January 19, 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: QUAD CITIES NUCLEAR POWER STATION - NRC INSPECTION REPORT 50-254/00-20(DRP), 50-265/00-20(DRP)

Dear Mr. Kingsley:

On December 31, 2000, the NRC completed an inspection at your Quad Cities Units 1 and 2 reactor facilities. The enclosed report documents the inspection findings which were discussed on January 5, 2001, with Mr. Dimmette and other members of your staff.

The 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 one issue regarding an inadequate operability evaluation which was categorized as being of very low safety significance (GREEN). This issue involved one 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 the 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, DC 20555-0001, with a copy 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 Quad Cities facility.

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/

Mark A. Ring, Chief
Reactor Projects Branch 1

Docket Nos. 50-254; 50-265
License Nos. DPR-29; DPR-30

Enclosure: Inspection Report 50-254/00-20(DRP),
50-265/00-20(DRP)

cc w/encl: D. Helwig, Senior Vice President, Nuclear Services
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U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-254, 50-265
License Nos:	DPR-29, DPR-30
Report No:	50-254/00-20(DRP), 50-265/00-20(DRP)
Licensee:	Commonwealth Edison Company (ComEd)
Facility:	Quad Cities Nuclear Power Station, Units 1 and 2
Location:	22710 206th Avenue North Cordova, IL 61242
Dates:	November 21 through December 31, 2000
Inspectors:	C. Miller, Senior Resident Inspector J. Adams, Resident Inspector D. Jones, Reactor Engineer R. Jickling, Emergency Preparedness Specialist
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	Safeguards
● Initiating Events	● Occupational	● Physical Protection
● Mitigating Systems	● Public	
● Barrier Integrity		
● Emergency Preparedness		

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: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

SUMMARY OF FINDINGS

IR 05000254-00-20(DRP), IR 05000265-00-20(DRP), on 11/21-12/31/2000, ComEd, Quad Cities Nuclear Power Station, Units 1 & 2. Operability Evaluations.

The inspection was conducted by resident inspectors, a regional reactor engineer, and an emergency preparedness specialist. This inspection identified one GREEN issue, which was also considered 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.

Cornerstone: Mitigating Systems

- GREEN. On November 6, 2000, the Number 2 turbine control valve fast closure trip failed to cause a half scram as expected during a Unit 2 surveillance test. The licensee then repeated the test three more times and the fast closure trip successfully caused the expected half scram each time. The licensee declared the trip function operable without taking the actions of Technical Specification 3.1.A, Action 1 for an inoperable channel. Generic Letter 91-18 states that repetitive testing to achieve acceptable results without first identifying and correcting the root cause of any problem is not an acceptable means for verifying operability. A subsequent autopsy of the pressure switch for the control valve fast closure trip found evidence of fretting which produced metallic particles believed to have caused the initial failure. The inspectors determined the Number 2 turbine control valve fast closure trip had been declared operable without adequate justification. The failure to implement the required actions of Technical Specification 3.1.A-1 for an inoperable channel of the turbine control valve fast closure trip was considered a **Non-Cited Violation (50-265/00-20-01)**.

  The finding was determined to be of very low safety significance due to the level of redundancy and diversity of the reactor protection system. During the period of time that the Number 2 turbine control valve fast closure trip was inoperable, a sufficient number of turbine control valve fast closure channels remained operable to result in an automatic scram, if required. Additionally, the turbine control valve fast closure trip is considered an anticipatory trip and, if inoperable, the reactor scram could still have been initiated by the reactor vessel high pressure or the average power range monitor high flux trips.

Report Details

1. REACTOR SAFETY

Plant Status

Unit 1 began the period operating at 98 percent power because of speed control circuit oscillations on the reactor recirculation motor generator set. Repairs were completed to the speed circuit, and the unit operated at full power until December 6, when a malfunction of the feedwater control system master controller caused a reactor trip due to low reactor vessel level. Following restart on December 8 and power ascension, Unit 1 operated at or near full power for the remainder of the period, except for minor power changes for control rod adjustments and to minimize the effects of turbine control valve oscillations.

Unit 2 was operating at 98 percent power at the beginning of the period due to oscillations of the Number 3 turbine control valve. The unit was taken to full power and then to about 98 percent power during various troubleshooting and repair attempts. On December 22 Unit 2 power was reduced to about 25 percent to complete repairs on the Number 3 turbine control valve. Unit 2 was returned to full power on December 24 and remained at or near full power for the remainder of the period.

1R01 Adverse Weather (71111.01)

a. Inspection Scope

The inspectors reviewed the completed QCOP 0010-01, “Winterizing Checklist,” as well as actions to comply with QCOP 0010-02, “Cold Weather Routines.” Inspectors toured various areas of the plant susceptible to freezing concerns in cold weather, reviewed discrepancies with the checklist, and performed spot checks of items completed in the checklist. Inspectors also reviewed Condition Reports Q2000-03604, 04367, 04202, 04402, and 03608 which addressed problems related to cold weather and the winterizing checklist.

b. Issues and Findings

No findings of significance were identified.

1R04 Equipment Alignments (71111.04)

.1 Semi-annual Walkdown of the Unit 2 Emergency Diesel Generator

a. Inspection Scope

The inspectors performed a complete (semi-annual) review of the Unit 2 emergency diesel generator system alignment in the Mitigating Systems Cornerstone. During the system walkdown, the inspectors compared as-found valve, breaker, and fuse

configuration with the configuration specified on system piping and instrument diagrams and system lineup procedures; reviewed condition reports, open action requests, and open work requests; reviewed open design changes, engineering requests, temporary modifications, and permanent modifications; reviewed operator work-arounds and challenges; and reviewed normal, abnormal, and emergency operating procedures. The inspectors discussed system configuration, performance, maintenance, and testing with operators and engineers.

b. Issues and Findings

No findings of significance were identified.

.2 Quarterly Walkdown of Standby Gas Treatment System

a. Inspection Scope

The inspectors reviewed the system lineup and conducted a system walkdown for the "A" standby gas treatment system while the "B" train was out-of-service for maintenance.

b. Issues and Findings

No findings of significance were identified.

1R07 Heat Sink Performance (71111.07)

a. Inspection Scope

The inspectors observed the licensee perform an inspection of the Unit 1 high pressure coolant injection room cooler heat exchanger, 1-5747. During this inspection, the inspectors observed the as-found condition of the heat exchanger to verify that no deficiencies that would mask degraded performance of the heat exchanger existed. Additionally, inspectors observed the heat exchanger for conditions that could indicate a potential for common cause problems. The inspectors reviewed Quad Cities Technical Procedure 0820-10, "Heat Exchanger and Room Cooler Inspection," Revision 1, and discussed the as-found condition, as-left condition, historical performance, and eddy current analysis results of the Unit 1 high pressure coolant injection room cooler heat exchanger with engineering personnel. The inspectors also reviewed 22 condition reports in the licensee's corrective action program associated with plant heat exchangers for identified deficiencies, performance issues, and potential common cause failures.

b. Issues and Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the maintenance rule requirements, including a review of scoping, goal setting, performance monitoring, short-term and long-term corrective actions, and current equipment performance status.

The inspectors reviewed the following condition reports for proper maintenance rule classifications:

Initiating Events Cornerstone

- Instrument Air and Drywell Pneumatics Condition Reports Q2000-00095, Q2000-02492, and Q2000-0336;

Mitigating Systems Cornerstone

- Unit 2 Turbine Electro-hydraulic Control Condition Reports Q2000-03450, Q2000-03599, Q2000-03630, and Q2000-04089;
- Unit 2 Emergency Diesel Generator Condition Reports Q2000-00092, Q2000-00441, Q2000-01436, Q2000-03323, Q2000-03341, and Q2000-03359;
- Unit 2 Station Blackout Diesel Generator Condition Reports Q2000-04115 and Q2000-04193;
- Safe Shutdown Make Up Pump Condition Reports Q2000-00244, Q2000-03659, and Q2000-03928;
- 4kV and 480 V Breaker Failure Condition Reports Q2000-04232, 04228, 04143, and 04181 and associated maintenance rule assessment documents; and

Barrier Systems Cornerstone

- Unit 2 Containment Atmosphere Monitor Condition Reports Q2000-00751, Q2000-03007, and Q2000-03626.

b. Issues and Findings

No findings of significance were identified.

1R13 Maintenance Risk and Emergent Work (71111.13)

a. Inspection Scope

The inspectors evaluated risk considerations for planned and emergent work on the following system and/or components:

Mitigating Systems Cornerstone

- Unit 1 average power range monitor power supply, and
- risk evaluations for work the week of December 18, 2000.

b. Issues and Findings

No findings of significance were identified.

1R14 Personnel Performance During Nonroutine Plant Evolutions (71111.14)

a. Inspection Scope

On December 6, 2000, Unit 1 experienced a reactor trip on low reactor vessel water level following the failure of the master feedwater level controller. The inspectors reviewed operator logs, Condition Report Q2000-04323, an event notification worksheet, sequence of events recorder output, and alarm printer output associated with the reactor trip to verify the plant responded as designed. The inspectors interviewed control room personnel with respect to their actions in response to the event. The inspectors reviewed operator actions to ensure they were consistent with Quad Cities Annunciator Response Procedure 901-5 F-8, "Reactor Vessel Low Level," Revision 4; Quad Cities Abnormal Operating Procedure 0201-09, "Reactor Low Water Level," Revision 9; and Quad Cities General Procedure 2-3, "Reactor Scram," Revision 35. The inspectors attended a Plant Operational Review Committee meeting held to discuss the event and recommend the restart of the unit. Prior to unit startup, inspectors verified that the licensee had determined the cause and had completed corrective actions.

An initial Licensee Event Report 50-254/00-010 was issued by the licensee prior to the root cause investigation being completed. Inspectors will review this event further as part of the routine baseline inspection following licensee issuance of a supplemental report which will include information from the root cause report.

b. Issues and Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

During the performance of Quad Cities Operating Surveillance Procedure (QOS) 5600-01, "Turbine Control Valve Fast Closure Scram Instrumentation Channel Functional Test," Revision 21, a reactor protection system relay failed to initiate a half scram. The inspectors reviewed the Unit 2 prompt and supporting operability determinations performed by operators and engineers following the failure. The inspectors also reviewed Condition Reports Q2000-04089 and Q2000-04469; Quad Cities Administrative Procedure RS-AA-105, "Operability Determination Process," Revision 0; Quad Cities Administrative Procedure CC-AA-309, "Control of Design Analyses," Revision 0; Quad Cities Administrative Procedure OP-AA-101-206.01, "Short Duration Time Clock Log," Revision 0; and the Apparent Cause Evaluation of Q2000-04089.

b. Issues and Findings

On November 6, 2000, during the performance of QOS 5600-01 on Unit 2, the reactor protection system relay associated with the fast closure of the Number 2 turbine control valve failed to change state and cause the expected half scram on the "A" train of reactor protection system. The shift manager discussed the issue with the electrical maintenance supervisor, repeated the test three additional times successfully, declared the Number 2 turbine control valve fast closure trip operable, exited Technical Specification 3.1.A-1, and forwarded the issue to engineering for an additional operability review. On November 9 the system engineers completed the supporting operability determination and concurred with the shift manager's operability determination. On November 13 the reactor protection system pressure switch for the Number 2 turbine control valve was replaced and an autopsy was subsequently performed on the suspect pressure switch. On December 6 an apparent cause evaluation was completed following the autopsy. The autopsy identified an age-related fretting problem between the pressure switch piston and the pressure switch cylinder that resulted in metallic particles. The resulting metallic particles are believed to have prevented the proper operation of the reactor protection system pressure switch.

In reviewing the Unit 2 prompt and supporting operability determinations, the inspectors identified that the licensee had credited the three successful follow-on tests to determine that the Number 2 turbine control valve was operable. There was no documentation of the root cause of the failure or its correction. The inspectors discussed with the shift manager and the system engineer that determination of operability based on repetitive testing was specifically identified in Generic Letter 91-18 as unacceptable.

The shift manager and the system engineer stated that engineering judgement was used in the determination of operability. The shift manager and system engineer assumed that previous problems with fast acting solenoid valves, a similar event associated with the Number 3 turbine control valve, and the three subsequent successful tests of the Number 2 turbine control valve constituted sufficient engineering judgement to justify operability.

The inspectors reviewed the licensee's definition of engineering judgement as it appeared in Administrative Procedure CC-AA-309, "Control of Design Analysis." Procedure CC-AA-309 identified three methods of applying engineering knowledge and power plant experience to form an opinion or perform an evaluation. The inspectors determined the knowledge and experience used by the shift manager and system engineer did not meet the criteria for any of the listed methods included in the definition of engineering judgement.

The inspectors reviewed the licensee's administrative procedure associated with the operability process, RS-AA-105. The inspectors noted that RS-AA-105, Attachment 1, stated, "Ensure the determination provides one or more of the following as basis for operability: a) Analysis, b) Test, c) Operating Experience, and d) Engineering judgement." The inspectors discussed this apparent contradiction between the user's procedure for determining operability and Generic Letter 91-18 guidance prohibiting the use of testing unless the root cause has been identified and corrected; the licensee

entered the condition into their corrective action program with Condition Report Q2000-04469.

The inspectors reviewed the impact of the unjustified operability determination with respect to Technical Specification compliance. The inspectors noted that the licensee properly entered Technical Specification 3.1.A-1 in accordance with QOS 5600-01. Shortly thereafter, operators recognized that the surveillance test acceptance criteria was not met when the Number 2 turbine control valve fast closed and the half scram was not received. As described previously, the shift manager declared the Number 2 turbine control valve fast closure trip operable and exited Technical Specification 3.1.A-1. The inspectors determined that the shift manager had not adequately justified operability of the Number 2 turbine control valve fast closure trip and therefore failed to comply with Technical Specification 3.1.A, Action 1, which would require operators to place the inoperable channel and that trip system in the tripped condition within 1 hour. The failure to place the "A" train of the reactor protection system in the tripped condition within 1 hour was considered a Non-Cited Violation of NRC requirements **(50-265/00-020-01(DRP))**.

The inspectors reviewed the significance of this event and determined that the issue was more than a minor issue because it could be viewed as a precursor to a significant event. The inspectors, with the assistance of the Regional Senior Reactor Analyst, screened the issue and determined the risk significance of this event to be very low (GREEN) due to the level of redundancy and diversity of the reactor protection system. During the period of time that the Number 2 turbine control valve fast closure trip was inoperable, a sufficient number of turbine control valve fast closure channels remained operable to result in an automatic scram if required. Additionally, the turbine control valve fast closure trip is considered an anticipatory trip and if inoperable, a reactor scram would be accomplished by the reactor vessel high pressure or by the average power range monitor high flux trips.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed portions of and reviewed the results of the following testing in the Mitigating Systems and Barrier Integrity Cornerstones:

- Quad Cities Chemistry Surveillance Procedure 0200-01, "Reactor Water Iodine Analysis," Revision 9;
- Quad Cities Operating Surveillance Procedure 1600-07, "Reactor Coolant Leakage in the Drywell," Revision 15;
- Quad Cities Operating Surveillance Procedure 2300-09, "HPCI [High Pressure Coolant Injection] Vent Verification," Revision 10; and
- Testing required by Technical Specification 4.2.F, "Post Accident Monitoring and Associated Condition Report," Q2000-04309.

b. Issues and Findings

No findings of significance were identified.

Emergency Preparedness (EP)

1EP4 Emergency Action Level and Emergency Plan Changes (71114.04)

a. Inspection Scope

The inspectors reviewed Revision 9 to Section 1.0, 4, 8, and 9 of the Generating Stations Emergency Plan, which was submitted by letter dated April 26, 2000, in order to determine whether the changes in Revision 9 might decrease the plan's effectiveness. This emergency plan revision was submitted in accordance with 10 CFR 50.54(q).

b. Observations and Findings

There were no findings of significance identified during this inspection. Implementation of these changes will be subject to future inspection.

4. OTHER ACTIVITIES (OA)

4OA2 Performance Indicator Verification

.1 Reactor Coolant System Specific Activity Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed the reactor coolant system specific activity analysis data obtained through the performance of Quad Cities Chemistry Surveillance Procedure 0200-01, "Reactor Water Iodine Analysis," for Unit 1 and Unit 2 from October 1, 1999, to September 30, 2000. The inspectors verified that the data reported by the licensee was accurate and complete.

b. Issues and Findings

No findings of significance were identified.

.2 Reactor Coolant System Leak Rate Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed Unit 1 and Unit 2 reactor coolant system leak rate data obtained through the performance of Quad Cities Operating Surveillance Procedure 1600-07, "Reactor Coolant Leakage in the Drywell," from October 1, 1999, to September 30, 2000. The inspectors verified that the data reported by the licensee was accurate and complete.

b. Issues and Findings

No findings of significance were identified.

4OA3 Event Follow-up (71153)

.1 Unit 1 Reactor Trip

a. Inspection Scope

On December 6, 2000, the inspectors responded to the control room and observed equipment and operator response to the Unit 1 reactor trip. The inspectors verified that operator actions were appropriate and no complications existed which could pose an undue increase in risk.

b. Issues and Findings

No findings of significance were identified.

.2 Review of Licensee Event Reports 50-265/00008-00 and 50-265/00008-01

a. Inspection Scope

The inspectors reviewed licensee event reports using Inspection Procedure 71153. The inspectors reviewed the licensee's root cause reports and corrective actions for these events.

b. Observations and Findings

(Closed) Licensee Event Report 50-265/00008-00 and 50-265/00008-01: Reactor Trip Due to a Main Generator Differential Relay Operation. On July 18, 2000, a fault on one of the offsite power feeds to the Quad Cities electrical ring bus caused electrical circuit breakers 1-3 and 3-4 to open, which isolated the fault. However, the Unit 2 main generator protective relays also detected the fault which resulted in the Unit 2 main generator and reactor tripping. Electrical circuit breaker 3-4 automatically reclosed about 10 seconds after the fault was detected. Since the fault was not cleared, a high current condition existed and electrical breaker 4-6 opened to isolate the fault. When breaker 4-6 opened, transformer 12 (Unit 1 reserve auxiliary transformer) de-energized. The significance of this event was reviewed by inspectors, was screened as having very low risk significance (GREEN), and was documented in Inspection Report 50-254/00011; 50-265/00011. The inspectors reviewed the causes of the event and corrective actions taken to prevent recurrence, and determined them to be reasonable. No violations of NRC requirements were identified. These items are closed.

4OA4 Management Meetings

The inspectors presented the inspection results to Mr. Dimmette and other members of licensee management on January 5, 2001. Following the conclusion of the inspection, the licensee acknowledged the findings presented. No proprietary information was identified.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. Dimmette	Site Vice President
G. Barnes	Station Manager
E. Anderson	Radiation Protection Manager
W. Beck	Regulatory Assurance Manager
P. Berhens	Chemistry Manager
G. Boerschig	Engineering Director
R. Chrzanowski	Nuclear Oversight Manager
R. Gideon	Work Management Manager
M. McDowell	Operations Manager
M. Perito	Maintenance Manager

NRC

M. Ring	Branch Chief, Branch 1

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-265/00-020-01	NCV	Failure to Place the “A” Train of the Reactor Protection System in the Tripped Condition

Closed

50-265/00-020-01	NCV	Failure to Place the “A” Train of the Reactor Protection System in the Tripped Condition
50-265/00008-00	LER	Reactor Trip Due to a Main Generator Differential Relay Operation
50-265/00008-01	LER	Reactor Trip Due to a Main Generator Differential Relay Operation

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	Title	Section
71111.01	Adverse Weather Preparations	1R01
71111.04	Equipment Alignment	1R04
71111.07	Heat Sink Performance	1R07
71111.12	Maintenance Rule Implementation	1R12
71111.13	Maintenance Work Prioritization & Control	1R13
71111.14	Nonroutine Evolutions	1R14
71111.15	Operability Evaluations	1R15
71111.22	Surveillance Testing	1R22
71114.04	Emergency Action Level and Emergency Plan Changes	1EP4
71151	Performance Indicator Verification	4OA2
71153	Event Follow-up	4OA3
(none)	Other	4OA4
(none)	Management Meetings	4OA5

LIST OF ACRONYMS AND INITIALISMS USED

CFR	Code of Federal Regulations
IDNS	Illinois Department of Nuclear Safety
IFI	Inspection Follow-up Item
LER	Licensee Event Report
URI	Unresolved Item
VIO	Violation