



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION II  
101 MARIETTA STREET, N.W.  
ATLANTA, GEORGIA 30323

Report No.: 50-261/91-14

Licensee: Carolina Power and Light Company  
P. O. Box 1551  
Raleigh, NC 27602

Docket No.: 50-261

License No.: DPR-23

Facility Name: H. B. Robinson

Inspection Conducted: May 11 - June 7, 1991

Lead Inspector: *R. E. Carroll for*  
L. W. Garner, Senior Resident Inspector

*6/25/91*  
Date Signed

Other Inspector: K. R. Jury, Resident Inspector

Approved by: *H. O. Christensen*  
H. O. Christensen, Section Chief  
Reactor Projects Branch 1  
Division of Reactor Projects

*6/25/91*  
Date Signed

SUMMARY

Scope:

This routine, announced inspection was conducted in the areas of operational safety verification, surveillance observation, maintenance observation, and followup.

Results:

A violation was identified for failure to document a Technical Specification limiting condition for operation entry into the Shift Foreman's Log (paragraph 3).

A non-cited violation was identified for failing to enter the correct action statement during an accumulator volume decrease on April 12, 1991 (paragraph 3).

A non-cited violation was identified for failure to implement the surveillance schedule for a maintenance surveillance test (paragraph 3).

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A non-cited violation was identified for failure to include emergency diesel generator components in the lubrication program (paragraph 4).

An unresolved item was identified to review the impact of entrainment losses on the small break loss of coolant accident analysis (paragraph 2).

Valve tagging was not aggressively pursued during refueling outage 13. Subsequent efforts have produced satisfactory results (paragraph 2).

Not providing a writers guide for operating and operations surveillance test procedures, development, and reviews was a weakness (paragraph 2).

On May 20, 1991, a rededication ceremony was held to commemorate the Unit's twentieth anniversary (paragraph 2).

System Engineer identification of missed lubrication points on the emergency diesel generators was noteworthy (paragraph 4).

An Nuclear Assessment Department observation of questionable torque values during leak repair to the B component cooling water pump discharge check valve was noteworthy (paragraph 4).

## REPORT DETAILS

### 1. Persons Contacted

R. Barnett, Manager, Outages and Modifications  
C. Baucom, Senior Specialist, Regulatory Compliance  
\*D. Bauer, Regulatory Compliance Coordinator, Regulatory Compliance  
C. Bethea, Manager, Training  
\*W. Biggs, Manager, Nuclear Engineering Department Site Unit  
\*S. Billings, Technical Aide, Regulatory Compliance  
\*R. Chambers, Manager, Operations  
\*T. Cleary, Manager - Balance of Plant Systems and Reactor Engineering,  
Technical Support  
D. Crook, Senior Specialist, Regulatory Compliance  
C. Dietz, Manager, Robinson Nuclear Project  
W. Doorman, Acting Manager, Nuclear Assessment Department  
J. Eaddy, Manager, Environmental and Radiation Support  
S. Farmer, Manager-Engineering Programs, Technical Support  
R. Femal, Shift Supervisor, Operations  
\*D. Gainey, Senior Specialist, Nuclear Engineering Department  
\*W. Gainey, Manager, Plant Support  
J. Kloosterman, Manager, Regulatory Compliance  
D. Knight, Shift Supervisor, Operations  
D. Labelle, Project Engineer, Nuclear Assessment Department Site Unit  
\*L. Lynch, Supervisor, Quality Control  
\*A. McCauley, Manager - Electrical Systems, Technical Support  
R. Moore, Shift Supervisor, Operations  
\*M. Page, Manager, Technical Support  
D. Seagle, Shift Supervisor, Operations  
\*J. Sheppard, Plant General Manager, H. B. Robinson Steam Electric Plant  
\*R. Smith, Manager, Maintenance  
\*R. Steele, Shift Supervisor, Operations  
W. Stover, Shift Supervisor, Operations  
\*B. Toney, Senior Specialist, Environmental and Radiation Control  
G. Walters, Operating Event Followup Coordinator, Regulatory Compliance  
D. Winters, Shift Supervisor, Operations

Other licensee employees contacted included technicians, operators, mechanics, security force members, and office personnel.

\*Attended exit interview on June 7, 1991.

Acronyms and initialisms used throughout this report are listed in the last paragraph.

### 2. Operational Safety Verification (71707)

The inspectors evaluated licensee activities to confirm that the facility was being operated safely and in conformance with regulatory requirements. These activities were confirmed by direct observation, facility tours,

interviews and discussions with licensee personnel and management, verification of safety system status, and review of facility records.

To verify equipment operability and compliance with TS, the inspectors reviewed shift logs, Operations records, data sheets, instrument traces, and records of equipment malfunctions. Through work observations and discussions with Operations Staff members, the inspectors verified the staff was knowledgeable of plant conditions, responded properly to alarms, adhered to procedures and applicable administrative controls, cognizant of in-progress surveillance and maintenance activities, and aware of inoperable equipment status. The inspectors performed channel verifications and reviewed component status and safety-related parameters to verify conformance with TS. Shift changes were routinely observed, verifying that system status continuity was maintained and that proper control room staffing existed. Access to the control room was controlled and Operations personnel carried out their assigned duties in an effective manner. Control room demeanor and communications were appropriate.

Plant tours and perimeter walkdowns were conducted to verify equipment operability, assess the general condition of plant equipment, and to verify that radiological controls, fire protection controls, physical protection controls, and equipment tagging procedures were properly implemented.

#### Non-conservative Basis For Transfer To Recirculation

On May 14, 1991, while performing IPE activities, the licensee identified that NFS Design Activity 89-0001 under-estimated the loss of inventory from the RCS while transferring from the injection phase to the recirculation phase during a large break LOCA. The calculation failed to include the inventory loss due to liquid entrainment in the steam. Subsequent re-analysis demonstrated that with the ECCS systems operating in the configuration contained in existing emergency procedures, the peak cladding temperature would remain approximately 950 degrees F below the maximum allowable temperature limit of 2200 degrees F specified in 10 CFR 50.46 (b) (1). The applicable emergency procedure, EPP-9, Transfer to Cold Leg Recirculation, requires one SI pump to be injecting into the RCS during alignment of ECCS components prior to the recirculation phase transfer.

The sequence of events associated with the above described deficiency is as follows:

- ° In May 1987, CP&L was notified by Westinghouse that RCS inventory would be depleted more rapidly than was previously anticipated/analyzed by decay heat boiling.
- ° On June 5, 1987, Westinghouse provided the results of an evaluation which demonstrated that with: (1) the injection by two SI pumps during the alignment for transfer to recirculation (2)

operation of one RHR pump for at least one minute immediately prior to the transfer and (3) a less than 3 minute interruption of ECCS flow during the transfer, peak cladding temperatures would be maintained below the 10 CFR 50.46 limitation.

- ° EPP-9 was revised on June 6, 1987, to incorporate the above described operating restrictions.
- ° On July 6, 1987, Westinghouse transmitted a more detailed evaluation including equations and descriptive text of the large break LOCA analysis previously summarized on June 5, 1987.
- ° In January 1988, single failure considerations resulted in the recognition that only one SI pump could be available during a LOCA. Unit operation was restricted to 60 percent of full power by TS Amendment 115.
- ° On June 20, 1988, TS Amendment 119 authorized full power operation with only one SI pump available for mitigation of postulated accidents, including a LOCA. The supporting analysis did not address the consequences of having only one SI pump available during performance of EPP-9.
- ° On January 5, 1989, NFS Design Activity 89-0001 was issued to demonstrate that one SI pump would provide sufficient flow to maintain core cooling within acceptable limitations during performance of EPP-9.
- ° On January 27, 1989, revision 5 to EPP-9 was issued to require operation of only one SI pump during alignment of ECCS components prior to the recirculation phase transfer.
- ° On May 8, 1991, NED requested NFS to provide details and supporting analysis for transfer to recirculation as provided for in EPP-9.
- ° On May 14, 1991, NFS review of Design Activity 89-001 and discussions with Westinghouse resulted in the recognition that the calculation did not correctly model the vessel inventory depletion during transfer to recirculation. Other existing analyses were available to support safe operation up to 65 percent of full power.
- ° On May 14, 1991, reactor power was decreased from 100 percent at 4:12 p.m., to less than 65 percent at 7:46 p.m..
- ° Westinghouse, assuming a 700 degree F maximum peak cladding temperature and an ANS-1979 decay heat load, justified return to 95 percent power. A power increase was initiated at 8:10 p.m. on May 14, 1991, and 90 percent power was obtained at 5:25 a.m. on May 15, 1991. Power was voluntarily limited to approximately 90 percent pending additional re-analysis.

- ° On May 15, 1991, the NRC questioned utilization of the ANS-1979 decay heat load. The decay heat load of ANS-1971 plus 20 percent is approved for 10 CFR 50.46 Appendix K analyses. Subsequently, using the latter heat load and a 700 degrees F maximum peak cladding temperature, Westinghouse demonstrated that 92.5 percent power operation was acceptable.
- ° On May 29, 1991, using the ANS-1971 plus 20 percent model, Westinghouse determined that operation of the ECCS system in accordance with EPP-9 would result in a maximum peak cladding temperature of approximately 1250 degrees F (well within the 10 CFR 50.46 ECCS performance criteria).
- ° On May 29, 1991, results of the Westinghouse re-analysis was discussed with the NRC. Full power operation was resumed later that day at 1:00 p.m..

As discussed above, the licensee failed in June 1988 to analyze the consequences of having only one SI pump delivering ECCS flow during performance of EPP-9. Furthermore, when EPP-9 was revised to require operation of only one SI pump, the January 5, 1989 analysis (NFD Design Activity 89-0001) failed to include losses due to entrainment. The latter item is of special concern because the licensee had in their possession since July 6, 1987, the Westinghouse analysis which addressed entrainment inventory losses. In addition to the above large break LOCA concerns, inventory losses due to entrainment during a small break LOCA are presently under review. Pending the results of this review, this is considered an Unresolved Item: Review Impact of Entrainment Losses on the Small Break LOCA Analysis, 91-14-01.

#### SI Accumulator In-Leakage (LER 91-005)

On April 10, 1991, the boron concentration in B SI accumulator was identified as being below the administrative limit of 2,000 ppm. Subsequent attempts to drain and fill the accumulator (using RWST water supplied through the SI pumps) while maintaining level within the TS required range, were unsuccessful in restoring the boron concentration to above the administrative limit. On April 12, in order to restore the boron concentration and to minimize SI pump cycling, the accumulator was drained below the TS required minimum volume of 825 cubic feet and refilled with water of the proper boron concentration. This evolution took approximately one-half hour to complete. The cause of the decreased boron concentration was considered to be check valve backleakage from the RCS into the accumulator (via check valves SI-875B and 875E).

During this drain and fill evolution on April 12, TS Action Statement 3.3.1.2a., which states that "One accumulator may be isolated for a period not to exceed four hours," was applied. As the accumulator was not isolated however, the inspectors informed the licensee on April 13, 1991, that since a specific action statement does not exist for an accumulator

not meeting boron concentration, pressure, or volume requirements, literal interpretation of TS required entrance into TS 3.0. Subsequent to this discussion, the licensee agreed with this interpretation and issued LER 91-005 as required for an entrance to TS 3.0.

LER 91-005 discusses the basis utilized by the licensee in applying TS action statement 3.3.1.2a. As addressed in the LER, the licensee believed entrance into the specification to be consistent with past applications, and that it was "considered to be conservative due to the more limiting time requirements imposed by this action statement". The LER also addresses TS inconsistencies which contributed to the misapplication of the action statement. The licensee initiated WRs 91-AGRH1 and AGRG1 to document and investigate the backleakage through the series of check valves between the RCS and B SI accumulator. Additionally, a review is to be performed to determine wording enhancements to "ensure proper and consistent application of associated action statement". This review, with any proposed TS change(s) identified and submitted, is to be complete by November 29, 1991. Accordingly, this LER remains open pending completion of the review and submittal of any proposed TS change(s). Not entering the correct TS action statement is considered a violation; however, this violation meets the criteria specified in Section V.A. of the NRC Enforcement Policy for not issuing a Notice of Violation and is not cited. This violation is identified as a NCV: Failure To Enter Applicable TS Action Statement, 91-14-02.

#### Facility Tours

On May 13, 1991, during an RTGB instrumentation channel check, the inspectors observed that PI-501, RCS wide range pressure indicator, had failed downscale. The control operator subsequently verified by ERFIS, that the associated pressure transmitter was functioning properly. The Regulatory Guide 1.97 indicator was subsequently repaired under WR/JO 91-AGZMI and returned to service on May 15, 1991.

#### OP And OST Writer's Guide

While reviewing log keeping practices associated with the overdue surveillances described in paragraph 3, the inspectors observed inconsistencies with LCO entries and surveillance test activities. Operations personnel are presently expected to be aware when a surveillance test places the unit in an LCO; however, procedures do not consistently address LCO entries. Operations procedure writers include a note immediately preceding the applicable procedure steps that a TS LCO applies. In other procedures, steps have been incorporated to ensure that when equipment is removed from service for testing, the redundant TS required equipment is available (i.e., help ensure TS 3.0 is not inadvertently entered). A

writers guide has not been developed to address this inconsistency in OPs and OSTs. Consistency is evidently attained by on-the-job training and consensus. The failure to provide a writer's guide for the development and review process of OPs and OSTs is a weakness. This item was discussed with the Operations Manager. A draft writer's guide for these procedures is expected to be in place by the end of the year.

### Valve Tagging

At the end of the RO 13, a total of 709 valves were identified as missing valve tags. This number included 477 valves identified during end-of-outage system lineups and 232 valves which were previously identified. The large number of missing tags is indicative of a non-aggressive valve tagging program during RO 13. Tagging efforts subsequent to the outage have produced satisfactory results. The number of identified valves with missing tags has been reduced to approximately 200. Most of these valves were located in either high radiation or locked high radiation areas, or were spare valves. The inspectors discussed the concern with the valve tagging program with the Operations Manager.

### Robinson Rededication

On May 20, 1991, a rededication ceremony was held at the H. B. Robinson's Visitor Center to commemorate the twentieth anniversary of Unit 2 commercial operations which commenced on March 7, 1971. Attendees included U. S. Senator Strom Thurmond; U. S. Representative Robin Tallon; William H. Young, Assistant Secretary For Nuclear Energy; state and local politicians; and business leaders.

One violation with two examples and one NCV were identified.

### 3. Monthly Surveillance Observation (61726)

The inspectors observed certain safety-related surveillance activities on systems and components to ascertain that these activities were conducted in accordance with license requirements. For the surveillance test procedure listed below, the inspectors determined that precautions and LCOs were adhered to, the required administrative approvals and tagouts were obtained prior to test initiation, testing was accomplished by qualified personnel in accordance with an approved test procedure, the test was completed at the required frequency, the test conformed to TS requirements, and the system was properly properly returned to service. Specifically, the inspectors witnessed/reviewed portions of the following test activities:

OST-401

Emergency Diesels



### Overdue Surveillances

On May 19, 1991, at 8:00 p.m., Operations personnel were informed that MST-101, Boric Acid Heat Tracing Operability, and MST-902, Battery Test - Daily, had not performed on May 17, 1991, as scheduled. The MSTs were subsequently completed by 8:15 p.m.. The latter surveillance test (TS 4.6.3.1 requirement) measures the voltage and temperature of each battery pilot cell at a frequency of 5 days per week. The first test, used to demonstrate that two channels of heat tracing are operable for the flow path from the boric acid storage tanks, is not a TS required surveillance test. In accordance with PLP-024, Surveillance Testing Program, section 6.4, both safety-related batteries were determined to be out of service from 8:00 p.m.; however, TS does not require equipment to be declared out of service (inoperable) when a surveillance test is not performed. The shift supervisor's log identified that the batteries were out of service for 15 minutes and a potential reportable event per 10 CFR 50.73(a)(2) (vii)(A) existed. However, the log entry did not specifically identify that with both safety-related batteries out of service, TS 3.0 was entered (i.e., unit shall be placed in hot shutdown within eight hours). The inspectors verified via interviews with the shift supervisor that he was aware at the time of notification that TS 3.0 was applicable. Procedure OMM-001, Operations - Conduct Of Operations, revision 25, paragraph 5.5.3, required the Shift Foreman's Log to include entry into any LCO condition with reference to the TS and time requirement. The failure to make the required log entry involving TS 3.0 is considered a violation: Failure To Maintain Logs As Required By Operating Procedures, 91-14-03.

The licensee conducted an investigation into the circumstance involving failure to perform MST-101 and MST-902 as scheduled. The procedures were scheduled for night shift on May 17, 1991; however, other work activities occupied the assigned crew. As a result, the procedures were left to the next night shift for performance. Apparently, the turnover consisted of attaching a note to the procedures and laying them on the night shift lead technician's desk; during housekeeping activities, the procedures were moved to another individual's desk. The informality of the turnover process contributed to the MSTs not being performed as scheduled. This was discussed with the Maintenance Manager who is reviewing the turnover process. Additionally, work practices are being revised to place additional controls on the maintenance surveillance scheduling process. The inspector reviewed ACR 91-166 which documented the incident and proposed corrective actions. Successful completion of these corrective actions should preclude recurrence. Failure to perform surveillance scheduling activities as required by TS 6.5.1.1.1.a and Item 1.f of Appendix A of Regulatory Guide 1.33 as implemented by plant procedure PLP-024 is a violation. This violation meets the criteria specified in Section V. A. of the NRC Enforcement Policy for not issuing a Notice of Violation and is not cited. The violation is identified as a NCV: Failure To Implement Surveillance Scheduling Procedure For MST-902, 91-14-04.

One violation and one NCV were identified.

#### 4. Monthly Maintenance Observation (62703)

The inspectors observed safety-related maintenance activities on systems and components to ascertain that these activities were conducted in accordance with TS, approved procedures, and appropriate industry codes and standards. The inspectors determined that these activities did not violate LCOs and that required redundant components were operable. The inspectors verified that required administrative, material, testing, radiological, and fire prevention controls were adhered to. In particular, the inspectors observed/reviewed the following maintenance activities:

PM-001	Daily Through Weekly Lubrication Procedure
WR/JO 91-ABIB1	Repair Check Valve CC-702B Leak

#### CCW Check Valve (CC-702B) Repair

During the leak repair (per TM 91-702 and WR 91-ABIB1) of CCW check valve CC-702B on May 22 and 23, 1991, the inspectors observed effective interface between the Technical Support System engineer, the Maintenance mechanic, and the vendor representatives. This interface was evident throughout the valve stud replacement evolution and associated "troubleshooting". Additionally, the inspectors noted the NAD's involvement in assessing this activity. The NAD representative identified a concern with the self-assessment process, in that, the stud torque value delineated in the TM was based upon lubricated threads, but no lubricant was applied prior to the actual torquing process. Lubricant was not used due to the vendor representative's concern with material incompatibility. Although no apparent safety concern exists with not lubricating the studs, the NAD representatives concern was noteworthy as this discrepancy was not documented in neither the WR nor the TM packages. As a result, during review of the packages it was not discernable that the studs' cap nuts were not torqued as the referenced torquing procedures specify (i.e., with lubricant). The inspectors discussed this concern with the Managers, Technical Support, and Maintenance; they indicated that a memo which was written to document torque acceptability would be attached to the TM package.

#### Inadequate Lubrication Schedule

On May 13, 1991, the inspectors observed lubrication of the B EDG as specified by PM-001, Daily Through Weekly Lubrication Procedure. The inspectors noted that the procedure did not include the fuel oil pump for the lubrication. The monthly, quarterly and semi-annual lubrication procedures, as well as PM-201, Equipment Lubrication List, did not include the EDG fuel oil pumps. The cognizant system engineer indicated that the failure to include the EDG fuel oil pumps and the EDG air inlet check valve bushings in the lubrication program had been identified in

April 1991. Intra-office memorandum, dated April 30, 1991, documented a telephone conversation between the system engineer and the EDG vendor concerning lubrication requirements for these items.

Corrective actions included additional inspections of the EDG and associated auxiliary components. This resulted in the identification of another item, governor speed adjusting motors, which is to be added to the lubrication program. Applicable procedures were being revised to incorporate these items into the lubrication program at the end of the report period. Regulatory Guide 1.33 Appendix A, item 9.b., and TS 6.5.1.1.1.a., require procedures for lubrication. Failure to adequately establish lubrication schedules for the above mentioned items is a violation of this requirement. This violation meets the criteria specified in Section V.G.1 of the NRC Enforcement Policy for not issuing a Notice of Violation and is not cited. The violation is identified as a NCV: Failure To Adequately Establish A Lubrication Schedule For EDG Components, 91-14-05.

The inspectors discussed the circumstances surrounding the EDG lubrication deficiencies discovered in April 1991, with the cognizant system engineer. During a system walkdown, the engineer identified grease fittings that he recognized as being lubrication points which were not included in the lubrication program. Identification of this deficiency during a routine walkdown demonstrated a strong sense of system ownership by the engineer.

One NCV was identified.

5. Followup (92700)

(Closed) LER 89-09, Relative Humidity Exceeds TS Limits With CV Purge In Progress. The inspectors verified that a second relative humidity standard has been procured and the calibration frequency of the standards has been revised to semi-annual. These actions are in accordance with the corrective actions provided in the LER. This LER is considered closed.

(Closed) LER 89-015, Breach Of Containment Integrity Due To Failure Of Airlock Equalizing Valve. A similar report, LER 90-006, Breach of Containment Integrity Due To Failure Of The Personnel Air Lock Door, is considered open. Supplement 1 to LER 89-015 was issued on April 27, 1990. This supplement combined the corrective action of LER 89-015 and LER 90-006, as well as, extending the completion date to RO 13. Airlock failure during RO 13 and associated root cause investigations resulted in issuance of LER 90-006 Supplement 1 on February 7, 1991. This supplement identified that a modification requiring a TS change, would be necessary to completely correct the root cause of the air lock door failures. The inspectors verified that implementation of PM-038, CV Personnel Airlock Maintenance And Inspection, issued February 21, 1991, was sufficient in

the interim to reduce the frequency of airlock door failures. Based upon the implementation of PM-038, the corrective actions associated with LER 89-015 have been completed; LER 89-015 is considered closed. LER 90-006 remains open pending development of a modification to correct the root cause of the failures.

(Closed) IFI 89-23-01, Review Of Shielding For Implementation Of The ALARA Program. The inspectors discussed the present ALARA implementation practices with cognizant plant personnel. These work practices and controls appear to be sufficient to preclude the type of observation documented in the IR 89-23. This item is considered closed.

(Closed) VIO 89-23-06, Failure To Establish And Implement Procedures As Required By 10 CFR 50 Appendix B Criterion V. The inspectors reviewed the licensee's response to the NOV dated January 17, 1990. The inspectors verified via training records that maintenance personnel received training on the root cause of the specific events as committed. This corrective action is considered sufficient to address the violation. This item is considered closed.

No violations or deviations were identified.

6. Exit Interview (30703)

The inspection scope and findings were summarized on June 7, 1991, with those persons indicated in paragraph 1. In addition, URI 91-14-01 was discussed with the Plant Manager on June 24, 1991. The inspectors described the areas inspected and discussed in detail the inspection findings listed below and in the summary. Dissenting comments were not received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection.

<u>Item Number</u>	<u>Description/Reference Paragraph</u>
91-14-01	URI - Review Impact of Entrainment Losses on the Small Break LOCA Analysis (paragraph 2)
91-14-02	NCV - Failure To Enter Applicable TS Action Statement (paragraph 2)
91-14-03	VIO - Failure To Maintain Logs As Required By Operating Procedures (paragraph 3)
91-14-04	NCV - Failure To Implement Surveillance Scheduling Procedure For MST-902 (paragraph 3)

91-14-05

NCV - Failure to Adequately Establish A  
A Lubrication Schedule For EDG  
Components (paragraph 4)

## 7. List of Acronyms and Initialisms

a.m.	Ante Meridiam
ALARA	As Low As Reasonable Achievable
ANS	American Nuclear Society
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CP&L	Carolina Power & Light
CV	Containment Vessel
ECCS	Emergency Core Cooling System
EDG	Emergency Diesel Generator
EPP	End Path Procedures
ERFIS	Emergency Response Facility Information System
F	Fahrenheit
i.e.	That is
IFI	Inspector Followup Item
INPO	Institute of Nuclear Power Operations
IPE	Independent Plant Examinations
IR	Inspection Report
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
MST	Maintenance Surveillance Test
NAD	Nuclear Assessment Department
NCV	Non-cited Violation
NED	Nuclear Engineering Department
NFD	National Fuels Department
NFS	Nuclear Fuels Section
NOV	Notice of Violation
NRC	Nuclear Regulatory Commission
OMM	Operations Management Manual
OP	Operations Procedure
OST	Operation Surveillance Test
p.m.	Post Meridiam
PI	Pressure Indicator
PLP	Plant Program
PM	Preventive Maintenance
PPM	Parts Per Million
RCS	Reactor Coolant System
RHR	Residual Heat Removal
RO	Refueling Outage
RTGB	Reactor Turbine Generator Board
RWST	Refueling Water Storage Tank
SI	Safety Injection
TM	Temporary Modification
TS	Technical Specification
URI	Unresolved Item
VIO	Violation
W/R	Work Request
WR/JO	Work Request/Job Order