP-57, "Diesel Generator Building Ventilation," dated October 9, 2001
Temporary Change Package N2-01-093
Temporary Change Package N1-01-034
Division III Diesel Generator Lube Oil sample results from December 2000 to October 2001
Procedure Change Request 58285, Procedure N1-ISP-068-002, "Reactor Building to Torus Vacuum Relief Valves Instrument Channel Test."
Procedure N1-ISP-068-001, "Torus to Drywell Vacuum Breaker Position Alarm," Rev. 0
Procedure N2-OSP-FOF-W001, "Engine Driven Fire Pump Operability & Storage Tank Level Test," Rev. 2
Procedure N2-OSP-HVC-M001, "Control Room Outdoor Air Special Filter Train Operability Test," Rev. 1
Calculation AX-071X, "Pipe Wall Thinning for Components RHS Line."
Plant Change Request N2-97-045, Diesel Fire Pump Alarm
Plant Change Request, N2-00-039, RHS Minimum Flow Line Re-Design
Design Change Document 1S00250, Redesign Vacuum Breaker Limit Switch Mounting

Deviation Event Reports (DERs)

DER 1-1998-3222
DER 1-2000-2026
DER 1-2000-3417
DER 1-2000-3438
DER 1-2000-4406
DER 1-2001-1132
DER 1-2001-1504
DER 1-2001-2845
DER 2-2001-1536
DER 2-2000-3179
DER 2-2001-2492
DER 2-2000-4622
DER 2-2001-3451
DER 2-2000-4159
DER 2-2000-2315
DER 2-2000-2129
DER 2-2001-1613
DER 2-2001-2298
DER 2-2001-1801
DER 2-2001-4842
DER 2-2001-2694
DER 2-2000-4629
DER 2-2000-2979
DER 1997-1003
DER 1998-0331
DER 1998-3921
DER 1999-3883
DER 1999-4144
DER 2000-1288
DER 2000-2230
DER 2000-3505
DER 2000-4308
DER 2000-4596
DER 2000-4618
DER 2001-0033
DER 2001-0330
DER 2001-0551
DER 2001-0851
DER 2001-1275
DER 2001-2280
DER 2001-1133
DER 2001-3411
DER 2001-4175
DER 2001-4558
DER 2001-4954
DER 2001-4811
DER 2001-4931
DER 2001-5107
DER 2001-5193
DER 2001-5217

Work Orders
01-06805
01-09073
01-04829
01-04830
01-08768
01-88620
01-74466
01-04400
01-06862
00-01578
00-13328
00-08921
00-13328
00-06923
99-05692
99-00184
97-16545

Action Requests (ACRs)
01-02900
01-11342
01-3455
01-03308
01-02807