# U. S. NUCLEAR REGULATORY COMMISSION

## REGION II

Docket Nos.: 50-250 and 50-251
License Nos.: DPR-31 and DPR-41

Report Nos.: 50-250/96-10 and 50-251/96-10

Licensee: Florida Power and Light Company

Facility: Turkey Point Units 3 and 4

Location: 9250 West Flagler Street
Miami, FL 33102

Dates: July 21 through August 17, 1996

Inspectors: T. P. Johnson, Senior Resident Inspector
B. B. Desai, Resident Inspector
J. K. York , DRS Inspector

Approved by: K. D. Landis, Chief
Reactor Projects Branch 3
Division of Reactor Projects

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EXECUTIVE SUMMARY
TURKEY POINT UNITS 3 and 4
Nuclear Regulatory Commission Inspection Report 50-250,251/96-10

This integrated inspection to assure public health and safety included aspects of licensee operations, maintenance, engineering, and plant support. The report covered a four week period (July 21 to August 17, 1996) of resident inspection. In addition, the report includes regional announced inspection of engineering.

Operations

- Portions of the Residual Heat Removal and Safety Injection Systems were walked down, and determined to be appropriately aligned (section O2.1).

- A condition report was appropriately initiated to resolve coordination issues between the site medical facility and the operations department. Technical Specifications were not violated when an on shift Assistant Nuclear Plant Supervisor was removed from licensing duties (section O8.1).

Maintenance

- License focus on resolving continuing problems with the containment process radiation monitors is warranted (section M2.1).

- Lack of attention to detail resulted in a nuclear instrumentation calibration procedure not being updated to reflect recent Technical Specification changes. This was classified as a non-cited violation (section M3.1).

Engineering

- An unresolved item pertaining to control of heavy loads was identified pending completion of licensee review and the submittal of a licensee event report (section E2.1).

- Licensee response to reactor trip breaker dual indication during testing was appropriate. Good interdepartmental coordination was noted (section E1.1).

- System engineering was very supportive in aiding the operations and maintenance personnel in the resolution of problems with the component cooling heat exchangers. System engineering's preparation of a Problem Status Summary document, outlining a problem and supplying solutions for use by the operations personnel, was a strength (section E1.2).

- The licensee conducted an adequate self assessment on a part of the Updated Final Safety Analysis Report and no Unresolved Safety Questions or operability problems were identified (section E1.1).

Plant Support

- The licensee's program to periodically inspect exclusion and locked high radiation areas was deficient in that not all areas were included. During tours of selected plant areas, the inspector noted deficiencies in the Unit 3 filter-demin room (section R1.1).

- Licensee efforts, including heightened awareness were appropriate following a security incident at the St. Lucie plant (section S1.1).

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## REPORT DETAILS

Summary of Plant Status

Unit 3

At the beginning of this reporting period, Unit 3 was operating at or near 100% reactor power and had been on line since March 29, 1996. On August 16, 1996, Unit 3 was reduced to approximately 15% power to perform turbine valve testing and to effect repairs on a main feedwater regulating valve packing leakage.

Unit 4

At the beginning of this reporting period, Unit 4 was operating at or near 100% reactor power and had been on line since April 10, 1996. The unit operated at or near full power during this inspection period.

NRC Activities

Other NRC activities that occurred during the period are summarized as follows:

| Dates | Item |
|---|---|
| July 26, 1996 | Division of Reactor Projects (DRP) Branch Chief Site Visit |
| August 14, 1996 | DRP Acting Deputy Director Site Visit |
| July 22-26, 1996 | Division of Reactor Safety (DRS) Safeguards Inspection (Inspection Report No. 96-09) |

### I. Operations

#### O2 Operational Status of Facilities and Equipment

O2.1 Residual Heat Removal, Safety Injection, Containment Spray, and Spent Fuel Pool Cooling System Walkdown (71707)

The inspector accompanied the system engineer during a scheduled system walkdown in accordance with procedures 3 and 4-OSP-202.1, Safety Injection/Residual Heat Removal Flowpath Verification. Further, the inspector walked down portions of the Unit 3 and 4 Spent Fuel Pool Cooling Systems.

The inspector concluded that the systems were aligned in accordance with required procedures and that the respective system engineers were knowledgeable and cooperative.

## 08 Miscellaneous Operations Issues

### 08.1 Control Room Shift Manning (71707)

On July 26, 1996, the site medical facility informed the Unit 3 Assistant Nuclear Plant Supervisor (ANPS) that he had failed his physical examination required by 10 CFR 55.21. This rendered the ANPS unavailable for licensed duty. Consequently, the Senior Reactor Operator (SRO) manning in the control room was reduced to one NPS and one ANPS from one Nuclear Plant Supervisor (NPS) and two ANPSs. Technical Specification 6.2.2, Table 6.2-1 requirements were not violated. However a coordination concern was identified by the licensee, and condition report 96-969 was initiated. The coordination concern involved prompt notification by site medical facility to plant management to immediately initiate actions to call out a replacement for the unavailable ANPS. The ANPS was re-examined and passed the physical examination.

The inspectors discussed this event with the licensee, as well as the ANPS, and concluded that the licensee appropriately initiated a condition report to track and resolve the coordination issue. Technical Specification requirements involving control room staffing were not violated.

## II. Maintenance

## M1 Conduct of Maintenance

### M1.1 General Comments

a. Inspection Scope (62703 and 61726)

Maintenance and surveillance test activities were witnessed or reviewed. This included operational surveillance procedures (OSP) and preventive maintenance-instrument procedures (PMI).

b. Observations and Findings

The inspectors witnessed or reviewed portions of the following maintenance and test activities in progress:

- 3-PMI-067.1, Process Radiation Monitoring System Channel R-3-11 and R-3-12 Calibration Procedure
- 3-PMI-059.9, Power Range Nuclear Instrumentation protection Set II Channel N-3-42 Calibration
- 3-OSP-049.1, Reactor Protection System Logic Test

- 3 and 4 OSP-202.1, Safety Injection/Residual Heat Removal Flowpath Verification

c. Conclusions

For those maintenance and surveillance activities observed or reviewed, the inspectors determined that the activities were conducted in a satisfactory manner and that the work was properly performed in accordance with approved maintenance work orders. The inspectors also determined that the above testing activities were performed in a satisfactory manner and met the requirements of the Technical Specifications.

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Process Radiation Monitor Problems

On August 5, 1996, the Unit 3 Containment Gaseous and Particulate Radiation Monitors (3-R-11/12) experienced problems including a channel failure alarm, loss of operate Light Emitting Diode (LED), and flow fluctuation between 3 - 5 standard cubic feet per minute (scfm). Monitors 3-R-11/12 were declared out-of-service and Technical Specification Action Statement (TSAS) 3.4.6.1 was entered. Condition report 96-1014 and troubleshooting were initiated. Monitor R-11 is currently in the 10 CFR 50.65 a (1) category due to maintenance preventable functional failures associated with filter paper misalignment problems. The problem experienced on August 5, 1995, did not appear to be related to the previous failures.

Troubleshooting identified a failed 5 volt regulating power supply. The power supply was replaced and 3-R-11/12 monitors were returned to service. The license postulated the cause of the power supply failure to be heat related. The hardware cabinet located on the monitor skid houses the power supply, in addition to other hardware. This cabinet was designed with heat sink fins. However, with the 3-R-11/12 monitor skid located in the Auxiliary Building, the licensee believes that the heat transfer capability of the fins was not sufficient to preclude heat related problems. Consequently, the licensee is considering a Plant Change/Modification (PC/M) to install a fan on the cabinet. Monitors 3-R-11/12 have also experienced previous problems with condensation moisture in the process sample lines. A PC/M to heat trace portions of the sample lines is also being considered to resolve this problem.

The inspector concluded that continued licensee focus on resolving this issue is warranted. The inspectors continue to monitor this issue.

M3 Maintenance Procedures and Documentation

M3.1 Power Range Nuclear Instrument (NI) Protection Set Channel Calibration

On July 30, 1996, during the performance of procedure 3-PMI-059.9, Power Range Nuclear Instrument Protection Set I Channel N-3-42 Calibration, I&C technicians noted that the loop Over-temperature-delta-temperature (OTΔT) meter located on the vertical panel board in the control room did not deflect as expected. The purpose of step 6.11 associated with procedure 4-PMI-059.9 was to check continuity between the NI instrument and the OTΔT indication which is processed through the Eagle 21 system. OTΔT and Over-pressure-delta- temperature (OPΔT) reactor trip setpoints are generated with (Δi) (axial flux difference) as an input. With a higher Δi, the calculated reactor trip setpoint is lowered. When the actual ΔT equals the calculated ΔT setpoint, a reactor trip is initiated.

The continuity between the NI drawer and the indicated OTΔT trip setpoint was verified in procedure step 6.11 by simulating Δi valves of +20% and -20%. Under these conditions, the OTΔT setpoint is calculated by the eagle 21 system and the trip setpoint is lowered. This manifests in the setpoint indication on OTΔT meter deflecting down. This is also referred to as "OTΔT taking a penalty".

When the cause of the absence of deflection was investigated, the licensee determined that the implementation of Westinghouse's NRC approved revised thermal design procedure (RTDP) changed the OTΔT and OPΔT setpoints. This change was approved by the NRC, and the operating licenses were amended on February 20, 1996. The RTDP changed the Δi threshold for inducing OTΔT and OPΔT penalty. The Δi valves to initiate penalty had been changed from +20% and -20% to +20% and -46%. Thus, Eagle 21 system would not have lowered the reactor trip setpoint until a simulated Δi of -46% was input. With procedure 3-PMI-059.9, step 6.11 requiring input of Δi valve -20%, the deflection of the OTΔT meter did not occur. A further review by the licensee concluded that procedure 3-PMI-59.9 had not been appropriately updated to reflect the changes brought about by the RTDP that was implemented through PC/Ms 94-35 and 95-100, RTDP Related Reactor Protection System/Engineered Safeguards Features Actuation System (RPS/ESFAS) Setpoint Changes for Units 3 and 4 respectively. This failure to appropriately change procedures 3 and 4-PMI-59.9 following a PC/M is considered as a non-cited violation 50-250, 251/96-10-01, Failure to Upgrade Procedure Following Modification.

The licensee discussed the issue with Westinghouse and concluded that step 6.11 of procedure 3 and 4 PMI-59.9 essentially served no purpose as the eagle 21 system has a self-diagnostic feature. Consequently, the licensee is planning to delete steps 6.11 form

procedures 3 and 4-PMI-59.9. Notwithstanding, the inspector concluded that a lack of attention to detail resulted in appropriate procedures not being updated following a modification.

## III. Engineering

### E1 Conduct of Engineering (37550, 37551, and 92700)

#### E1.1 Updated Final Safety Analysis Report (UFSAR) Reviews

The inspectors reviewed a self-assessment that was performed by the licensee to review the site UFSAR. This review was made in order to determine the nature and extent of discrepancies between the UFSAR descriptions, and the design/procedural configuration. Approximately three fourths of the UFSAR text volume was reviewed.

Ninety six potential discrepancies were identified, and placed in one of four categories. In the least serious category, some of these were just questions that were resolved by further discussion, some were already in the UFSAR change process, and some were bounded by other information. There were 67 items of the 96 in this category. There were 23 of the 96 items in the second category. These were either administrative, inconsistent, or of a historical nature and resulted in a minor clarification change to the UFSAR. There were eight items in the third category. In this category, the UFSAR description was not consistent with the plant engineering design or operating procedures. No Unreviewed Safety Questions(USQ) or operability problems were discovered. The licensee has submitted a plan to management for completing this UFSAR review.

The inspector concluded that the licensee had conducted an adequate self assessment on a part of the UFSAR and no USQs or operability problems had been identified.

#### E1.2 Engineering Support of Operations and Maintenance

A problem with tube plugging in the component cooling water(CCW) heat exchangers was chosen for evaluating the support for operations and maintenance by the mechanical systems engineering group. The inspectors walked the system down with the systems engineer, discussed an emerging problem with the CCW heat exchangers, and discussed a metallurgical failure analysis of one of the tubes. One of the heat exchangers had a number of plugged tubes, and was approaching an administrative limit. The systems engineer was very familiar with the system, and worked with operations in evaluating the operability of the heat removal capability of the heat exchangers and worked with maintenance in determining when it was necessary to clean the tubes.

The system engineer provided a comprehensive Problem Status Summary document for inclusion in a book for operations in the control room. This book contained Problem Status Summary documents for other systems and components. Each of these summaries contained a problem statement, actions completed, subsequent actions planned, and additional information. This information in the control room area was deemed by the inspector to be useful to operations.

The inspector concluded that system engineering was very supportive in aiding the operations and maintenance personnel in the resolution of problems with the CCW heat exchangers. System engineering's preparation of a Problem Status Summary document, outlining a problem and supplying solutions for use by the operations personnel, was a strength.

## E2 Engineering Support of Facilities and Equipment

### E2.1 Control of Heavy Loads

During a review associated with NRC Bulletin 96-02, Movement of Heavy Loads Over Spent Fuel, Over Fuel in the Reactor Core, or Over Safety Related Equipment, the licensee identified on July 29, 1996, that the safe load path for the Turbine gantry crane, identified in administrative procedure (ADM) 0-ADM-717, deviated from the path approved in the Turkey Point NUREG 0612 Safety Evaluation Report (SER) issued by NRC on November 1, 1983. Condition report 96-977 was initiated on July 29, 1996 to address this issue.

The safe load path for the turbine gantry crane procedure 0-ADM-717 included all areas of the turbine deck with the exception of the area directly over the 4KV switchgear rooms of each unit. A review of documents submitted to the NRC, as a result of FPL's NUREG 0612 review, indicated that this load path was provided in the original submittal requested by NRC's generic letter dated December 22, 1980. However, the licensee noted that subsequent submittals, including the final submittals referenced in the NUREG 0612 SER, changed the safe load path. The load path was changed to exclude the area directly east of the switchgear rooms of each unit, for loads greater than 1760 pounds, and established a new north/south corridor by allowing heavy loads to be lifted over the 4KV switchgear rooms west of the turbine pedestals. It appears that the adjusted load path was not transferred properly to the plant procedure at that time, and had not been recognized since then. Consequently, the licensee postulated that there were occasions during which loads exceeding the 1760 pounds capacity may have been lifted over the areas directly east of the switchgear rooms of each unit. The area east of the switchgear room was restricted to 1760 pounds apparently due to the unprotected electrical equipment (conduit and cable trays) in the area. The licensee also noted that procedure 0-ADM-717 defined

heavy load as any load in excess of 2000 pounds. This contradicted licensee submittals to the NRC which defined heavy loads as those exceeding 1760 pounds.

Upon identification of this situation, the licensee notified the NRC pursuant to 10 CFR 50.72 b(ii)B, as well as the resident inspector. As immediate corrective actions, the licensee implemented a clearance on the Turbine Gantry crane, pending procedure update and a training brief. Procedure 0-ADM-717 was updated to include the area east of the switchgear rooms of each unit where a load greater than 1760 pounds would be prohibited. Further, a training bulletin, 96-28, was promulgated to all Turkey Point Staff. Further, while the licensee has not completed the review, the licensee's initialed review of other load paths, (e.g., Polar Crane, Mobile Crane, Spent Fuel Pool Crane, etc.,) has concluded that the path, and loading criteria are acceptable. An LER associated with this issue as well as a response to NRC Bulletin 96-02 are forthcoming.

The inspector reviewed and discussed the issue with the licensee. Pending completion of licensee review and issuance of the LER, this issue is considered as Unresolved Item 50-250,251/96-10-02, Control of Heavy Loads.

## E3 Engineering Procedures and Documentation

### E3.1 Unit 3 Reactor Protection System (RPS) Circuit

On August 6, 1996, during the performance of surveillance procedure 3-OSP-049.1, Reactor Protection System Logic Test, the operator stationed in the cable spreading room noticed that the red (closed) indication lamp located on test rack 3QR41 was dimly lit. At this time, the 3B reactor trip breaker was open and the green (open) indication light was also lit. Additionally, during RPS logic testing, operations noticed that CCW process radiation monitor, R-17B, was spiking every time two channels of a given function were tripped. The dimly lit red indication lamp, and the spiking of process radiation monitors R-17B were not expected by the operator performing the OSP. Consequently, I&C was contacted. Further, TSAS 3/4.3.1 was entered, and condition report 96-1010 was initiated.

Troubleshooting efforts by I&C located the circuit that gave the dual indication with the B reactor trip breaker open. This circuit allowed current to flow from the positive power source through both control room red indication lamps and then to the red indication lamp located in the cable spreading room to negative power source. This circuit was modified in 1995 during the implementation of PC/M 94-117, DC Indicating Light Replacement. The PC/M installed current limiting resistors in series with the B reactor trip breaker's indication lamps in order limit current in the event that a short were to be experienced associated with a

lamp socket or bulb. The PC/M did not consider the effects of minor variances in circuit voltages due to variances in bus loading. The PC/M was intended to prevent unnecessary reactor trips.

The licensee concluded that the operability of the B reactor trip breaker or the operability of the automatic RPS trip functions was not affected. The B reactor trip breaker was cycled several times without any problems, and the RPS trip logic was verified to work as expected. The TSAS was exited at approximately 1:30 p.m. The spiking of process monitor R-17B was determined to be caused a problem in the power supply associated with the detector. The licensee is evaluating the course of action to rectify the problem through the condition report system.

The inspector reviewed the condition, including applicable drawings, and discussed the issue with the licensee. The inspector concluded that the licensee appropriately responded to the noted condition. Interdepartmental coordination during the resolution of this problem was noted to be a strength.

E8 Miscellaneous Engineering Issues

E8.1 Monthly Operating Report

The inspectors reviewed the July 1996 monthly operating report and determined it to be complete and accurate.

## IV. Plant Support

### R1 Radiological Protection and Chemistry (RP&C) Controls (71750)

R1.1 Locked High Radiation Areas Inspections

Based on recent industry events and NRC Information Notice (IN) 96-14, "Degradation of Radwaste Facility Equipment at Millstone Unit 1", the inspector reviewed licensee controls of locked high radiation areas. The inspector noted that the licensee initiated Condition Report No. 96-765 to address the IN. This action was consistent with their operating experience feedback program. Based on weekly walkdowns of radwaste facility equipment and no noted problems, the licensee closed the condition report.

The inspector reviewed the list of locked high radiation area rooms, including those associated with radwaste equipment. The listing included:

a. Units 3 and 4 spent fuel pool (SFP) demin rooms,

b. Units 3 and 4 volume control tank (VCT) rooms,

c. Unit 3 and 4 filter demin rooms,

d. Evaporator demin room,

e. Ten foot pipe way,

f. Spent resin storage tank (SRST) room,

g. Waste hold up tank (WHUT) rooms,

h. Radwaste high-level storage room,

i. South evaporator room,

j. Unit 3 and 4 containment tendon galleries,

k. Steam generator (SG) storage building,

l. Gas decay tank (GDT) room.

The inspector independently toured rooms and areas above indicating b, c, d, e, g, h, and i. Areas j and k were inspected during NRC Inspection Report 50-250,251/95-01. Areas a, f, and l were not inspected based on radiation dose considerations and accessibility. Also, the GDT room requires a plug removal for access. For the areas inspected, conditions were acceptable with some noted minor housekeeping issues. These were noted by the inspector and documented by the licensee to address. However, the Unit 3 filter demin room had a noted small dry boric acid leak in the vicinity of the "C" CVCS vessel. Further, a scaffolding and bag of tools were in the room. These deficiencies were documented and addressed in Condition Report No. 96-946. At the close of the inspection, this condition report was still open. However, the licensee intends to address periodic inspections for the areas which are normally not accessible (e.g., areas a, c, d, f, and l above).

The inspector concluded that the licensee had adequately addressed routine inspections of the radwaste building and facilities. However, certain auxiliary building rooms were not periodically inspected (e.g., areas a, c, d, f, and l) above. Further, the licensee was responsive to the inspector's comments.

## S1 Conduct of Security and Safeguards Activities

### S1.1 Heightened Awareness

The licensee initiated actions, including inspection of safety equipment as well as placing the security force in heightened awareness following the vandalism incident that occurred at St Lucie. The inspection of major safety related equipment at Turkey Point did not identify any abnormalities. There was substantial local news media attention related to the St. Lucie incident. The

inspector concluded that the licensee appropriately responded to the event.

## V. Management Meetings

### X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on August 16, 1996. The licensee acknowledged the findings present.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

Partial List of Persons Contacted

Licensee

T. V. Abbatiello, Site Quality Manager
R. J. Acosta, Director, Nuclear Assurance
J. C. Balaguero, Plant Operations Support Supervisor
P. M. Banaszak, Electrical/I&C Engineering Supervisor
C. R. Bible, Systems Engineering Manager
W. H. Bohlke, Vice President, Engineering and Licensing
T. J. Carter, Project Engineer
B. C. Dunn, Mechanical Systems Supervisor
R. J. Earl, QC Supervisor
S. M. Franzone, Instrumentation and Controls Maintenance Supervisor
R. J. Gianfrancesco. Maintenance Support Supervisor
R. G. Heisterman, Maintenance Manager
J. R. Hartzog, Business Systems Manager
P. C. Higgins, Outage Manager
G. E. Hollinger, Licensing Manager
R. J. Hovey, Site Vice-President
M. P. Huba, Procurement Supervisor
D. E. Jernigan, Plant General Manager
T. O. Jones, Acting Operations Supervisor
M. D. Jurmain, Electrical Maintenance Supervisor
V. A. Kaminskas, Services Manager
J. E. Kirkpatrick, Fire Protection, EP, Safety Supervisor
J. E. Knorr, Regulatory Compliance Analyst
G. D. Kuhn, Procurement Engineering Supervisor
M. L. Lacal, Training Manager
J. D. Lindsay, Health Physics Supervisor
J. T. Luke, Engineering Manager
E. Lyons, Engineering Administrative Supervisor
F. E. Marcussen, Security Supervisor
R. B. Marshall, Human Resources Manager
H. N. Paduano, Manager, Licensing and Special Projects
M. O. Pearce, Projects Supervisor
K. W. Petersen, Site Superintendent
T. F. Plunkett, President, Nuclear Division
K. L. Remington, System Performance Supervisor
R. E. Rose, Nuclear Materials Manager
C. V. Rossi, QA and Assessments Supervisor
A. M. Singer, Operations Supervisor (Acting Operations Manager)
W. Skelley, Plant Engineering Manager
R. N. Steinke, Chemistry Supervisor
E. A. Thompson, Project Engineer
D. J. Tomaszewski, Component Specialist Supervisor
B. C. Waldrep, Mechanical Maintenance Supervisor
G. A. Warriner, Quality Surveillance Supervisor
R. G. West, Operations Manager

Other licensee employees contacted included construction craftsmen, engineers, technicians, operators, mechanics, and electricians.

NRC Resident Inspectors

B. B. Desai, Resident Inspector
T. P. Johnson, Senior Resident Inspector

**Partial List of Opened, Closed, and Discussed Items**

Opened

| | |
|---|---|
| 50-250,251/96-10-01 | NCV, Failure to Upgrade Procedure Following Modification (section M3.1) |
| 50-250,251/96-10-02 | URI, Control of Heavy Loads (section E2.1) |

Closed

None

Discussed

None

**List of Inspection Procedures Used**

| | |
|---|---|
| IP 37550: | Engineering |
| IP 37551: | Onsite Engineering |
| IP 40500: | Effectiveness of Licensee Controls in Identifying, Resolving, and Prevent Problems |
| IP 61726: | Surveillance Observations |
| IP 62703: | Maintenance Observations |
| IP 71707: | Plant Operation |
| IP 71750: | Plant Support Activities |
| IP 90712: | Inoffice Review of Written Reports |
| IP 90713: | Review of Periodic Reports |
| IP 92700: | Onsite Followup of Written Reports of Nonroutine Events at Power Reactor Facilities |

List of Acronyms and Abbreviations

| | |
|---|---|
| ADM | Administrative (Procedure) |
| Δi | Axial Flux Difference |
| ANPS | Assistant Nuclear Plant Supervisor |
| CCW | Component Cooling Water |
| CFR | Code of Federal Regulations |
| dpm | Disintegrations Per Minute |
| DPR | Power Reactor License |
| DRS | Division of Reactor Safety |
| ESF | Engineered Safeguards Feature |
| etal | "and the rest" |
| FL | Florida |
| FPL | Florida Power and Light |
| GDT | Gas Decay Tank |
| I&C | Instrumentation and Control |
| KV | Kilovolt |
| LED | Light Emitting Diode |
| LER | Licensee Event Report |
| MWe | Megawatts Electric |
| NCV | Non-Cited Violation |
| NPS | Nuclear Plant Supervisor |
| NRC | Nuclear Regulatory Commission |
| OSP | Operations Surveillance Procedure |
| OPΔT | Over pressure delta temperature |
| OTΔT | Over temperature delta temperature |
| PC/M | Plant Change/Modification |
| PDR | Public Document Room |
| PMI | Preventive Maintenance - I&C |
| RPS | Reactor Protective System |
| RTDP | Revised Thermal Design Procedure |
| scfm | standard cubic feet per minute |
| SER | Safety Evaluation Report |
| SFP | Spent Fuel Pool |
| S/G | Steam Generator |
| SRO | Senior Reactor Operator |
| TS | Technical Specification |
| TSAS | TS Action Statement |
| UFSAR | Updated Final Safety Analysis Report |
| URI | Unresolved Item |
| USQ | Unreviewed Safety Question |
| VCT | Volume Control Tank |
| VIO | Violation |
| WGDT | Waste Gas Decay Tank |
| WHT | Waste Holdup Tank |