

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-315; 50-316
License Nos: DPR-58; DPR-74

Report No: 50-315/98015(DRP); 50-316/98015(DRP)

Licensee: Indiana and Michigan Power
500 Circle Drive
Buchanan, MI 49107-1395

Facility: Donald C. Cook Nuclear Generating Plant

Location: 1 Cook Place
Bridgman, MI 49106

Dates: June 12 through July 16, 1998

Inspectors: B. L. Bartlett, Senior Resident Inspector
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Reactor Projects Branch 6

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EXECUTIVE SUMMARY

D. C. Cook Units 1 and 2
NRC Inspection Report 50-315/98015(DRP); 50-316/98015(DRP)

This inspection included aspects of licensee operations, maintenance, engineering, and plant support. The report covers a 5-week period of resident inspection and includes the follow-up to issues identified during previous inspection reports.

Operations

- The inspectors identified that the licensee was inappropriately entering and exiting an administrative Limiting Condition for Operation (LCO) whenever the outside air temperature exceeded 88°F. The licensed operators had questioned whether this was a conservative practice but had not taken actions to resolve their questions or to ask for management assistance. The inspectors' review of other licensee entries into TS LCOs determined there appeared to be an appropriate use of LCO time clocks (Section 01.2).

Maintenance

- Steady progress was being made in repairs to the ice condensers in both units. Some instances of foreign material intrusion into the ice making system were quickly identified and corrected. Initial lapses in command and control which resulted in minor scheduled impacts were part of the reason the licensee assigned additional project management (Section M2.1).
- The inspectors concluded that the licensee staff responded appropriately to mitigate the consequences of an oil leak in the Unit 2 main turbine lubricating oil cooler. However, the inspectors concluded that this leak was caused by equipment material condition problems (Section M2.2).
- CO₂ was inadvertently discharged into the auxiliary building crane bay. Use of a procedure intended for operability testing of the CO₂ system as the post maintenance testing was identified by the licensee as a significant contributor to the incident. An investigation was promptly initiated and interim preventive actions taken. A formal root cause investigation is being conducted to evaluate this event (Section M4.1).

Plant Support

- The inspectors noted several minor occurrences of lack of attention to detail concerning anti-contamination personnel protective clothing dress requirements. NRC inspection activities will continue to monitor worker compliance with radiation work permit requirements (Section R4.1).

Report Details

Summary of Plant Status

Unit 1 remained in Mode 5, Cold Shutdown, during this inspection period. The licensee presented the schedule for restart of Unit 1 to the NRC on July 9, 1998. The schedule indicates that proposed maintenance activities will extend into early November, followed by a 3 to 6-week heat-up and start-up period. Work on Unit 1 will take precedence over Unit 2.

Unit 2 remained in Mode 5, Cold Shutdown, during this inspection period. The restart schedule for Unit 2 is not yet complete.

I. Operations

O1 Conduct of Operations

O1.1 General Comments (71707)

Using the referenced inspection procedure, the inspectors conducted frequent reviews of control room and in-plant operation of equipment during the extended outage of both reactor units. During observations of control room activities such as shift turnovers, operator response to annunciators, and equipment operations, the inspectors identified that control room operators monitored and operated equipment in a professional manner.

O1.2 Multiple Entries Into An Administrative Technical Specification (TS) Limiting Condition for Operation (LCO) Time Clock (Unit 2)

a. Inspection Scope (71707)

During a routine tour of the control room the inspectors questioned the licensee's practice of going into and out of a TS LCO every day and resetting the time clock. The inspectors also performed follow up of the licensed operator's failure to resolve the inappropriate resetting of the LCO.

b. Observations and Findings

On June 24, 1998, the licensee identified that the 600 VAC transformer room supply fan (2-HV-SGRS-9) was unable to deliver air due to a failed inlet damper. Licensee procedure 12 Plant Managers Procedure (PMP) 4030.001.001, Revision 0 addressed the impact of safety-related ventilation on TS required equipment. As required by attachment 9 to PMP 4030.001.001, the control room operators verified the outside air temperature was less than 88°F.

Procedure PMP 4030 also required that with 2-HV-SGRS-9 unable to supply air and the outdoor air temperature greater than 88°F, either restore the nonfunctional fan within 7 days or declare all 600 VAC buses inoperable. The inspectors' review of the control room logs on June 26, 1998, identified the following pattern of entering and exiting the administrative LCO:

- June 24, 1998 - 2:00 p.m. EDT Outdoor air temperature greater than 88°F entered 7 day administrative LCO
 - 11:20 p.m. EDT Outdoor air temperature less than 88°F exited 7 day administrative LCO
- June 25, 1998 - 12:00 p.m. EDT Outdoor air temperature greater than 88°F entered 7 day administrative LCO
 - 1:00 p.m. EDT Outdoor air temperature less than 88°F exited 7 day administrative LCO
 - 2:00 p.m. EDT Outdoor air temperature greater than 88°F entered 7 day administrative LCO
 - 8:00 p.m. EDT Outdoor air temperature less than 88°F exited 7 day administrative LCO
 - 9:10 p.m. EDT Outdoor air temperature greater than 88°F entered 7 day administrative LCO
- June 26, 1998 - 12:20 a.m. EDT Outdoor air temperature less than 88°F exited 7 day administrative LCO

The inspectors questioned the Reactor Operators (RO) and the Unit Supervisor (US) regarding the repeated entries and exits from the administrative LCO and the resultant resetting of the 7-day clock. The operators agreed that the repeated resetting of the clock appeared to be non-conservative and that they had been questioning this practice just before the inspectors raised the issue. It was not the normal practice of the licensee to enter, exit, and reset time clocks inappropriately.

The inspectors questioned the Shift Supervisor (SS) and the Assistant Shift Supervisor (Assistant SS) on the resetting of the administrative LCO. The shift management stated that they had also discussed the issue, had not reached any conclusions, and had not passed their questions to their management.

The inspectors reviewed the Action Request (AR) for the repair of the inlet damper to 2-HV-SGRS-9 and determined that it was scheduled to be worked on July 13, 1998. This was approximately two weeks after the 7-day administrative LCO would have expired. The inspectors informed the SS, the Assistant SS, and the Plant Manager that the resetting of the administrative LCO clock was being performed in a non-conservative manner. The inspectors also informed licensee management that it was important that operators had recognized and questioned the non-conservative practice but that a decision should have been reached and action taken to resolve the problem. Following the inspectors' comments the schedule for the repair of the damper was modified. The damper was repaired the following day and the need to enter the administrative LCO was eliminated.

A previous occurrence of the inappropriate resetting of LCO clocks was identified by the NRC inspectors and documented in Inspection Report 50-315/96-002(DRP). On

February 22, 1996, the NRC inspectors determined that the licensee was performing surveillance activities on the Unit 2 ice condenser. The surveillance required the entry into an LCO when intermediate deck doors were made inoperable. The licensee was exiting the LCO at the end of each work day and reentering the LCO on the following day. Upon inspector questioning of the non-conservative practice, the licensee began tracking the time spent in the LCO and implemented a cumulative limit. The cumulative limit was less than the TS limit and had not been exceeded prior to the inspectors' observation.

The inspectors review of other licensee entries into TS LCOs determined there appeared to an appropriate use of LCO time clocks. The instances noted above did not appear to be indicative of the licensee's usual practices.

c. Conclusions

The inspectors identified that the licensee was inappropriately entering and exiting an administrative LCO whenever the outside air temperature exceeded 88°F. The licensed operators had questioned whether this was a conservative practice but had not taken actions to resolve their questions or to ask for management assistance. The inspectors' review of other licensee entries into TS LCOs determined there appeared to be an appropriate use of LCO time clocks.

II. Maintenance

M1 Conduct of Maintenance

M1.1 General Comments

a. Inspection Scope (62707 and 61726)

Portions of the following maintenance job orders, action requests, and surveillance activities were observed or reviewed by the inspectors:

- A162056, 2-IFI-335, Residual Heat Removal Return Flow Rate to Reactor Coolant System, Flow Cycling
- A150707, 2-IFI-335, Residual Heat Removal Return Flow Rate to Reactor Coolant System, Flow Cycling
- A162563, Standing Ground on Unit 1 250 VDC Vital Bus
- A163103, Inspection and Cleaning of the Unit 2 Essential Service Water Forebay
- A160832, East Residual Heat Removal Heat Exchanger Outlet Valve 1-IRV-310, leaks by.
- 12 - Operations Head Procedure (OHP) 4030.Surveillance Test Procedure (STP) 121 MD, Revision 3, Electric Fire Pump Operability Test
- 01- OHP 4030.STP.0526E, Revision 6, Centrifugal Charging Pump Operability Test



b. Observations and Findings

The inspectors observed that the workers followed their procedures and appropriately documented the required information. The action request initiated for the standing ground on the Unit 1 vital 250 VDC bus had been worked and the ground had been cleared; however, at the end of the inspection period the job order had not been closed in the licensee's work control system.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Ice Condenser Repairs (Both Units)

a. Inspection Scope

The inspectors observed licensee activities involved with inspection and repair of the Unit 1 ice condenser and preparation to perform the melt out of the Unit 2 ice condenser.

b. Observations and Findings

The licensee continued to manufacture borated ice for reloading into the Unit 1 ice condenser after the material condition problems in the ice condenser are repaired. As the loading capability rate greatly exceeds the ice production rate, the licensee is making and storing ice in preparations for the reloading activities.

Early ice production difficulties appear to have been overcome; however, production was interrupted by two instances of foreign material entering the ice making machinery. The first instance occurred when a flashlight used for inspection in the ice bin area was allowed to enter the bin and was crushed by the ice auger. The person assigned to monitor foreign material exclusion at the ice loading station immediately identified the foreign material as it emerged from the ice transport system and stopped the ice loading operation. The foreign material was removed from the ice transport system and flushes of the system were performed to assure proper cleanliness. The entire flashlight was recovered from the melt water of the discarded batch of ice. The second instance of foreign material occurred when grease from the ice auger drive entered the ice bin, contaminating the batch of ice in the bin. The grease was immediately identified by the ice making machine operators and ice production was stopped. The ice was discarded and the excess grease removed from the ice auger.

Both instances of foreign material entry into the ice making/transport system were quickly identified by the operators and appropriate corrective actions were taken to prevent recurrence.

Preparations for the thaw in Unit 2 included sealing the ice condenser foamed concrete floor and wear slab to minimize water leakage into the floor and the spaces below the ice condenser. Prior to sealing the floor, heating of the concrete was required to defrost the floor, thus improving the adhesion of the sealant. During the heating, operators failed to adequately monitor the ice bed temperature and as a result, ice bed temperature increased by 9°F before being identified as a problem. The rise in ice bed temperature

delayed further work in the ice condenser until ice bed temperatures were reduced. This instance demonstrated that command and control of ice condenser operations needed improvement.

On June 22, 1998, the licensee announced that a project manager was being brought in from the American Electric Power (AEP) corporate office to oversee the ice condenser repair project. The project manager had previous nuclear experience at the D. C. Cook site as plant manager. The assignment of an experienced project manager for the ice condenser work was designed to enhance command and control over ice condenser activities.

c. Conclusions

Steady progress was being made in repairs to the ice condensers in both units. Some instances of foreign material intrusion into the ice making system were quickly identified and corrected. Initial lapses in command and control which resulted in minor scheduled impacts were part of the reason the licensee assigned additional project management.

M2.2 Oil Release into Lake Michigan (Unit 2)

a. Inspection Scope

On June 17, 1998, following a second low level alarm in the Unit 2 main turbine lubricating oil (MTLO) tank, oil was discovered in the non-essential service water (NESW) side of the Unit 2 northeast MTLO tank cooler. The operators isolated the cooler and inspected the system to determine extent of the oil leak. The inspectors observed and followed the licensee's spill response and investigation.

b. Observations and Findings

The inspectors reviewed the Unit 2 control room logs and Condition Report 98-2774. These documents indicated the following sequence of events:

- On June 12, 1998, the operators started the Unit 2 MTLO system in preparation for placing the main turbine on the turning gear. At the time the system was placed in service, the MTLO tank level gauge indicated that the tank was full.
- On June 15, 1998, a low level alarm was received on the MTLO tank and oil was transferred to the tank to clear the alarm. The tank level was raised to approximately one-quarter full.
- On June 16, 1998, a second low level alarm was received on the Unit 2 MTLO tank. The operators sampled the NESW side of the Unit 2 MTLO tank coolers and found oil on the NESW side of the north cooler.

The Unit 1 circulating water system was isolated to prevent further releases of oil into Lake Michigan through the open discharge cross connect valve. The licensee placed several oil booms in both units' circulating water discharge vaults and around the circulating water pumps. The licensee's environmental staff reported to the State of Michigan that approximately 900 gallons of oil were missing from the MTLO system but that 120 gallons

had been recovered using the oil booms. Following the clean up, the Unit 1 circulating water system was returned to service. The inspectors reviewed the licensee's estimate of oil released from the MTLO system and oil spill recovery actions but did not identify any discrepancies.

The licensee inspected the Unit 2 northeast MTLO cooler and found that seven tubes were leaking and that other tubes were degraded. The seven leaking tubes were plugged, and the other Unit 2 MTLO coolers were inspected. All of the Unit 2 MTLO coolers were found to have some degradation. The licensee planned to inspect all Unit 1 MTLO coolers. The inspectors concluded that the degraded MTLO coolers were indicative of equipment material condition problems; however, outside of the potential for further oil releases to the environment, this event was not safety significant.

The licensee informed the inspectors that the probable cause of the tube degradation was the coolers had been left with standing NESW water and the water had aggressively attacked the tube metal. The licensee was performing an assessment of their equipment lay up program for long term shutdown conditions.

c. Conclusions

The inspectors concluded that the licensee staff responded appropriately to mitigate the consequences of an oil leak in the Unit 2 main turbine lubricating oil cooler. However, the inspectors concluded that this leak was caused by equipment material condition problems.

M4 Maintenance Staff Knowledge and Performance

M4.1 Accidental Discharge of Carbon Dioxide in Auxiliary Building

a. Inspection Scope (62707)

An accidental discharge of carbon dioxide (CO₂) gas occurred in the auxiliary building during post maintenance testing of 21 CO₂ hose reel-stations. The inspectors observed the licensee response and corrective actions.

b. Observations and Findings

On July 2, 1998, an accidental discharge of approximately one and one-half tons of CO₂ gas occurred during pressure and operability testing of 21 CO₂ hose reel stations, installed as part of plant fire protection. The operability test was being used to satisfy post maintenance testing requirements following replacement of the 21 separate hose reels.

Plant personnel who were not involved with the testing investigated an unusual noise, pinpointing the source as hose station 12-ZCH-21 in the southwest section of the auxiliary building crane bay. Plant personnel restricted access to the affected area. Testing personnel had identified a significant leak in another portion of the auxiliary building CO₂ distribution header and had immediately stopped the test. Testing personnel were not aware of the leak at hose station 12-ZCH-21. Operations department personnel were in process of isolating the CO₂ system when the leak at 12-ZCH-21 was identified.

The cause of the discharge of CO₂ was that the discharge valve at the nozzle was installed backwards. This allowed the valve seat to lift when pressurized in the reverse direction, resulting in the discharge of the CO₂.

Licensee management promptly and extensively responded to this event. A Near-Miss-Accident Investigation was initiated to determine the sequence of events and the root causes for the accident. Issues were identified in the areas of workmanship and supervisory oversight; improper post maintenance testing methodology; lack of communications and follow-up; and scheduler pressures as contributing factors to this event. Results of the accident investigation had not been formalized as of the end of this inspection period.

The improper post-maintenance methodology involved the use of a test designed as an operability test of the system, not as a post-maintenance test (PMT), after maintenance. The system operability test used CO₂ as the test medium, which was suitable for the small puff releases to be used to determine operability of the hose reel system. The possibility of leaking joints after the hose reel replacements and the consequences associated with a failure of the PMT were not taken into account by the testing or maintenance planning groups. Personnel were not stationed at hose reel stations, no warning signs were posted and no contingency actions planned for the possibility of PMT failure.

Preventive measures were put in place to preclude completion of the testing until the test procedure was modified, the discharge nozzle was installed correctly and lessons learned training performed for maintenance personnel.

The licensee subsequently determined that PMT leak testing using pressurized air would be performed prior to operability testing using CO₂. Leak testing had not been completed as of the end of this inspection reporting period.

A formal root cause investigation team has been chartered, in addition to the accident investigation team discussed above.

c. Conclusions

CO₂ was inadvertently discharged into the auxiliary building crane bay. Use of a procedure intended for operability testing of the CO₂ system as the post maintenance testing was identified by the licensee as a significant contributor to the incident. An investigation was promptly initiated and interim preventive actions taken. A formal root cause investigation is being conducted to research the event.

III. Engineering

E8 Miscellaneous Engineering Issues

E8.1 (Closed) Unresolved Item 50-315/93006-01(DRS):50-316/93006-01(DRS) The degraded voltage calculations did not assume the worst case grid voltage as the starting point for evaluating the available voltage at motor operated valve motors.

This item was discussed in Inspection Reports 50-315/94018(DRP), 95006(DRP), and 95010(DRP). Report 95006 documented that the licensee had revised the majority of the degraded voltage calculations to use the degraded voltage relay setpoint minimum value, and the remainder of the valves in the program were scheduled to be modified to improve the capability at the lower voltage. The inspector verified that the licensee has modified the remainder of the valves to improve capability at the relay setpoint lower voltage. Report 95006 also documented in Section 6.b that the licensee had not completed evaluation of the existing capability of these valves. The inspector verified that the licensee has subsequently performed an operability determination for the valves in question, and that they are operable. This item is closed.

E8.2 (Closed) Violation 50-315/94009-03(DRS) The licensee did not perform an engineering evaluation of a motor-operated valve (MOV) that was in an over-thrust condition.

This item was discussed in Inspection Report 50-315/94018(DRP). That report documented that the licensee had completed its evaluation and NRC review of the evaluation package determined it to be adequate. The inspector verified the corrective actions described in the licensee's response letter, dated July 26, 1994, to be reasonable and complete. No similar problems were identified. Corrective actions included revision to Procedure 12 IHP 5030.EMP.002, Revision 2, Change Sheet 5 on June 10, 1994, to require that the justification for acceptance of any test discrepancies be documented in the remarks section of the procedure. Review of Procedure 12 IHP 5030.EMP.002, June 10, 1998, Revision 6, confirmed that this requirement still existed. This item is closed.

IV. Plant Support

R4 Staff Knowledge and Performance in Radiation Protection and Chemistry (71750)

R4.1 Improper Wearing of Personal Protective Clothing

a. Inspection Scope (83750)

The inspectors observed work occurring in the lower ice condenser and other portions of containment. During the work observations the inspectors observed some workers with their protective clothing not secured as required.

b. Observations and Findings

On June 19, 1998, while inspecting the lower ice condenser in containment, the inspectors identified a Plant Performance Assurance (PPA) technician who was not wearing the hood of his personal protective clothing (PC) as required by the radiation work permit (RWP).

The technician had secured the hook and loop fastener of the PC hood behind his neck instead of beneath his chin, exposing his neck to possible contamination. The inspectors discussed the requirement for wearing of PC hoods with the technician, who stated that it was optional to wear a hard hat in place of the PC hood when working in lower ice, and that if he were wearing a hard hat his neck would also be exposed. The inspectors discussed their observation with the PPA supervisor who subsequently reinforced the requirement for the technician to wear the selected PC ensemble properly. A condition report was initiated to document the occurrence.

On June 23, 1998, while inspecting the upper ice condenser, the inspectors observed three PPA technicians who were wearing their PC hoods with the neck closure unfastened, contrary to the dress requirements of the radiation work permit. The hoods did not have the hook and loop fasteners secured in back, as was the case in the previous issue discussed above, but the hook and loop fastener of the PC hood was unconnected. After being informed by the inspectors the workers promptly closed the front fasteners. PPA management initiated an additional condition report and conducted training with all PPA personnel regarding RWP PC dress compliance following the additional NRC inspector findings.

PPA management took prompt action to correct these minor discrepancies in PC compliance. These occurrences were violations of minor significance that are not subject to formal enforcement action.

b. Conclusions

The inspectors noted several minor occurrences of lack of attention to detail concerning anti-contamination personnel protective clothing dress requirements. NRC inspection activities will continue to monitor worker compliance with radiation work permit requirements.

S1 Conduct of Security and Safeguards Activities (71750)

During normal resident inspection activities, routine observations were conducted in the area of security and safeguards activities using Inspection Procedure 71750. No discrepancies were noted.

F1 Control of Fire Protection Activities (71750)

During normal resident inspection activities, routine observations were conducted in the area of fire protection activities using Inspection Procedure 71750. No discrepancies were noted.

F8 Miscellaneous Fire Protection Issues 92700

F8.1 (Closed) Licensee Event Report (LER) 50-316/93005-00 and 50-316/93005-01 10 CFR 50, Appendix R Cable Routing and Compliance Strategy Concerns.

Revision 0 to this LER retracted the 10 CFR 50.72 notification as the conditions were not reportable per 10 CFR 50.72(b)(ii)(B). The remainder of the Revision 0 described the conditions that were not in compliance with 10 CFR 50 Appendix R from 1986 to 1990,

and the corrective actions that had been taken in 1990. Also discussed, were the corrective actions that would be taken to ensure the identified issues with the local shutdown indication (LSI) panels did not exist in other LSI panels. Revision 1 to the LER discussed the corrective actions taken and also stated that no additional cases of noncompliance with 10 CFR 50 Appendix R were identified. This item is closed:

X1 **Exit Meeting**

The inspectors presented the inspection results to members of the licensee management at the conclusion of the inspection on July 16, 1998. The licensee had additional comments on some of the findings presented. No proprietary information was identified by the licensee.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

- # J. Allard, Ice Project Production Supervisor
- # G. Allen, Production Engineering
- # K. Baker, Manager, Production Engineering
- # A. Barker, Maintenance
- # P. Barrett, Manager of Protection Assurance
- # J. Boesch, Maintenance Superintendent
- # K. Burkett, Plant Protection
- D. Cooper, Plant Manager
- # S. DeLong, Management Information
- #MB. Depuydt, Nuclear Licensing
- # S. Farlow, I&C Engineering
- # M. Finissi, Electrical and Auxiliary Systems Engineering
- # R. Gillespie, Operations Superintendent
- # A. Gort, Mechanical Component Engineering
- # D. Hafer, Manager, Plant Engineering
- # D. Morey, Corrective Action Supervisor
- # D. Noble, Radiation Protection/ Chemistry Superintendent
- # T. Postlewait, Manager, Design Engineering
- # J. Sampson, Site Vice-President
- # P. Schoepf, Supervisor, Safety-Related Mechanical Systems
- # A. Verteramo, Production Engineering
- # W. Walschot, Corrective Action
- # P. Wyckoff, Materials Management

USNRC

- # E. Schweibinz, Project Engineer, Region III

Martin-Sigmon Consulting Services

- # J. Martin
- # J. Crews

#Denotes those present at the July 16, 1998, exit meeting.

INSPECTION PROCEDURES USED

IP 37551	On-site Engineering
IP 61726	Surveillance Observations:
IP 62707	Maintenance Observation
IP 71707	Plant Operations
IP 71750	Plant Support Activities
IP 92700	Onsite Review of LERs

ITEMS OPENED, CLOSED, AND UPDATED

ITEMS OPENED

None

ITEMS CLOSED

50-315/93006-01;
50-316/93006-01

URI The degraded voltage calculations did not assume the worst case grid voltage as the starting point for evaluating the available voltage at motor operated valve motors.

50-316/93005-00 and
50-316/93005-01

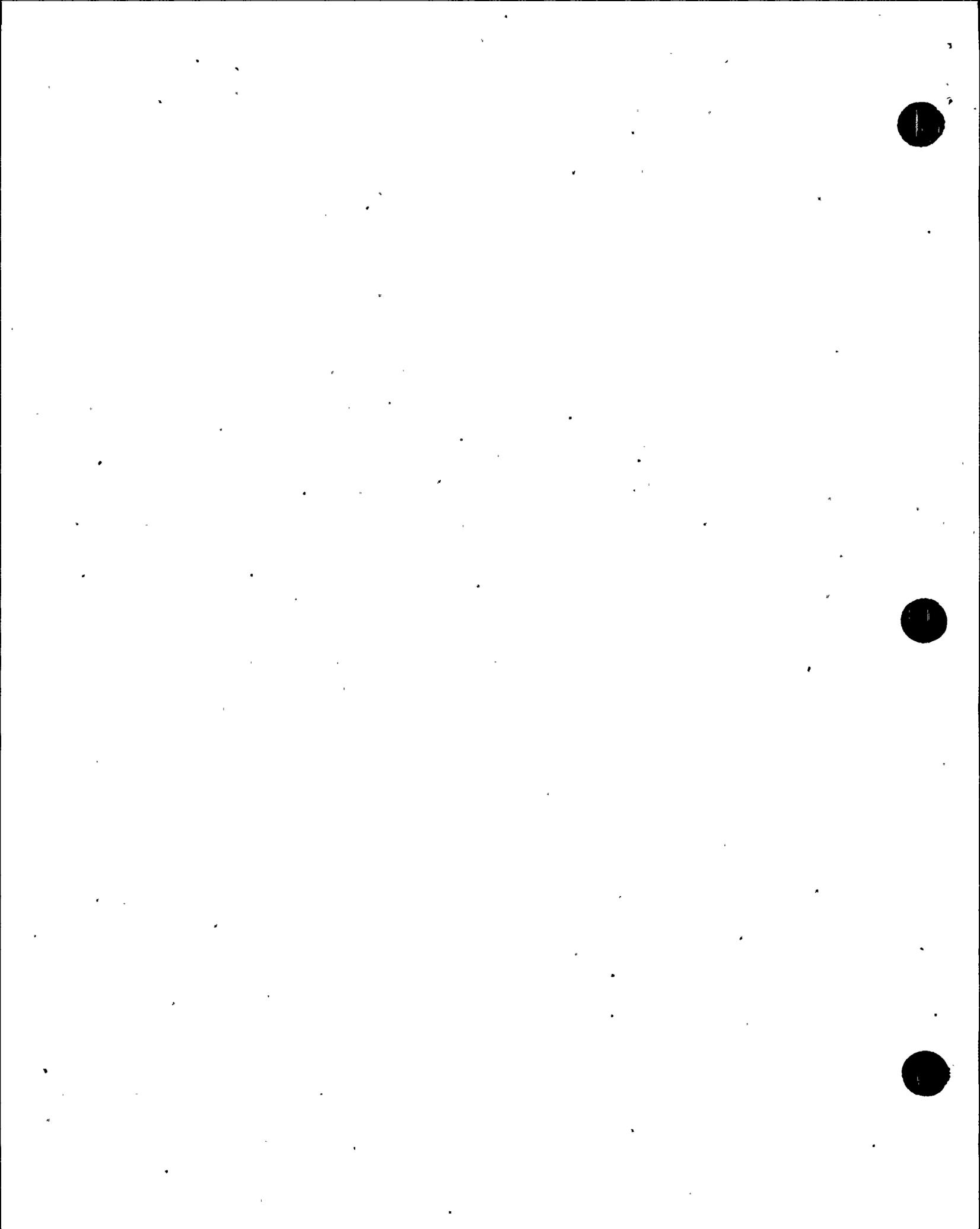
LER 10 CFR 50, Appendix R Cable Routing and Compliance Strategy Concerns.

50-315/94009-03

VIO The licensee did not perform an engineering evaluation of a motor-operated valve (MOV) that was in an over-thrust condition.

ITEMS UPDATED

None



LIST OF ACRONYMS

AEP	American Electric Power
AR	Action Request
BOP	Balance of plant
bcc	blind carbon copy
BIT	Boron Injection Tank
cc	carbon copy
CCW	Component Cooling Water
CFR	Code of Federal Regulations
CR	Condition Report
DCC	Donald C. Cook
D/G	Emergency Diesel Generator
DRP	Division of Reactor Projects
DPR	Demonstration Power Reactor
EDT	Eastern Daylight Time
ESF	Engineered Safety Feature
ESW	Essential Service Water
IR	Inspection Report
JO	Job Order
LCO	Limiting Condition for Operation
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
LSI	Local Shutdown Indication
MI	Michigan
MOV	Motor-Operated Valve
MTLO	Main Turbine Lubricating Oil
NESW	Non-Essential Service Water
NOV	Notice of Violation
NRC	Nuclear Regulatory Commission
NRR	Nuclear Reactor Regulation
OHI	Operations Head Instruction
PC	Protective Clothing
PMI	Plant Manager's Instruction
PMP	Plant Manager's Procedure
PPA	Plant Performance Assurance
PDR	Public Document Room
QC	Quality Control
RG	Regulatory Guide
ROC	Restart Oversight Committee
RWP	Radiation Work Permit
STP	Surveillance Test Procedure
UFSAR	Updated Final Safety Analysis Report
URI	Unresolved Item

