



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION I
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November 2, 2023

David P. Rhoades
Senior Vice President
Constellation Energy Generation, LLC
President and Chief Nuclear Officer (CNO)
Constellation Nuclear
4300 Winfield Road
Warrenville, IL 60555

**SUBJECT: CALVERT CLIFFS NUCLEAR POWER PLANT, UNIT 1 – 95001
SUPPLEMENTAL INSPECTION REPORT 05000317/2023040 AND FOLLOW-
UP ASSESSMENT LETTER**

Dear David Rhoades:

On September 22, 2023, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection using Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs," and discussed the results of this inspection and the implementation of your corrective actions with Patrick Navin, Site Vice President, and other members of your staff.

The NRC performed this inspection to sufficiently challenge your station's actions in response to a White finding in the Mitigating Systems cornerstone. The preliminary White finding, and Apparent Violation was documented in NRC Inspection Report 05000317/2022003 (ML22311A045). The final significance determination of the White finding and Notice of Violation was documented in NRC Inspection Report 05000317/2022090 (ML22314A100). On August 15, 2023, you informed the NRC that your station was ready for the supplemental inspection.

The NRC determined that your staff's evaluation identified the cause of the White finding. Specifically, The NRC determined that your staff's evaluation identified the root cause of the White finding. Specifically, the NRC inspectors determined your staff's root cause analysis identified two root causes and one contributing cause. The first root cause was that site leadership did not consistently engage workers to reinforce foreign material exclusion program requirements and behaviors necessary to achieve sustained event free performance prior to the August 2020 1A emergency diesel generator system outage window. The second root cause was that excellence in maintenance foreign material exclusion program behaviors were not implemented and applied during the August 2020, 1A emergency diesel generator system outage window. The contributing cause was that the site did not effectively use performance improvement tools to drive foreign material exclusion program improvements prior to the 1A emergency diesel generator system outage window in August 2020.

After sufficiently challenging aspects of Constellation's actions in addressing the White performance issue subject of this Inspection Procedure 95001, "Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs," the NRC determined that completed or planned corrective actions were adequate, and concluded Constellation's actions met the inspection objectives.

Therefore, in accordance with the guidance in Inspection Manual Chapter (IMC) 0305, "Operating Reactor Assessment Program," the White finding at Calvert Cliffs Nuclear Power Plant, Unit 1, will not be considered as an Action Matrix input as of the date of the Exit and Regulatory Performance Meeting, September 22, 2023. Calvert Cliffs Nuclear Power Plant, Unit 1, remains in the Regulatory Response Column (Column 2) of the Action Matrix until the supplemental inspection objectives for the remaining White finding and Notice of Violation issued on October 26, 2023, in NRC Inspection Report 05000317/2023090 (ML23297A192) are met.

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

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 Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding."

Sincerely,

Brice A. Bickett, Chief
Projects Branch 3
Division of Operating Reactor Safety

Docket No. 05000317
License No. DPR-53

Enclosure:
As stated

cc w/ encl: Distribution via LISTSERV

SUBJECT: CALVERT CLIFFS NUCLEAR POWER PLANT, UNIT 1 – 95001
SUPPLEMENTAL INSPECTION REPORT 05000317/2023040 AND FOLLOW-UP ASSESSMENT LETTER DATED NOVEMBER 2, 2023

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

Docket Number: 05000317

License Number: DPR-53

Report Number: 05000317/2023040

Enterprise Identifier: I-2023-040-0003

Licensee: Constellation Energy Generation, LLC

Facility: Calvert Cliffs Nuclear Power Plant, Unit 1

Location: Lusby, MD

Inspection Dates: September 18, 2023 to September 22, 2023

Inspectors: R. Clagg, Senior Project Engineer
C. Dukehart, Resident Inspector, Peach Bottom Atomic Power Station

Approved By: Brice A. Bickett, Chief
Projects Branch 3
Division of Operating Reactor Safety

Enclosure

SUMMARY

The U.S. Nuclear Regulatory Commission (NRC) continued monitoring the licensee's performance by conducting a 95001 supplemental inspection at Calvert Cliffs Nuclear Power Plant, Unit 1, 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.

The inspectors determined that the licensee's problem identification, causal analysis, and corrective actions adequately addressed the performance issue that led to the White finding.

List of Findings and Violations

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

Additional Tracking Items

Type	Issue Number	Title	Report Section	Status
NOV	05000317/2022003-01	Failure to Prevent Introduction of Foreign Material into Emergency Diesel Generator EA-22-089	95001	Closed

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 – TEMPORARY INSTRUCTIONS, INFREQUENT AND ABNORMAL

95001 - Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs

The inspectors reviewed and sufficiently challenged aspects of Constellation's problem identification, causal analysis, and corrective actions to ensure the causes of the White performance issue were correctly identified and corrective actions were adequate to promptly and effectively address and preclude repetition. The White finding and related Notice of Violation of Calvert Cliffs Unit 1, Technical Specification 5.4.1, "Procedures," was associated with the failure to implement adequate foreign material exclusion (FME) procedure and practices such that during prior emergency diesel generator (EDG) maintenance on the 1A EDG foreign material was introduced in the 1A EDG fuel oil system and remained undetected. Consequently, on February 19, 2022, the 1A EDG experienced a 1A1 engine, 3A cylinder failure and tripped during surveillance testing. The preliminary White finding, and Apparent Violation was documented in NRC Inspection Report 05000317/2022003 (ML22311A045). The final significance determination of the White finding and Notice of Violation was documented in NRC Inspection Report 05000317/2022090 (ML22314A100).

Constellation performed and documented a root cause evaluation in issue report (IR) 04518072. The NRC inspectors' review of the Calvert Cliffs Nuclear Power Plant, Unit 1 White performance issue and the associated assessment are documented below.

Supplemental Inspection Response to Action Matrix Column 2 (Regulatory Response) Inputs (1 Sample)

- (1) From September 18 to September 22, 2023, the inspectors conducted inspection to sufficiently challenge and verify all objectives of the inspection procedure were met.

INSPECTION RESULTS

Assessment	95001
1. Problem Identification	
<u>Identification</u>	
The inspectors determined that the licensee's root cause analysis documented who identified the performance issues and under what conditions. Specifically, the licensee documented that on February 19, 2022, during routine surveillance testing, the 1A EDG tripped on high	

crankcase pressure for the 1A1 engine. The White performance issue was identified when, during conduct of licensee procedure EDG-13, “24 Month Inspection of SACM Diesel Generator,” Revision 11 in August 2020 the licensee failed to properly implement FME procedures and practices as required by licensee procedure MA-AA-716-008, “Foreign Material Exclusion Program,” Revision 14, Regulatory Guide 1.33, “Quality Assurance Program Requirements (Operation),” Revision 2, and Calvert Cliffs Unit 1, Technical Specification 5.4.1, “Procedures.” Specifically, the failure to properly implement FME procedures and practices allowed the introduction of foreign material into the 1A EDG diesel fuel oil system for the 1A1 engine, cylinder 3A, which resulted in the failure of the 1A EDG during surveillance testing on February 19, 2022.

Prior Opportunities for Identification

The inspectors determined that the licensee’s root cause analysis documented when and for how long the performance issue existed and prior opportunities for identification. Specifically, the licensee documented that the foreign material was most likely introduced during maintenance on the 1A EDG on August 22, 2020, and existed until the 1A EDG failure on February 19, 2022. The licensee also documented that opportunities did not exist to identify the foreign material present in the 1A EDG diesel fuel system prior to the February 19, 2022 failure. The inspectors noted that no maintenance occurred on the 1A EDG diesel fuel oil system specific to the 1A1 engine, cylinder 3A subsequent to August 2020 which would have allowed identification of any foreign material present. The licensee documented that while larger pieces of FME were present in the system, these pieces required degradation to a size that would allow introduction into the fuel injector before the performance issue would be detectable.

Consequences and Compliance

The inspectors determined that the licensee’s root cause analysis documented significant plant-specific consequences and compliance concerns associated with the performance issue. Specifically, the licensee documented that the failure of 1A EDG resulted in its inoperability and required entry into Calvert Cliffs Nuclear Power Plant Unit 1, Technical Specification Limiting Condition for Operation 3.8.1, “AC Sources – Operating Action,” Condition E. In addition, the licensee documented the NRC’s determination of a White finding and Notice of Violation for Failure to Prevent Introduction of Foreign Material into Emergency Diesel Generator as documented in NRC Inspection Reports 05000317/2022003 (ML22311A045) and 05000317/2022090 (ML22314A100). The NRC’s risk evaluation was documented in NRC Inspection Report 05000317/2022003 (ML22311A045).

NRC Assessment:

Based on a review of the licensee’s root cause analysis, the inspectors determined that the IP 95001 inspection requirements related to Problem Identification were met.

Assessment	95001
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2. Causal Analysis

Methodology

The inspectors determined that the licensee’s root cause analysis evaluated performance issues using a systematic methodology to identify root and contributing causes. Specifically, the licensee’s root cause analysis utilized a diverse set of techniques in conducting the

investigation, these included Independent Vendor Analysis, Event and Causal Factors Charts, Barrier Analysis, Organizational Effectiveness Evaluation, and Safety Culture Component review.

The licensee's root causes analysis documented two root causes and one contributing cause.

Root Cause 1 (RC1): Site Leadership did not consistently engage workers to reinforce FME Program requirements and behaviors necessary to achieve sustained event free performance prior to the August 2020 1A EDG System Outage Window. Standards were not internalized, and leaders did not always demonstrate ownership and accountability for FME Program requirements.

Root Cause 2 (RC2): Excellence in Maintenance FME Program behaviors were not implemented and applied during the August 2020 1A EDG System Outage Window.

Contributing Cause (CC1): The site did not effectively use performance improvement tools to drive FME Program Improvements prior to the 1A EDG System Outage Window in August 2020.

Level of Detail

The inspectors determined that the licensee's root cause analysis was conducted to a level of detail commensurate with the significance and complexity of the White performance issue. Specifically, the licensee's root cause analysis utilized a formal cause evaluation process to identify problems and determine corrective actions. The root cause analysis was performed by a cross-disciplinary team of individuals with various backgrounds and levels of experience, including external subject matter experts in causal analysis. Additionally, the root cause evaluation was reviewed by a third-party organization, as required by licensee procedures.

Operating Experience

The inspectors determined that the licensee's root cause analysis considered prior occurrences of the performance issue and knowledge of prior operating experience. Specifically, the licensee's root cause analysis included searches of industry databases, the licensee's corrective action program, and review of other internal and external operating experience. The inspectors noted that, as a result of this review, the licensee identified instances that supported the development of RC1 and RC2.

Extent of Condition and Cause

The inspectors determined that the licensee's root cause analysis identified the extent of condition and the extent of cause of the performance issue. For the extent of condition, the licensee's root cause analysis identified that foreign material similar to that identified in the February 2022 1A EDG failure could potentially be present in the 1B, 2A, 2B EDGs and the 0C diesel generator. As a result, the licensee developed corrective actions to perform replacement of all 1A EDG and 0C DG fuel injectors and perform inspections of the 1B, 2A, and 2B EDG fuel injectors.

For the extent of cause, the licensee root cause analysis identified additional instances where

RC1, RC2, and CC1 existed with other plant processes, programs, equipment, or human performance. The inspectors noted that the licensee developed corrective actions to address the identified issues.

Safety Culture

The inspectors determined the root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture traits in NUREG-2165, "Safety Culture Common Language."

NRC Assessment:

Based on a review of the licensee's root cause analysis, the inspectors determined that the IP 95001 inspection requirements related to Causal Analysis were met.

Observation: Extent of Condition and Cause	95001
<p>The inspectors identified that actions specified in extent of condition review for the root cause analysis extent of condition review, Action Tracking Item 04518072-30, had not been updated to include operating experience and corrective actions taken in response to the April 2023 1A EDG failure. As a result, the licensee initiated IR 04703905 to evaluate this issue and update the extent of condition review to document corrective actions already taken as a result of the April 2023 1A EDG failure. The inspectors determined that this issue was not of more than minor significance.</p>	

Assessment	95001
<p>3. Corrective Actions</p> <p>Corrective Action to Preclude Repetition (CAPR)</p> <p><u>Completed</u></p> <p>The licensee identified the following CAPR for Root Cause 1 associated with site leadership not consistently engaged with workers to reinforce FME Program requirements and behaviors necessary to achieve sustained event free performance:</p> <ol style="list-style-type: none"> 1. Implement a Station Policy that establishes standards targeting improved Leadership engagement and accountability for the execution of the FM Program. (CAPR 04518072-73). <p>The licensee identified the following CAPRs for Root Cause 2 associated with excellence in Maintenance FME Program behaviors not implemented and applied during the August 2020 1A EDG System Outage Window:</p> <ol style="list-style-type: none"> 1. Implement revision to EDG-13, 24 Month Inspection of SACM Diesel Generator and EDG-20, Fairbanks Morse Diesel Generator Inspection to control the job as FME Zone 1 for fuel injector removal/reinstallation. (CAPR 04518072-43). 2. Implement revision to EDG-13, 24 Month Inspection of SACM Diesel Generator to add specificity for actions pertaining to FME. (CAPR 04518072-76) 3. For the 1A EDG, revise the EDG-13 PM (10242141) Maintenance Impact Plan to require the FME Zone to be Zone 1 and revise the already generated Work Order (WO) C93900575 to reflect being FME Zone 1 and ensure the FME Zone 1 requirements are included. Add key step in WO task for Responsible Maintenance 	

Supervisor to sign off after the injector line is purged and free of FM. (CAPR 04518072-68)

Effectiveness Review The inspectors determined that the documented actions, owners, and due dates were appropriate and commensurate with the corresponding CAPR. The inspectors noted that effectiveness reviews were not completed for the corresponding completed corrective actions to preclude repetition at the time of the supplemental inspection. The inspectors determined the documented effectiveness review actions contained appropriate quantitative and qualitative measures of effectiveness.

Other Corrective Actions (CAs)

Completed

The licensee identified the following corrective actions to address Root Cause 1:

1. Senior Leaders and/or Mid-Managers are to conduct and implement a Leadership Training case study for first line supervisors and above. (CA 04518072-73-02).
2. Implement training on Nuclear Professionalism, what it is and what it means. This training is for all employees. (CA 04522477-84).

The licensee identified the following corrective actions to address Root Cause 2:

1. Implement revision to EDG-13 to add specificity for actions pertaining to FME. For example, the pressure to use to blow the lines, the length of time to blow out the lines, and the purpose to ensure no FM left in the system. (CA 04518072-32).
2. Perform a Self-Assessment of a sample size of 10% of stations Zone 1 and 2 work orders to ensure compliance and best practices are integrated into these products. (CA 04518072-37).
3. Give training to Chemistry, Operations, Mechanical Maintenance, Instrument Maintenance, Electrical Maintenance, Maintenance Support craft, and first line supervisors on foreign material program, applicable governance, and best practices related to worker practices and controls. (CA 04518072-39).
4. For the 1B EDG, revise the EDG-20, Fairbanks Morse Diesel Generator Inspection, preventative maintenance Maintenance Impact Plan to require the FME Zone to be Zone 1. Add key step in work order task for Responsible Maintenance Supervisor to sign off after the injector line is purged and free of foreign material. (CA 04518072-69).
5. For the 2A EDG, revise the EDG-20, Fairbanks Morse Diesel Generator Inspection, preventative maintenance Maintenance Impact Plan to require the FME Zone to be Zone 1 and revise the already generated WO C93892025 to reflect being FME Zone 1 and ensure the FME Zone 1 requirements are included. Add key step in work order task for Responsible Maintenance Supervisor to sign off after the injector line is purged and free of FM. (CA 04518072-70).
6. For the 2B EDG, revise the EDG-20, Fairbanks Morse Diesel Generator Inspection, preventative maintenance Maintenance Impact Plan to require the FME Zone to be Zone 1 and revise the already generated WO C93892025 to reflect being FME Zone 1 and ensure the FME Zone 1 requirements are included. Add key step in work order task for Responsible Maintenance Supervisor to sign off after the injector line is purged and free of FM. (CA 04518072-71).

7. For the 0C DG1, Add Key Step to the PM "C" PERFORM EDG-13 SUBSECTIONS 6.18 & 6.19" WO Task to verify that "The injector nozzles and fuel lines were reinstalled free of foreign material" or comparable wording. (CA 04518072-72).
8. Implement the requirements that anytime a system is open, a first line supervisor or above is to be present to inspect and verify through the use of a borescope or other suitable tooling that will provide adequate verification that the system is clean and free of foreign material before system is closed. The first line supervisor or above will be required to sign off a step in the work order to attest the FME closeout inspection has been conducted satisfactorily. (CA 04518072-83).
9. Conduct an out-of-the-box evaluation on FME practices, FME Governance and Procedure (MA-AA-716-008-1001). The following disciplines are to receive the evaluation: Chemistry, Operations, Mechanical Maintenance, Instrument Maintenance, Electrical Maintenance, Maintenance Support craft, and first line supervisors on foreign material program, applicable governance, and best practices related to worker practices and controls. (CA 04518072-85).
10. Perform revision to EDG-20, Fairbanks Morse Diesel Generator Inspection, to add specificity for actions pertaining to FME. For example, the pressure to use to blow out the lines, and the purpose to ensure no FM left in system based on lessons learned from this Root Cause. This action will also basis capture the changes made to EDG-20 for the additional injection line blow out requirements and FME Zone 1 applicability. (CA 04518072-89).
11. Perform revision to EDG-20A, Fairbanks Morse Cylinder Liner Replacement, to add specificity for actions pertaining to FME. For example, the pressure to use to blow out the lines, and the purpose to ensure no foreign material left in system based on lessons learned from this Root Cause. This action will also basis capture the changes made to EDG-20A for the additional injection line blow out requirements and FME Zone 1 applicability. (CA 04518072-90).

The licensee identified the following corrective actions to address Contributing Cause 1:

1. Implement the Leadership Training developed in CA 04518072-93 that includes the lessons learned and gaps in leadership behavior related to CC1 that determined the site did not effectively use Performance Improvement Tools to drive FME Program Improvements prior to the 1A EDG System Outage Window. (CA 04518072-53).
2. Implement performance improvement / corrective action program metrics by department for review and trending, including if senior leadership team or manager and below initiated work group evaluation, human performance review board, individual excellence plan, and operator excellence plan. (CA 04522477-42).
3. Implement training on Nuclear Professionalism, what it is and what it means. This training is for all employees. (CA 04522477-84).

NRC Assessment:

Based on a review of the licensee's root cause analysis, the inspectors determined that the IP 95001 inspection requirements related to Corrective Actions were met.

Observation: Quantitative or Qualitative Measures of Success	95001
The inspectors identified that Effectiveness Reviews 04518072-95-01 and 04518072-95-02 lacked clear criteria and contained subjective language. As a result, the licensee initiated IR 04703907 to evaluate this issue and update the effectiveness review. The inspectors determined that this issue was not of more than minor significance.	

Observation: Quantitative or Qualitative Measures of Success	95001
<p>The inspectors identified that a fleet FME key performance indicator contained multiple errors in how the data is calculated and graphically represented. The inspectors noted the licensee's initial investigation indicated that this error had no impact on actions taken by the site with regards to the FME Program. As a result, the licensee initiated IR 04703509 to evaluate this issue and update the fleet FME key performance indicator calculations. The inspectors determined that this issue was not of more than minor significance.</p>	

Assessment	95001
<p>Inspection Conclusion</p> <p>The inspectors determined that the corrective actions have been prioritized commensurate with the significance and regulatory compliance, and corrective actions taken were prompt and effective, and that the Notice of Violation related to the supplemental inspection is sufficiently addressed. The inspectors also determined that the final root cause analysis produced corrective action plans which appear to effectively address and preclude repetition of significant performance issues. The inspectors determined that the root cause analysis contained sufficient information such that licensee met the objectives of the inspection procedure, and this inspection is, therefore, closed.</p>	

EXIT MEETINGS AND DEBRIEFS

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

- On September 22, 2023, the inspectors presented the 95001 supplemental 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
95001	Corrective Action Documents	IR 04287771	2019 Mid Cycle Gap to Excellence (GTE) (MA.2-16)	0
		IR 04333157	CC-R25 FME Lessons Learned	0
		IR 04479267	A EDG Tripped Due to Hi Crankcase Pressure	0
		IR 04512180	NRC ID PI&R Comments on 1A EDG CAPE	0
		IR 04518072	Latent Deficiencies in the FME Program Not Addressed	1
		IR 04522477	Inadvertent U-2 SIAS Actuation - CC Level 2	0
		IR 04541761	NRC NOV – 05000317-2022003-01, 1A DG Failure Due to FM	0
		IR 04546315	CCNPP 95001 Insp Readiness Self-Assessment (1A DG Failure)	0
		IR 04553408	95001 S/A ID: Gaps 1-7 – RCA Gaps to NRC IP 95001	0
		IR 04553411	95001 S/A ID: Gap 8 – RCA Assignments	0
	IR 04553415	95001 S/A ID: Gaps 9/10 - DG Extent of Condition	0	
	Corrective Action Documents Resulting from Inspection	IR 04703509	PM.10 FME KPI Calculation Issue	0
		IR 04703905	Evaluate EoCo Fuel Injector Inspection Plan	0
		IR 04703907	Enhancement/Clarification to Two 2022 1A EDG RCE EFR Actions	0
	Procedures	EDG-04	Fabrication of Flexible Hoses	5
		EDG-11	Cleaning and Inspection of Air Start Distributor and Check Valves	4
		EDG-13	24 Month Inspection of SACM Diesel Generator	20
		EDG-13	24 Month Inspection of SACM Diesel Generator	11
		EDG-14	EDG Fuel Oil: Relief Valve Adjustme	1
		EDG-20	Fairbanks Morse Diesel Generator Inspection	19
		EDG-20A	Fairbanks Morse Cylinder Liner Replacement	3
		MA-AA-716-008	Foreign Material Exclusion Program	17
		MA-AA-716-008	Foreign Material Exclusion Program	14
MA-AA-716-008-1000		Definitions and Measurements of FME Events	6	
MA-AA-716-008-F-01	Foreign Material Exclusion Program Work Package Forms	2		

Inspection Procedure	Type	Designation	Description or Title	Revision or Date
		PI-AA-120	Issue Identification and Screening Process	13
		PI-AA-125	Corrective Action Program Procedure	8
		PI-AA-125-1001	Root Cause Analysis Manual	6
		PI-AA-125-1003	Corrective Action Program Evaluation Manual	7
		PI-AA-125-1004	Effectiveness Review Manual	2
		PI-AA-127	PassPort Action Tracking Management Procedure	4