UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W., SUITE 2900
ATLANTA, GEORGIA 30323-0199

Report No.: 50-261/95-14

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 Unit 2

Inspection Conducted: April 23 - May 13, 1995

Lead Inspector: Sallie Stanford for 6-12-95
W. T. Orders, Senior Resident Inspector Date Signed

Other Inspector: Sallie Stanford for 6-12-95
C. R. Ogle, Resident Inspector Date Signed

Approved by: David M. Verrelli 6-12-95
David M. Verrelli, Chief Date Signed
Reactor Projects Branch 1A
Division of Reactor Projects

SUMMARY

SCOPE:

This routine, resident inspection was conducted in the areas of plant operations, maintenance activities, engineering efforts, and plant support functions. The inspection effort included reviews of activities during non-regular work hours on April 28, 29, and 30, as well as May 5, 7, and 9, 1995.

RESULTS:

Plant Operations:

One of three examples of a Violation pertaining to inadequate control of contracted services was identified in this functional area. An Unresolved Item was identified concerning an inadequate equipment clearance.

Maintenance:

Two of three examples of a Violation concerning inadequate control of contracted services were identified in this functional area. A Violation was also identified pertaining to an inadequate operations surveillance test procedure.

Engineering:

A Non-Cited Violation was identified concerning deficiencies in the fuel pool inventory process.

Plant Support:

A Non-Cited Violation was identified concerning the failure of a contracted technician to follow RWP requirements. An unresolved item was identified pertaining to the administration of the fire protection program.

REPORT DETAILS

1. PERSONS CONTACTED

Licensee Employees:

*B. Baum, Director, Robinson Nuclear Project, Human Resources
W. Brand, Supervisor, Environmental Radiation Control
*M. Brown, Manager, Design Engineering
A. Carley, Manager, Site Communications
*A. Canterbury, Project Engineer/Technical Support
G. Castleberry, Manager Plant Electrical Engineering
*B. Clark, Manager, Maintenance
*D. Crook, Senior Specialist, Licensing/Regulatory Compliance
*W. Dorman, Supervisor, Quality Control
*M. Foerster, Manager, Robinson Engineering Support Section Administration and Programs
*A. Garrou, Acting Manager, Licensing Regulatory Programs
C. Gray, Manager, Materials and Contract Services
D. Gudger, Senior Specialist, Licensing/Regulatory Programs
*C. Hinnant, Vice President, Robinson Nuclear Project
P. Jenny, Manager, Emergency Preparedness
J. Kozyra, Licensing/Regulatory Programs
*R. Krich, Manager, Regulatory Affairs
*D. Markle, Senior Specialist, Configuration Control
E. Martin, Manager, Document Services
*B. Meyer, Manager, Operations
G. Miller, Manager, Robinson Engineering Support Section
*H. Moyer, Manager, Nuclear Assessment Section
*E. Rossman, Engineer, Robinson Engineering Support Section
B. Steele, Manager, Shift Operations
*D. Taylor, Plant Controller
G. Walters, Manager, Support Training
*R. Warden, Manager, Plant Support Nuclear Assessment Section
*D. Weber, Senior Specialist, Robinson Engineering Support Section
W. Whelan, Industrial Health and Safety Representative
D. Whitehead, Manager, Plant Support Services
*T. Wilkerson, Manager, Environmental Control
*S. Williams, Senior Engineer, Robinson Engineering Support Section
L. Woods, Manager, Technical Support
*D. Young, Plant General Manager

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

NRC Personnel:

*W. Orders, Senior Resident Inspector
*C. Ogle, Resident Inspector

*Attended exit interview

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

2. PLANT STATUS AND ACTIVITIES

a. Operating Status

The unit began the report period operating at full power, and had operated at or near full power for 265 days prior to April 28 when a planned shutdown was begun for refueling outage 16. The report period ended with the unit in day 15 of a planned 37 day refueling outage.

b. Other NRC Inspections and Meetings

One Region II based inspection was conducted during the report period. The inspection, conducted on May 9 and 10, 1995, was performed by M. Ernstes. The inspection results are documented in report 50-261/95-300.

3. OPERATIONS

a. Plant Operations (71707)

The inspectors evaluated the licensee's performance to determine if the facility was operated safely and in conformance with regulatory requirements. These activities were assessed through direct observation, facility tours, discussions with licensee personnel, evaluation of equipment status, and review of facility records.

The inspectors reviewed shift logs, operation's records, data sheets, instrument traces, and the equipment malfunctions list to assess equipment operability and compliance with TS. The inspectors evaluated the operating staff to determine if they were knowledgeable of plant conditions, responded properly to alarms, adhered to procedures and applicable administrative controls, and were cognizant of in-progress surveillance and maintenance activities. The inspectors performed instrument channel checks, reviewed component status, and assessed safety-related parameters to determine conformance with TS. Shift changes were routinely observed to determine that system status continuity was maintained and that proper control room staffing existed. It should be noted that during this report period, a major modification to the control room was initiated. The modification process had a dramatic effect on the internal control room boundaries and access to the active control room area. The inspectors devoted increased attention to this operator challenge, and determined that access to the control room was adequately controlled, and operations personnel carried out their assigned duties in an effective manner. Control room demeanor and communications were appropriate.

Routine plant tours were conducted to evaluate 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.

b. Unit Shutdown

Between April 28, 1995, and April 30, 1995, the inspectors witnessed portions of the unit shutdown for refueling outage 16 including reactor and secondary plant shutdown, transition to RHR cooling, and collapsing the pressurizer bubble. For the most part, these evolutions were well conducted. Strong procedure usage was evident. The inspectors also noted increased crew emphasis in areas which had represented previous challenges; namely monitoring pressurizer cooldown rates and ensuring that signatures were appropriately transferred from field copies of procedures. Pre-evolution briefs were adequate but the inspectors noted that the quality varied widely.

c. Inadequate Control Of Contract Refueling Personnel

On May 8, 1995, a refueling crew signed off nineteen steps of procedure FMP-019, Fuel and Insert Shuffle, indicating that an equal number of thimble plugs had been moved. In actuality, none of the plugs had been moved. It was determined that the thimble plug tool, used by a contracted refueling technician, had been rotated 90 degrees out of alignment. This had prevented effective tool engagement. After the tool was realigned and additional lighting was employed, the crew started over.

The refueling crew consisted of a contracted refueling technician, two CP&L refueling technicians who were to be trained on the use of the thimble plug tool, and a licensed RO. The contractor was to actually perform the relocation of the thimble plugs and train the CP&L refueling technicians. The RO was responsible for coordinating the activities and for ensuring adherence to procedures.

The contractor and the trainees were located on the SFP bridge. The RO was located on the side of the SFP reading the steps of the procedure to the contractor and initialing the completion of each step. He was also updating the fuel location status board in the SFP area and communicating the moves to the CR.

The first thimble plug was documented as being moved at 2:10 p.m., on May 8, 1995. The RO stated that he was able to verify the grid locations of the fuel assemblies but was unable to see the assemblies themselves. The RO presumed that the contractor was actually performing the steps, but the contractor stated that he also had difficulty seeing. As the evolution proceeded to an area in the SFP where lighting conditions were better, it was noticed that a thimble plug that had supposedly already been moved was still in the assembly. They lowered a light for a closer

inspection and noted that none of the thimble plugs had been moved. The contractor, after referring to a copy of FHP-001, Fuel Handling Tools Operating Procedure, discovered that the thimble plug tool had been rotated 90 degrees out of alignment. The correct orientation was clearly delineated in FHP-001. It should be noted that FHP-001 was one of approximately 10 procedures the contractor had attested to having read on April 18, 1995.

After restarting the evolution and successfully completing two steps, problems were experienced on step three during the installation of a thimble plug in a fuel assembly. Investigation revealed a bent finger on the thimble plug. The crew was instructed to place the damaged thimble plug in a receptacle in the SFP. The RO notified the CR of this specific problem but failed to mention the original problem experienced with the tool. By this time, it was close to shift turnover and no further steps of the procedure were performed. During turnover with the oncoming shift, the personnel communicated to their relief that they had repeated nineteen steps of the procedure due to the tool being improperly oriented, but management was not informed.

The contractor failed to follow the instruction afforded in FHP-001, Fuel Handling Tools Operation, which clearly described the correct alignment of the thimble plug tool. The RO failed to verify that the procedure steps had actually been performed before signing off the procedure. This event is the first of three examples which collectively constitute Violation 50-261/95-14-01, Inadequate Control Of Contractor Services.

d. Inadequate Clearance For Work On Valve V1-8A

On April 17, 1995, routine preventive maintenance was to be performed on valve V1-8A, a motor operated valve which supplies motive steam to the steam driven auxiliary feedwater pump. Due to an inadequate clearance, valve MS-20 which is immediately downstream of V1-8A, was left open. As a result, the steam driven auxiliary feedwater pump started when valve VI-8A was manually opened. It was also discovered that if valve V1-8A were to be greater than 96 percent open with the steam driven auxiliary feedwater pump not running, a close signal would be sent to the other two valves which supply steam to the pump. That would result in the pump being inoperable.

At the end of this report period, the inspectors had not completed their review of the circumstances associated with this event. Accordingly, pending the completion of these efforts, this issue will be tracked as Unresolved Item URI 50-261/95-14-02, Inadequate Clearance For Work On Valve V1-8A.

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

4. MAINTENANCE

a. 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 detailed below:

WR/JO 95FXU002	Disassemble, Inspect, and Reassemble MS-VI-3C
WR/JO 95AGUQ001	Perform MST-925 Molded Case Circuit Breakers Thermal and Instantaneous Trips Test (MCC-10 Feed Only)
WR/JO 95ACDI001	Fabricate Hydro Rig For SI-856A/B Testing
WR/JO 95AGF002	E1 Circuit Breaker Inspection and Test (Partial)

Inadequate Control Of Contract Crane Operators

Collision of Polar Crane And Manipulator Crane Event

At approximately 7:20 p.m., on May 3, 1995, the Robinson containment polar crane collided with the refueling manipulator crane. A contracted refueling technician had moved the manipulator crane into the path of the polar crane. Subsequently, a contracted polar crane operator, began moving the polar crane without verifying the position of the manipulator crane. The polar crane impacted a cross piece on the manipulator crane's monorail. The top of the manipulator crane was bent approximately two or three feet which broke welds in three places. Some of the broken welds were repairs from a previous, similar collision that occurred in the late 1970s. The manipulator crane was repaired and returned to service.

An investigation of the event revealed that the refueling technician had apparently not received CP&L crane operator training; the contracted organization, which had the responsibility for coordinating and operating the cranes, did not have a formal coordination process to use when multiple cranes were being used simultaneously; the polar crane operator had not been trained on MI-510 which contains a requirement to check the manipulator crane's position prior to polar crane movement; a copy of MI-510, Polar Crane General Instructions, was not posted in the polar crane cab as required; and the polar crane operator did not

receive a cogent proficiency verification on the polar crane's operation.

This event is indicative of inadequate measures to control the quality of contracted services. This constitutes the second of three examples which collectively comprise Violation 50-261/95-14-01, Inadequate Control of Contractor Services.

Polar Crane Auxiliary Hook Strikes Steam Generator Cubicle

At approximately 10:00 p.m., on May 4, 1995, the polar crane auxiliary hook struck the concrete cubicle surrounding the "C" steam generator. The polar crane's operator had been operating the crane from the refueling floor, using the remote control. He had lowered the auxiliary hook for a planned lift. Before that lift could be made, the priorities for the polar crane changed. The polar crane operator left the auxiliary hook down (6 to 8 feet off the floor) and began moving the polar crane into position for the next lift. He did so from his position on the floor, from which he could not see the auxiliary hook. Furthermore, the operator began the repositioning of the polar crane on his own initiative, with no communication or direction from the signalman. The polar crane's auxiliary hook hit the north side of the concrete cubicle around steam generator "C", causing superficial damage.

The contract polar crane operator was the same operator involved in the collision of the polar crane and manipulator crane. Therefore, the aforementioned deficiencies delineated in the previous section will not be reiterated.

This constitutes the third of three examples which collectively comprise Violation 50-261/95-14-01, Inadequate Control Of Contractor Services.

OST-156 Valve Lineup Improperly Established

On May 8, 1995, the inspectors questioned the valve lineup for Operations Surveillance Test, OST-156, Safety Injection and Containment Spray Systems Suction Lines Leak Test. This test is used to qualify the atmospheric leakage of portions of the safety injection, residual heat removal, and containment spray systems in accordance with license condition 3.G.(2). During a plant tour, the inspectors noted that SI-887, the RHR Pump Discharge to SI and CV Spray Suction valve was closed. The inspectors concluded that with this valve closed, test pressure would not be applied to the piping between valves SI-887 and the SI-863 A and B. The licensee confirmed the inspectors observation on May 8, 1995, and revised OST-156 to require SI-887 be open during the test. The licensee also added additional valves to the procedure in a subsequent temporary procedure change on May 8, 1995.

In response to this issue, the inspectors scrutinized OST-156 and interviewed the coordinator involved in its initial performance. The inspectors were advised that SI-887 was closed as the result of a clearance on the valve, and the impact of this mis-positioning had not been previously recognized. The inspectors noted that SI-887 is a normally locked open valve and it was not included in the valve lineup contained in OST-156.

On May 15, 1995, while conducting a post-test review, the inspectors detected another deficiency in OST-156. The OST valve lineup requires that SI-862A, RWST to RHR valve be closed. In that configuration, the piping between SI-862A and SI-862B would not be tested. However, End Path Procedure, EPP-9, Transfer To Cold Leg Recirculation permits the operators to close either SI-862A or SI-862B while establishing the CV sump recirculation valve lineup. The inspectors were concerned that OST-156 as conducted, failed to test all portions of piping which could be in contact with highly radioactive fluids during an accident. This was identified to the licensee for resolution. After confirming the inspectors' observation, the licensee stated that a condition report would be generated and that the piping between SI-862A and SI-862B would be tested.

The inspectors concluded that procedure OST-156 was inadequate. This is contrary to the requirements of TS 6.5.1.1 and is identified as a violation, VIO 95-14-03, OST-156 Valve Lineup Improperly Established.

b. 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. On a selective basis, 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 approved test procedures, test instrumentation was properly calibrated, the tests were completed at the required frequency, and that the tests conformed to TS requirements. Upon test completion, the inspectors verified the recorded test data was complete, accurate, and met TS requirements, test discrepancies were properly documented and rectified, and that the systems were properly returned to service. One such test was SP-1353, Leak Test SI-864A and B and SI-856A and B.

Leak Test Of RWST Isolation Valves

On May 8, 1995, the inspectors witnessed portions of Special Procedure, SP-1353, Leak Test SI-864A and B and SI-856A and B. This procedure was performed to quantify individual seat leakage through SI-864A, SI-864B, SI-856A, and SI-856B, to demonstrate

compliance with license condition 3.G (2). Overall, the conduct of the test was satisfactory. Anomalies associated with the initial test performance were recognized by the licensee and resolved. Applicable portions of the test were performed again with satisfactory results on May 10, 1995.

(Closed) URI 94-12-02, Basis For Closed System Outside Containment, documents inspectors' concerns with the licensee's basis for closed systems outside containment which are normally vented to the RWST. The testing accomplished by SP-1353 provides reasonable assurance that significant flow past these valves would not occur in the event of sump recirculation. Based on this, URI 94-12-02 is closed.

5. ENGINEERING

Onsite Engineering (37551)

Fuel Pool Inventory Discrepancy

On April 19, 1995, during fuel movement within the SFP, a fuel assembly could not be fully lowered into its planned storage position, MM-24. The assembly was withdrawn and returned to its original storage location. A visual examination revealed an undocumented filter canister stored in rack position MM-24. The fuel movement was subsequently completed without incident. The licensee generated a CR in response to this event.

As a followup to this event, the inspectors reviewed Fuel Management Procedure, FMP-021, Control of Materials in the Spent Fuel Pit, interviewed an operator involved in the fuel movement, and the spent fuel pool system engineer.

The inspectors determined that the filter canister was not documented as having been stored in MM-24 on the spent fuel pool storage log sheet which is maintained in accordance with procedure FMP-021. Hence, nothing precluded the reactor engineering staff from utilizing MM-24 as a fuel storage location during the SFP fuel movement. The inspectors concluded that this error was the result of an administrative oversight on the part of the system engineer while implementing FMP-021. The inspectors also noted that the licensees implementation of the spent fuel pool inventory process failed to include basic safeguards to preclude fundamental administrative errors such as the one described.

As corrective action, the licensee conducted a visual inspection of all SFP locations involved in the SFP fuel shuffle and fuel offload. No additional undocumented material was identified. Additionally, the licensee committed to revising FMP-021 to require a second party verification of the SFP storage log sheets and SFP location data sheets.

The failure to properly control the material stored in the SFP is contrary to the requirements of FMP-021. However, this violation will not be subject to enforcement action because the licensee's efforts in identifying and correcting the violation meet the criteria specified in section VII.B of the Enforcement Policy. This is identified as a Non-Cited Violation, NCV 50-261/95-14-04, Fuel Pool Inventory Not Properly Maintained.

6. PLANT SUPPORT

a. Plant Support Activities (71750)

CO_2 Bottle Explosion

Event Summary

On April 30, 1995, a 5 lb. CO_2 cylinder, which had been stored in a compressed gas storage shed, exploded. The explosion destroyed a storage cage, the cylinder ricocheted off one of six stationary hydrogen storage cylinders used as emergency make-up for the Unit 2 hydrogen supply system, and ultimately came to rest some 20 feet from the shed. The hydrogen cylinder was torn from its mounts and came to rest approximately 10 feet from its original location. The hydrogen manifold tubing was severed, creating an unrestricted leak path for the remaining five hydrogen cylinders. The hydrogen gas ignited, engulfing the immediate area. The Site Fire Brigade responded and the fire was out within seven minutes. No off-site fire assistance was required. Damage was restricted to the CO_2 cylinder, the six hydrogen cylinders, associated piping, and the storage cage.

Event Details

At approximately 1:55 p.m., on the afternoon of April 30, 1995, a Unit 2 outside auxiliary operator heard an explosion in the vicinity of the compressed gas shed. This shed is located approximately 70 feet east of the perimeter of the Unit 2 Protected Area. Upon investigating, the operator observed a hydrogen cylinder laying on the ground, about 10 feet west of the shed. He also heard a loud "blow down" noise being emitted from the same general area. The operator notified Unit 2 Control Room personnel who in turn dispatched the Fire Brigade. As previously mentioned, the Fire Brigade responded and the fire was out within seven minutes.

The licensee sent the ruptured CO_2 cylinder to the metallurgy lab at their E&E Center. Preliminary results indicated that the rupture was caused by tensile strength overload, and that there was no apparent flaw in the cylinder. The licensee's analysts indicated that over-filling the cylinder would be strongly suspected as the cause of the cylinder failure.

It was determined that the CO_2 cylinder which failed and another 5 lb. CO_2 cylinder had been taken off site for vendor servicing on April 24, 1995, and were returned the following day. Licensee personnel performed OST-621, Diesel Generator CO_2 Cylinder Weight Test later that day. The test revealed that the cylinder which failed was charged to 180 percent of full weight and the other CO_2 cylinder was charged to 131 percent of full weight. The latter cylinder was placed in service at approximately 2:00 p.m. that same day as the control cylinder for the Diesel Generator CO_2 System. The cylinder which failed was placed in the storage area of the Unit 1 gas shed. The licensee's surveillance procedure, OST-621, did not limit the maximum quantity of charge on the cylinders, only the minimum quantity of charge.

These cylinders were originally fitted with a rupture disk designed to prevent cylinder over-pressurization. The original rupture disks were designed to relieve at approximately 3000 psi. The licensee determined that the cylinder which failed had three rupture disks installed in series. The licensee removed the other CO_2 cylinder from service to determine if a similar situation existed. The licensee found two rupture disks installed on that cylinder. With multiple rupture disks installed, the cylinders could be pressurized to pressures exceeding their rating. The licensee determined that due to the cylinder being overfilled and the negation of the overpressure protection, the cylinder which failed had been pressurized to approximately 6,583 psi. At the end of this report period, the inspectors have not completed their review of the circumstances associated with this event. Accordingly, pending the completion of these efforts, this issue will be tracked as an Unresolved Item, URI 50-261/95-14-05, Operations Surveillance Test 621 Deficiency.

Unresolved items are matters about which more information is required to determine whether they are acceptable or may involve violations or deviations.

RWP Requirements For Protective Clothing Not Followed

On May 11, 1995, during a routine tour of containment, the inspectors observed a contract worker involved in MOD-1074, work which required full anti-Cs, yet the worker was not wearing an anti-contamination head covering. The inspectors questioned the HP assigned to coverage of the first level of the CV on the appropriateness of this observed dress. After examining the situation, the HP advised the inspectors that the worker's outfit was incomplete and not in compliance with the assigned RWP. The worker was subsequently escorted from containment and a condition report was generated.

The inspectors reviewed the appropriate RWP, interviewed the lead HP, and reviewed Plant Program Procedure, PLP-016, Radiation Work Permit Program.

The inspectors noted that the RWP required a cloth hat or single cloth hood. The inspectors were advised that the worker had entered the CV with a cloth hat beneath a hard hat. The cloth hat was inadvertently removed with the hard hat when the worker put on a phone headset. The licensee stated that the worker did not recognize this error at the time. As corrective action, the licensee counselled personnel involved in the modification on the need to comply with RWP requirements.

Overall, the inspectors concluded that the worker's failure to comply with the RWP was contrary to the requirements of PLP-016. However, this NRC identified violation is not being cited because criteria specified in Section VII.B of the NRC Enforcement Policy were satisfied. This is identified as a Non-Cited Violation, NCV 50-261/95-14-06, RWP Requirement For Protective Clothing Not Followed.

It should be noted that since the start of the refueling outage the inspectors have noted several isolated incidents involving HP work practices that fall short of established plant practices. All of these observations have been relatively minor and involved personnel not permanently assigned to the facility. The inspectors have discussed these observations with licensee management. Based on these observations, the inspectors concluded that additional emphasis on routine HP practices by contract workers may be required.

At the exit, the licensee stated that their trending program had also detected a similar trend in contractor performance in the radiological controls area. Furthermore, the licensee advised the inspectors that they had implemented corrective actions to resolve these concerns. The licensee subsequently provided the inspectors a copy of the CR generated in response to this effort. The inspectors reviewed the CR and have no further questions on this issue.

7. EXIT INTERVIEW

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on May 19, 1995. During this meeting, the inspectors summarized the scope and findings of the inspection as they are detailed in this report. The licensee representatives acknowledged the inspector's comments and did not identify as proprietary any of the materials provided to or reviewed by the inspectors during this inspection. No dissenting comments from the licensee were received.

Item Number	Status	Description/Reference Paragraph
VIO 95-14-01	Opened	Inadequate Control Of Contractor Services/paragraphs 3, 4
URI 95-14-02	Opened	Inadequate Clearance For Work On Valve V1-8A/paragraph 3
VIO 95-14-03	Opened	OST-156 Valve Lineup Improperly Established/paragraph 4
NCV 95-14-04	Opened/Closed	Fuel Pool Inventory Not Properly Maintained/paragraph 5
URI 95-14-05	Opened	Operations Surveillance Test 621 Deficiency/paragraph 6
NCV 95-14-06	Opened/Closed	RWP Requirement For Protective Clothing Not Followed/paragraph 6
URI 94-12-02	Closed	Basis For Closed System Outside Containment/paragraph 4

8. ACRONYMS AND INITIALISMS

CFR	Code of Federal Regulations
CP&L	Carolina Power and Light
CR	Condition Report, Control Room
CV	Containment Vessel
E&E	Energy And Environmental
EPP	End Path Procedure
FHP	Fuel Handling Procedure
FMP	Fuel Management Procedure
HP	Health Physics
LCO	Limiting Condition For Operation
MCC	Motor Control Center
NCV	Noncited Violation
NRC	Nuclear Regulatory Commission
OST	Operations Surveillance Test
PDR	Public Document Room
PLP	Plant Program Procedure
psi	Pounds Per Square Inch
RFO	Refueling Outage
RHR	Residual Heat Removal
RO	Reactor Operator
RWP	Radiation Work Permit
RWST	Refueling Water Storage Tank
SFP	Spent Fuel Pit
SI	Safety Injection
TS	Technical Specification
URI	Unresolved Item
VIO	Violation
WR/JO	Work Request/Job Order