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

Report No.: 50-400/90-02

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:

Inspectors: _____ 2/27/90
for J. Tedrow, Senior Resident Inspector Date Signed

_____ 2/27/90
for M. Shannon, Resident Inspector Date Signed

Approved by: _____ 2/27/90
for 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, review of an NRC Bulletin, cold weather preparations, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on backshifts.

Results:

Two violations were identified: Failure to properly implement procedure OST-1039 resulting in inadequate QPTR data calculation, paragraph 2.b.(1); Failure to calculate the QPTR as required by TS 4.2.4.1, paragraph 2.b.(1).

A weakness is identified in paragraph 2.b.(1) concerning the technical support staff's failure to properly implement plant procedures.

Licensee strengths were identified relating to the administrative controls established for equipment clearances, paragraph 2.a, and plant housekeeping, paragraph 2.b.(3). Licensee identified violations are discussed in paragraphs 5.f, 5.h, 5.m, and 5.q.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

D. Braund, Supervisor, Security
J. Collins, Manager, Operations
*G. Forehand, Director, QA/QC
*C. Gibson, Director, Programs and Procedures
*P. Hadel, Manager, Maintenance
*C. Hinnant, Plant General Manager
C. Olexik, Supervisor, Shift Operations
*R. Richey, Manager, Harris Nuclear Project Department
*J. Sipp, Manager, Environmental and Radiation Monitoring
*H. Smith, Supervisor, Radwaste Operation
*D. Tibbits, Director, Regulatory Compliance
*B. Van Metre, Manager, Technical Support
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 throughout this report are listed in the last paragraph.

2. Review of Plant Operations (71707)

The plant resumed 100 percent power operation after an inoperable main steam safety valve was returned to service on January 6 and continued in power operation (Mode 1) for the duration of this inspection period.

a. Shift Logs and Facility Records

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. In addition, the inspector independently verified clearance order tagouts.

The inspector reviewed procedures AP-20, Clearance Procedure, and OMM-14, Operations - Operation of the Clearance Center, to determine the licensee's administrative controls regarding equipment

clearances. Clearances are prepared by a licensed operator and receive an independent verification by another licensed operator for accuracy. The licensee utilizes a shift foreman designee (licensed senior reactor operator) to approve the prepared equipment clearance to remove the administrative burden on the shift foreman. The licensee also utilizes a specification appraisal computer to generate the required clearances. After approval, clearance tags are hung on required components by trained operating personnel (usually auxiliary operators). Components important to the safe operation of the plant receive an additional verification that the tags are properly hung. These systems are specified in procedure PLP-702, Independent Verification. After these verifications are made, a work group representative physically verifies system status and proper positioning of tagged components.

Restoration positions of tagged components also receive independent verification by licensed operators. When work on the affected system is complete, the tags are removed and the component is repositioned. Position is independently verified if applicable.

The licensee performs a weekly administrative audit of the clearance forms with the clearance index. A more detailed monthly audit includes physical verification that tags are in place, undamaged, and components are in the required position. The inspector considers the licensee's administrative controls for equipment clearances to be good and should prevent personnel injury or equipment damage from occurring due to improper system alignment.

No violations or deviations were identified.

b. Facility Tours and Observations

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:

(1) 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.

As discussed in NRC Inspection Report 89-34 on December 30, 1989 the resident inspector noted that the nuclear instrument (NI)-44 upper and lower comparator channels were placed in bypass. The comparator channels are used to calculate the Quadrant Power Tilt Ratio (QPTR) and provide input to the QPTR alarm.

The inspector was informed that during the reactor power increase to 55 percent on December 28, 1989, that the upper and lower QPTR channels went into alarm. OST-1039, Calculation of Quadrant Power Tilt Ratio, was performed on December 28, 1989, and it indicated that the channels were close to the alarm setpoint. The upper and lower NI-44 detectors were subsequently placed in bypass by operations personnel. Discussions with the operators revealed that the NI-44 instruments had not been declared inoperable, no additional surveillance requirements were being performed, and that the operator logs did not document "when" and "why" the detectors were placed in bypass.

The inspector conducted a review of recently completed surveillances for calculating the Quadrant Power Tilt (OST-1039) including the OST performed on December 28, 1989. The review concluded that the detector current data recorded for OST-1039, on December 28, 1989, per step 7.1, was recorded in error by the licensed operator. Further discussions with licensee personnel confirmed that the operator had used the wrong scale on the meter to obtain the data. With the plant operating at only 55 percent power, the recorded current values exceeded the 100 percent power normalized currents. The normalized fractions and average normalized fractions should have calculated out to be approximately 55 percent. A subsequent review by two senior licensed shift foremen failed to identify the inaccurate data obtained from the control room instrumentation. It was also noted that the operator who recorded the data had recently returned to shift work following assignment to the procedure writing group and may have been somewhat unfamiliar in performing this procedure.

The detector currents, required by step 7.1 of OST-1039, were improperly recorded and a subsequent review by two senior licensed shift foremen failed to identify the improperly performed TS surveillance. Failure to properly perform surveillance testing is contrary to TS 6.8.1.a and is considered to be a violation.

Violation (90-02-01): Failure to properly implement procedure OST-1039 resulting in inadequate QPTR data calculation.

Further review of OST-1039 by the inspector determined that the 100 percent power normalized currents recorded on the December 28, 1989 surveillance test were not the same as those recorded on subsequent surveillances completed during January 1990. They also did not correlate to current values found at the end of cycle two. The procedure used to obtain the normalized currents, EST 717, Incore/Excore Detector Calibration, required that reactor power be at 75 percent to perform the calibration. Discussions with technical support personnel discovered that the 100 percent power normalized currents were calculated based on a 35 percent flux map without utilizing procedure EST-717. The inspector concluded that plant procedures were not utilized to obtain the normalized current values. Discussions with the discipline supervisor indicated that he was unaware that unauthorized means were used to obtain the normalized current values.

The licensee was recently issued a violation (90-01-01) involving the miscalibration of power range nuclear instruments in NRC Inspection Report 50-400/90-01. One of the causes for that violation involved the failure of technical support personnel to properly implement a plant procedure. The inability of the technical support staff to properly implement plant procedures is considered to be a weakness. This problem is not being cited in this report due to the recent issuance of violation 90-01-01 and insufficient time for the licensee to respond.

Following the receipt of the upper and lower QPTR alarms, the manual calculation of the QPTR was performed. Based on the manual QPTR, operations personnel bypassed the upper and lower NI-44 channel inputs to the QPTR alarm circuitry. Selective removal of detector inputs in the QPTR alarm circuit will inhibit an active alarm, and therefore sufficient justification should be made prior to removing any channel from operation. The alarm response procedure ALB-013-5-3 and ALB-013-5-4 both detail bypassing a faulty channel and require the subsequent removal of the channel from service by tripping various bistables. Only the bypassing step was completed and no other actions were taken by licensee personnel.

By bypassing an active detector channel the QPTR comparator circuitry was not capable of performing its intended function which resulted in an inoperable QPTR alarm. With an inoperable QPTR alarm, TS surveillance 4.2.4.1.b requires a manual calculation of the QPTR every 12 hours. Contrary to the above, from 6:55 a.m. on December 28, 1989 until approximately 2:25 a.m. on December 30, 1989, the licensee failed to perform the required 12 hour TS surveillance, which is considered to be a violation.

Violation (90-02-02) Failure to calculate the QPTR as required by TS 4.2.4.1.

(2) 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.

(3) 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.

The inspector accompanied licensee management personnel on an inspection of the emergency service water building. This team of approximately 10 managers was led by the plant general manager and focused on the general cleanliness and the material condition of equipment. This type of management involvement has had a positive effect on plant housekeeping and the general good material condition of equipment.

(4) 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.

(5) 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.

(6) 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.

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:

EST-219	Personnel Air Lock Door Seals Local Leak Rate Test
OST-1021	Daily Surveillance Requirements
MST-E0010	1E Battery Weekly Test
OST-1090	Spent Fuel Pool Cooling System Quarterly Interval
OST-1013	1A-SA Emergency Diesel Generator Operability Test
EST-717	Incore/Excore Detector Calibration
OST-1039	Calculation of Quadrant Power Tilt Ratio

No violations or deviations were 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.

Maintenance was observed and work packages were reviewed for the following maintenance (WR/JO) activities:

- Replace exhaust gasket on the "B" Emergency Diesel Generator (EDG) in accordance with procedure CM-M0150, Emergency Diesel Generator Cylinder Head Removal, Disassembly and Reassembly.
- Verification of diesel fire pump battery operability in accordance with procedure MPT-E0019, Diesel Fire Pump Battery Weekly Test.
- Replace turbine driven auxiliary feedwater pump exhaust rupture disk.
- Clean, inspect and calibrate actuator for valve AF-19 in accordance with procedure PIC-I058, Calibration Check and Stroking of a Milliampere Hydramotor Actuator.
- Lubricate coupling on the "A" EDG auxiliary lube oil pump in accordance with procedure PM-M0011, Annual Lubrication Schedule.
- Repair fuel oil leak on #5 cylinder for "A" EDG.

- Repair oil leak on #6 cylinder for "A" EDG in accordance with procedure CM-M0150, Emergency Diesel Generator Cylinder Head Removal, Disassembly and Reassembly.

- Replace hold-down bolts for the "A" EDG turbo-chargers in accordance with procedure MPT-M0024, Emergency Diesel Generator Turbocharger Bracket Bolting Inspection.

- Brown Boveri LK1600 Breaker Failure Testing.

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.

a. (Closed) LER 88-06: This LER reported inoperable emergency service water systems due to isolation valve failure. This event was previously discussed in NRC Inspection Report 50-400/88-03 and was the subject of an unresolved item (88-03-01). The licensee issued a supplemental report dated April 15, 1988. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

b. (Closed) LER 88-21: This LER reported the automatic start of an auxiliary feedwater pump during a surveillance test. This matter was also the subject of a violation (88-25-01) discussed in NRC Inspection Report 50-400/89-25. For record purposes the LER will be closed and corrective action tracked by the violation.

c. (Closed) LER 88-23: This LER reported that the reactor coolant system was not adequately vented during a plant outage in August, 1988. This event was previously discussed in NRC Inspection Report 50-400/88-25 and the licensee has issued a supplemental report dated September 13, 1988. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

d. (Closed) LER 89-06: This LER reported a reactor trip which occurred on March 14, 1989 due to the loss of a main feedwater pump. This event is discussed in more detail in NRC Inspection Report 50-400/89-06. Corrective actions for this event have been completed.

e. (Closed) LER 89-07: This LER reported an inadvertent isolation of the containment ventilation system due to personnel error. The

inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

f. (Closed) LER 89-08: This LER reported that testing of the thermal overload bypass circuit for motor operated valve MS-72 was inadequate. The licensee identified this problem during an independent review of thermal overload bypass testing procedures. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER. This matter is considered to be a licensee identified Non-Cited Violation (NCV) and is not being cited because criteria specified in section V.G.1 of the NRC Enforcement Policy were satisfied.

NCV (90-02-03): Failure to properly test thermal overload bypass circuitry for valve MS-72.

g. (Closed) LER 89-13: This LER reported the inadvertent actuation of a service water booster pump during load sequencer troubleshooting. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

h. (Closed) LER 89-14: This LER reported the emergency core cooling system piping was not being vented periodically as required by the TS. The licensee discovered this problem during a walkdown on this system and associated procedures. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER. This matter is considered to be a licensee identified NCV and is not being cited because criteria specified in section V.G.1 of the NRC Enforcement Policy were satisfied.

NCV (90-02-04): Failure to periodically vent emergency core cooling system piping.

i. (Closed) LER 89-15: This LER reported that the fuel handling building equipment hatch was not installed during fuel movement. This matter was previously discussed in NRC Inspection Report 50-400/89-21 and was considered to be a licensee identified violation. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

j. (Closed) LER 89-16: This LER reported the inadvertent start of the "B" Emergency Service Water Pump during testing on the load sequencer. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

k. (Closed) LER 89-18: This LER reported a manual reactor trip due to the cable failure on a digital rod position indicator. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

l. (Closed) LER 89-19: This LER reported on auxiliary feedwater system actuation caused by a miscalibrated main feedwater pump switch. The inspector reviewed and verified implementation of the licensee's corrective action as stated in the LER.

m. (Open) LER 89-20: This LER reported that several motor operated valve gear boxes had been overfilled with grease which damaged wiring and affected the operator's environmental qualification. The licensee has repaired the damaged wiring for the identified valves and has completed an inspection of the remaining motor operators inside the containment building and the steam tunnel. The licensee is planning to revise applicable maintenance procedures to provide better guidance on maintaining proper grease levels in the limit switch gear boxes and to train maintenance personnel on this problem. This matter is considered to be a licensee identified NCV and is not being cited because criteria specified in section V.G.1 of the NRC Enforcement Policy were satisfied.

NCV (90-02-05): Failure to maintain proper grease levels in motor operated valve gear boxes.

n. (Open) LER 89-21: This LER reported an auxiliary feedwater system actuation caused by personnel error in controlling feedwater flow. This matter was also discussed in NRC Inspection Report 50-400/89-34. The licensee has not yet completed all of the corrective actions stated in the LER. The following items remain to be accomplished:

- Repair valve SP-226.
- Revise procedure GP-005, Power Operation Mode 2 to Mode 1, to prohibit the simultaneous transfer of all three steam generators from bypass flow feedwater control to main feed regulating valve control.
- Evaluation of the time delay relays for main feedwater pump low flow trip and response time of the recirculation flow control valve.
- Training to applicable personnel on this event.

The LER will remain open pending completion of this corrective action.

o. (Open) LER 89-22: This LER reported the spurious loss of a residual heat removal train during testing of interlocks. The following corrective action remains to be accomplished:

- Revise test procedure to ensure that the operating loop's suction valve power supply breakers are open during installation and removal of test equipment.

- Pursue TS changes to eliminate the requirement for an auto-closure interlock.

This LER will remain open pending completion of this corrective action.

p. (Closed) LER 89-23: This LER reported that power range nuclear instrumentation indicated non-conservatively during a plant startup in December, 1989. This matter is also the subject of a violation (90-01-01) in NRC Inspection Report 50-400/90-01. For record purposes, the LER will be closed and further action tracked by the violation.

q. (Open) LER 90-01: This LER reported a TS violation regarding response time testing of Engineered Safety Feature (ESF) channels in a periodic rotation. On January 5, 1990, during a review by licensee personnel of procedure MST-I0645, Group 2 of 2 Channel RTS and ESFAS Response Time Test, the licensee discovered that testing performed during the previous 1988 refueling outage failed to adequately response time test ESF Channel III. The other three ESF channels had been tested satisfactory. The licensee determined that the cause for this event was an inadequate change to the surveillance procedure, which has subsequently been revised. Training will be provided for personnel responsible for writing and approving procedure changes and Channel III will be tested no later than February 1, 1992. This matter is considered to be a licensee identified NCV and is not being cited because criteria specified in section V.G.1 of the NRC Enforcement Policy were satisfied.

NCV (90-02-06): Failure to response time test ESF Channel III at the correct periodicity.

This LER will remain open pending completion of required training and testing of the ESF channel.

6. Review of NRC Bulletins (92703)

(Open) NRC Bulletin 88-11, Pressurizer surge line thermal stratification. This bulletin alerted licensees to the potential for thermal stratification to exist in pressurizer surge lines during plant heatup and cooldown operations, which could result in unexpected piping movements and potential high piping stress. The licensee has submitted correspondence to the NRC dated December 29, 1989, addressing the actions required by the bulletin. A visual inspection of the pressurizer surge line has been completed with no structural damage identified. The Westinghouse Owners Group performed a bounding evaluation of this phenomenon for several Westinghouse plants. However, since this evaluation is not plant specific, and does not encompass the full design lifetime of the surge line, a justification for continued operation of the plant was submitted. This justification concluded that continued plant operation was acceptable

based on the results of similar plants analyzed thus far, consideration of leak-before-break concepts, and results of non-destructive examinations of other plant pressurizer surge lines. Additional monitoring and analysis are presently in progress. The licensee plans to obtain plant specific surge line data and update the stress/fatigue analysis to ensure compliance with code requirements. This action is expected to be completed by December 29, 1990. The bulletin will remain open pending completion of this additional action.

7. Cold Weather Preparations (71714)

The inspector reviewed the licensee's preparations and administrative controls established to protect plant equipment during cold weather. The licensee implements procedure AP-301, Adverse Weather Operations, section 5.1, Cold Weather Operation, whenever ambient air temperature reaches 35 degrees F. This procedure requires that freeze protection devices for plant equipment be verified operable to prevent systems and equipment from freezing. The licensee utilizes portable space heaters for critical instrumentation cabinets without installed space heaters. The inspectors walked through the procedure with licensee personnel and observed implementation of the procedure during cold weather conditions.

No violations or deviations were identified.

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

a. (Closed) Violation 88-25-01 Failure to establish and implement procedures. The inspector reviewed and verified implementation of the corrective actions as stated in the licensee's response letter dated October 26, 1988.

b. (Closed) Violation 89-15-01 Improper flow orifice installation. The inspector reviewed and verified implementation of the corrective actions as stated in the licensee's response letter dated September 12, 1989.

c. (Closed) IFI 89-03-02, Followup on diesel generator injection valve holder inspections. The spare and installed delivery valve holders were inspected and all discrepancies have been resolved.

d. (Closed) IFI 89-03-01, Implementation of PCR 3241 to resolve low temperature overpressure concerns. Plant change request PCR 3241 was completed and turned over to operations on November 28, 1989.

e. (Closed) IFI 89-08-02 Throttle valve position verification. Procedure changes were made to the following procedures; OST-1216, Component Cooling Water System Quarterly Operability (1A-SA and 1B-SB pumps), OST-1316, Component Cooling Water System Quarterly

Operability (Pump 1C-SAB), and OST-1016, Component Cooling Water System Monthly Operability, which now include specific component cooling water to residual heat removal heat exchanger valve positions and signoff verifications.

f. (Closed) Violation 89-15-02, Failure to maintain an active senior reactor operator license. The inspector reviewed and verified implementation of the corrective actions as stated in the licensee's response letter dated September 20, 1989.

g. (Closed) IFI 88-39-01 Review findings and corrective actions for October 30, 1988 reactor trip. The corrective actions, developed from the licensee's task force, were implemented within the time specified. Items included in the corrective action program were: maintain current system descriptions, provide operator retraining, provide operator aids, modify booster pump trip settings, and starting of auxiliary feedwater pumps on a loss of one main feedwater pump.

h. (Open) Violation 89-28-02: Failure to have an adequate procedure for the performance of local leak rate testing which resulted in instrument air contamination. The licensee has flushed and decontaminated the instrument air system. However, due to the possibility of hot particles still remaining inside the system, use of this system was formally prohibited for breathing air purposes by procedure AP-512, Use of Respiratory Equipment. The licensee has further revised procedure EST-212, Type C Local Leak Rate Tests, to require that any deviation from normal system venting and draining practices be covered by a temporary change to the procedure. The licensee is evaluating overtime work of personnel involved in testing of safety related equipment to develop appropriate guidelines and is developing a plant general order to specify controls and exclusions for use of the instrument air system. This item will remain open pending completion of the overtime guidance and issuance of the plant general order.

9. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on February 16, 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 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
90-02-01	Violation: Failure to properly implement procedure OST-1039, resulting in inadequate QPTR data calculation, (paragraph 2.b.(1)).

90-02-02	Violation: Failure to calculate the QPTR as required by TS 4.2.4.1, (paragraph 2.b.(1)).
90-02-03	NCV: Failure to properly test thermal overload bypass circuitry for valve MS-72, (paragraph 5.f).
90-02-04	NCV: Failure to periodically vent emergency core cooling system piping, (paragraph 5.h).
90-02-05	NCV: Failure to maintain proper grease levels in motor operated gear boxes, (paragraph 5.m).
90-02-06	NCV: Failure to response time test ESF channel III at correct periodicity, (paragraph 5.q).

10. Acronyms and Initialisms

AF	-	Auxiliary Feedwater
AP	-	Administrative Procedure
ALB	-	Alarm Response Procedure
CM	-	Corrective Maintenance
EDG	-	Emergency Diesel Generator
EPT	-	Engineering Performance Test
ESF/AS	-	Engineered Safety Feature Actuation System
EST	-	Engineering Surveillance Test
GP	-	General Procedure
IFI	-	Inspector Follow-up Item
LER	-	Licensee Event Report
MPT	-	Maintenance Performance Test
MST	-	Maintenance Surveillance Test
NCV	-	Non-Cited Violation
NI	-	Nuclear Instrument
NRC	-	Nuclear Regulatory Commission
OST	-	Operations Surveillance Test
OMM	-	Operations Management Manual
PCR	-	Plant Change Request
PIC	-	Process Instrument Control Procedure
PLP	-	Plant Program
QA	-	Quality Assurance
QC	-	Quality Control
QPTR	-	Quadrant Power Tilt Ratio
RHR	-	Residual Heat Removal
RTS	-	Reactor Trip System
RWP	-	Radiation Work Permit
SP	-	Sampling System
TS	-	Technical Specification
WR/JO	-	Work Request/Job Order