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

Report No.: 50-400/89-34

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

Docket No.: 50-400 License No.: NPF-63

Facility Name: Harris 1

Inspection Conducted: November 18, 1989 - January 5, 1990

Inspectors: H C Dance / for 1/31/90
J. Tedrow, Senior Resident Inspector Date Signed

H C Dance / for 1/31/90
M. Shannon, Resident Inspector Date Signed

Approved by: H-C Dance 1/31/90
H. Dance, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope:

This routine inspection was conducted by two resident inspectors in the areas of plant operations; radiological controls; security; fire protection; surveillance observation; maintenance observation; licensee event reports; non-conformance reports; system engineer program; fitness for duty training; design changes and modifications; plant startup from refueling; followup of onsite events; and licensee action on previous inspection items.

Results:

Two violations were identified: Failure to perform surveillance testing for an inoperable emergency diesel generator, paragraph 3.a; Failure to properly implement surveillance procedures, paragraphs 3.b and 3.c.

An unresolved item is identified in paragraph 6.a concerning the operability of the main steam lines when filled with condensate.

A licensee identified violation is discussed in paragraph 6.b concerning a failure to perform a visual inspection of check-valve internals.

Operational weaknesses are discussed in paragraph 11, concerning secondary plant transients causing AFW actuations, and paragraph 6.a, failure to control heatup activities which resulted in a main steam safety actuation, and filling of main steam lines with condensate during plant heatup.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

S. Allen, Fitness for Duty Site Coordinator
D. Braund, Supervisor, Security
J. Collins, Manager, Operations
*G. Forehand, Director, QA/AC
*C. Gibson, Director, Programs and Procedures
*P. Hadel, Project Specialist, Planning
*J. Hammond, Manager, Onsite Nuclear Safety
*C. Hinnant, Plant General Manager
*D. McCarthy, Unit Manager, Site Engineering
T. Morton, Manager, Maintenance
C. Olexik, Supervisor, Shift Operations
*H. Powell, Manager, Training
*R. Richey, Manager, Harris Nuclear Project Department
*J. Sipp, Manager, Environmental and Radiation Monitoring
*J. Smith, Supervisor, Radwaste Operation
*D. Tibbits, Director, Regulatory Compliance
*R. Van Metre, Manager, Technical Support
*M. Wallace, Senior Specialist, Regulatory Compliance
E. Willett, Manager, Outages and Modifications

Other licensee employees contacted included office, operations, engineering, maintenance, chemistry/radiation and corporate personnel.

*Attended exit interview

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

2. Review of Plant Operations (71707)

The plant began this inspection period in a refueling outage with the reactor vessel defueled. The outage activities included repairs of damage which resulted from the turbine generator/main transformer fire on October 9, core refueling, an integrated leak rate test of containment, and steam generator eddy-current testing. On November 23 refueling activities (Mode 6) were recommenced and the core was completely refueled on November 25. Following installation and torquing of the reactor vessel head, the plant entered cold shutdown (Mode 5) at 4:30 p.m. on December 1. A plant heatup was commenced and the hot-standby condition (Mode 3) reached on December 17. On December 20 a reactor start-up was performed followed by reactor criticality at 9:47 a.m. Power operation (Mode 1) was

resumed at 5:17 a.m. on December 22. The plant continued in power operation (Mode 1) for the duration of this inspection period. Power was limited to approximately 75% due to an inoperable main steam safety valve (see paragraph 6.a for details).

The inspector reviewed records and discussed various entries with operations personnel to verify compliance with the Technical Specifications (TS) and the licensee's administrative procedures. The following records were reviewed: Shift Foreman's Log; Control Operator's Log; Auxiliary Operator's Log; Night Order Book; Equipment Inoperable Record; Active Clearance Log; Jumper and Wire Removal Log; Shift Turnover Checklist; and selected Chemistry/Radiation Protection and Radwaste Logs.

Throughout the inspection period facility tours were conducted to observe operations and maintenance activities in progress. Some operations and maintenance activity observations were conducted during backshifts. Also, during this inspection period, licensee meetings were attended by the inspectors to observe planning and management activities. The facility tours and observations encompassed the following areas: security perimeter fence; control room; emergency diesel generator building; reactor auxiliary building; waste processing building; fuel handling building; emergency service water building; battery rooms; and electrical switchgear rooms.

During these tours, the following observations were made:

a. Monitoring Instrumentation - Equipment operating status, area atmospheric and liquid radiation monitors, electrical system lineup, reactor operating parameters, and auxiliary equipment operating parameters were observed to verify that indicated parameters were in accordance with the TS for the current operational mode.

   During a control room tour on December 30, 1989 the inspector noted that the upper and lower power range nuclear instruments for NI-44 were in channel defeat. The instruments had not been declared inoperable and no surveillance testing was in progress. During discussions with plant operators, the inspector learned that operators had placed the channel in defeat because of low NI readings which caused both an upper and lower flux deviation alarm. Although no apparent TS action applied, this action to remove an instrument channel from service without declaring it inoperable is considered to be a poor practice.

b. Shift Staffing - The inspectors verified that operating shift staffing was in accordance with TS requirements and that control room operations were being conducted in an orderly and professional manner. In addition, the inspector observed shift turnovers on various occasions to verify the continuity of plant status, operations problems, and other pertinent plant information during these turnovers.

c. Plant Housekeeping Conditions - Storage of material and components, and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards existed.

d. Radiological Protection Program - Radiation protection control activities were observed routinely to verify that these activities were in conformance with the facility policies and procedures, and in compliance with regulatory requirements. The inspectors also reviewed selected RWPs to verify that the RWP was current and that the controls were adequate.

e. Security Control - In the course of the monthly activities, the inspector included a review of the licensee's physical security program. The performance of various shifts of the security force was observed in the conduct of daily activities to include: protected and vital area access controls; searching of personnel, packages, and vehicles; badge issuance and retrieval; escorting of visitors; patrols; and compensatory posts. In addition, the inspector observed the operational status of Closed Circuit Television (CCTV) monitors, the Intrusion Detection system in the central and secondary alarm stations, protected area lighting, protected and vital area barrier integrity, and the security organization interface with operations and maintenance.

f. Fire Protection - Fire protection activities, staffing and equipment were observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable.

No violations or deviations were identified.

3. Surveillance Observation (61726)

Surveillance tests were observed to verify that approved procedures were being used; qualified personnel were conducting the tests; tests were adequate to verify equipment operability; calibrated equipment was utilized; and TS requirements were followed.

The following tests were observed and/or data reviewed:

GP-002	Normal Plant Heatup From Cold Solid to Hot Subcritical
OST-1004	Power Range Heat Balance
OST-1005	Control Rod and Rod Position Indicator Exercise
OST-1036	Shutdown Margin Calculation
OST-1073	1B-SB Emergency Diesel Generator Operability Test
OST-1804	RHR Remote Position Indication and Timing
EPT-069	Initial Criticality

EPT-152T Main Steam Safety Valve Test at Power
EST-202 Main Steam Safety Valve Test

a. During the performance of OST-1073 on December 31, the "B" Emergency Diesel Generator started but did not stabilize within the required frequency range. TS 4.8.1.1.2.a.4 requires that the diesel generator shall start and accelerate to synchronous speed with a generator voltage of 6900 ±690 volts and frequency of 60 ±1.2 hertz (Hz) within a 10 second time period. The diesel generator initially stabilized at a frequency of 62 Hz and returned to 60 Hz in 58 seconds. Operators declared the diesel inoperable at 10:40 p.m. and implemented the requirements of TS 3.8.1.1 action "b". This action statement specifies that with one diesel generator inoperable, the AC offsite power sources shall be demonstrated operable by verifying correct breaker alignment and power availability within one hour and at least once per 8 hours thereafter.

Subsequent review of this matter by licensee personnel determined that the diesel generator was capable of performing its safety function and therefore should not have been considered inoperable. At 9:45 a.m. on January 1, the diesel generator was declared operable even though it was not capable of satisfying the requirements of TS 4.8.1.1.2.a.4. Implementation of the requirements of TS 3.8.1.1 action "b" were discontinued at this time.

During a review of the shift foreman's log on January 2, the inspector noticed the above sequence of events and discussed this situation with licensee management. The licensee was informed that the TS had not been complied with and that the "B" diesel generator should not be considered operable. The "B" diesel generator was subsequently determined to be inoperable by the licensee at 2:35 p.m. on January 2.

Although the offsite power source remained available during this event, failure to continue to perform the breaker alignment and power availability verification surveillance for the AC offsite power sources for an inoperable diesel generator every 8 hours, is contrary to the requirements of TS 3.8.1.1 and is considered to be a violation.

Violation (89-34-01): Failure to perform surveillance testing for an inoperable emergency diesel generator.

b. During the performance of procedure OST-1804 on November 28, operators observed an increase in reactor vessel level. The plant was in Mode 6 on "B" RHR system cooling. The "A" RHR system was aligned for standby operation with valves RH-1 and RH-2, Reactor Coolant System Loop Suction Valves, open. Procedure OST-1804 directed valve 1SI-322, Refueling Water Storage Tank Suction to "A" RHR Pump, to be stroked open and then closed. When operators stroked

open this valve, a flowpath was created from the RWST to the reactor vessel through valves RH-1 and RH-2, allowing borated water to gravity drain into the reactor vessel. The reactor vessel filled, and contaminated water overflowed into the seal table area of containment through open instrument guide tubes. Licensee personnel estimated that approximately 25 gallons of water overflowed into the seal table area. No personnel contaminations or equipment damage resulted from this event.

Step 3.1 of procedure OST-1804 specifies a prerequisite for the performance of this test and requires that the system being tested be aligned in a manner that will support the performance of the test. This step had been completed and initialed by the senior control operator. Failure to adequately review the system lineup to ensure that the system was aligned for the safe performance of the test is contrary to the requirements of procedure OST-1804 and is considered to be a violation of TS 6.8.1.a.

Violation (89-34-02): Failure to adhere to the requirements of plant procedures which resulted in a spill of contaminated water into the seal table area of containment.

Upon further review of procedure OST-1804, the inspector noticed a discernible lack of precautions and limitations. Only a statement addressing system operability and a statement regarding radiological controls were included. The lack of any specific precautions alerting operators to the potential for this type of event is considered to be a contributing cause for this event.

c. The inspector conducted a review of the licensee's activities to adjust the power range nuclear instruments following a calorimetric calibration. Following the calorimetric, plant personnel noted that the "fine" gain potentiometer for the nuclear instruments did not have an adequate range to adjust the NI's to the required values. The fine gain potentiometer is located on the front panel of each NI channel and is used by operations personnel following a calorimetric calibration to adjust the channel as needed. Therefore, a course gain potentiometer, which is located inside the channel drawer, was used to make the calorimetric adjustment. The inspector discussed this action with the I&C foreman and learned that he was not aware that a course adjustment had been made.

Attachment VII of procedure OST-1004 specifies the steps necessary to adjust the NI gain, and states that if there is insufficient adjustment on gain potentiometer R303 (fine gain adjust), then a work request will be initiated for I&C personnel to adjust the course gain potentiometer. This work request was not generated as required.

The inspector was also informed that the course adjustment was made without utilizing plant procedures. The existing procedure for performing this evolution would not have been adequate to achieve the required final course adjust position. The licensee plans in future cases to set the course adjust by detailed work instructions in the work request.

The failure to generate the work request, which would alert management to changing plant conditions as required by procedure OST-1004, is considered to be another example of the violation discussed in paragraph 3.b of this report.

One violation with two examples was identified.

4. Maintenance Observation (62703)

The inspector observed/reviewed maintenance activities to verify that correct equipment clearances were in effect; work requests and fire prevention work permits, as required, were issued and being followed; quality control personnel were available for inspection activities as required; and, TS requirements were being followed.

Various open and closed work request packages were reviewed for the safety injection/charging system, in coordination with the system walkdown inspection.

No violations or deviations were identified.

5. Review of Licensee Event Reports (92700)

The following LERs were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events that were reported immediately were reviewed as they occurred to determine if the TS were satisfied. LERs were reviewed in accordance with the current NRC Enforcement Policy.

(Closed) LER 87-64: This LER reported that a special report for an inoperable radiation monitor was not submitted as required. The inspector reviewed and verified the licensee's corrective action as stated in this report.

(Closed) LER 89-17: This LER reported an electrical fault on main generator output bus causing plant trip and fire damage. The licensee's corrective action included bus repairs, redesign of the isolated phase bus duct supports, redesign of the radio frequency monitor and redesign of the bus duct fan cooling system to prevent debris intrusion. All items have been completed satisfactorily and the unit was returned to power operation.

6. Review of Nonconformance Reports (71707)

Significant Operational Occurrence Reports (SOORs) and Nonconformance Reports (NCRs) were reviewed to verify the following: TS were complied with, corrective actions as identified in the reports were accomplished or being pursued for completion, generic items were identified and reported, and items were reported as required by the TS.

a. SOOR 89-164 reported that a steam generator safety valve lifted during plant heatup. On December 17 the plant was in Mode 3 with RCS pressure at 2235 PSIG and RCS temperature at 557 ± 2 degrees F. The "B" steam generator PORV was isolated due to problems with the valve actuator. Also, the main condenser was under clearance and the drain lines from the main steam headers were closed. Plant operators were experiencing some difficulty in maintaining the established RCS temperature band (±2F) due to the "B" PORV being isolated and the slow response of the "A" and "C" PORVs in automatic. The operators therefore placed the "A" and "C" PORV controllers in manual. Operator inattentiveness allowed reactor coolant system temperature to increase above normal temperature. Due to saturation conditions in the steam generators, the increase in primary system temperature to approximately 565 F corresponded with an increase in steam generator pressure until the setpoint of a steam generator safety valve was reached. After lifting the safety valve, operators promptly reduced temperature and pressure which allowed the safety valve to reseat. The safety valve remained open for approximately 20 seconds. The licensee's investigation determined that a safety valve for the "A" steam generator had lifted.

The failure of the reactor operator to adequately control the heatup activity with the degraded condition of the PORVs, is considered to be weak. A lack of supervisory involvement in the heatup process was also evident.

On December 18, 1989, at approximately 11:20 a.m. a "B" steam generator safety valve (1MS-44) opened for approximately 20 seconds. Steam generator pressure had reached approximately 1093 PSIG which was well below the lowest valve lift setpoint of 1170 PSIG. The setpoint for this valve had recently been tested satisfactory during the refueling outage in October. Licensee personnel investigated this event and reverified the setpoint for the valve. On December 21, 1989, at approximately 12:19 p.m., 1MS-44 again lifted for approximately 5 seconds. Steam generator pressure had reached approximately 1097 PSIG and was still well below the required lift setpoint for the valve. The valve was subsequently declared inoperable and the requirements of TS 3.7.1.1 implemented.

The main steam line drains had been isolated during plant heatup and while the plant was maintained at hot standby. This allowed the steam lines to partially fill with condensate. The water interaction

with the safety valve could have been a contributing factor in the low lifting of the safety valves. It was noted by various plant personnel that an unusually large amount of water was found on the building roof following the first two safety valve lifts. Further, problems associated with the turbine driven auxiliary feedwater pump, which resulted in pump overspeed trips on two occasions, were attributed to water in the steam lines. Also the seismic analysis for the main steam lines may not be valid when the steam lines are filled with water. This could lead to an unanalyzed plant condition during a seismic event, which would result in an overcooling accident and a containment overpressurization accident, both due to multiple steam line failures. The licensee agreed to perform a seismic analysis for this system assuming the main steam lines were filled with condensate. This item is considered to be unresolved pending completion of the licensee's seismic analysis.

Unresolved Item (89-34-03): Operability of the main steam lines when filled with condensate.

The failure of operations to adequately drain the main steam lines during plant heatup, which resulted in an inoperable condition for the turbine driven AFW pump, potential safety valve actuation, and potential unreviewed safety question is considered to be an operational weakness.

b. NCR 89-56 reported that during a disassembly of cold leg accumulator check valves 1SI-251 and 1SI-252 during the refueling outage, a visual inspection of the valve internal surfaces was not performed as required by the licensee's inservice inspection program. The licensee's technical support group has revised its internal document used for reviewing proposed work requests to prevent recurrence of this nonconformance. In addition, the valves will be disassembled and inspected during the next scheduled refueling outage. This matter will be considered to be a licensee identified Non-Cited Violation (NCV).

NCV (89-34-04): Failure to perform a visual inspection of cold leg accumulator check valve internal surfaces.

7. Review of the System Engineer Program (71707)

A survey of the licensee's implementation of the system engineering concept was performed in accordance with a NRC Region II Memorandum dated November 15, 1989. The number of system engineers, as well as their responsibilities, interfaces, and reporting hierarchy were reviewed.

The system engineers report directly to the Manager of Technical Support. Their duties and responsibilities are formally defined in procedure TMM-100, Technical Support Conduct of Operations. These duties include,

in part, log reviews, system walkdowns, special test preparation, review of system modifications, system description preparation, and assistance to various other plant organizations. The system engineers perform an active role in troubleshooting system problems and serve as the lead contact in coordinating corrective action. This support provided to plant operation is considered to be a strength of the licensee's technical support group.

No violations or deviations were identified.

8. Inspection of Initial Fitness for Duty Training (2515/104)

The inspector attended selected licensee fitness for duty training sessions to determine whether required training was being conducted to implement the Fitness for Duty Program. A policy awareness training session for general employees as well as a training session for supervisory personnel were observed. The licensee's program and 10 CFR Part 26 were reviewed to determine the training requirements. The inspector also discussed the program with the Site Fitness for Duty Coordinator.

All personnel who held an active security badge at the plant were required to attend the policy awareness training. Although escorts did not receive separate training, their duties and responsibilities were discussed during the policy awareness training. In addition to the policy awareness training, supervisors also received additional training on their duties and responsibilities.

The class room discussion did not discuss techniques for recognizing drugs or indications of the sale or possession of drugs. A booklet was distributed, however, which provided information on the identification, use, and description of drug paraphernalia. The booklet was to be reviewed by the individual at his convenience.

A handout provided to supervisors included a copy of the program and training notes which could serve as a valuable future reference.

No violations or deviations were identified.

9. Design Changes and Modifications (37828)

Installation of new or modified systems were reviewed to verify that the changes were reviewed and approved in accordance with 10 CFR 50.59, that the changes were performed in accordance with technically adequate and approved procedures, that subsequent testing and test results met acceptance criteria or deviations were resolved in an acceptable manner, and that appropriate drawings and facility procedures were revised as necessary. This review included selected observations of modifications and/or testing in progress.

The following plant change requests (PCRs) were reviewed and/or associated testing observed:

- PCR-4007, Electrical Penetration Protection
- PCR-4682, Consequences of Losing Both S-4 Fans
- PCR-4434, 480 volt Circuit Breaker Replacement
- PCR-4869, NH Series Hydromotor Operators
- PCR-4922, Engineering Evaluation for Hanger Removal on RHR System

PCR 4869 provided instructions to modify various HVAC system damper actuators. During troubleshooting of an HVAC damper in October, 1989, licensee personnel noticed that the oil in the actuator motor for the damper was discolored and the wiring insulation had degraded and was brittle. The investigation into the cause for this condition revealed that previous modifications to install oil pressure switches and to eliminate an oil control valve in the actuator, resulted in an increase in the oil temperature inside the actuator. The increase in internal temperature resulted in the design temperature being exceeded and thereby reduced the environmentally qualified life of the wiring. These modifications had been performed on several damper actuators in various plant HVAC systems. Systems affected included the Diesel Generator Building HVAC, Emergency Service Water Intake Structure HVAC, and Reactor Auxiliary Building HVAC. The licensee has established a schedule to send the affected actuators to the vender for refurbishment. Due to the length of time involved (the licensee estimates approximately 12-18 months to refurbish all the actuators), the licensee has performed an evaluation and justification for continued plant operation. Most of the affected actuators fail to the position required for the performance of its safety function. However, three actuators associated with RAB HVAC switchgear room cooling have been modified (blocked open) so that the dampers will remain open pending failure. Other compensatory measures include monitoring the Diesel Generator Building room temperature and placement of portable heaters if excessively low temperatures are experienced.

Inspector Followup Item (89-34-05): Follow the licensee's activities to replace HVAC system actuators.

10. Plant Startup From Refueling (71711)

The inspector observed plant activities during unit startup following refueling to verify that plant systems were properly returned to service and that the startup was conducted in accordance with approved procedures and in compliance with the TS.

The plant began deboration to criticality on December 20 and entered the startup mode (Mode 2) at 3:23 a.m. Criticality was achieved at 9:47 a.m. on December 20. The inspectors observed the approach to criticality and

verified that criticality occurred within the limits calculated by the licensee. Implementation of the following procedures was verified:

- GP-004, Reactor Startup
- EPT-069, Initial Criticality

No violations or deviations were identified.

11. Followup of Onsite Events (93702)

On December 20, 1989 at 8:35 p.m., during the initial start of the a main feedwater (MFW) pump following the refueling outage, the "A" MFW pump failed to start. The start failure satisfied the circuitry for an AFW actuation signal due to both MFW pumps being in a tripped condidtion. All AFW components functioned as designed and plant personnel initiated a maintenance work request to investigate and repair the discrepancy.

Following a breaker check for the "A" MFW pump, a second attempt to start the pumps was made on December 21, at 3:20 a.m. The pump again failed to start and another AFW actuation signal was generated. Subsequently, a third attempt was made to start the "A" MFW pump at 5:40 a.m. even though no apparent corrective maintenance had been performed following the last trip. The "A" MFW pump tripped again and caused another AFW actuation. Following this actuation, licensee personnel determined that the low lube oil pressure switch was causing the pump to trip. The lube oil pressure switch was recalibrated and the "A" MFW pump was started successfully.

On December 27, 1989 at 4:50 p.m., the "A" MFW pump tripped resulting in yet another AFW actuation. This trip of the "A" MFW pump was due to operator errors while operating at low power (12%) with all three feed regulating valves in manual. Upon increasing flow to two steam generators, the MFW pump recirc valve closed automatically as designed, which resulted in an increase in feedwater flow to all the steam generators. The operator therefore reduced flow through the feed regulating valves in response to increasing steam generator level. The decreasing feedwater flow actuated the MFP low flow trip and, due to the already secured "B" MFW pump, thereby satisfied the AFW actuation logic for loss of both MFWs. Once into this transient the operator had little chance of recovery. This AFW actuation is considered to be an operational weakness, in that the new inexperience operator needed additional guidance during this difficult startup evolution.

12. Licensee Action on Previously Identified Inspection Findings (92702 & 92701)

(Closed) Unresolved Item 400/89-28-01, Review the licensee's engineering evaluation of RHR system operability with two pipe supports missing.

The inspector reviewed PCR 4922, Engineering Evaluation for Hanger Removal on RHR System. The licensee determined that the affected system remained operable with the missing supports. Calculations showed that supports adjacent to the ones missing were still capable of performing their intended function even with the additional loads which resulted from the missing supports.

(Closed) IFI 400/89-21-02, Emergency Service Water Flow Balance Inconsistencies. This item was previously discussed in NRC Inspection Report 50-400/89-28. Following the Licensee's completion of flow balance/pressure testing of the emergency service water system, the licensee's nuclear engineering department reviewed the test data and calculated minimum supply flows to equipment under worse case conditions. The calculations confirmed that the emergency service water system was capable of supplying adequate cooling flow to safety related components as originally designed and as assumed in the FSAR. The inspector was informed that the licensee intended to develop a computer model to facilitate future system work and to assist in their response to the NRC service water system generic letter.

13. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on January 5, 1990. During this meeting, the inspectors summarized the scope and findings of the inspection as they are detailed in this report, with particular emphasis on the Violations, Unresolved Item, and Inspector Follow-up item addressed below. 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.

Item Number	Description and Reference
50-400/89-34-01	Violation - Failure to perform surveillance testing for an inoperable emergency diesel generator, (paragraph 3.a).
50-400/89-34-02	Violation - Failure to adhere to the requirements of plant procedures, paragraphs 3.b and 3.c).
50-400/89-34-03	Unresolved Item - Operability of the main steam lines when filled with condensate, (paragraph 6.a).

Item Number (cont'd)	Description and Reference
50-400/89-34-04	Licensee Identified Violation - Failure to perform a visual inspection of cold leg accumulator check valve internal surfaces, (paragraph 6.b).
50-400/89-34-05	IFI - Follow the licensee's activities to replace HVAC system actuators, (paragraph 9).

14. Acronyms and Initialisms

AC	-	Alternating Current
AFW	-	Auxiliary Feedwater
CCTV	-	Closed Circuit Television
CFR	-	Code of Federal Regulations
EPT	-	Engineering Performance Test
EST	-	Engineering Surveillance Test
F	-	Fahrenheit
FSAR	-	Final Safety Analysis Report
HVAC	-	Heating, Ventilation and Air Conditioning
HZ	-	Hertz
GP	-	General Procedure
I&C	-	Instrumentation and Control
IFI	-	Inspector Follow-up Item
LER	-	Licensee Event Report
MFW	-	Main Feedwater
MS	-	Main Steam
NCR	-	Non-conformance Report
NCV	-	Non-cited Violation
NI	-	Nuclear Instrumentation
NRC	-	Nuclear Regulatory Commission
OST	-	Operations Surveillance Test
PCR	-	Plant Change Request
PORV	-	Power Operated Relief Valve
PSIG	-	Pounds per Square Inch Gage
QA	-	Quality Assurance
QC	-	Quality Control
RAB	-	Reactor Auxiliary Building
RCA	-	Radiation Control Area
RCS	-	Reactor Coolant System
RHR/RH	-	Residual Heat Removal
RWP	-	Radiation Work Permit
RWST	-	Refueling Water Storage Tank
SI	-	Safety Injection
SOOR	-	Significant Operational Occurrence Report
TMM	-	Technical Support Management Manual
TS	-	Technical Specification