UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION IV
611 RYAN PLAZA DRIVE, SUITE 400
ARLINGTON, TEXAS 76011-8064

January 21, 2003

Joseph E. Venable
Vice President Operations
Waterford 3
Entergy Operations, Inc.
17265 River Road
Killona, Louisiana 70066-0751

SUBJECT: WATERFORD 3 - NRC INSPECTION REPORT 50-382/02-04

Dear Mr. Venable:

On December 28, 2002, the NRC completed an inspection at your Waterford Steam Electric Station, Unit 3, facility. The enclosed report documents the inspection findings which were discussed on January 6, 2002, with Mr. Randy Douet 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. Within these areas, the inspection consisted of selected examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection, the NRC has identified two issues that were evaluated under the risk significance determination process as having very low safety significance (Green). The NRC has also determined that violations are associated with these two issues. These violations are being treated as noncited violations (NCVs), consistent with Section VI.A of the Enforcement Policy. These NCVs are described in the subject inspection report. If you contest these violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region IV, 611 Ryan Plaza Drive, Suite 400, Arlington, Texas 76011; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Waterford Steam Electric Station, Unit 3, facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be made 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/reading-rm/adams.html (the Public Electronic Reading Room).

Should you have any questions concerning this inspection, we will be pleased to discuss them with you.

Sincerely,

/RA/

William B. Jones, Chief
Project Branch E
Division of Reactor Projects

Docket: 50-382
License: NPF-38

Enclosure:
NRC Inspection Report
50-382/02-04

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ENCLOSURE

U.S. NUCLEAR REGULATORY COMMISSION
REGION IV

Docket:	50-382
License:	NPF-38
Report:	50-382/02-04
Licensee:	Entergy Operations, Inc.
Facility:	Waterford Steam Electric Station, Unit 3
Location:	Hwy. 18 Killona, Louisiana
Dates:	September 29 through December 28, 2002
Inspectors:	M. C. Hay, Senior Resident Inspector G. F. Larkin, Resident Inspector
Approved By:	W. B. Jones, Chief, Project Branch E
Attachment:	Supplemental Information

SUMMARY OF FINDINGS

Waterford Steam Electric Station, Unit 3
NRC Inspection Report 50-382/02-04

IR05000382-02-04; Entergy Operations, Inc.; 09/29/02-12/28/02; Waterford Steam Electric Station; Unit 3; Equipment Alignment.

The report covered a 13-week period of inspection by resident inspectors. The inspectors identified two Green issues which were determined to be violations of NRC requirements. 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 may be "Green" or assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

A. Inspector Identified and Self-Revealing Findings

Cornerstone: Barrier Integrity

- Green. The licensee failed to establish an adequate maintenance procedure to ensure Switchgear Ventilation Damper SVS-102 remained in its safe position during maintenance and after the switchgear ventilation system was returned to an operable condition. Specifically, the damper was worked over a two day period without the damper being gagged in its safety minimum open position. The switchgear ventilation system was returned to an operable condition on September 19, 2002, without the associated actuator having been connected or a gag installed to maintain the damper in the minimal open position. The failure to gag the damper or restore the damper to an operable condition would have prevented the damper from being able to perform its safety function (minimum open position) on a safety injection actuation signal.

  The failure to provide adequate work instructions to repair Ventilation Damper SVS-102 is a violation of Technical Specification 6.8.1(a). This finding is greater than minor because the barrier integrity objective, to provide reasonable assurance that the physical design barriers protect the public from radionuclide releases caused by accidents or events, was affected. A Phase 3 review was performed that considered the potential impact the switchgear ventilation system could have on the control envelope. The NRC risk analyst considered both radiological and toxic gas atmosphere. This finding is of very low safety significance, in part, based on a redundant damper being operable and the short duration the condition actually existed (Section 1R04).

Cornerstone: Mitigating Systems

- Green. The licensee failed to follow Operating Procedure OP-002-003, "Component Cooling Water System," Revision 13, following maintenance activities on Essential Chiller A. The failure to follow procedure resulted in Component Cooling Water Valve CC-305A being mispositioned on

November 22, 2002, affecting operability of both Component Cooling Water System Train A and Essential Chiller AB.

The failure to follow an operating procedure is a violation of Technical Specification 6.8.1(a). This finding is greater than minor because the mitigating systems objective to ensure the availability and capability of the component cooling water and essential chill water systems were affected. The finding is of very low safety significance since the mispositioned valve did not result in loss of safety function for a single train for greater than the Technical Specification allowed outage time. The condition was promptly identified and corrected by the licensee approximately 1.5 hours after Valve CC-305A was mispositioned (Section 1R04).

Report Details

Summary of Plant Status: The plant was operated at approximately 100 percent power September 29 through December 6, 2002. Power was reduced to approximately 89 percent on December 6, 2002, to support main turbine valve testing and maintenance activities on Heater Drain Pump C. On December 7, 2002, reactor power was restored to 100 percent. Reactor power was maintained at approximately 100 percent throughout the remainder of the inspection period.

1 REACTOR SAFETY

Initiating Events, Mitigating Systems, Barrier Integrity (R)

1R04 Equipment Alignment (71111.04)

The inspectors performed the following three partial system equipment alignment inspections during the inspection period:

.1 Failure to Establish an Adequate Maintenance Procedure

a. Inspection Scope

The inspectors performed a partial equipment alignment inspection of the reactor auxiliary building cable vault and switchgear area ventilation system (SVS). A review of select maintenance work orders and corrective action documents was performed to assess the material condition and performance of the system. System configuration was assessed using Operating Procedure OP-003-026, "Cable Vault and Switchgear HVAC," Revision 7. A walkdown of accessible portions of the system was performed to assess material condition, such as system leaks and housekeeping issues, that could adversely affect system operability.

b. Findings

Introduction

The licensee failed to establish an adequate maintenance procedure to repair Ventilation Damper SVS-102 to ensure that the as-left configuration of the damper would meet its safety function. During the performance of the maintenance action instruction on September 18, 2002, the damper was repaired to move freely, however, the actuator was not replaced and the associated air supply remained isolated. The switchgear ventilation system was returned to service on September 19, 2002, with the damper actuator not operable and the damper not gagged in the minimum open position. This damper receives a close signal (minimum open) on a safety injection actuation signal. On September 21, 2002, the damper failed to remain in its safety function (minimum open) position. The failure to provide an adequate maintenance procedure (maintenance action item (MAI)) to ensure the damper was left in a configuration to meet its safety function is a violation of Technical Specification 6.8.1(a). Using the significance determination process, this issue was characterized as having very low safety significance (Green).

Description

On September 21, 2002, control room operators noted that Ventilation Damper SVS-102 indicated open, which was not its expected position. Attempts to manually close (minimum open position) Damper SVS-102 from the control room were unsuccessful. Ventilation Damper SVS-102 is normally maintained in a minimum open position and can be fully opened by control room operators to purge smoke from the switchgear and cable vault areas. The damper is designed to close to its minimum open position on a safety injection actuation signal. This minimum open positions assists with maintaining the control room ventilation envelop operable. The licensee does not credit the switchgear ventilation system in their probabilistic risk assessment for backup room cooling or recovery from a fire event.

The inspectors reviewed the damper's maintenance history and noted that the licensee had initiated troubleshoot activities in October 2001 to free Ventilation Damper SVS-102 from its seized (minimum open) position. Subsequent troubleshooting and maintenance activities were conducted using MAI 431410 in December 2001, June 2002, and September 2002.

During the maintenance activities conducted on September 18-19, 2002, the licensee removed the dirt and grit from the operator shaft and shaft sleeve interface until the damper was able to fully open and close. MAI 431410 required installation of a new actuator, however, a new actuator was not available for installation. The maintenance activity had freed the damper but the actuator air supply remained isolated. No gagging device had been installed to ensure the damper remained in the minimum open position when the switchgear ventilation system was returned to service. This as-left configuration allowed the damper to subsequently drift open and operators were unable to close it manually from the control room. The inspectors noted that the maintenance procedure failed to provide instructions on maintaining the damper in its safe minimum open position.

Analysis

Using the guidance in Appendix B of Inspection Manual Chapter 0612, this issue screens more than minor because the barrier integrity objective to provide reasonable assurance that the physical design barriers to protect the public from radionuclide releases caused by accidents or events was affected.

An NRC senior reactor analyst performed a bounding review of this condition based on a potential effect on the control room operating envelope. A Phase 1 screening was performed for the issue utilizing NRC Manual Chapter 0609, Appendix A, Attachment 1. The finding was assessed as potentially affecting the radiological barrier function for the control room, as well as the barrier function for the control room against smoke or a toxic atmosphere. A Phase 3 review was performed which considered that a redundant Damper SVS-101 was operable in the switchgear ventilation system that was at the minimum open position during the period SVS-102 had been freed and the time the damper actually went open. The duration of this condition was considered as less than

72 hours. The analysis also considered the core damage frequency from internal events, the initiating event frequency for fire in the areas that could be affected by the switchgear ventilation system, and the potential for a toxic atmosphere to require the barrier function of the control room. Based on these assumptions, the finding was determined to be of very low safety significance (Green).

Enforcement

Technical Specification 6.8.1(a) requires that the licensee establish, implement, and maintain written procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Appendix A recommends procedures for maintenance activities. The failure to provide an adequate maintenance procedure that resulted in restoring the switchgear ventilation system to service with Damper SVS-102 in a configuration where its safety function was not met for the period from September 19-21, 2002, is a violation of Technical Specification 6.8.1(a). This violation is being treated as a Noncited Violation (50-382/0204-01) consistent with Section VI.A of the NRC Enforcement Policy. The licensee documented this issue in the corrective process as Condition Report CR-WF3-2001-1360.

.2 Failure to Follow Procedure Resulting in Misalignment of Component Cooling Valve CC-305A

a. Inspection Scope

The inspectors reviewed a loss of configuration control of Component Cooling Water Valve CC-305A that potentially rendered Component Cooling Water Train A inoperable. The inspectors interviewed licensed operators and reviewed written statements, plant equipment parameter trends, and control room logs. Since the problem was related to maintenance clearance removals, the inspectors also reviewed the protective and caution tagging work controls.

b. Findings

Introduction

The licensee failed to follow Operating Procedure OP-002-003, “Component Cooling Water System,” Revision 13, following maintenance activities on Essential Chiller A. The failure to follow Operating Procedure OP-002-003 resulted in Component Cooling Water Valve CC-305A being mispositioned on November 22, 2002, affecting operability of both Component Cooling Water Train A and Essential Chiller AB by diverting flow to Essential Chiller A. The failure to follow Operating Procedure OP-002-003 is a violation of Technical Specification 6.8.1(a). This issue was characterized under the significance determination process as having a very low safety significance (Green).

Description

On November 22, 2002, operators discovered that Component Cooling Water Train A flow was aligned to both Essential Chiller A and AB. Operators discovered this condition by recognizing that component cooling water flow to Essential Chiller AB was abnormally low.

On November 22, 2002, Essential Chiller AB was placed in service to provide cooling to Train A unit coolers while maintenance activities were being performed on Essential Chiller A. Following maintenance on Essential Chiller A, Clearance Order RFR-ESS Chiller A-012, was released to restore Essential Chiller A to its standby condition. During the release of the clearance order the licensee failed to place Component Cooling Valve CC-305A to its correct position (closed) as described by Operating Procedure OP-002-003, “Component Cooling Water System,” Revision 13. Component Cooling Valve CC-305A is the inlet valve to Essential Chiller A. The final clearance instructions incorrectly directed the operator to position Valve CC-305A to its locked open position instead of locked closed ((standby position) as directed by the operating procedure. The failure to lock closed Valve CC-305A resulted in adversely affecting the required amount of component cooling water flow through Essential Chiller AB and placed the remainder of the flow requirements in through components in Component Cooling Water Train A in an unanalyzed condition .

Analysis

Using the guidance in Appendix B of Inspection Manual Chapter 0612, this issue screens more than minor because the mitigating systems objective to ensure the availability and capability of the component cooling water system was affected. Using the Significance Determination Process Phase 1 Screening Worksheet, found in Appendix A of Inspection Manual Chapter 0609, the finding was characterized as having very low safety significance (Green). The finding did not result in the loss of safety function for a single train for greater than the Technical Specification allowed outage time. The condition was recognized and corrected by the licensee approximately 1.5 hours after Component Cooling Water Valve CC-305A was mispositioned.

Enforcement

Technical Specification 6.8.1(a) requires that the licensee establish, implement, and maintain written procedures recommended in Regulatory Guide 1.33, Revision 2, Appendix A, February 1978. Appendix A recommends operating procedures. The failure to line up the component cooling water system in accordance with Operating Procedure OP-002-003, "Component Cooling Water System," Revision13, on November 22, 2002, is a violation of Technical Specification 6.8.1(a). This violation is being treated as a Noncited Violation (50-382/0204-02) consistent with Section VI.A of the NRC Enforcement Policy. The licensee documented this issue in their corrective action process as Condition Report CR-WF3-2002-01898.

.3 Containment Spray System Train A

a. Inspection Scope

The inspectors walked down the mechanical and electrical components of a critical portion of Containment Spray System Train A. The inspectors considered whether the system was properly aligned as described in the Updated Final Safety Analysis Report and Technical Specifications. This inspection focused on verifying that system valve and electrical breaker alignments were appropriate and that system instrumentation was both available and functional. The walkdown was conducted using Operations Procedure OP-009-001, "Containment Spray," Revision 10. The inspectors reviewed the containment spray system design requirements in the Updated Final Safety Analysis Report with the installed system to assess the system's ability to provide water to containment when required for safety-related mitigation operations.

b. Findings

No findings of significance were identified.

1R05 Fire Protection (71111.05)

The inspectors conducted seven inspections to assess whether the licensee had implemented a fire protection program that adequately controlled combustibles and ignition sources within the plant, effectively maintained fire detection and suppression capabilities, and maintained passive fire protection features in good material condition.

The following areas were inspected:

- Reactor auxiliary building wing area -4-foot and -35-foot elevation on October 9, 2002
- Reactor auxiliary building +35-foot and +46-foot elevation on October 22, 2002
- Reactor auxiliary building +46-foot elevation and +21-foot elevation on November 1, 2002
- Fuel handling building +46-foot elevation, +21-foot elevation, +1-foot elevation, and -35-foot elevation on November 26, 2002
- Reactor auxiliary building +46-foot elevation, +21-foot elevation, and -35-foot elevation on November 27, 2002
- Wet Cooling Towers Trains A and B, Dry Cooling Towers Trains A and B, Switchgear Rooms A, B and A/B on December 12, 2002
- Reactor auxilliary building wing area -4-foot and -35-foot elevation on December 23, 2002

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification (71111.11)

a. Inspection Scope

On October 23, 2002, the inspectors observed operator simulator training. The simulator training evaluated the operator's ability to recognize, diagnose, and respond to a interfacing system loss of coolant accident requiring plant shutdown, cooldown, and depressurization. The inspectors observed and evaluated the following areas:

- Formality of communications
- Prioritization, interpreting, and verification of alarms
- Procedural implementation
- Control board operation and manipulation of controls
- Oversight and direction provided by the shift supervisor
- The crew's and evaluator's critiques

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation (71111.12)

a. Inspection Scope

During the inspection period, the inspectors reviewed licensee implementation of the Maintenance Rule. The inspectors considered the characterization, safety significance, performance criteria, and the appropriateness of goals and corrective actions. The inspectors assessed the licensee's implementation of the Maintenance Rule to the requirements outlined in 10 CFR 50.65, and Regulatory Guide 1.160, "Monitoring the Effectiveness of Maintenance at Nuclear Power Plants," Revision 2. The inspectors reviewed the following two components and/or systems that displayed performance problems:

- Emergency Diesel Generator Train A
- Low-Pressure Safety Injection System Train A

b. Findings

No findings of significance were identified.

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

a. Inspection Scope

The inspectors reviewed risk assessments for planned or emergent maintenance activities to determine if the licensee met the requirements of 10 CFR 50.65(a)(4) for assessing and managing any increase in risk from these activities. The following two risk evaluations were reviewed:

- On October 18, 2002, Start Up Transformer A was declared inoperable for scheduled maintenance
- On October 31, 2002, Low Pressure Safety Injection Train A was declared inoperable for scheduled maintenance

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations (71111.15)

a. Inspection Scope

The inspectors reviewed the technical adequacy of two operability evaluations to verify that they were sufficient to justify continued operation of a system or component. The inspectors considered that, although equipment was potentially degraded, the operability evaluation provided adequate justification that the equipment could still meet its Technical Specification, Updated Final Safety Analysis Report, and design-bases requirements and that the potential risk increase contributed by the degraded equipment was thoroughly evaluated. The following evaluations were reviewed:

- Operability evaluation addressing the acceptability of securing reactor auxiliary building normal ventilation prior to performing a control room envelope pressurization test (Condition Report CR-WF3-2002-1579)
- Operability evaluation addressing missing nuts, washers, and a U-bolt affecting the auxiliary component cooling water system Wet Cooling Tower B (Condition Report CR-WF3-2002-01949)

b. Findings

No findings of significance were identified.

1R19 Postmaintenance Testing (71111.19)

.1 Postmaintenance Testing Verification

a. Inspection Scope

The inspectors reviewed postmaintenance tests to verify system operability and functional capabilities. The inspectors considered whether testing met design and licensing bases, Technical Specifications, and licensee procedural requirements. The inspectors reviewed the following four testing results:

- Containment Spray Pump A following a shaft sleeve gasket replacement on November 1, 2002
- Emergency Diesel Generator A following emergent repairs on October 7, 2002
- Component Cooling Water Valves CC-823A and CC-807A following maintenance activities on October 30, 2002
- Emergency Feedwater Valve EFW-223A following emergent repairs on December 3, 2002

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors observed or reviewed the following surveillance test to ensure the system was capable of performing its safety function and to assess its operational readiness. Specifically, the inspectors considered whether the following surveillance test met Technical Specifications, the Updated Final Safety Analysis Report, and licensee procedural requirements:

- Surveillance Procedure OP-903-046, " Emergency Feedwater Pump Operability Check," Revision 15, was reviewed on October 16, 2002. This surveillance tested the functional capability of the turbine-driven Emergency Feedwater Pump A/B and tested the ability of Main Steam Valves MS-401A and -401B to properly stroke.

b. Findings

No findings of significance were identified.

EMERGENCY PREPAREDNESS (EP)

1EP6 Drill Evaluation (71114.06)

a. Inspection Scope

The inspectors reviewed the drill scenario and observed activities in the simulated control room, the emergency operations facility, the technical support center, and the operations support center. The drill scenario simulated equipment failures, a site evacuation, a loss of coolant accident, and the release of radioactive material offsite. In addition, the inspectors reviewed the drill critiques and the resolution of identified performance problems. The drill was conducted on October 29, 2002.

b. Findings

No findings of significance were identified.

4 OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification (71151)

a. Inspection Scope

The inspectors reviewed data for initiating events and barrier integrity cornerstone performance indicators from the fourth quarter of 2001 through the third quarter of 2002 for the following:

- Performance indicator data for unplanned scrams per 7,000 critical hours
- Performance indicator data for reactor coolant system leakage

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems (71152)

a. Inspection Scope

The inspectors reviewed select licensee problem identification and resolution efforts associated with equipment alignment problems. The inspectors reviewed the associated licensee operability and reportability evaluations to verify corrective actions were appropriately focused to correct the problem, determine whether corrective actions were completed in a manner commensurate with the safety significance of the issue, and whether a proper extent of condition was determined.

b. Findings

Two self-revealing issues of very low safety significant findings were identified. These findings are discussed in detail in section 1R04, "Equipment Alignment."

4OA6 Meetings

Exit Meeting Summary

The resident inspectors presented the inspection results with Mr. Randy Douet, General Manager of Plant Operations, and other members of licensee's staff on January 6, 2003. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

4OA7 Licensee Identified Findings

The following finding of very low safety significance (Green) was identified by the licensee.

.1 During the 2002 Annual Operator Requalification Operating Test, two out of ten total crews failed the dynamic simulator portion of their operating test. The safety significance of this finding was very low because the overall crew failure rate was less than 34 percent, the crews were appropriately retrained and retested prior to being returned to licensed duties. This issue was entered into the licensee's corrective action process as Condition Report CR-WF3-2002-01593.

ATTACHMENT

PARTIAL LIST OF PERSONS CONTACTED

Licensee

J. Douet, General Manager, Plant Operations
C. Lambert, Director, Engineering
R. Murrillo, Senior Staff Licensing Engineer
K. Peters, Director, Nuclear Safety Assurance/Emergency Preparedness
G. Scott, Engineer, Licensing

NRC

G. Larkin, Resident Inspector

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened and Closed		
50-382/0204-01	NCV	Failure to establish an adequate maintenance procedure
50-382/0204-02	NCV	Failure to follow an operating procedure

DOCUMENTS REVIEWED

Procedures

Operations Procedure OP-009-001, “Containment Spray,” Revision 10

Operating Procedure OP-100-009, “Control of Valves and Breakers,” Revision **?????**

Operating Procedure OP-009-002, “Emergency Diesel Generator,” Revision 18

Surveillance Procedure OP-903-118, “Primary Auxiliaries Quarterly IST Valve Tests,” Revision 6

Surveillance Procedure OP-903-068, “Emergency Diesel Generator and Subgroup Relay Operability Verification,” Revision 12

Surveillance Procedure OP-903-046, “Emergency Feedwater Pump Operability Check,” Revision 15

Operating Procedure OP - 903-121, "Safety Systems Quarterly IST Valve Tests," Revision 4

Operations Procedure OP-002-003, “Component Cooling Water System,” Revision 13

Administrative Procedure UNT 005-003, "Waterford 3 Protective and Caution Tagging Guidelines," Revision 17

Administrative Procedure OP-102, "Protective and Caution Tagging," Revision 0

Corrective Action Documents

CR 2002-1634, CR 2002-1549, CR 2001-1360, CR 2002-1704, CR 2002-1587, CR 2002-1622, CR 2002-0880, CR 2002-1622, CR 2002-1607, CR 2002-1539, CR 2002-0818, CR 1995-1165, CR 1997-0238, CR 2002-1539, CR 2002-1545, CR 2002-1546, CR 2002-1704, CR 2002-1898

Other

Waterford 3 Station Performance Indicator System Availability Management Guidelines, Revision 0

W3-DBD-038, "Safety Related HVAC - Control Room Design Basis Document," Revision 1-3
Information Notice 86-76, “Problems Noted in Control Room Emergency Ventilation Systems”

Information Notice 88-61, "Control Room Habitability - Recent Reviews of Operating Experience”

Equipment Out-Of-Service Checklist Number 02-0591

Equipment Out-Of-Service Checklist Number 01-0540

Equipment Out-Of-Service Checklist Number 02-0637

Equipment Out-Of-Service Checklist Number 02-0641

Clearance Removal Authorization Number WF-02-1010

Maintenance Action Items

431410, 438125, 440414, 435152, 439979, 434492, 439377, 437064, 432683, 439890