



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**
REGION I
2100 RENAISSANCE BOULEVARD, SUITE 100
KING OF PRUSSIA, PENNSYLVANIA 19406-2713

August 26, 2019

Mr. Bryan C. Hanson
Senior Vice President, Exelon Generation Company, LLC
President and Chief Nuclear Officer, Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

**SUBJECT: PEACH BOTTOM ATOMIC POWER STATION, UNITS 2 AND 3 – BIENNIAL
PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
05000277/2019010 AND 05000278/2019010**

Dear Mr. Hanson:

On July 12, 2019, the U.S. Nuclear Regulatory Commission (NRC) completed a problem identification and resolution inspection at Peach Bottom Atomic Power Station, Units 2 and 3 and discussed the results of this inspection with Patrick Navin, Site Vice President and other members of your staff. The results of this inspection are documented in the enclosed report.

The NRC inspection team reviewed the station's corrective action program and the station's implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

The team also evaluated the station's processes for use of industry and NRC operating experience information and the effectiveness of the station's audits and self-assessments. Based on the samples reviewed, the team determined that your staff's performance in each of these areas adequately supported nuclear safety.

Finally the team reviewed the station's programs to establish and maintain a safety conscious work environment, and interviewed station personnel to evaluate the effectiveness of these programs. Based on the team's observations and the results of these interviews the team found no evidence of challenges to your organization's safety conscious work environment. Your employees appeared willing to raise nuclear safety concerns through at least one of the several means available.

The NRC inspectors did not identify any finding or violation of more than minor significance.

This letter, its enclosure, and your response (if any) will be made available for public inspection and copying at <http://www.nrc.gov/reading-rm/adams.html> and at the NRC Public Document Room in accordance with 10 CFR 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

/RA/

Jonathan E. Greives, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Docket Nos. 05000277 and 05000278
License Nos. DPR-44 and DPR-56

Enclosure:
As stated

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SUBJECT: PEACH BOTTOM ATOMIC POWER STATION, UNITS 2 AND 3 – BIENNIAL
 PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT
 05000277/2019010 AND 05000278/2019010 DATED AUGUST 26, 2019

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**U.S. NUCLEAR REGULATORY COMMISSION
Inspection Report**

Docket Numbers: 05000277 and 05000278

License Numbers: DPR-44 and DPR-56

Report Numbers: 05000277/2019010 and 05000278/2019010

Enterprise Identifier: I-2019-010-0006

Licensee: Exelon Generation Company, LLC

Facility: Peach Bottom Atomic Power Station, Units 2 and 3

Location: Delta, PA

Inspection Dates: June 10, 2019 to July 12, 2019

Inspectors: A. Rosebrook, Senior Project Engineer (Team Lead)
E. Andrews, Health Physicist
J. Cherubini, Senior Physical Security Inspector
J. Dolecki, Resident Inspector
J. Heinly, Senior Resident Inspector
J. Rey, Physical Security Inspector

Approved By: Jonathan E. Greives, Chief
Reactor Projects Branch 4
Division of Reactor Projects

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a biennial problem identification and resolution inspection at Peach Bottom Atomic Power Station, Units 2 and 3 in accordance with the Reactor Oversight Process. The Reactor Oversight Process is the NRC's program for overseeing the safe operation of commercial nuclear power reactors. Refer to <https://www.nrc.gov/reactors/operating/oversight.html> for more information.

List of Findings and Violations

No findings or violations of more than minor significance were identified.

Additional Tracking Items

None.

INSPECTION SCOPES

Inspections were conducted using the appropriate portions of the inspection procedures (IPs) in effect at the beginning of the inspection unless otherwise noted. Currently approved IPs with their attached revision histories are located on the public website at <http://www.nrc.gov/reading-rm/doc-collections/insp-manual/inspection-procedure/index.html>. Samples were declared complete when the IP requirements most appropriate to the inspection activity were met consistent with Inspection Manual Chapter (IMC) 2515, "Light-Water Reactor Inspection Program - Operations Phase." The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel to assess licensee performance and compliance with Commission rules and regulations, license conditions, site procedures, and standards.

OTHER ACTIVITIES – BASELINE

71152B - Problem Identification and Resolution

Biennial Team Inspection (IP Section 02.04) (1 Sample)

- (1) The inspectors performed a biennial assessment of the licensee's corrective action program, use of operating experience, self-assessments and audits, and safety conscious work environment.
 - **Corrective Action Program Effectiveness:** The inspectors assessed the corrective action program's effectiveness in identifying, prioritizing, evaluating, and correcting problems. The inspectors conducted a five-year review on the adjustable speed drives (ASDs) for the reactor recirculation pumps.
 - **Operating Experience, Self-Assessments, and Audits:** The inspectors assessed the effectiveness of the station's processes for use of operating experience, audits, and self-assessments.
 - **Safety Conscious Work Environment:** The inspectors assessed the effectiveness of the station's programs to establish and maintain a safety conscious work environment.

INSPECTION RESULTS

Assessment	71152B
The NRC inspection team reviewed the station's corrective action program and their implementation of the program to evaluate its effectiveness in identifying, prioritizing, evaluating, and correcting problems, and to confirm that the station was complying with NRC regulations and licensee standards for corrective action programs. Based on the samples selected for review, the team determined that the implementation of the corrective action program and overall performance related to evaluating and resolving problems was effective. In most cases, Exelon identified issues and entered them into the corrective action program at a low threshold, prioritized and evaluated concerns appropriately, and implemented corrective actions to resolve problems in a timely manner, commensurate with the safety significance of the issues. Notwithstanding this, the team identified weaknesses in some of Exelon's evaluations, the scheduling and implementation of corrective actions, and in the management of some station programs.	

In addition to implementation of the corrective action program, the inspectors also reviewed Exelon's use of operating experience, conduct of self-assessments, and safety conscious work environment at the station. Based on the samples selected for review, the inspectors concluded the use of operating experience and self-assessments were generally effective in identifying issues and improvement opportunities.

Finally, the inspectors found no evidence of significant challenges to Peach Bottom's safety conscious work environment. Based on the inspectors' observations, Peach Bottom staff are willing to raise nuclear safety concerns through at least one of the several means available.

Observation: Corrective Action Program Effectiveness

71152B

In the area of problem evaluation, inspectors identified two issues where plant operators did not adequately evaluate how degraded conditions should be treated per plant technical specifications (TSs) for emergency diesel generators (EDGs):

- On May 29, 2019, the E-1 EDG tripped during surveillance testing due to a failed cable (IR 4252679). TS 3.8.1, Emergency Power Sources, was entered appropriately; however, neither Action Statement 3.8.1 B.4.1 or B.4.2, which require an evaluation to determine if the remaining EDGs were inoperable due to a common cause, or completion of Surveillance Requirement 3.8.2, respectively, were adequately completed within 24 hours. In this case, Exelon decided to evaluate the other EDGs to ensure they were not inoperable due to a common cause and made this determination based, in large part, on satisfactory performance of previous surveillance tests and review of maintenance history. Because all four EDGs have similar cables, with similar environmental conditions and maintenance/test history, the inspectors determined that Exelon's evaluation to satisfy Action Statement B.4.1 was inadequate. Because all EDGs subsequently completed Surveillance Requirement 3.8.2 satisfactorily and no operability concerns were identified with the remaining EDGs, inspectors determined this performance deficiency and associated violation were of minor significance in accordance with IMC 0612, Appendix B, Issue Screening.
- On February 11, 2019, electrical bus E434 failed to re-energize after a partial loss of offsite power due to a lightning strike (IR 4219461). Operators did not identify that this issue required the E-4 EDG to be considered inoperable. This was identified several hours later during an Exelon fleet call. This action delayed entry into a TS action statement; however, the systems were restored prior to the allowed outage time being exceeded so there was no violation of TSs. This issue was documented in Licensee Event Report 2019-001-00 and was closed out in Inspection Report 2019002 (ML19109A097).

In the area of problem evaluation, inspectors identified several weakness in the quality of corrective action program evaluations. Specifically, the team identified the following examples of evaluations which were not technically accurate or performed in accordance with Exelon's corrective action program procedure:

- IR 4070302: The inspectors reviewed a cause evaluation for a Unit 3 primary containment isolation valve, AO-3523, which experienced elevated local leak rate testing results. Exelon determined that the cause of the elevated leakage was due to misalignment of the valve in the closed position as evidenced by a saw tooth pattern on the valve test data. The inspectors identified that the evaluation did not account for the reverse actuating actuator when the data was reviewed. This resulted in the data being assessed opposite of its actual stroke pattern and invalidated the cause of the

elevated leak rates. Furthermore, the inspectors determined that the leak rate values assessed in the evaluation were not consistent with the testing results and test acceptance criteria. The evaluation, as documented, showed AO-3523 2015 local leak rate testing as-left testing results were out of tolerance. Without an evaluation being performed, operability of the primary containment isolation valve function of AO-3523 would have been in doubt from 2015-2017. Exelon staff was able to promptly demonstrate to the team using the actual test data that the valve had been left in specification and no operability concerns existed. The licensee documented the issues with the evaluation under IR 4256962 and will re-perform the cause evaluation. The inspectors determined that the cause evaluation did not accurately identify the cause of the elevated leakage; however, the corrective actions created to replace the valve and actuator assembly were reasonable to address the issues associated with the valve and/or actuator.

- IR 4185296: The inspectors reviewed a cause evaluation which assessed a pile of metal shavings in the Unit 2 torus that were identified during the 2018 refuel outage. The inspectors reviewed the licensee's determination of the cause and determined it to be less than adequate. The cause of the metal shavings was determined to be from equipment degradation; however, no specificity of the equipment, location, or mechanism of degradation was provided. Upon further investigation, the inspectors determined that the metal shavings were likely caused by the 2K safety relief valve cycling at power in 2016 which resulted in residual rust on the tail pipe of the safety relief valve to become dislodged and enter the torus. The licensee documented the issue in the corrective action program under IR 4256326 and will update the cause evaluation.
- IR 4153095: Inspectors reviewed a cause evaluation which assessed thermal overloads that unexpectedly tripped on the E434 breaker. Exelon determined that the cause of the trip could not be identified; however, replacement of the breaker would address potential unknown failure modes. The inspectors reviewed the cause evaluation and determined that it adequately assessed the condition and that the corrective actions to replace the breaker was adequate. However, the inspectors identified that the Exelon failed to perform an ER-AA-2003 risk evaluation in accordance with PI-AA-125. Specifically, PI-AA-125 requires a risk evaluation when a cause of a failure cannot be determined. The licensee entered the issue into their corrective action program under IR 4256535 and created an assignment to complete the ER-AA-2003 risk evaluation and perform an extent of condition review. The inspectors did not identify any performance deficiencies greater than minor as a result of this observation. Two additional examples of failing to perform ER-AA-2003 risk assessment were subsequently identified during the onsite portion on the inspection.

In the area of management and implementation of corrective actions, inspectors identified several corrective actions which were not appropriately managed or which did not effectively correct the problem:

- IR 4178845: On September 30, 2018, Unit 3 experienced a trip of the 'B' and 'C' condensate pumps which resulted in a low water level SCRAM of the unit. Exelon's evaluation determined that when the condensate pump cables were replaced in 2017, they were pulled thru a wet conduit allowing moisture intrusion into the cables. Post work testing in 2017 included performance of Tan-Delta testing on the new cables. The Tan-Delta test results on the 'B' cable showed abnormal results and additional actions were required by Exelon's cable monitoring program. However, no actions were taken prior to placing the cables back in service and the cable subsequently

failed. This was documented in NRC Inspection Report 05000277& 05000278/2018004 as Green FIN 05000278/2018-004-01.

- IR 3962563 and IR 3985185: In January 2017, a reverse closing relay (RCR) associated with a motor-operated valve in the reactor coolant isolation cooling (RCIC) failed, resulting in unplanned inoperability of the Unit 3 RCIC system. The relay was identified during an extent of condition for a 2013 RCR relay failure as being vulnerable to failure due to age and were to be replaced. This corrective action was never scheduled. This failure was documented as a Green NCV in Inspection Report 05000277 & 05000278/2017002. Following the January 2017 failure, AR 03977949 was written to risk-inform their corrective maintenance schedule for replacing all RCRs that currently exceeded their service life. Inspectors reviewed IR 03985185 and determined the condition report represented a second example of NCV 05000278/2017002-01. Specifically, in March 2017, another RCR relay associated with the Unit 2 RCIC system failed, rendering the system inoperable. The inspectors determined that it was not reasonable for this corrective action to be completed on Unit 2 RCIC during the short time between the 2017 failures. Therefore, the March 2017 failure is considered to be an additional example of the performance deficiency documented in NCV 05000278/2017002-01. In accordance with NRC Enforcement Manual Section 1.3.4, "Documenting Multiple Examples of a Violation," multiple examples of a single violation are allowed to be documented as a single violation bounded by the characterization of the most significant example. NCV 05000278/2017002-01 is the most significant example because the motor-operated valve controlled by the failed relay is normally closed and would have been required to open to perform its safety function. As such, there is no additional enforcement actions, and the issue is not entered into the plant issues matrix. All 56 safety-related relays have since been replaced or are scheduled to be replaced during the next refueling outage.
- IR 4181284: An issue with primary containment isolation valve testing was identified regarding not testing a function of the system as a result of a procedure change. The extent of condition identified additional systems which may have the same vulnerability and could result in having exceeding TS surveillance requirements. Actions were created to evaluate the additional systems but were deferred for 9 months. No justification had been completed to determine why it was acceptable to defer evaluating whether a surveillance requirement was met. After inspectors brought this to Exelon's attention, the systems were evaluated and no issues were identified.
- In 2014 and 2016, cable testing results for four cables associated with the emergency auxiliary transformers were identified as abnormal. A work request was initiated to schedule enhanced monitoring and replacement of the cables in 2018. No work order was generated and the cables were neither monitored nor replaced. Upon discovery, a work order was generated and the cables are now scheduled for replacement.
- Inspectors also identified two minor violations associated with corrective actions either being cancelled or not implemented correctly. These issues are documented separately in Inspection Report 05000277 & 05000278/2019411 (ML19232A327).

Observation: Operational Experience Program	71152B
While the team identified that, in general, the station appropriately identified and implemented industry and NRC operating experience, there were a few equipment failures that properly evaluating operating experience could have prevented. Most notably was the E-3 EDG	

failure and White Notice of Violation (EA-18-107) as discussed in NRC Supplemental Inspection Report 05000277 & 05000278/2019040 (ML19178A008). Other examples include main steam isolation valve 80B valve stroking issues and a high pressure coolant injection system pressure boundary leak. These failures and their associated performance deficiencies were dispositioned in Inspection Report 05000277 & 05000278/2019001 (ML19130A086). Exelon agreed with the team's observation and, as detailed in IRs 04243817 and 04195110, are performing corrective actions, including training personnel on effective search techniques of the operating experience database.

Observation: Review of long term corrective actions for EA-18-107	71152B
Per the requirements of NRC IP 71152B, the team reviewed Exelon's progress with long term corrective actions for EA-18-107, which were not completed by the end of the supplemental inspection (Inspection Report 05000277 & 05000278/2019040). The team verified that IRs 04249183, 04249340, and 04249874, documenting the supplemental inspection team's observations, had been properly screened and evaluations were performed as appropriate. No major open corrective actions were completed from the end of the supplemental inspection until the completion of the problem identification and resolution team inspection. Corrective actions such as effectiveness reviews remain open as expected.	

EXIT MEETINGS AND DEBRIEFS

The inspectors verified no proprietary information was retained or documented in this report.

- On July 12, 2019, the inspectors presented the biennial problem identification and resolution inspection results to Patrick Navin, Site Vice President and other members of the licensee staff.

DOCUMENTS REVIEWED

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
71152B	Corrective Action Documents		1264501, 1271575, 1483753, 1484815, 1556263, 1571377, 1573040, 1573674, 1576515, 1649868, 2527605, 2568186, 2608175, 3801443, 3962563, 3966838, 3977949, 3985974, 3993931, 3994000, 3994568, 3997923, 3999609, 4001804, 4003608, 4005630, 4008207, 4008476, 4009511, 4012756, 4013582, 4016856, 4019651, 4020294, 4020298, 4020301, 4021001, 4021004, 4021006, 4021010, 4022441, 4030168, 4031002, 403027, 4030367, 4034253, 4034266, 4035036, 4035409, 4036492, 4037363, 4038804, 4040629, 4042507, 4042954, 4042605, 4044373, 4044444, 4045487, 4047278, 4052562, 4052566, 4054327, 4056699, 4057393, 4059720, 4065691, 4065757, 4067087, 4070302, 4070392, 4070745, 4070781, 4076103, 4071144, 4073299, 4077304, 4079959, 4083059, 4083518, 4083178, 4083714, 4085436, 4088290, 4090461, 4092287, 4092566, 4097059, 4097357, 4010888, 4101666, 4106618, 4107475, 4111840, 4116548, 4112720, 4112733, 4115309, 4118666, 4121224, 4123548, 4122474, 4127608, 4128185, 4128201, 4128214, 4129583, 4141255, 4142103, 4143007, 4144923, 4146926, 4153095, 4153350, 4162534, 4163735, 4163825, 4165672, 4171947, 4174830, 4175355, 4175404, 4175898, 4175920, 4176097, 4176229, 4177767, 4178993, 4181284, 4185296, 4186914, 4187727, 4194026, 4194514, 4194889, 4195447, 4197731, 4200142, 4201953, 4020305, 4211923, 4212231, 4212758, 4213437, 4221542, 4221544, 4221559, 4235568, 4235573, 4236188, 4239989, 4240548, 4241393, 4241392, 4242421, 4244532, 4246563, 4248475, 4248688, 4249277, 4249284, 4256326, 4256535, 4256840*, 4256962, 4258087, 4258942, 4259050, 4259331, 4259510, 4259562,	
	Drawings	6280-M-367, Sheet 2	P&I DIAGRAM CONTAINMENT ATMOSPHERIC CONTROL SYSTEM	Revision 81
	Miscellaneous		PLANT HEALTH COMMITTEE MEETING AGENDA, DATED	

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			JUNE 19, 2019	
			PEACH BOTTOM NRC INSPECTION - PROBLEM IDENTIFICATION AND RESOLUTION (2019) STATUS REPORT	June 26, 2019
			MAINTENANCE FUNCTIONAL AREA AUDIT REPORT, NOSA-PEA-18-01 (AR 4090541) PBAPS	February 5 to February 16, 2018
			SECURITY PROGRAMS AUDIT REPORT, NOSA-PEA-17-02 (AR 3958635), PBAPS	January 23 to January 27, 2017
			NCV 50-277 & 50-278/2017-002-01 NCV 50-277 & 50-278/2017-003-01 NCV 50-277 & 50-278/2017-008-01 NCV 50-277 & 50-278/2017-008-02 NCV 50-277 & 50-278/2017-201-01 NCV 50-277 & 50-278/2017-201-02 NCV 50-277 & 50-278/2017-403-01 NCV 50-277 & 50-278/2017-403-01 NCV 50-277 & 50-278/2018-001-01 NCV 50-277 & 50-278/2018-002-01 NCV 50-277 & 50-278/2018-002-01 NCV 50-277 & 50-278/2018-003-01 NCV 50-277 & 50-278/2018-004-01 NCV 50-277 & 50-278/2018-010-01 NCV 50-277 & 50-278/2018-010-02 NCV 50-277 & 50-278/2018-012-01 NCV 50-277 & 50-278/2018-410-01 NCV 50-277 & 50-278/2019-001-01 NCV 50-277 & 50-278/2019-001-02 NCV 50-277 & 50-278/2019-011-01 EA-17-20 (Enforcement Discretion) EA-18-08 (Enforcement Discretion)	
			ZONE ALARM HISTORY BY CLEAR CODE	06/24/2019
	Procedures	CC-AA-102	DESIGN INPUT AND CONFIGURATION CHANGE IMPACT	Revision 32

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
			SCREENING	
		EP-AA-112-200-F-04	SECURITY COORDINATOR CHECKLIST	Revision 32
		MA-AA-716-008	FOREIGN MATERIAL EXCLUSION PROGRAM	Revision 14
		NO-AA-10	QUALITY ASSURANCE TOPICAL REPORT (QATR)	Revision 94
		NO-AA-210	NUCLEAR OVERSIGHT REGULATORY AUDIT PROCEDURE	Revision 10
		OP-AA-108-115	OPERABILITY DETERMINATIONS (CM-1)	Revision 21
		OP-AA-108-115-1001	OPERABILITY EVALUATION PASSPORT ENGINEERING CHANGE DESKTOP GUIDE	Revision 1
		OP-AA-108-115-1002	SUPPLEMENTAL CONSIDERATION FOR ON-SHIFT IMMEDIATE OPERABILITY DETERMINATIONS (CM-1)	Revision 3
		OP-PB-102-106	OPERATOR RESPONSE TIME PROGRAM AT PEACH BOTTOM	Revision 10
		PI-AA-101	CONDUCT OF PERFORMANCE IMPROVEMENT	Revision 1
		PI-AA-101-1001	PERFORMANCE MONITORING AND ANALYSIS MANUAL	Revision 2
		PI-AA-101-1002	PI MANAGEMENT REVIEW MEETINGS AND REPORTING	Revision 2
		PI-AA-101-1003	PERFORMANCE GAP RESOLUTION	Revision 0
		PI-AA-115	OPERATING EXPERIENCE PROGRAM	Revision 4
		PI-AA-115-1001	PROCESSING OF LEVEL 1 OPEX EVALUATIONS	Revision 2
		PI-AA-115-1001-F-01	PRIORITY OF LEGACY IER AND SOER RECOMMENDATIONS	Revision 0

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		PI-AA-115-1002	PROCESSING OF LEVEL 2 OPEX EVALUATIONS	Revision 3
		PI-AA-115-1003	PROCESSING OF LEVEL 3 OPEX EVALUATIONS	Revision 5
		PI-AA-115-1004	PROCESSING OF NER AND ICES REPORTS	Revision 6
		PI-AA-115-1004-F-03	ICES REPORT SCREENING FORM	Revision 0
		PI-AA-120	ISSUE IDENTIFICATION AND SCREENING PROCESS	Revision 8
		PI-AA-125	CORRECTIVE ACTION PROGRAM (CAP) PROCEDURE	Revision 6
		PI-AA-125-001-F-01	CAPCO INDOCTRINATION GUIDE	Revision 1
		PI-AA-125-1001	ROOT CAUSE ANALYSIS MANUAL	Revision 3
		PI-AA-125-1003	CORRECTIVE ACTION PROGRAM EVALUATION MANUAL	Revision 4
		PI-AA-125-1004	EFFECTIVENESS REVIEW MANUAL	Revision 2
		PI-AA-125-1006	INVESTIGATION TECHNIQUES MANUAL	Revision 4
		PI-AA-126	SELF-ASSESSMENT AND BENCHMARK PROGRAM	Revision 2
		PI-AA-126-1001	SELF-ASSESSMENTS	Revision 2
		PI-AA-126-1001-F-01	SELF-ASSESSMENT	Revision 2

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		PI-AA-126-1006	BENCHMARK PROGRAM	Revision 2
		PI-AA-126-1006-F-01	BENCHMARK	Revision 2
		PI-AA-126-1006-F-03	OPPORTUNITY FOR IMPROVEMENT BENCHMARK	Revision 0
		PI-AA-127	PASSPORT ACTION TRACKING MANAGEMENT PROCEDURE	Revision 2
		RT-S-045-911-2	Precautions, Limitations, and General Instructions	Revision 24
		ST/LLRT 20.00.01	LOCAL LEAK RATE TEST DOCUMENTATION AND TRACKING	REVISION 4
		ST/LLRT 30.00.01	LOCAL LEAK RATE TEST DOCUMENTATION AND TRACKING	Revision 4
		ST/LLRT 30.07B.16	D/W PURGE SUPPLY (AO-3-07B-3523, CHK-3-07B-50095A, CHK-3-07B-50095B)	Revision 9
		SY-AA-101-122-1001	Performance of Security System Tests	Revision 13
		SY-PB-101-122-1001	Performance of Security System Tests	Revision 1
		SY-PB-101-122-1001-F-01	Security Weekly Equipment Testing - CAS	REvision 1
	WC-AA-106	WORK SCREENING AND PROCESSING	Revision 18	
	Work Orders		0246671	