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United States Nuclear Regulatory Commission
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Perry Nuclear Power Plant
Docket No. 50-440
License No. NPF-58

Subject: Response to Issues Identified in NRC Inspection Report
5000440/2006014

Ladies and Gentlemen:

In a letter, Subject: Perry Nuclear Power Plant Confirmatory Action Letter (CAL) Followup Inspection, Inspection Procedure (IP) 95002 Issues Action Item Effectiveness Review, NRC Inspection Report 05000440/2006014, dated September 20, 2006, the NRC requested that FirstEnergy Nuclear Operating Company (FENOC) respond to issues raised during the inspection. The request was to respond within 30 days of the date of receipt of the letter and describe the specific actions that have been taken, or are planned, to address these issues. The letter was received by FENOC on September 26, 2006.

Attached is the requested response to the issues identified and discussed in NRC Inspection Report 05000440/2006014. There are no commitments contained in this submittal. If you have any questions or require additional information, please contact Mr. Jeffrey Lausberg, Manager, Regulatory Compliance at (440) 280-5940.

Very truly yours,


L. William Pearce
Vice President

for

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Attachment: FENOC Response to Issues Identified in Perry Nuclear Power Plant
Confirmatory Action Letter (CAL) Followup Inspection
NRC Inspection Report 05000440/2006014

cc: NRC Region III Administrator
NRC Project Manager
NRC Resident Inspector
Eric R. Duncan, NRC RIII

**FENOC Response to Issues Identified in Perry Nuclear Power Plant
Confirmatory Action Letter (CAL) Followup Inspection
NRC Inspection Report 05000440/2006014**

Although no findings of significance were identified during the inspection activities, the NRC recommended that the FirstEnergy Nuclear Operating Company (FENOC) staff should carefully consider the issues identified in the inspection report and ensure the implemented corrective actions, individually and collectively, will support the sustainability of improving performance at the station. The NRC also recommended that the FENOC response should describe the specific actions to address the issues raised during the inspection. In particular, the NRC emphasized that if FENOC intends or has revised planned actions as a result of the observations in the associated inspection report, FENOC should describe the changes made or intended to make and the basis for those changes.

The following are excerpts from the pertinent portions of NRC Inspection Report 05000440/2006014 that characterize the issues identified in the inspection report. Each excerpt is followed by a FENOC response to address the issue.

Section 3.0 – Maintenance Procedure Adequacy

3.1.b.1 Supplemental Procedure Review Effort:

The inspectors determined that licensee personnel accomplished these reviews without using a pre-established completion schedule. This approach was not successful in completing this effort in a timely manner and resulted in the issuance of only one procedure at the end of this inspection.

All of the remaining procedures were in various stages of the supplemental review process. Subsequently, based on discussions with the inspectors, licensee personnel developed a schedule that prescribed that 70 of these procedures be completely reviewed by October 23, 2006, and that all 118 maintenance procedures be reviewed by the end of the year.

FENOC Response:

FENOC personnel developed a schedule as described above that effectively displayed the status of procedures within major steps of the supplemental review process. By October 23, 2006, 73 of these procedures were completely reviewed. Current status of the supplemental review process indicates that the remainder of the subject procedures

will be completed by the end of the year. The activities are being tracked through Condition Report 06-00418.

3.1.b.1 Supplemental Procedure Review Effort (continued):

During the review of the (FENOC) supplemental maintenance procedure review effort, the inspectors identified two maintenance procedure revision process vulnerabilities... Both of these issues had the potential to adversely affect (FENOC's) ability to sustain improvements in the maintenance procedure adequacy area.

The first maintenance procedure revision process vulnerability involved the performance of procedures in the field that had been previously identified as deficient in a document change request (DCR), condition report (CR), or on a marked-up hard copy of the procedure. In this case, the inspectors identified that (FENOC) personnel had not established any mechanism to inform maintenance supervisors and workers of these identified procedure issues so that they could be discussed during pre-job briefings. In addition, in a number of cases, (FENOC) personnel had not expeditiously addressed the procedure deficiencies nor placed the procedures on "hold." As a result, the inspectors identified that in some cases, workers had performed maintenance activities in the field using procedures that had been previously identified as requiring revision, but which had not been revised. In addressing this issue, on an interim basis, (FENOC) planned to insert "pink sheets" in work order (WO) packages to alert maintenance personnel to the issue and later planned to add a requirement for maintenance personnel to check for open DCRs for a procedure prior to performing a procedure in the field. In addition, because several of the deficient procedures were used in the maintenance personnel training program, (FENOC) established processes to ensure that procedure revisions were appropriately incorporated into the training program.

FENOC Response:

As noted above, on an interim basis, FENOC personnel instituted measures to insert "pink sheets" in WO packages to alert maintenance personnel to the issue and added a requirement to the work package walkdown process for maintenance personnel to check for pending Procedure Change Requests (PCR) for procedures required to perform the task.

With the completion of a review of all open maintenance PCRs, these interim measures have been discontinued. More than 1100 open maintenance PCRs were reviewed to determine whether the PCRs documented requests for procedure enhancements or whether the associated procedure was deficient and, therefore, should be put on hold and entered into the corrective action program. Going forward, PCRs are screened during supervisor review, and any that are identified as procedure deficiencies will be documented in the corrective action program. Deficient procedures entered into the

corrective action program are placed on hold and will not be used in training or in the field.

3.1.b.1 Supplemental Procedure Review Effort (continued):

A second maintenance procedure process vulnerability concerned the exceptions to procedural guidance and management expectations that procedure steps be accomplished in the order prescribed by the procedure...., the inspectors identified a statement in several procedures that provided the provision for maintenance personnel, at the discretion of the first line supervisor, to perform procedure steps out-of-sequence. This statement had originally been provided in 69 of the 118 maintenance procedures. (FENOC's) ongoing supplemental maintenance procedure review effort had eliminated this statement from all but 2 of the 69 procedures. However due to difficulties in performing several procedures as written, (FENOC) personnel re-incorporated the statement into 4 of the procedures.

In a second case, the inspectors identified that PAP-0905 "Work Order Process," Revision 24, which allowed maintenance personnel to perform steps in any order unless otherwise specified in the work order package, was in direct conflict with corporate procedure NOP-WM-1001, "Order Planning Process," Revision 6.

FENOC Response:

Through the investigation of CR 06-03307 it was found that four of the six procedures (GEI-0135, GEI-0136, ICI-B12-0001, and PMI-0030) which contained the provision for maintenance personnel, at the discretion of the first line supervisor, to perform procedure steps out of sequence, had the provision removed on July 26 or 27, 2006. PMI-0095, "Division 3 EDG Electrical Maintenance," was placed on hold along with 71 other maintenance procedures on July 27, 2006 pending revision. After a review of GEI-0019, "ECCS Pump Motors" it was discovered that the blanket option statement for the work supervisor was not in this procedure. The statement inside this procedure states "The work order shall state what steps are appropriate for the maintenance activity scheduled. For those steps not required by the work order, put "N/A" in those step blanks. For those steps that are applicable, initial each step as completed." This statement will be removed during the procedure revision to reformat this procedure into the current procedure format. Corrective action 06-00418-05 is tracking the completion of the revisions for these procedures. However, deletion is being considered for GEI-0019 due to its extremely limited use.

During the investigation of CR 06-03256, the potential conflict between PAP-0905 and NOP-WM-1001 was investigated. No conflict was found to exist.

PAP-0905, Work Order Process, Revision 24, Section 6.4.5.2 states, "Work Order instructions may be performed in any order unless otherwise specified in the package."

NOP-WM-1001 Revision 6 step 4.3.4.5 is for the planner to create the order while considering a logical sequence for operation steps. The intent of this step is to have an order that can be followed in a logical sequence, but the order cannot take into account all the variables that can occur during order execution. It allows some work activities to be performed in parallel without impact on the successful completion of the work activity. This may also provide for work efficiencies that can reduce out-of-service time for equipment. The current NOP-WM-1001 (Revision 8) contains the same guidance.

Work Order planning requires the steps to be laid out in a logical sequence, but Work Order execution allows steps in the Work Order to be performed in any order unless specified in the Work Order. Neither PAP-0905 nor NOP-WM-1001 will be changed for this issue.

3.1.b.2, Issues Identified During In-Field Observations:

During this observation [of Work Order (WO) 200087890], the inspectors identified Attachment 5... of GEI-0136 did not provide adequate instructions for the replacement of the auxiliary switch. Subsequently, the inspectors determined that these same procedure deficiencies were also applicable to GEI-0135, Revision 13. The inspectors also identified that the WO incorrectly sequenced the work activities.

FENOC Response:

The procedure references in GEI-0136 did not adequately provide instructions for switch replacement. GEI-0136 has since been revised to correctly describe the switch installation. GEI-0135 has not been evaluated, FENOC initiated CR 06-8900 to address this issue.

The specified sequence of steps in the order had been written to allow for flexibility by the work group. This provided the work group with the ability to perform replacement or refurbishment activities depending on the availability of parts. Since the availability of parts cannot be assured, refurbishment may be required.

3.1.b.2, Issues Identified During In-Field Observations (continued):

The inspectors observed (WO 200087860) the racking of an ABB circuit breaker,... the inspectors identified that although the WO directed electricians to measure voltage across the open and closed contacts for an alarm, the WO did not provide an expected voltage value or acceptance criteria.

FENOC Response:

In WO 200087860, the worker is expected to verify the contact status by measuring voltage across the contact terminals. The craft reviewed drawings to determine the expected voltage with contacts open, and this was discussed during the pre-job briefing.

The specific voltage measured is not critical to these steps since it is only used to determine contact status. Voltage measurement along with the "skill of the craft" is used to establish the contact status. No specific voltage value needs to be provided for this evolution.

3.1.b.2, Issues Identified During In-Field Observations (continued):

While observing the use of GMI-0073 during a hands-on training session, the inspectors identified a number of deficiencies with the procedure. GMI-0073 did not specify that a particular step only needed to be performed when a pulley was replaced. As a result, workers either recorded meaningless data or stopped work to obtain guidance from maintenance supervision. The inspectors also determined that although this deficiency was originally identified in July 2005, the procedure had not been revised nor was feedback provided to maintenance personnel. In addition, while reviewing the procedure against applicable vendor manuals, the inspectors identified that although a section in the procedure was found to contain guidance for tensioning drive belts, the guidance was only applicable to units that contained multiple belts. The inspectors' review of the vendor manual also identified that shaft damage could occur if this section was applied to single-belt units. The inspectors determined that although (FENOC) personnel had identified this issue in March 2006, the procedure had not been revised and (FENOC) personnel had not provided feedback to the maintenance staff.

FENOC Response:

GMI-0073 was placed on HOLD, effective July 28, 2006. Measurement step 5.1.5, which only applies if the pulley is being replaced, was previously flagged for deletion. This step called for recording the pitch diameter. This step was not discussed at the pre-job briefing.

The issue of not discussing pending procedure changes during pre-job briefings was noted. As a result, an immediate change was implemented to the walkdown process. During the walkdown, personnel were required to look in books created and maintained for pending procedure changes for procedures required to perform the task. This provided a peer check for changes determined to be enhancements versus deficiencies. This peer check was intended to determine if the work could be performed using the current version of the procedure as written. As a result, More than 1100 open maintenance PCRs were reviewed to determine whether the PCRs document requests for procedure enhancements or whether the associated procedure is deficient and, therefore, should be put on hold and entered into the corrective action program. Going forward, PCR's are screened during supervisor review, and any that are determined to contain deficiencies will be documented in the corrective action program.

3.1.b.3, Effectiveness in Addressing Previously Identified Human Performance

Weaknesses:

The inspectors observed mechanical maintenance personnel perform WO 200144551, which involved work on a scaffold to replace an air compressor relief valve.

The mechanics were observed to be working on a scaffold that did not have a mid-rail installed on one of the four sides of the scaffold, as required. In addition, although workers on scaffolds were required to use lanyards on tools because toeboards were not installed on the scaffold, the workers did not consistently meet this requirement. Tools from a bucket, which had been lanyarded, were placed on a platform without a lanyard.

FENOC Response:

FENOC personnel installed the missing mid-rail and inspected all plant scaffolding and verified that no similar problems existed. CR 06-03217 was initiated.

The requirements for accessing scaffolding and reviewing the scaffold tag were reviewed during the October 2, 2006, supervisor briefing. The material covered included: requirement to have scaffold user training prior to accessing scaffolds; scaffold tag must be green, and approved for use by scaffold supervisor; requirement to review the scaffold tag for any hazards identified; expectation to perform "two minute drill" prior to accessing scaffold; and ways to identify any additional potential safety hazards in the relative area of the scaffold.

Supervisors reviewed these requirements with their respective work groups/units the following day during the normal shop briefings.

3.1.b.3, Effectiveness in Addressing Previously Identified Human Performance

Weaknesses (continued):

Inspectors observed the performance of WO 200166718, which involved the megging of several motors using GEI-001, "Performing Insulation Resistance Checks," and Preventive Maintenance Instruction (PMI)-0098, "Radwaste Crane Preventive Maintenance," Revision 3. The inspectors noted that the electricians did not stop and contact maintenance supervision when they were unable to perform step 5.5.8 of PMI-0098. The step contained substep 5.5.8.1, which could not be performed because the step was unrelated to the mechanical maintenance task. In addition, the attachment to the PMI was not conducive to placekeeping.

FENOC Response:

The Electrical Maintenance craft personnel observed by the NRC did not perform sub-step 5.5.8.1 because this step was, instead, to be completed by Mechanical Maintenance craft personnel. Major Step 5.5.8 was to be performed by electrical maintenance. FENOC initiated PCR 46988 to change the sub-step to a major step and eliminate any confusion with place keeping. This item was entered into CR 06-03247.

Maintenance management communicated expectations and methods for place keeping to maintenance workers for procedures that are not formatted to facilitate placekeeping. This expectation aligns with the requirements of NOP-LP-2601, "Procedure Use and Adherence", to facilitate consistent use of placekeeping. This action was completed on October 17, 2006.

3.1.b.3, Effectiveness in Addressing Previously Identified Human Performance Weaknesses (continued):

During performance of WO 200134219, the inspectors observed that electricians failed to properly verify a room adjacent to the 4160 volt bus was not occupied by personnel prior to installing a grounding truck in a cubicle on the 4160 volt bus. Personnel were required to remain 20 feet away during this installation activity per SOI-R22.

FENOC Response:

CR 06-03249 was initiated to track this item. On August 21, 2006, The following note was added to Maintenance Plans 23621 for Transformer EHF-2-A and 26583 for Transformer EHF-1-A:

ENSURE THE REMOTE SHUTDOWN ROOM IS CLEAR OF PERSONNEL PRIOR TO ESTABLISHING FLASH PROTECTION BOUNDARIES / BARRIERS REQUIRED FOR THE PERFORMANCE OF THIS WORK. REF. NOBP-LP-3008.

"Activity Initiation Form" 50736 was submitted to change NOBP-LP-3008, "FENOC Electrical Arc Practices," be revised to add a note requiring that adjacent rooms having doors that open into the confines of a designated flash protection barrier be verified vacant prior to establishing the barrier.

3.1.b.3, Effectiveness in Addressing Previously Identified Human Performance Weaknesses (continued):

The inspectors noted varying responses during pre-job briefings when maintenance personnel discussed the human performance aspects associated with the performance of critical steps.

FENOC Response:

As noted in Inspection Report 2006014, PAP-0500, "Perry Technical Procedure Writer's Guide," Revision 2, effective July 13, 2006, provided a revised and more narrowly focused definition of "critical step." This more narrowly focused revision to the definition of "critical step" likely accounts for the varying responses from maintenance personnel during pre-job briefings observed by the inspectors. The concept of a "critical step" has since been discussed with the shops in pre-job briefs.

3.2.b Maintenance Procedure Adequacy – Records Review:

The inspectors determined that placekeeping was inadequate because some of the procedure steps in PMI-0075 that were completed were not annotated as having been completed using placekeeping tools.

During a review of WO 200053854, the inspectors identified that workers used all available options for annotating that procedure steps had been completed. For example, steps 5.1.3.1 and 5.1.3.2 of the procedure were each circled and then slashed through, initialed, and marked "N/A." As a result, the inspectors could not determine if the steps had been performed by the workers.

During a review of WO 200123164, the inspectors identified that workers failed to properly implement placekeeping tools because substeps of several sections of the procedure were not circled and initialed or lined-out. The corresponding substeps on the data sheet indicated that all the substeps had been performed by the workers.

FENOC Response:

The generic issue with inconsistent placekeeping techniques was addressed by CR 06-03250. Training materials have been developed for Maintenance personnel for both classroom and laboratory settings. One of the enabling objectives of the training is for the trainee to state the requirements for placekeeping. The laboratory performance assesses trainee placekeeping proficiency. The Maintenance organization has implemented this training.

Maintenance management communicated to maintenance workers expectations and methods for placekeeping procedures that are not formatted to facilitate for placekeeping. This expectation aligns with the requirements of NOP-LP-2601, "Procedure Use and Adherence", to facilitate consistent use of placekeeping. This action was completed on October 17, 2006.

Section 4.0 ESW Pump Coupling Assembly Concerns

4.1.b, QC Inspection Point Assignment Review:

Although all required quality control (QC) hold points had been identified, the inspectors noted that Section 4.6 of Nuclear Operating Procedure (NOP)-LP-2018, "Quality Control Inspection of Maintenance and Modification Activities," (Revision 1), included guidelines for the performance of random QC monitoring inspections... The inspectors identified that (FENOC) personnel had not performed any random QC monitoring since the implementation of NOP-LP-2018 in December, 2005.

FENOC Response:

The intent of the process for monitoring inspections, as provided in NOP-LP-2018, is to be used to supplement the QC inspection program.

Since the inspection FENOC has conducted random observations. For example, on October 5, 2006, QC performed a random inspection for the replacement of the fuel oil pump rack locating screws in accordance with Order 200137904.

Although there is no specific number of required random QC monitoring per NOP-LP-2018, FENOC will continue to use this practice based on resource allocation and priority.

Section 5.0 Training Deviations in Stressful Situations

5.2.b, Training Deviations in Stressful Situations – Records Review:

The inspectors determined that (FENOC) had previously utilized a program that specifically observed and documented performance in the area of pushback, and that this program had provided management with a tool to assess pushback performance trends on a regular basis. However, in March 2006, Perry became the pilot plant to evaluate a new fleet-wide program. This new program resulted in the loss of the direct ability to record, evaluate, and track those aspects of human performance deficiencies that were directly related to pushback.

FENOC Response:

As noted in Inspection Report 2006014, FENOC re-assessed the pilot program to enhance the quality of the input as well as the ability to retrieve the raw data from the observations. These actions will provide a mechanism for the timely identification of declining trends in pushback or other human performance areas. In particular, FENOC

revised Nuclear Operating Business Practice (NOBP)-LP-2018, "Integrated Performance Assessment/Trending," to specifically review this raw data for aspects of pushback and held a workshop with specific personnel responsible for assessing the raw data and developing trend reports. The inspectors concluded that these actions ensured FENOC's ability to sustain improving performance in this area.

Specific corrective actions associated with this observation include expanding the definition of attributes through formation of a guide book, providing a field observation hard card available for use by management in the field, and standardizing the monthly analysis of observation data and improving the report capabilities of the observation program. These corrective actions are currently in process and being tracked by CR 06-03346 and they are expected to be completed by November 30, 2006.

CONDITION REPORT						CR Number 04-03936	
TITLE: CALIBRATION OF PORTABLE VIBRATION INSTRUMENTS							
O R I G I N A T I O N	DISCOVERY DATE	TIME	EVENT DATE	TIME	SYSTEM / ASSET#		
	7/28/2004	16:00	7/28/2004	N/A	C41 1C41C0001A,B		
	EQUIPMENT DESCRIPTION STANDBY LIQUID CONTROL						
	DESCRIPTION OF CONDITION and PROBABLE CAUSE (if known) Summarize any attachments. Identify what, when, where, why, how.						
	<p>Problem Statement Vibration instruments used to collect data for the SLC pumps under SVI's C41T2001A & B do not meet the current ASME OM Code for pump and valve testing (ASME/ANSI OM-1987 Operation and Maintenance of Nuclear Power Plants, 1988 Addenda).</p>						
	<p>Additional Details The ASME OM code requires vibration instruments to be calibrated for frequency response of +/- 5% at one-third minimum pump shaft rotational speed to at least 1000 Hz. One-third of the speed for the 1C41C0001A and B pumps is 120 CPM (2 Hz). Pump shaft speed is 361 CPM (6 Hz).</p>						
	<p>SKF Microlog CMVA digital vibration analyzers are currently used to obtain data. These analyzers are only calibrated from 5 Hz to 5 kHz at +/- 5%.</p>						
	<p>Consequences This issue is a calibration issue only. It does not affect the operation of the SLC Pumps. The calibration down to 2 Hz may affect the accuracy of the vibration magnitude collected but the data is still trendable. The SKF Microlog analyzers used for SLC pump data collection are set up to take data from 0 Hz to 2500 Hz. The purpose of routine pump testing is to determine degradation of the pump. A reference value is obtained when the pump is known to be operating correctly, typically during preservice testing, the first inservice test, or after repair, replacement or routine maintenance. This reference value is used as the "baseline" and subsequent data is compared to the "baseline" value to determine degradation.</p>						
	<p>Review of the vibration trends since the SKF Microlog analyzers have been used to collect SLC pump data (2 + years) show a flat trend for both A & B SLC pumps. No signs of degradation at this point.</p>						
	IMMEDIATE ACTIONS TAKEN / SUPV COMMENTS (Discuss CORRECTIVE ACTIONS completed, basis for closure.)						
Discussed issue with control room personnel, System Engineer and ISTP program owner. Notified licensing personnel of issue.							
QUALITY ORGANIZATION USE ONLY			IDENTIFIED BY (Check one)			ATTACHMENTS	
Quality Org. Initiated		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Individual/Work Group		<input type="checkbox"/> Self-Revealed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Quality Org. Follow-up		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Supervision/Management		<input type="checkbox"/> Internal Oversight <input type="checkbox"/> External Oversight		
ORIGINATOR	ORGANIZATION	DATE	SUPERVISOR	DATE	PHONE EXT.		
MASSUCCI, M	PES	7/28/2004	DAME, R	7/28/2004	5421		

CONDITION REPORT							CR Number 04-03936			
TITLE: CALIBRATION OF PORTABLE VIBRATION INSTRUMENTS										
P L A N T O P E R A T I O N S	SRO REVIEW <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		EQUIPMENT OPERABLE <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		OPERABILITY ASSESSMENT REQUIRED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		ORG. NOTIFIED	IMMEDIATE INVESTIGATION REQUIRED <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	ORG. NOTIFIED PES	MODE CHANGE RESTRAINT <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	MODE	ASSOCIATED TECH SPEC NUMBER(S)			ASSOCIATED LCO ACTION STATEMENT(S)					
	N/A	N/A			#1 N/A					
					#2					
					#3					
	DECLARED INOPERABLE (Date / Time) N/A		REPORTABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Eval Required		One Hour N/A			APPLICABLE UNIT(S) <input checked="" type="checkbox"/> U1 <input type="checkbox"/> U2 <input type="checkbox"/> Both		
					Four Hour N/A					
					Eight Hour N/A					
					Other N/A					
	COMMENTS This is being treated as a missed surveillance requirement. ALCO 04-804 generated to track the testing not performed per tech spec 5.5.6. T.S. S.R. 3.0.3 requires the performance of the surveillance within the test interval, 92 days. A risk evaluation is required if testing will not be performed within 24 hours. John Rose has been contacted for the risk evaluation.									
Current Mode - Unit 1 1		Power Level - Unit 1 100		Current Mode - Unit 2 N/A		Power Level - Unit 2 N/A				
SRO - UNIT 1 Nemcek, M				SRO - UNIT 2 N/A			DATE 7/28/2004			
CRPA / SUPV / MRB	CATEGORY / EVAL CA		ASSIGNED ORGANIZATION PYPT		DUE DATE 9/11/2004		REPORTABLE? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> LER No. _____			
	TREND CODES Process / Activity / Cause Code(s)			Comp Type / ID (If Cause T or W)		Cause Org		REPORTABILITY REVIEWER Russell, K		
	ER2		3950		B02		PYPT		DATE 08/30/04	
	_____		_____		_____		_____			
INVESTIGATION OPTIONS <input type="checkbox"/> Maint. Rule <input type="checkbox"/> OE Evaluation						CLOSED BY		DATE 4/3/2005		