

June 14, 2002

Mr. Peter E. Katz  
Vice President - Nuclear Energy  
Constellation Nuclear  
Calvert Cliffs Nuclear Power Plant, Inc.  
1650 Calvert Cliffs Parkway  
Lusby, MD 20657-4702

SUBJECT: CALVERT CLIFFS NUCLEAR POWER PLANT - NRC INSPECTION REPORT  
50-317/02-03, 50-318/02-03

Dear Mr. Katz:

On May 18, 2002, the NRC completed an inspection at your Calvert Cliffs Nuclear Power Plant Units 1 & 2. The enclosed report documents the inspection findings which were discussed on June 6, 2002, with Mr. Neitmann and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, one licensee identified violation is listed in Section 40A7 of this report. If you contest the associated Non-Cited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk, Washington, D.C. 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement; and the NRC Resident Inspector at the Calvert Cliffs facility.

Immediately following the terrorist attacks on the World Trade Center and the Pentagon, the NRC issued an advisory recommending that nuclear power plant licensees go to the highest level of security, and all promptly did so. With continued uncertainty about the possibility of additional terrorist activities, the Nation's nuclear power plants remain at the highest level of security and the NRC continues to monitor the situation. This advisory was followed by additional advisories, and although the specific actions are not releasable to the public, they generally include increased patrols, augmented security forces and capabilities, additional security posts, heightened coordination with law enforcement and military authorities, and more limited access of personnel and vehicles to the sites. The NRC has conducted various audits of your response to these advisories and your ability to respond to terrorist attacks with the capabilities of the current design basis threat (DBT). On February 25, 2002, the NRC issued an Order to all nuclear power plant licensees, requiring them to take certain additional interim compensatory measures to address the generalized high-level threat environment. With the issuance of the Order, we will evaluate Calvert Cliffs Nuclear Power Plant, Inc. compliance with these interim requirements.

Peter E. Katz

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Sincerely,

/RA/

Michele G. Evans, Chief  
Projects Branch 1  
Division of Reactor Projects

Docket Nos.: 50-317, 50-318  
License Nos.: DPR-53, DPR-69

Enclosures: Inspection Report 50-317/02-03 and 50-318/02-03

Attachment 1 - Supplementary Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket Nos.: 50-317, 50-318

License Nos.: DPR-53, DPR-69

Report Nos.: 50-317/02-03  
50-318/02-03

Licensee: Calvert Cliffs Nuclear Power Plant, Inc.

Facility: Calvert Cliffs Nuclear Power Plant, Units 1 and 2

Location: 1650 Calvert Cliffs Parkway  
Lusby, MD 20657-4702

Dates: March 31, 2002 - May 18, 2002

Inspectors: David Beaulieu, Senior Resident Inspector  
Leonard Cline, Resident Inspector  
Ronald Nimitz, Senior Health Physicist  
E. Harold Gray, Senior Reactor Inspector  
Kenneth S. Kolaczyk, Reactor Inspector

Approved by: Michele G. Evans, Chief,  
Projects Branch 1  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000317-02-03, IR 05000318-02-03; Calvert Cliffs Nuclear Plant, Inc.; on 3/30-05/18/2002, Calvert Cliffs Nuclear Power Plant, Units 1 & 2. Resident Inspector Report.

The inspection was conducted by resident inspectors, a senior health physicist, and regional specialist inspectors. 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 are indicated by "No Color" or by the severity level of the applicable violation. 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. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at: <http://www.nrc.gov/reactors/operating/oversight.html> (the Public Electronic Reading Room).

### A. Inspection Findings

No findings of significance were identified.

### B. Licensee Identified Violations

Violations of very low safety significance, which were identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program. These violations and corrective action tracking numbers are listed in Section 4OA7 of this report.

## Report Details

Unit 1 was shutdown for a refueling outage and steam generator replacement during the entire inspection period. Unit 2 operated at or near 100 percent power for the entire inspection period.

### **1. REACTOR SAFETY**

Cornerstones: Initiating Events, Mitigating Systems and Barrier Integrity

#### 1R01 Adverse Weather Protection

##### a. Inspection Scope

The inspector reviewed the licensee's preparations and response to the tornado that touched down in Maryland on April 28, 2002. The inspectors examined control room logs and interviewed plant operators to verify that the licensee took appropriate actions in accordance with Emergency Response Plan Implementation Procedure (ERPIP) 3.0, Attachment 20, "Severe Weather," and Operations Administrative Policy 00-01, "Severe Weather Operations." In addition, the inspector reviewed procedure ERPIP 3.0, Attachment 1, "Emergency Action Level Criteria," to verify that the licensee's determination was correct that this event did not require an emergency declaration.

##### b. Findings

No findings of significance were identified.

#### 1R04 Equipment Alignment - Partial Walkdown

##### a. Inspection Scope

The inspectors conducted an equipment alignment partial walkdown to evaluate the operability of a selected redundant train, while the affected train or system was inoperable. The walkdown included a review of system operating instructions to determine correct system lineup and verification of critical components to identify any discrepancies that could affect operability of the redundant train or backup system. The inspectors performed a partial system walkdown on the following system:

- The 11 control room ventilation system while train "B" was removed from service for unplanned maintenance on April 15, 2002.

The inspectors reviewed the following Calvert Cliffs Nuclear Power Plant documentation:

- Operating Instruction OI-22F, Control Room and Cable Spreading Room Ventilation
- System Description 030, Control Room Ventilation System

##### b. Findings

No findings of significance were identified.

#### 1R05 Fire Protection - Fire Area Tours

a. Inspection Scope

The inspectors conducted tours of areas important to reactor safety to evaluate conditions related to: (1) licensee control of transient combustibles and ignition sources; (2) the material condition, operational status, and operational lineup of fire protection systems, equipment and features; and (3) the fire barriers used to prevent fire damage or fire propagation. The inspectors used administrative procedure SA-1-100, "Fire Prevention," during the conduct of this inspection.

The areas inspected included:

- Unit 1, Facility 1 and 2, Emergency Core Cooling System Pump Rooms
- Unit 1 125 Vdc Battery Rooms
- Unit 2 125 Vdc Battery Rooms

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors reviewed performance-based problems involving selected in-scope structures, systems, or components (SSCs) to assess the effectiveness of the maintenance program. Reviews focused on: (1) proper maintenance rule scoping, in accordance with 10 CFR 50.65; (2) characterization of failed SSCs; (3) safety significance classifications; (4) 10 CFR 50.65 (a)(1) and (a)(2) classifications; and (5) the appropriateness of performance criteria for SSCs classified as (a)(2), and goals and corrective actions for SSCs classified as (a)(1). The inspectors reviewed the most recent system health reports and system functional failures of the last two years. The following SSCs were reviewed:

- Unit 1 emergency safety features actuation system (ESFAS) sensor channel ZE shutdown sequencer. The licensee classified this system as (a)(1) in May 2001 because it exceeded the functional failure performance criteria of less than 2 functional failures per sensor channel per unit per two years. The failures were caused by a sticking test button and a failed potentiometer. The inspector evaluated the acceptability of the licensee's corrective action plan as documented in Issue Report IR3-050-469, and also reviewed actions taken with respect to a recent Unit 1 sensor channel ZE shutdown sequencer failure identified in Issue Report IR3-062-102.
- Unit 1 and 2 Control Room Panel Recorders. Although recorders are not a separate maintenance rule system, due to repeated failures, the licensee chose to consider the recorders a maintenance rule (a)(1) system to provide additional management attention.

The inspectors also reviewed the following Calvert Cliffs Nuclear Power Plant documentation:

- Station Procedure MN-1-112, Managing System Performance
- Maintenance Rule Scoping Document, Revision 18
- Maintenance Rule Indicator Report, March 2002

b. Findings

No findings of significance were identified.

1R13 Maintenance Risk Assessments and Emergent Work Evaluation

a. Inspection Scope

For the selected maintenance orders (MO) listed below, the inspectors verified: (1) risk assessments were performed in accordance with Calvert Cliffs procedure NO-1-117, "Integrated Risk Management;" (2) risk of scheduled work was managed through the use of compensatory actions; and (3) applicable contingency plans were properly identified in the integrated work schedule.

- MO2200202091 On May 1, 2002, the 12 control room ventilation system supply fan tripped off, and the unit was removed from service to troubleshoot and correct a grounded motor. The inspector assessed the risk impact for the operating unit.
- MO2200202014 On May 22, 2002, the 2A emergency diesel generator would not load above 2.7 megawatts during monthly testing. The inspector verified the licensee appropriately assessed the maintenance risk while the diesel was removed from service for troubleshooting.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed operability determinations to assess the correctness of the evaluations, the use and control of compensatory measures if needed, and compliance with technical specifications. The inspector's review included a verification that the operability determinations were made as specified by the licensee's procedure NO-1-106, "Functional Evaluations/Operability Determination." The technical adequacy of the determinations was reviewed and compared to technical specifications, the final safety analysis report, and associated design basis documents. The following evaluations were reviewed:

- Operability Determination No. 01-018 - Degradation of the neutron absorbing material, Boraflex, in the Unit 2 spent fuel racks.

- The inspector reviewed all active operability determinations to evaluate; whether compensatory measures were still valid; whether the corrective actions remained appropriate; and estimated completion dates were still commensurate with the safety significance of the issue. The operability determinations reviewed were OD 1997-001, 1999-001, 2001-007, 2001-008, 2001-011, 2001-013, 2001-015, 2001-016, 2001-020, 2002-001, and 2002-002.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed post-maintenance test procedures and associated testing activities for selected risk significant mitigating systems to assess whether: (1) the effect of testing on the plant had been adequately addressed by control room and engineering personnel; (2) testing was adequate for the maintenance performed; (3) acceptance criteria were clear and adequately demonstrated operational readiness, consistent with design and licensing basis documents; (4) test instrumentation had current calibrations, range, and accuracy for the application; (5) tests were performed, as written, with applicable prerequisites satisfied; and (6) that equipment was returned to the status required to perform its safety function. The following maintenance orders were reviewed:

- MO1200102493, Remove the Unit 1 containment recirculation pipe motor-operated throttle valve, 1-MOV-5462, to allow containment normal sump pipe cleaning. The valve was successfully retested by performing an "as-left" local leak rate test, an "as-left" valve operation test and evaluation system (VOTES) test in accordance with maintenance procedure, MOV-9, "Operating the VOTES 100 System," and stroking the valve in accordance with surveillance test procedure STP-O-65D, "Miscellaneous Containment Isolation Valves Quarterly Test."

b. Findings

No findings of significance were identified.

## 1R20 Refueling and Outage Activities

### a. Inspection Scope

For the Unit 1 refueling outage, inspectors verified that licensee control of Unit 1 safety-related equipment was in accordance with administrative procedure NO-1-103, "Conduct of Lower Mode Operations," and verified operators were tracking and maintaining minimum essential equipment status in accordance with administrative procedure, NO-1-207, "Nuclear Shift Operations Turnover." During this period the inspectors also reviewed the following activities related to the Unit 1 refueling outage for conformance with the applicable procedures, and witnessed selected activities associated with each evolution:

- Reactor coolant system fill to 43 feet.
- Initiation of Shutdown cooling.
- Preparations for entering Mode 6.

On May 16, 2002, the inspectors observed Unit 1 refueling activities in the refuel pool, the spent fuel pool, and the control room. The inspectors verified that fuel movement sheets, computer tracking, and mimic boards were used to control fuel movement in accordance with Fuel Handling Procedure 305, "Core Alterations."

### b. Findings

No findings of significance were identified.

## 1R22 Surveillance Testing

### a. Inspection Scope

The inspectors witnessed performance of surveillance test procedures and reviewed test data of selected risk-significant systems, structures, and components (SSCs) to assess whether the SSCs satisfied Technical Specifications, Updated Final Safety Analysis Report, Technical Requirements Manual, and licensee procedure requirements. The inspectors assessed whether the testing appropriately demonstrated that the SSCs were operationally ready and capable of performing their intended safety functions. The following tests were witnessed:

- STP O-55A-1 Containment Closure Verification
- PE-1-36-3-O-R 12 Turbine Driven Auxiliary Feedwater Pump Overspeed Test

### b. Findings

No findings of significance were identified.

## 1R23 Temporary Plant Modifications

### a. Inspection Scope

The inspectors reviewed temporary modification No. 2-02-0015, which temporarily replaced the reactor protection system signal derived from the auto-stop oil header pressure switch, 2PS8276, with the auto-stop oil header pressure signal from the digital feedwater system. The inspectors assessed: (1) the adequacy of the 10 CFR 50.59 evaluation; (2) that the installations were consistent with the modification documentation; (3) that drawings and procedures were updated as applicable; and (4) the adequacy of the post installation testing.

### b. Findings

No findings of significance were identified.

## 2. **RADIATION SAFETY**

Cornerstone: Occupational Radiation Safety

## 2OS1 Access Control to Radiologically Significant Areas

### a. Inspection Scope

The inspector toured the Unit 1 reactor containment, reviewed on-going work activities, and reviewed radiological data for on-going and completed work activities to evaluate the adequacy and effectiveness of applied radiological controls.

Three high radiation area access control points were physically inspected to determine if access controls (e.g., surveys, postings, and barricades) were sufficient to preclude unauthorized entry, as appropriate. Independent radiation surveys were made at boundary areas and within high radiation areas to verify radiological survey data. Electronic dosimetry setpoints (integrated dose and dose rate) were reviewed for adequacy. Remote access control coverage practices (video cameras) were reviewed for adequacy.

Radiological controls and survey records were reviewed for work activities (e.g., pipe cutting, pipe decontamination) with the potential for workers to sustain intakes of airborne radioactive materials. For these tasks, the inspector reviewed radiological survey records, engineering controls, placement and use of air samplers, and source term evaluations, as appropriate.

The inspector selectively evaluated current occupational radiation doses received by workers relative to applicable limits included in 10 CFR 20. Results reviewed included deep-dose equivalent, shallow-dose equivalent, lens-dose equivalent, committed effective dose equivalent, and committed dose equivalent. The frequency of personnel contaminations, and potential radioactive material intakes including internal dose assessments (for selected workers), were reviewed.

Access and egress controls for Radiological Controlled Areas (RCA) were reviewed including personnel monitoring practices to detect personnel contamination during RCA egress. The inspector made independent contamination surveys at the Unit 1 Butler Building RCA boundary to review effectiveness of contamination control practices.

The inspector observed radiation technician job coverage performance during plant tours relative to potential radiological hazards. Also reviewed were problem reports to determine the frequency and significance of potential radiation protection technician errors.

The inspector observed radiation worker performance during tours to determine if performance was commensurate with potential radiological hazards present. Radiological problem reports were reviewed to determine the frequency and significance of worker errors.

The inspector selectively reviewed licensee self-assessments and issue reports to determine if issues were being entered into the corrective action program, that follow-up activities were conducted, and that corrective actions were initiated consistent with the risk significance of the identified issue. (Issue Reports IR3-071-011, IR3-077-720, IR3-070-145, IR3-077-858, IR3-071-969)(2002 Quality Oversight Team Summary Reports: 3/27, 4/3, 4/11, 4/16, 4/23, 4/30)

The reviews in this area were against criteria contained in 10 CFR 20 and applicable licensee radiation protection procedures.

b. Findings

No findings of significance were identified.

2OS2 ALARA Planning and Controls

a. Inspection Scope

The inspector reviewed completed and on-going radiological work activities to evaluate the adequacy and effectiveness of the program to reduce occupational radiation exposure to as low as is reasonably achievable (ALARA).

The inspector reviewed the total occupational exposure results for those work activities expected to result in the highest personnel collective exposures. The inspector compared the results achieved (dose rate reductions, person-rem sustained) with the intended dose established in the ALARA plans for the work activities. The inspector evaluated inconsistencies (e.g., higher or low doses and dose rates) between intended and actual work activity doses and dose rates. Tasks reviewed included pipe cutting/welding, pipe end decontamination, steam generator removal, scaffolding, reactor head penetration inspections, and radiation protection coverage activities.

The inspector selected high risk special radiation work permits and reviewed the implementation of specified ALARA requirements. The inspector reviewed the in-process/post-job reviews for the permits, as appropriate.

The inspector conducted in-field observations of work activities to determine if ALARA requirements included in special work permits were implemented, workers and radiation protection personnel were using ALARA practices to minimize exposures, and workers were briefed on radiological hazards and job plans as appropriate. Job coverage records were reviewed as appropriate.

b. Findings

No findings of significance were identified.

**4 OTHER ACTIVITIES**

4OA3 Event Follow-up

(Closed) Licensee Event Report 50-317/2002-01-00 Vital Bus Circuit Breaker Inoperable Due to Seismic Positioner Mounting

On March 5, 2002, electrical maintenance personnel determined that the seismic restraint bracket on the 14B 480 Volt AC vital bus supply circuit breaker was installed upside down. Licensee and vendor evaluations of the breaker condition and its maintenance history determined that it had been inoperable but functional in all conditions but a safe shutdown earthquake from the initial construction of Unit 1 until the breaker replacement on March 5, 2002. This condition resulted in a violation of the Limiting Condition for Operation for Technical Specification (TS) 3.8.9, and TS 3.8.10, which require all AC vital busses to be operable in modes 1 through 4 and during fuel movement or core alterations. At the time of discovery, Unit 1 was defueled. The licensee determined that the root causes of this TS violation were vendor quality issues and inadequate acceptance testing during initial construction. Corrective actions included the inspection of all 480 Volt AC breakers at both Units 1 and 2. No other breakers were found to have the seismic restraint bracket incorrectly installed. This licensee-identified violation is considered more than minor because it had a credible impact on safety. With the seismic restraint installed upside down, vendor seismic testing determined that during a safe shutdown earthquake, the breaker would have sustained damage sufficient to render it inoperable, which would have removed power from several safety-related loads. This finding was determined to be of very low safety significance (green) because of the low probability of a safe shutdown earthquake, and because the safety-related loads powered by the affected safety-related bus were not of high risk significance. This licensee-identified violation is discussed in Section 4OA7 of this report. This finding was documented in the licensee's corrective action program as Issue Report IR3-065-117. LER 50-317/2002-001 is closed.

#### 40A5 Other - Steam Generator Replacement Project

##### a. Inspection Scope

The inspectors observed steam generator lifting and rigging activities associated with removing the 11 steam generator steam drum assembly, as well as activities associated with installation of the new lower assembly inside containment. Prior to these activities, the inspectors reviewed the procedures for load testing the temporary lift device, and installation of the auxiliary crane assembly to verify their adequacy. The inspectors also reviewed nonconformance reports that documented issues associated with lifting and rigging activities to verify that identified problems were appropriately resolved.

The inspectors verified that the transport of the old 11 and 12 steam generators to the steam generator storage facility was completed in accordance with criteria contained in 10 CFR 20, site technical specifications, and applicable site and project procedures. Pre and post transport radiation and contamination survey data were reviewed as were radiation dose maps and post-move contamination surveys for the travel routes of the steam generators. The inspectors made independent radiation measurements around the steam generator storage facility to verify licensee survey data, verify readings from a local real-time environmental radiation monitor, and verify conformance with facility radiation dose rate limits.

The inspectors reviewed the preliminary weld packages for the project and compared them to code test and inspection requirements. The inspectors also reviewed radiographs of the reactor coolant system pipe welds (prior to post-weld heat treatment) and the intermediate radiographs for the 11 steam generator girth weld and related radiograph procedure to verify their adequacy. The inspectors observed the shell cone girth welding on the outside of both steam generators and on the inside of the 12 steam generator. The inspectors observed the internal girth weld surface of 12 steam generator for compatibility with the upcoming inservice inspection ultrasonic inspection. The post-weld heat treatment temperature and conditions for the 11 steam generator hot and cold leg welds were also reviewed.

##### b. Findings

No findings of significance were identified.

#### 40A6 Management Meetings

##### .1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on June 6, 2002. The licensee acknowledged the findings presented.

The inspectors reviewed some proprietary materials during the steam generator replacement inspection; however, no proprietary information is included in this report.

##### .2 Annual End-of-Cycle Assessment Meeting

A meeting between the NRC and Constellation Generation was held on April 5, 2002, in the Education Center at the Calvert Cliffs Nuclear Power Plant, to discuss the End-of-Cycle Plant Performance Assessment results. This assessment was documented in a letter to the licensee, dated March 4, 2002, for the period April 1 through December 31, 2001. An additional discussion topic was the Unit 1 failure of the 11 auxiliary feedwater pump turbine in May 2001, as described in an NRC letter of January 14, 2002, and its enclosed supplemental inspection report. This additional discussion satisfied the NRC Inspection Manual Chapter 0305, "Action Matrix," requirement to conduct a Regulatory Performance Meeting. The NRC presentation was lead by Michele G. Evans, Chief, Projects Branch 1, Division of Reactor Projects.

#### 40A7 Licensee Identified Violation

The following violation of very low significance (green) was identified by the licensee and is a violation of NRC requirements which meets the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as a Non-Cited Violation (NCV).

Technical Specifications 3.8.9 and 3.8.10 require all vital AC busses to be operable in modes 1 through 4 and during fuel movement or core alterations. Contrary to this, the 14B 480 Volt AC vital bus supply circuit breaker was inoperable since Unit 1 initial construction due to a seismic restraint that was installed upside down. This issue was documented in the licensee's corrective action program as Issue Report IR3-065-117. This event was determined to be of very low safety significance (green) because of the low probability of a safe shutdown earthquake, and because the safety-related loads powered by the affected safety-related bus were not of high risk significance. Therefore, this violation is being treated as an NCV.

## Supplementary Information

a. Key Points of Contact

M. Geckle, Director, Nuclear Regulatory Matters  
 D. Holm, Superintendent, Nuclear Operations  
 T. Kirkham, Senior Plant Health Physicist  
 M. Korsnick, Superintendent, Work Management  
 K. Nietmann, Manager, Nuclear Performance Assessment Department  
 W. Paulhardt, Assistant General Supervisor, Radiation Safety  
 T. Pritchett, Manager, Nuclear Engineering Department  
 S. Sanders, General Supervisor, Radiation Safety  
 J. Spina, Superintendent, Nuclear Maintenance  
 R. Szocho, General Supervisor, Plant Engineering  
 L. Weckbaugh, Manager, Nuclear Support Services  
 W. Wyvill, ALARA Supervisor

b. Items Opened, Closed, and DiscussedClosed

50-317/02-01-00      LER      Supply circuit breaker to a 480 Volt AC vital bus was inoperable since Unit 1 initial construction due to an incorrectly installed seismic restraint. (Section 4AO3)

c. List of Documents ReviewedSteam Generator Replacement Project

Welder Status report dated 2/26/02  
 Welding Procedure Specification GT/3.3-1, Rev. 0  
 QEP 12.6, "Radiographic Examination," Rev. 1, dated 1/18/02  
 QEP 18.1, "Quality Assurance Audits," dated 3/14/01  
 QEP 20.1, "Control of Welding," dated 7/16/01  
 QEP 20.2, "Welding Procedure Qualification," dated 8/14/01  
 QEP 20.3, "General Welding Requirements for American Society of Mechanical Engineers," dated 12/30/01  
 QEP 20.4, "Welder Performance Qualification," dated 11/30/01  
 QEP 20.5, "Control of Weld Filler Material," dated 1/30/02  
 QEP 20.6, "Control of Pre and Post Weld Heat Treatment," dated 5/25/01  
 CCNPP Replacement Steam Generator Drawing - Weld Map, Small Bore Non-destructive Examination, Rev. 1  
 CCNPP Replacement Steam Generator Drawing - Weld Map, Large Bore Non-destructive Examination, Rev. 1  
 SGRP-UT-2, "Ultrasonic Test of Class 1 and 2 Vessel Welds," Rev. 0  
 SGRP-UT-3, "Ultrasonic Test of Ferritic Piping Welds," Rev. 0  
 ES199601526-100, Replacement of Steam Generators  
 ES199601526-101, Temporary Lifting Device

ES199601526-102, Hatch Transfer System  
ES199601526-103, Installation of Temporary Platforms  
ES199601526-104, Unit 1 Reactor Cavity Decking  
ES199601526-105, Miscellaneous Rigging and Handling  
ES199601526-106, Unit 1 Reactor Coolant System Temporary Supports  
ES199601526-109, Unit 1 Feedwater  
ES199601526-111, New Steam Generator Recirculation Piping  
ES199601526-116, Unit 1 Replacement Steam Generator Modification  
ES199601526-119, Unit 1 Component Cooling Water  
ES199601526-120, Unit 1 Miscellaneous Interferences  
NCR101, Rebar Clearance Violation  
NCR126, Weld Oven Temperature and Operation is Inadequate  
NCR130, Welder not Certified for Two Inch Pipe Weld  
MEI-80205-P02, "Temporary Lift Device"  
WP 1-5085, "Temporary Crane Installation/Removal"  
MN-1-104, "Load Handling"  
Temporary Alteration No. 1-02-010, Bypass Polar Crane Main Hoist Geared Upper Limit Switch  
Steam Generating Team In-service Inspection Plan