March 7, 2002

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

SUBJECT: DRESDEN NUCLEAR POWER STATION
NRC INSPECTION REPORT 50-237/02-02(DRP); 50-249/02-02(DRP)

Dear Mr. Skolds:

On February 6, 2002, the NRC completed the baseline problem identification and resolution inspection at Dresden Units 2 and 3. The enclosed report documents the inspection findings which were discussed on February 6, 2002, with Mr. P. Swafford and other members of your staff.

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

The inspectors concluded that although a corrective action process, procedures and practices were in place that typically identified and corrected conditions adverse to quality, there were a number of examples over the past year of repetitive issues indicative of ineffective corrective actions. Self-revealing issues and issues identified by outside organizations illustrated how improved evaluations were needed to fully resolve problems.

Based on the results of this inspection, the inspectors identified two issues of very low safety significance (Green). One of these issues was determined to involve a violation of NRC requirements. However, because of the very low safety significance and because it has been 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. 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001; and the NRC Resident Inspectors at the Dresden Nuclear 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 (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
Branch 1
Division of Reactor Projects

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

Enclosure: Inspection Report 50-237/02-02(DRP);
50-249/02-02(DRP)

cc w/encl: W. Bohlke, Senior Vice President, Nuclear Services
C. Crane, Senior Vice President - Mid-West Regional
J. Cotton, Senior Vice President - Operations Support
J. Benjamin, Vice President - Licensing and Regulatory Affairs
R. Hovey, Operations Vice President
K. Ainger, Director - Licensing
R. Helfrich, Senior Counsel, Nuclear
DCD - Licensing
P. Swafford, Site Vice President
D. Bost, Station Manager
R. Rybak, Acting Regulatory Assurance Manager
M. Aguilar, Assistant Attorney General
Illinois Department of Nuclear Safety
State Liaison Officer
Chairman, Illinois Commerce Commission

DOCUMENT NAME: C:\ORPCheckout\FileNET\ML020660376.WPD

To receive a copy of this document, indicate in the box:"C" = Copy without enclosure "**E**"= Copy with enclosure"**N**"= No copy

OFFICE	RIII		RIII					
NAME	RLerch/trn		MRing					
DATE	03/06/02		03/07/02					

OFFICIAL RECORD COPY

ADAMS Distribution:
AJM
DFT
LWR
RidsNrrDipmIipb
GEG
HBC
DRC1
C. Ariano (hard copy)
DRPIII
DRSIII
PLB1
JRK1

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-237; 50-249
License Nos:	DRP-19; DRP-25
Report No:	50-237/02-02(DRP); 50-249/02-02(DRP)
Licensee:	Exelon Generation Company
Facility:	Dresden Nuclear Power Station, Units 2 and 3
Location:	6500 North Dresden Road Morris, IL 60450
Dates:	January 14 through February 6, 2002
Inspectors:	R. Lerch, Lead Inspector D. Smith, Senior Resident Inspector Z. Falevits, Reactor Inspector
Approved by:	Mark Ring, Chief Branch 1 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000237-02-02, IR 05000249-02-02; on 01/14 - 02/6/2002; Exelon Generation Company; Dresden Nuclear Power Plant; Units 2 and 3. Problem Identification and Resolution.

The inspection was conducted by regional, and resident 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 Inspection Manual Chapter 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. 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.

Problem Identification and Resolution

The inspectors concluded that although a corrective action process, procedures and practices were in place that typically identified and corrected conditions adverse to quality, there were a number of examples over the past year of repetitive issues indicative of ineffective corrective actions. Self-revealing issues and issues identified by outside organizations illustrated how improved evaluations were needed to fully resolve problems. The examples raised by the inspectors as findings were the repetitive tripping of station blackout diesel air compressor breakers and debris caught in component cooling service water pumps three times in the past year. These were repetitive issues, captured in the corrective action process and addressed with higher level management attention. Significant issues with ineffective corrective actions were identified in inspection reports during the year. These included Inspection Report 50-237;249/01-21 on a high pressure coolant injection system pressure transient, Inspection Report 50-237;249/01-16 on the 3B reactor building closed cooling water temperature control valve failure, and Inspection Report 50-10/01-01 and 02 on Unit 2/Unit 3 crane certification issues. For problem identification, the licensee used a low threshold for initiating most Condition Reports (CR) which supported a safety conscious work environment. The priorities assigned to issues in accordance with the program were generally appropriate, although in some instances, thorough and aggressive action to address issues was lacking.

Cornerstone: Mitigating Systems

- Green. The inspectors determined from operator log entries that the station blackout diesel (SBO) 2A air compressor breaker had tripped approximately 20 times since March 2001. The repetitive trips were documented by operations in the control room logs; however, the licensee did not initiate a condition report for each trip. The corrective actions taken by the licensee to correct this problem were ineffective and a common cause analysis was initiated in January 2002. Also, a rework evaluation was not initiated until questioned by the inspectors in January 2002.

  Lack of timely and effective action is a corrective action issue that is more than minor because if left uncorrected, would become a more significant safety concern for SBO

diesel availability. However, the safety significance was very low because with a second air start train available, the breaker trips did not make an SBO diesel unavailable. Therefore, this is a Green finding.

- Green. The 2A component cooling service water (CCSW) pump failed the quarterly surveillance due to high vibrations on 8/16/01. Foreign material was found obstructing the pump and an apparent cause evaluation (ACE) was assigned to the issue. The ACE identified three similar fouled CCSW pumps in the previous 10 months. Subsequently a common cause analysis was assigned for the 11 fouling events which had occurred since 1985. Failure to correct the causes for CCSW foreign material intrusion from 11/14/00 and 12/07/00 to 8/16/01 was a Non-Cited Violation of Appendix B.

  The issue of fouling component cooling service water pumps had an actual impact on safety, so it was more than minor. However, when the 2A pump was found fouled on 8/16/01, flow was reduced, but not stopped, and the other component cooling service water pumps were available, therefore the safety significance for this occurrence was concluded to be very low (Green).

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Identification and Resolution of Problems (71152)

.1 Corrective Action Program (CAP) Review

a. Inspection Scope

The inspectors conducted a review of the Dresden process for identifying and correcting problems at the plant. The inspection started with a review of applicable procedures and records for indication of corrective action effectiveness. The reviews evaluated the program at each stage in the process for identifying issues, documenting and evaluating the issues, and assigning appropriate corrective actions and tracking them to completion. The problem identification program was also evaluated by reviewing issues identified in previous NRC inspections, corrective action program documents and records, and by discussing the program with licensee personnel, which included management and supervision as well as engineers and craftsmen. The inspectors looked for issues associated with the cornerstones of safety and for risk significant equipment issues.

b. Issues and Findings

The inspectors concluded that although a corrective action process, procedures and practices were in place that typically identified and corrected conditions adverse to quality, there were a number of examples over the past year of repetitive issues indicative of ineffective corrective actions. Self-revealing issues and issues identified by outside organizations illustrated how improved evaluations were needed to fully resolve problems. The examples raised by the inspectors as findings were the repetitive tripping of station blackout diesel air compressor breakers and debris caught in component cooling service water pumps three times in the past year. These were repetitive issues, captured in the corrective action process and addressed with higher level management attention. Significant issues with ineffective corrective actions were identified in inspection reports during the year. These included Inspection Report 50-237;249/01-21 on a high pressure coolant injection system pressure transient, Inspection Report 50-237;249/01-16 on the 3B reactor building closed cooling water temperature control valve failure, and Inspection Report 50-10/01-01 and 02 on Unit 2/Unit 3 crane certification issues. For problem identification, the licensee used a low threshold for initiating most Condition Reports (CR) which supported a safety conscious work environment. The priorities assigned to issues in accordance with the program were generally appropriate, although in some instances, thorough and aggressive action to address issues was lacking.

.2 Problem Identification

a. Inspection Scope

Inspectors reviewed inspection reports, logs, work authorizations and corrective action documents to verify that when issues were identified, they were appropriately characterized and entered into the licensee's problem identification and resolution program.

b. Issues and Findings

The inspectors observed that, with few exceptions, issues were being entered into the corrective action process via condition reports (CR). Other observations which might negatively influence the generation of CRs were that the computer system did not allow for submitting a CR anonymously, and that procedures did not provide examples of level 4 or 5 CRs that should be written. The operations department had not performed and had not planned to perform a self-assessment of the corrective action program. The radiation protection department had not performed a CAP self-assessment, but had a CAP use survey in progress at the time of the inspection.

Initiation of Condition Reports

The inspectors noted a decline in initiation of CRs in the year 2001 (mainly in the engineering department). The licensee had implemented a new process, CAP Exelon, in August 2001. The inspectors interviewed plant personnel and noted that training on the new "CAP Exelon" process has not been provided to many working level engineers, operations and craft personnel. Trained supervisors were to provide training to the rest of their staff; however, this training did not appear to be effective. The licensee plans to improve training of plant personnel on initiation of CRs. The initiation rate appeared to be increasing in the first weeks of 2002.

Log Entries Without Condition Reports

Operators made log entries for SBO breaker trips on the 2A air compressor for the 2 station blackout (SBO) diesel, but did not initiate condition reports. In only five of twenty occurrences were condition reports generated. Condition reports were not being written because a work order was already open, however, search and trending information did not always include information from the work order database to give a complete picture of equipment problems. The system engineer was not aware of all of the SBO air compressor breaker trips, so the reliance on work orders was masking a repetitive problem from the rest of the organization. The inspectors also noted that the guidance for the initiation of a condition report was not very clear in procedure LS-A-125, "Corrective Action Program Procedure," and associate guidance document LS-AA-125-1006, "CAP Process Expectations Manual." The documents provided multiple examples for initiation of a Level 3 condition report, but no examples were given for initiation of a Level 4 or 5 condition report. For example, it was not clear by procedure if a condition report must be initiated for the breaker trips discussed above.

.3 Evaluation of Issues

a. Inspection Scope

The inspectors conducted an assessment of the prioritization and evaluation of issues through a selected sample of condition reports, apparent cause evaluations, common cause analyses, root cause investigations and action tracking items. The assessment included a review of the significance level assigned, evaluation class, action taken, similar or repeat conditions, extent of condition evaluations, cause investigations, and the appropriateness and effectiveness of the assigned corrective actions. In addition, the inspectors attended several daily management review committee (MRC) meetings to observe management review and assignments of CR categories, cause investigations for plant issues, and plan-of-the-day meetings to observe program oversight by management. The documents reviewed are listed in Attachment 1.

b. Issues and Findings

There were no findings with the prioritization of issues based on the assigned significance levels, however, there were concerns with the adequacy of evaluations of issues. There were items identified by the licensee staff and NRC inspectors where the evaluations in apparent cause evaluations (ACE) were weak. Inspector identified examples are discussed below. The licensee had evaluated the quality of ACEs, concluded that actions to improve ACEs were needed, and planned further review and training.

Inspectors also identified inconsistencies and an apparent lack of knowledge by the individuals responsible for the identification and documentation of the extent of condition in many of the condition reports and apparent cause evaluations reviewed. The scope of review for potentially related deficiencies appeared narrowly focused when determining the extent of condition. Examples of inadequate extent of condition evaluations included entries such as: "None," "unknown," "breaker contacts sometimes get out of alignment," and "clearing of a clearance order is an often missed step in work process." Inconsistency in identifying the extent of condition could affect trending and timely identification and resolution of repeat failures. On February 1, 2002, the licensee initiated CR 00093386 to evaluate and address this issue.

Inadequate Apparent Cause Evaluations

Reactor Building Floor Drain Sump Pump Failures

The inspectors reviewed the corrective actions taken to address concerns identified in CR D2001-01027, dated February 21, 2001, "Maintenance Rule Failure Cause Determination not Performed." The CR requested that an ACE be performed on two Maintenance Rule failures that occurred in January 2001, where cause determinations were not performed as required to identify causal factors of the control fuse failures for all four Reactor Building Floor Drain Sump pumps (Maintenance Rule functional failures). The failures for which a cause determination was not identified as required by Maintenance Rule procedure ER-AA-310 were documented in CR D2001-00297, January 17, 2001, "3A&C

Reactor Building Floor Drain Sump Pump Failure," and CR D2001-00494, January 26, 2001, "3B&D Reactor Building Floor Drain Sump Pump Failure." CR D2001-01027 further stated that the ACE was needed to ensure that the actual cause of the failures is determined and that appropriate corrective actions are taken to minimize the chance of repetitive failures occurring.

Action Tracking Item (ATI) 45969-02, dated April 6, 2001, documented the ACE for the failures identified by CRs D2001-00297 and D2001-00494. The inspectors reviewed the ACE and determined that it did not identify the correct cause of failure of the fuses for the four pumps. The fuses for Pumps 3A, B, C, and D were found blown and were replaced. The ACE stated that the fuses were non-safety, located in non-safety equipment, and that the extent of condition is not an issue with non-safety fuses since they are run-to-failure. The ACE also stated that the 3A pump was bad and had to be replaced. The ACE incorrectly concluded that the apparent cause of both of the events was blown fuses. The inspectors noted that the ACE for the blown fuses was performed by a mechanical system engineer. Also, the inspectors determined that training on how to perform an ACE or common cause analysis was not provided to plant staff. Training was only provided to individuals who perform root cause investigations.

On January 18, 2002, the licensee initiated CR 00091371 to reopen the ATI 45969-02 and redo the ACE to determine the apparent cause of the functional failures and correctly identify the cause of the failure of the fuses to prevent repetitive failures. In addition, CR 00093386 was initiated on January 31, 2002, to evaluate and determine causes of poor ACE quality noted by the NRC inspectors.

Station Blackout Diesel Air Compressor SBO Breaker Trips

The ACE, D2001-03523 initiated 7/03/2001, performed to evaluate repetitive breaker trips on station blackout diesel air compressors, concluded that breaker degradation due to pressure switch calibration was the cause. This was based on a review of condition reports which provided an inaccurate record because not all breaker trips were documented. In January 2002, the breaker trips were still recurring. This highlighted a weakness in the ACE process that did not recognize that additional information or troubleshooting would be necessary to reach the apparent cause. See the discussion on SBO air compressor breaker trips in paragraph .4 Effectiveness of Corrective Actions.

On January 31, 2002, the licensee initiated CR 00093386 to re-examine the conclusions made in ACE D2001-03523 for the repetitive SBO breaker trips and conduct troubleshooting and equipment monitoring to identify the cause of the breaker repeat tripping.

Jumpers in HVAC

From a review of CR D2001-01391, inspectors concluded that the extent of condition review was too narrowly focused. A jumper was left in an HVAC panel

during a modification. The extent of condition did not address jumpers from other modifications. Condition Report 93386 was initiated to review this issue.

Cancellation of Condition Reports and Action Tracking Items

Inspectors observed that the justifications for canceled CRs were not being properly documented. A total of 156 CRs had been canceled since July 2001. The inspectors selected five for review. Two of five canceled CRs reviewed by the inspectors were canceled without providing justification and proper notes as required by procedure LS-AA-127-3001, "Passport Action Tracking Management Manual," Section 2.3.2 and 2.5.6 (CR 79348 and CR 88541).

On February 1, 2002, the licensee initiated CR 93382 to complete the extent of condition for canceled CRs and to initiate corrective actions as necessary. Also, on February 4, 2002, the licensee initiated CR 0093782 to document an additional case of inadequate closure or cancellation of corrective actions because action request 71298-03 had been canceled without meeting expectations delineated in procedure LS-AA-127-3001.

.4 Effectiveness of Corrective Actions

a. Inspection Scope

The inspectors reviewed past inspection results, selected condition reports and apparent cause evaluations to evaluate the effectiveness of the corrective actions. The inspectors focused on corrective action documents relating to risk significant systems. The documents reviewed are listed in Attachment 1.

b. Issues and Findings

Significant issues with ineffective corrective actions were identified in inspection reports during the year. These included Inspection Report 50-237;249/01-21 on a high pressure coolant injection system pressure transient, Inspection Report 50-237;249/01-16 on the reactor building closed cooling water temperature control valve failure in July of 2001, and Inspection Reports 50-10/01-01 and 50-10/01-02 on Unit 2/Unit 3 crane certification issues. The inspectors also identified issues where corrective actions were ineffective or untimely. The following examples showed inadequate implementation of the corrective action program to address repetitive problems and ineffective corrective actions:

Repetitive Foreign Material in Component Cooling Water Pumps

The 2A component cooling service water pump (CCSW) failed its quarterly surveillance due to high vibrations on 8/16/01. Foreign material was found obstructing the pump and an ACE assigned to the issue. The ACE identified 2 similar fouled CCSW pumps in the previous 10 months. Subsequently a common cause analysis was assigned for the 11 fouling events which had occurred since 1985. Procedures were strengthened to prevent foreign material entry into the pump suction bay and a multi-departmental team was created to

evaluate the issue further (ATI 00073081-03) to address the common cause captured in CR 90504 dated 1/15/2002.

Repeated fouling events in the past 10 months represented ineffective corrective actions to address entry of foreign material into these safety-related pumps. 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, required that measures shall be established to assure that significant conditions adverse to quality are promptly identified and corrected and corrective action taken to preclude repetition. Failure to correct the causes for CCSW foreign material intrusion from earlier occurrences on 11/14/00 and 12/07/00 to 8/16/01 was a violation of Appendix B. However, because this issue had very low safety significance, it is being treated as a **Non-Cited Violation (NCV 50-237;249/02-02-01)** consistent with Section VI.A.1 of the NRC Enforcement Policy. This issue is in the licensee's corrective action program in CR 00090504.

The issue of fouling CCSW pumps had an actual impact on safety, so it is more than a minor issue. However, when the 2A was found fouled on 8/16/01, flow was reduced, but not stopped and other CCSW pumps were available, therefore the safety significance for this occurrence was concluded to be very low (Green).

Station Blackout Diesel Air Compressor SBO Breaker Trips

The inspectors determined from operator log entries that the station blackout (SBO) diesel 2A air compressor breaker had tripped approximately 20 times since March 2001. The repetitive trips were documented by operations in the control room logs; however, the licensee did not initiate a condition report for each trip. The corrective actions taken by the licensee to correct this problem were ineffective and a common cause analysis was initiated in January 2002. During interviews, the system engineer stated that he was not informed by Operations of the numerous trips recorded in the control room logs. Also, a rework evaluation was not initiated until questioned by the inspectors in January 2002. Lack of timely and effective action is a corrective action issue that is more than minor because, if left uncorrected, it could become a more significant safety concern for SBO diesel availability. However, the safety significance at this point was very low because the breaker trips did not make an SBO diesel unavailable because there were two air start trains. Therefore, this is a Green finding.

Ineffective Corrective Action for a Buzzing Solenoid Valve

During review of canceled Work Orders, the inspectors noted that WO 00375841 was initiated on December 17, 2001, to document that the 2A Instrument Air Dryer AO 2-4799-814 solenoid valve was making a strange buzzing sound when energized. On December 27, 2001, WO 00375841 was canceled by another operator noting that the noise was no longer present and the solenoid would be replaced under a preventive maintenance WO in July 2003. Further inquiry by the inspectors revealed that on January 3, 2002, the same solenoid valve stuck

open rendering the 2A instrument air dryer inoperable. The solenoid valve was replaced on January 4, 2002 using WR 394511. The inspectors considered this an ineffective corrective action where failure to replace the solenoid at the sign of deterioration (buzzing) resulted in the equipment becoming inoperable. On February 1, 2002 the licensee initiated CR 00093549 to perform an ACE to determine the cause of event.

.5 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During interviews and discussions of CAP issues, the plant staff was asked questions similar to those listed in Appendix 1 to Inspection Procedure 71152, "Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues."

b. Findings

No significant findings were identified. The inspectors did not identify of a lack of willingness to identify safety issues.

4OA4 Management Meetings

The inspectors presented the inspection results to Mr. P. Swafford and other members of licensee management at the conclusion of the inspection on February 6, 2002. The licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee - Exelon

D. Ambler, Regulatory Assurance Manager
J. Basher, System Engineering Manager
D. Bost, Plant Manager
K. Bowman, Operations Manager
C. Cerovoc, Training Director
L. Coyle, Site Vice President Staff
P. Fairfax, Operations Corrective Action Program Coordinator
T. Fisk, Chemistry Manager
T. Heistorman, Licensing Engineer
R. Kelly, Site Corrective Action Program Coordinator
K. Ludwig, Acting Maintenance Manager
P. Murray, Site Vice President Assistant
J. Nolan, Acting Nuclear Oversight Manager
F. Polak, Engineering Corrective Action Program Coordinator
M. Porter, QC Supervisor
B. Rybak, Licensing Engineer
R. Ruffin, NRC Coordinator
P. Simpson, Midwest Reactor Operations Group Licensing Manager
J. Smith, Radiation Protection/Chemistry Corrective Action Program Coordinator
D. Stoiber, Support Corrective Action Program Coordinator
P. Swafford, Site Vice President
C. Taylor, Engineering Corrective Action Program Coordinator
S. Taylor, Radiation Protection Manager
D. Williams, Acting Work Control Manager

NRC

B. Dickson, Dresden Resident Inspector
Z. Falevits, Reactor Inspector, Region III
G. Grant, Director, Division of Reactor Projects, Region III
R. Lerch, Project Engineer, Reactor Projects Branch 1, Region III
M. Ring, Branch Chief, Reactor Projects Branch 1, Region III
D. Smith, Dresden Senior Resident Inspector

IDNS

R. Zuffa, Illinois Department of Nuclear Safety

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-249;237/2002-001	NCV	Repetitive fouling of CCSW pumps

Closed

50-249;237/2002-001	NCV	Repetitive fouling of CCSW pumps

LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire document, but, rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. In addition, inclusion of a document on this list does not imply NRC acceptance of the document, unless specifically stated in the body of the inspection report.

Procedures

LS-AA-125	Corrective Action Program (CAP) Procedure	Revision 0
LS-AA-125-1001	Root Cause Analysis Manual	May 18, 2001
LS-AA-125-1002	Common Cause Analysis Manual	May 18, 2001
LS-AA-125-1003	Apparent Cause Evaluation Manual	May 18, 2001
LS-AA-125-1004	Effectiveness Review Manual	May 18, 2001
LS-AA-125-1005	Coding and Trending Manual	May 18, 2001
LS-AA-125-1006	CAP Process Expectations Manual	June 12, 2001
MA-AA-716-013	Rework	
DAN 902(3)-3-C-4		
DIS 1300-01		
ER-AA-520		

Condition Reports, Action Tracking Items, Effectiveness Reviews

D2001-0130 D2001-0131 D2001-297 D2001-00302 D2001-494 D2001-02340
D2001-03358 D2001-03847 D2000-04772 D2000-06752 7357 21024 26096 31235 31552
33425 34416 39849 39928 40951 43309 43498 45969 47111 47177 47377 50987
52757 53622 56395 56649 70871 70555 72181 72259 73081 73238 73897 74034
74389 75511 76684 76923 78465 79348 80613 80552 81009 81157 81532 81624
81678 82032 82349 82589 83049 83340 84182 84857 85046 85479 85691 86346
87305 87778 87944 88458 88461 88467 88468 88469 88541 88710 88980 89246
89596 90343 90363 90364 90365 90378 90402 90504 91371 91401 91883 92805
93382 93386 93478 93549 93690 93782

Work Orders, Action Requests, Simple Work Requests and Work Requests

WO 337267 WR 8372 WO 362929 SWR 17772 WR 990250925 AR 990127777
WO 99248710 AR 71928 AR 88710 AR 52357 AR 81661 AR 81194 WO 391603
WO 375841 W099193910-01 WO 348879 W099237373-01 WO319595 WO394511-01
WO 375841 WR 22941

Miscellaneous

Ops Logs 1/01/01 – 1/30/02.
Calibrations – 990235601-01, 321644-01, 347318-01, 372215-01
Drawing 12E-2506 Sht. 1, 2, and 3
DCP 9900730

LIST OF ACRONYMS USED

ACE	Apparent Cause Evaluation
CAP	Corrective Action Program
CCSW	Component Cooling Service Water
CR	Condition Report
IDNS	Illinois Department of Nuclear Safety
LER	Licensee Event Report
MRC	management review committees
NRC	Nuclear Regulatory Commission
NCV	Non-Cited Violation
WR	Work Request