March 15, 2002

Mr. John L. Skolds, President
and Chief Nuclear Officer
Exelon Nuclear
Exelon Generation Company, LLC
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: CLINTON POWER STATION
NRC INSPECTION REPORT 50-461/01-16

Dear Mr. Skolds:

On February 17, 2002, the NRC completed a safety inspection at your Clinton Power Station. The enclosed report documents the inspection findings which were discussed on February 20, 2002, with Mr. J. M. Heffley and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and 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 two issues of very low safety significance (Green). One of the issues involved a violation of NRC requirements. However, because of its' very low safety significance and because it was entered into your corrective action program, the NRC is treating the 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 a basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Clinton Power Station.

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 (PARS) 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/ Christine A. Lipa

Christine A. Lipa, Chief
Branch 4
Division of Reactor Projects

Docket No. 50-461
License No. NPF-62

Enclosure: Inspection Report No. 50-461/01-16

cc w/encl: J. Heffley, Vice President
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-461
License No:	NPF-62
Report No:	50-461/01-16
Licensee:	AmerGen Energy Company, LLC
Facility:	Clinton Power Station
Location:	Route 54 West Clinton, IL 61727
Dates:	January 1 through February 17, 2002
Inspectors:	P. L. Louden, Senior Resident Inspector C. E. Brown, Resident Inspector M. W. Mitchell, Radiation Specialist D. E. Zemel, Illinois Department of Nuclear Safety
Approved by:	Christine A. Lipa, Chief Branch 4 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000461-01-16, on 01/01-02/17/2002, AmerGen Energy Company LLC, Clinton Power Station; integrated inspection report; Surveillance Testing, Temporary Plant Modifications.

This report covers a 6-week routine inspection, conducted by resident and regional specialist inspectors. The inspection identified two Green findings, one of which was a Non-Cited Violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609, "Significance Determination Process" (SDP). The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

A. Inspection Findings

Cornerstone: Initiating Events

Green. A finding of very low safety significance was identified associated with a temporary modification installed on the control circuitry for the "A" flow control valve (FCV) of the reactor recirculation system. Problems with the design instructions and other technician knowledge-based deficiencies resulted in an unplanned opening of the "A" flow control valve. Following this unplanned flow control valve movement, operators removed the temporary modification and manually shut down the reactor.

The finding was of very low safety significance because unplanned flow control valve movement contributed only to the likelihood of a reactor trip and did not affect mitigating system availability.

Cornerstone: Mitigating Systems

Green. Procedural inadequacies were determined to be a Non-Cited Violation of Technical Specification 5.4.1. These inadequacies led to the "A" residual heat removal system pump being declared operable without performing the appropriate pump supply breaker functionality checks for the conditions.

The finding was of very low safety significance because the licensee subsequently tested the "A" residual heat removal system pump supply breaker with satisfactory results. Therefore, system operability was not impacted.

B. Licensee Identified Findings

No findings of significance were identified.

Report Details

Summary of Plant Status

The plant was operated at essentially 100 percent power throughout the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R04 Equipment Alignments (71111.04Q)

a. Inspection Scope

The inspectors reviewed piping and instrument diagrams, system procedures, training manuals, previously identified equipment deficiencies, condition reports, and vendor information as part of a partial system walkdown of high risk-importance, safety systems during scheduled system maintenance outages on the opposite division or complementing system.

- Control room ventilation (VC) system "B" walkdown during a VC system "A" outage.
- Divisions I and II emergency diesel generator (EDG) room ventilation systems during Division III EDG testing.
- Residual heat removal (RHR) systems "B" and "C" during an RHR system "A" and low pressure core spray system maintenance outage.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05Q)

a. Inspection Scope

The inspectors reviewed portions of the licensee's Fire Protection Evaluation Report (FPER) and the Updated Safety Analysis Report (USAR) to verify consistency in the documented analysis with installed fire protection equipment at the station. To assess the control of transient combustibles and ignition sources, the material and operational condition of fire-protection systems and equipment, and the status of fire barriers, the inspectors conducted walk downs of the following risk significant areas:

- Turbine building 800 foot level walkdown during crane installation (FPER Zone T-1m).
- Fuel building - FPER Zones F-1a through 1i, 1m, 1n, and 1p
- Diesel generator building - 762 foot level, FPER Zones D-7 through 10
- Auxiliary building - 762 and 781 foot levels, FPER Zones A-2b, 2k, 2m, 2n, 2o, 3a, 3c, 3d, 3f, 3g, 4 and 5

- Control Building - 800 foot level, FPER Zones CB-6a through 6d
- Screen house including the shutdown service water pump rooms - FPER Zones M-1, 2a, 2b, 2c, 3, and 4
- Auxiliary building - 707 foot level, FPER Zones A-1a, 2a, 2b, 2c, 3a, 3b, and 3c

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11Q)

a. Inspection Scope

The inspectors reviewed licensed operator requalification training to evaluate operator performance in mitigating the consequences of a simulated event, particularly in the areas of human performance. The inspectors reviewed newly developed operator training materials that addressed the upcoming extended power uprate of the facility. The training included a discussion and simulator demonstration of plant responses to transients (loss of coolant accidents and off-normal operations) following the power uprate.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12Q)

a. Inspection Scope

The inspectors reviewed the effectiveness of the licensee's maintenance efforts in implementing the maintenance rule (MR) requirements, including a review of scoping, goal-setting, performance monitoring, short-term and long-term corrective actions, and current equipment performance problems. These systems were selected based on their designation as risk significant under the MR, or their being in the increased monitoring (MR category (a) (1)) group. The systems were:

- Diesel Generator Building Ventilation System
- Standby Gas Treatment System

b. Findings

No findings of significance were identified.

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

a. Inspection Scope

The inspectors observed the licensee's risk assessment processes and considerations used to plan and schedule maintenance activities on safety-related structures, systems, and components, particularly, to ensure that maintenance risk and emergent work contingencies had been identified and resolved. The inspectors assessed the effectiveness of risk management activities for the following work activities or work weeks:

- Risk evaluation associated with the turbine building crane load test.
- Risk assessment reviews performed following emergent work activities associated with the "5B" feedwater heater emergency drain valve controller.
- Review of emergent work associated with drywell cooling systems "A" and "B".

b. Findings

No findings of significance were identified.

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

a. Inspection Scope

The inspectors reviewed personnel performance during planned and unplanned plant evolutions and selected licensee event reports focusing on those involving personnel response to non-routine conditions. The review was performed to ascertain that operators' responses were in accordance with procedural requirements. In particular, the inspectors reviewed personnel performance during the following plant events:

- Turbine building crane load testing.
- Response to an unexpected trip of the emergency reserve auxiliary transformer (ERAT)-static VAR [Volts-Ampere-reactive] compensator which rendered the ERAT inoperable.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the following operability determinations and evaluations affecting mitigating systems to determine wether operability was properly justified and the component or system remained available such that no unrecognized risk increase had occurred.

- Operability evaluation conducted in response to Condition Report (CR) 98442 involving Division I EDG generator bearing over greasing.
- Operability evaluation conducted in response to CR 92344 involving the failure of the Division I EDG direct current lubricating oil pump.
- An operability determination associated with CR 92936 which addressed a 10 CFR Part 21 notification regarding Terry turbine trip and throttle valve stem material concerns.

b. Findings

No findings of significance were identified.

1R19 Post Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed and observed portions of the following post-maintenance testing (PMT) activities involving risk significant equipment to determine whether the activities were adequate to verify system operability and functional capability:

- The online replacement of the "5B" feedwater heater emergency drain valve controller.
- Service water system pump "C" motor replacement per CPS 3212.01.
- New turbine building crane weight test.
- Main turbine electro-hydraulic control system "A" and "B" pump PMs and PMT.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed portions of the following surveillance tests to determine whether risk significant systems and equipment were capable of performing their intended safety functions. The inspectors also assessed the operational readiness of the systems.

- Division I EDG monthly operability testing.
- Division III EDG diagnostic trend data acquisition.
- RHR system "A" operability testing.
- Remote shutdown panel (RSP) operability testing.

b. Findings

Green. A Non-Cited Violation of Technical Specification (TS) 5.4.1 for an inadequate surveillance procedure, which resulted in the "A" residual heat removal (RHR) system

pump being declared operable without completing the appropriate post surveillance system restoration testing. During the conduct of a quarterly operability surveillance for the remote shutdown panel, the licensee racked out the supply breaker for the RHR "A" pump. During restoration of the system, the RHR "A" pump supply breaker was racked back in. In accordance with the surveillance procedure, the RHR "A" pump operability verification continuity check was completed per another referenced procedure. That procedure describes the completion of the continuity check as satisfactory if energized light indications are confirmed for the close and trip fuses. There was no requirement to physically manipulate the breaker to confirm mechanical operability in this part of the procedure.

The inspectors raised this issue to operations shift management who concurred that the procedure was incorrect and subsequently started the RHR "A" pump to verify breaker operability. The breaker tested satisfactory; therefore, operability was not impacted.

The performance deficiency associated with this event was a discrepancy between various functional check criteria contained in CPS 9027.01C001 "RSP [remote shutdown panel] Operability - RHR A Checklist." In Section 8.1.2.7, the procedure states that If plans are to continue with the valve operability portion of the surveillance then to mark the step "N/A" and continue on in the procedure. If the valve surveillance is not to be performed then the RHR "A" pump shall be functionally checked by operating the system in pool-to-pool mode. Procedure Step 8.2.1, following the valve operability surveillance portion, states to restore the RHR "A" pump by replacing the control power fuses and perform a continuity check per CPS 9027.01, or run RHR "A". This instruction for operability is not consistent with the guidance provided earlier in the procedure for restoring the RHR "A" pump if no valve surveillances were conducted.

The finding was more than minor because if left uncorrected, the problem could become a more significant safety concern. Furthermore, the problem could affect the operability of a mitigating system. Consequently, the inspectors evaluated the significance of the issue using the At-Power Operations Significance Determination Process (SDP). Since the licensee had subsequently adequately tested the pump (proving operability), the inspectors determined that the finding was of very low safety significance (Green).

Technical Specification 5.4.1 requires that written procedures be established, implemented, and maintained covering the activities specified in Regulatory Guide 1.33, Appendix A. Regulatory Guide 1.33, Appendix A, Item 8b, requires procedures for surveillance tests listed in TSs. Contrary to TS 5.4.1 and Regulatory Guide 1.33, Clinton Station procedure 9027.01C001 was not maintained and is a violation. However, because of the very low safety significance and because the issue is in the licensee's corrective action program, it is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the Enforcement Policy **(NCV 50-461/2001-016-01)**. This violation is in the licensee's corrective action program as CR 94752.

1R23 Temporary Plant Modifications (71111.23)

a. Inspection Scope

The inspectors reviewed a temporary modification (T-mod) that was installed on the "A" reactor recirculation (RR) system flow control valve (FCV) control circuitry on December 14, 2001. The T-mod was installed because reliability of the normal control circuitry was in question. The T-mod was developed to assist operators in performing a controlled reactor shutdown. The inspectors' review included the T-mod design adequacy, plant personnel performance during T-mod installation, and the quality of the root cause evaluation which was conducted after a problem was identified with the T-mod.

Findings

Green. A finding of very low safety significance was identified. On December 14, 2001, the licensee installed a temporary modification on the "A" RR FCV control circuitry. The T-mod was installed to assist the operators in manually controlling the "A" RR FCV because the reliability of the normal control circuitry was in question. During the implementation portion of the T-mod installation, the "A" RR FCV unexpectedly moved from 94 percent open to 102 percent open at which point the protective position circuitry locked the valve at the 102 percent position. Reactor power was observed to go from 94 percent to 98 percent during this unexpected valve movement. Following this unexpected FCV movement, operations personnel ordered the T-mod to be removed and operators then proceeded to manually shut down the reactor without any further movements of the "A" RR FCV.

The licensee's root cause evaluation into the matter identified the root cause to be a failure during the design process, to fully evaluate a critical attribute of the online (interim) configurations of plant components during the installation of the T-mod. Specifically, the design package lacked sufficient details regarding adjustments that were to be made to the FCV rate limiter. Since very specific details were not included in the design package, technician and operator decisions that were made during the T-mod installation introduced a change in the performance of the T-mod which led to the subsequent unexpected opening of the FCV. The results of the root cause evaluation also noted several contributing causes associated with the matter. The more significant contributing causes included a lack of questioning attitude from operators involved in the T-mod installation, weaknesses in the set-up and training for the T-mod on the main control room simulator, and weaknesses in the work job steps and impact matrices.

The performance deficiency associated with this event was a lack of thoroughness and detail in the design process for the T-mod which ultimately led to an unplanned reactivity excursion during the installation adjustments of the T-mod. This issue is more than minor because even though the design process procedure was followed, a lack of thoroughness and specificity in design packages, if not corrected, could lead to a more significant safety concern and could cause or increase the frequency of an initiating event. Consequently, the inspectors evaluated the significance of the issue using the At-Power Operations Significance Determination Process (SDP). Since the finding

contributed only to the likelihood of a reactor trip and did not affect mitigating system availability, the inspectors used the phase 1 SDP to determine that the finding was of very low safety significance **(FIN 50-461/2001-016-02)**.

2. RADIATION SAFETY

Cornerstone: Occupational Radiation Safety

2OS1 Access Control to Radiologically Significant Areas (71121.01)

Plant Walkdowns

a. Inspection Scope

The inspectors reviewed the radiological conditions of work areas within radiation areas and high radiation areas (HRAs) in the auxiliary, containment, radwaste, and turbine buildings. The inspectors performed walkdowns and reviewed licensee controls to determine if the controls (i.e., surveys, postings, and barricades) were adequate to meet 10 CFR Part 20 and TS requirements. The inspectors also selectively reviewed year 2001 CRs that addressed access control deficiencies, to verify that the licensee had effectively implemented the corrective action program.

b. Findings

No findings of significance were identified.

3. PUBLIC RADIATION SAFETY

Cornerstone: Public Radiation Safety

3PS1 Radioactive Material Processing and Transportation (71122.02)

.1 Walkdown of Radioactive Waste Systems

a. Inspection Scope

The inspectors reviewed the liquid and solid radioactive waste system description in the Updated Safety Analysis Report (USAR) and the most recent information regarding the types and amounts of radioactive waste generated and disposed. The inspectors performed walkdowns of the liquid and solid radwaste processing systems to verify that the systems agreed with the descriptions in the USAR and the process control program, and to assess the material condition and operability of the systems. The inspectors reviewed the current processes for transferring waste resins into transportation containers to determine if appropriate waste stream mixing and/or sampling procedures were utilized. The inspectors also reviewed the methodologies for waste concentration averaging to determine if representative samples of the waste product were provided for the purposes of waste classification in accordance with 10 CFR 61.55. During this inspection, the licensee was not conducting waste processing.

b. Findings

No findings of significance were identified.

.2 Waste Characterization and Classification

a. Inspection Scope

The inspectors reviewed the licensee's radiochemical sample analysis results for each of the licensee's waste streams, including dry active waste, resins, and filters. The inspectors also reviewed the licensee's use of scaling factors to quantify difficult-to-measure radionuclides (e.g., pure alpha or beta emitting radionuclides). The reviews were conducted to verify that the licensee's program assured compliance with 10 CFR 61.55 and 10 CFR 61.56, as required by Appendix G of 10 CFR Part 20. The inspectors also reviewed the licensee's waste characterization and classification program to ensure that the waste stream composition data accounted for changing operational parameters and thus remained valid between the annual sample analysis updates.

b. Findings

No findings of significance were identified.

.3 Transportation Records

a. Inspection Scope

The inspectors reviewed six non-exempted package shipment manifests completed in year 2001 to verify compliance with NRC and Department of Transportation requirements (i.e., 10 CFR Parts 20 and 71 and 49 CFR Parts 172 and 173). The licensee did not have any non-exempt package preparation or shipping underway during the inspection.

b. Findings

No findings of significance were identified.

.4 Identification and Resolution of Problems

a. Inspection Scope

The inspectors reviewed a quality assurance audit of the radioactive waste and transportation program, along with self-assessments of the radioactive waste and transportation program to evaluate the effectiveness of the self-assessment process to identify, characterize, and prioritize problems. The inspectors also reviewed corrective action documentation to verify that previous radioactive waste and radioactive materials transportation related issues were adequately addressed. The inspectors also selectively reviewed year 2001 CRs that addressed radioactive waste and radioactive

materials transportation program deficiencies, to verify that the licensee had effectively implemented the corrective action program.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Event Follow-up (71153)

(Closed) Licensee Event Report (LER) 50-461/01-002: Failure to Incorporate Recommendations from Technical Information Letter Results in Random Reactor Scram During Turbine Valve Testing. On February 4, 2001, the reactor automatically shut down during the performance of turbine combined intermediate valve testing. The licensee determined that a low fluid pressure transient occurred in the turbine electro-hydraulic control system during the turbine valve testing. The cause of the low pressure condition was attributed to the licensee's failure to implement the recommendations of a vendor technical bulleting which advised installing an orifice in the system. The inspectors reviewed the LER and no findings of significance were identified. The licensee documented the issue in CR 2-01-02-053 (AR 64280). This LER is closed.

4OA6 Meeting(s)

Exit Meeting

The inspectors presented the inspection results to Mr. J. M. Heffley and other members of licensee management at the conclusion of the inspection on February 20, 2002. The licensee acknowledged the findings that were presented. No proprietary information was identified.

Technical Debrief Meeting

Senior Official:	Mr. Warren Lipscomb, Executive Assistant to the Site Vice-President
Date:	January 11, 2002
Proprietary:	No
Subject:	Access Control, ALARA, Instrumentation, and Transportation
Change to Inspection Findings:	No

KEY POINTS OF CONTACT

Licensee

K. Baker, Design Engineering Manager
R. Campbell, Radiation Protection
A. Daniels, Chemistry Manager
R. Davis, Radiological Engineering Manager
C. Dieckmann, Shift Operations Superintendent
R. Frantz, Regulatory Assurance Representative
J. Heffley, Site Vice President
W. Iliff, Regulatory Assurance Director
J. Madden, Nuclear Oversight Manager
T. Miracle, Radiation Protection
M. Pacilio, Plant Manager
J. Randich, Work Management Director
J. Sears, Radiation Protection Director
T. Shortell, Operations Training Manager
R. Svaleson, Operations Director
F. Tsakeres, Training Manager
J. Williams, Site Engineering Director

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

NCV	50-461/01-016-01	Non-cited violation of T.S. 5.4.1 for an inadequate surveillance procedure.
FIN	50-461/01-016-02	Lack of detail in T-Mod led to unplanned reactivity excursion

Closed

NCV	50-461/01-016-01	Non-cited violation of T.S. 5.4.1 for an inadequate surveillance procedure.
FIN	50-461/01-016-02	Lack of detail in T-Mod led to unplanned reactivity excursion
LER	50-461/2001-002	Failure to Incorporate Recommendation from Technical Information Letter Results in Random Reactor Scram During Turbine Valve Testing.

LIST OF ACRONYMS USED

CFR	Code of Federal Regulations
CR	Condition Report
DBT	Design Basis Threat
EDG	Emergency Diesel Generator
ERAT	Emergency Reserve Auxilary Transformer
FCV	Flow Control Valve
FPER	Fire Protection Evaluation Report
HRA	High Radiation Area
LER	Licensee Event Report
MR	Maintenance Rule
PMT	Post Maintenance Testing
RHR	Residual Heat Removal System
RSP	Remote Shutdown Panel
RR	Reactor Recirculation
T-mod	Temporary Modification
TS	Technical Specification
USAR	Updated Safety Analysis Report
VC	Control Room Ventilation

LIST OF DOCUMENTS REVIEWED

1R04Q Equipment Alignments

Operational Schematics 1102	Control Room Heating, Ventilation, and Air Conditioning System	Revision 6
Operational Schematics 1103	Emergency Diesel Generator Room Ventilation System	Revision 6
Operational Schematics 1075	Residual Heat Removal System	Revision 5

1R12Q Maintenance Rule Implementation

Clinton Power Station Plant Health Report	Fourth Quarter 2001

1R15 Operability Evaluations

CR 98442	Division I EDG generator bearing over greasing	Revision 0
CR 92344	Division I EDG direct current lubricating oil pump failure	Revision 0
CR 92936	Review of 10 CFR Part 21 Notification Concerning Terry Turbine Trip and Throttle Valve Stem Material Concerns	Revision 0

1R19 Post Maintenance Testing

Work Order 40058	EHC Pump Filter Changeout	
CPS 3105.02	Swap of EHC Pumps (Weekly)	Revision 11

1R22 Surveillance Testing

CPS 9080.01	Diesel Generator 1A(1B) Operability - Manual and Quick Start Operability,"	Revision 46c
CPS 9080.02	Diesel Generator 1C Operability - Manual and Quick Start Operability	Revision 44g
CPS 2700.23	Diesel Generator Diagnostic Testing	Revision 0
CPS 9053.04	RHR Loop A Valve Operability	Revision 43a

CPS 9080.01	Diesel Generator 1A(1B) Operability - Manual and Quick Start Operability,"	Revision 46c
CPS 9052.02	LPCS/RHR A Pumps and LPCS/RHR A Water Leg Pump Operability	Revision 41e
CPS 9027.01	Remote Shutdown Panel Operability	Revision 30
CPS 9027.01C001	RSP Operability - RHR Checklist	Revision 4b

1R23 Temporary Plant Modifications

Temporary Modification 333952	Defeat RR "A" Runback Logic
CR 86899	Condition Report and Root Cause Evaluation
Temporary Modification 334153	Manual RR "A" Flow Position Control

2OS1 Access Control to Radiologically Significant Areas

PAP-0114	Radiation Protection Program	Revision 3
PAP-0123	Control of Locked High Radiation Areas	Revision 6

3PS1 Radioactive Material Processing and Transportation

5467-14	NOS Field Observation	July 31 to August 2, 2001
CPS 6418.04	Analysis of Radwaste Samples for Solid Waste Processing	Revision 8
CPS 7013.40	10 CFR Part 61 Compliance Program	Revision 8a
CR-64771	10 CFR Part 61 Sample for Phase Separator Outside +/-20% Criteria Between Vendor and Station Results	September 20, 2001
CR-64376	Remote Grapple Would Not Engage HIC	May 4, 2001
CR-64555	Water Found Leaking from a Sea/Land Container	July 11, 2001
CR-64673	Braided Wire Rope Testing Not Current	July 31, 2001
CR-64694	HAZMAT Technician Not Qualified to Package RAM	July 31, 2001
CR-64700	Isotopic Analysis Used for Shipment Not Recorded	August 9, 2001
CR-64704	Question of Radwaste Personnel Training Adequacy	August 2, 2001

RP-AA-600	Administrative Process for Radioactive Material/Waste Shipment	Revision 4
RW-AA-100	Process Control Program for Radioactive Wastes	Revision 2
W01-014	Concentrate Waste Shipping Package	May 24, 2001
W01-016	Phase Separator Sludge Shipping Package	June 8, 2001
W01-017	Waste Sludge Shipping Package	June 22, 2001
W01-020	Fuel Pool Sludge Shipping Package	July 19, 2001
W01-031	Spent Resin Shipping Package	December 18, 2001
W01-032	Dry Active Waste Shipping Package	December 18, 2001
	Transportation Function Specific Training Records	December 18, 2001