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

Report No.: 50-400/91-24

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: October 19 - November 15, 1991

Inspectors: _____ 11/27/91
For J. Tedrow, Senior Resident Inspector Date Signed

_____ 11/27/91
M. Shannon, Resident Inspector Date Signed

Approved by: _____ 11/27/91
H. Christensen, 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, safety system walkdown, licensee event reports, review of plant nuclear safety committee activities, 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:

Four violations were identified: Failure to properly post required notices to workers, paragraph 2.d; Failure to provide an adequate surveillance test procedure for the boric acid system, paragraph 3; Failure to perform adequate boric acid pump testing, paragraph 5.a; and, Failure to adequately identify, document, and correct deficiencies with the boric acid heat trace system, paragraph 5.c.

One unresolved item was identified: Failure to maintain heat trace systems on various Technical Specification monitors, paragraph 5.f.

Four weaknesses were identified: The licensee's failure to recognize that additional pump testing may have been required following valve maintenance, paragraph 5.a; the licensee's failure to maintain design control by not reconnecting a pipe strut, paragraph 5.b; the licensee's failure to implement the manufacturer's recommendations for calibration frequency of the heat trace system, paragraph 5.d; and, the technical support staff's failure to adequately identify in a timely manner all circuits related to meeting technical specification surveillance requirements, paragraph 5.e.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*H. Banks, Manager, Corporate Quality Assurance
*P. Beane, Manager, Quality Control
*J. Collins, Manager, Operations
*C. Gibson, Manager, Programs and Procedures
C. Hinnant, General Manager, Harris Plant
*D. McCarthy, Manager, Site Engineering
*B. Meyer, Manager, Environmental and Radiation Monitoring
*T. Morton, Manager, Maintenance
*J. Nevill, Manager, Technical Support
*C. Olexik, Manager, Regulatory Compliance
*A. Powell, Manager, Harris Training Unit
*R. Richey, Vice President, Harris Nuclear Project
*H. Smith, Manager, Radwaste Operation
*F. Strehle, Manager, Quality Assurance Engineering
*A. Taylor, Manager, Project Services
E. Willett, Manager, Outages and Modifications
*W. Wilson, Manager, Spent Nuclear Fuel

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 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 Supervisor's Log; Control Operator's Log; Night Order Book; Equipment Inoperable Record; Active Clearance Log; Jumper and Wire Removal Log; Temporary Modification Log; Chemistry Daily Reports; Shift Turnover Checklist; and selected Radwaste Logs. In addition, the inspector independently verified clearance order tagouts.

The inspectors found the logs to be readable, well organized, and provided sufficient information on plant status and events. Clearance tagouts were found to be properly implemented. However, one deficiency regarding a clearance tagout was identified. The inspector noticed that a radwaste clearance (RW91-0997) had been implemented to isolate the reactor coolant drain tank for maintenance by tagging closed containment isolation valve 1ED-161. The inspector considered the radwaste clearance peculiar because the control switch for this valve was located in the main control room which components were usually under operations control. The inspector discussed this matter with operating personnel who checked the computerized specification appraisal system for system status. This system's data base had not been updated with the current closed position of valve 1ED-161. The specification appraisal system was intended to provide a backup to the operators to check for TS limiting conditions for operation for different system configurations. Although in this case TS requirements were not violated, the potential for a loss of system configuration control existed. The inspector discussed this potentiality with management personnel.

b. Facility Tours and Observations

Throughout the inspection period, facility tours were conducted to observe operations, surveillance, and maintenance activities in progress. Some of these 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; turbine building; fuel handling building; emergency service water building; battery rooms; electrical switchgear rooms; and the technical support center.

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.

(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, operational 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.

(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 radiation work permits to verify that controls were adequate.

(5) Security Control - The performance of various shifts of the security force was observed in the conduct of daily activities which included: 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 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.

The inspectors found plant housekeeping and component material condition to be quite good. The licensee's adherence to radiological controls, security controls, fire protection requirements, and TS requirements in these areas were satisfactory.

c. Review of Nonconformance Reports

Adverse Condition Reports (ACRs) 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.

d. Review of Required Notices to Workers (71707)

The inspector checked the licensee's official bulletin boards to verify that all required notices to workers were appropriately posted in accordance with 10 CFR 19.11. The licensee maintained five official bulletin boards located at various conspicuous places throughout the plant to display the required information. Designation of the bulletin board locations and information to be

exhibited was specified in administrative procedure AP-002, Plant Conduct of Operations. Specifically this procedure required Form NRC-3, Notice to Employees, to be posted and the locations specified where the regulations of 10 CFR 19 and 10 CFR 20, license and license conditions, and plant operating procedures could be viewed.

The official bulletin boards were reviewed and the inspector noted that two boards did not contain the location where 10 CFR 19 and 10 CFR 20 could be viewed, and one board did not contain the locations for viewing the license and license conditions. This omission was discussed with licensee personnel who took immediate action to post the required information. This NRC identified violation is not being cited because criteria specified in Section V.A of the NRC Enforcement Policy were satisfied.

NCV (400/91-24-01): Failure to properly post required notices to workers.

One violation was 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:

- MST-I0052 Pressurizer Level Loop (L-0460) Calibration
- MST-I0164 Nuclear Instrumentation System Power Range N42 Operational Test
- MST-I0182 Containment Spray Additive Tank Level Loop (L-7150) Calibration
- EST-222 Procedure for the Type B Local Leak Rate Test of the Personnel Air Lock Barrel
- OST-1004 Power Range Heat Balance Daily Interval
- OST-1005 Control Rod and Rod Position Indicator Exercise Monthly Interval
- OST-1007 CVCS/SI System Operability Quarterly Interval
- OST-1021 Daily Surveillance Requirements
- OST-1039 Calculation of Quadrant Power Tilt Ratio, Weekly Interval

- OST-1118 Containment Spray Operability Train A Quarterly Interval

The performance of these procedures was found to be satisfactory with proper use of calibrated test equipment, necessary communications established, notification/authorization of control room personnel, and knowledgeable personnel performed the tasks. The personnel air lock leak rate test results were very good and showed a substantial decrease in air leakage from previous test results. The licensee's maintenance efforts to reduce this leakage were effective. Preplanning and good operator control was evident during the pressurizer level loop calibration. Also good supervisory involvement was noted during this test.

Surveillance requirements 4.1.2.1.a and 4.1.2.2.a require that the licensee verify the flow path between the boric acid tank and the charging pump suction header greater than or equal to 65 degrees F at least once per seven days when a flow path from the boric acid tank is used. Procedure OST-1021, Attachment 4, was used to document the completion of this surveillance by measuring the boric acid tank room and boric acid blender local temperatures. The inspector noted that these temperature readings were not adequate to verify that the flow path, between the boric acid tank room and the charging pump suction header, was maintained greater than 65 degrees F because the boric acid flow path runs through various other rooms and pipe chases. Procedure OST-1021 was inadequate to accomplish its intended function of documenting adequate temperature of the boric acid system and is considered to be a violation of TS 6.8.1.a.

Violation (400/91-24-02): Failure to provide an adequate surveillance test procedure for boric acid system temperature.

When informed of this finding, licensee personnel reviewed operating records and verified that an alternate flowpath from the refueling water storage tank was available to satisfy the TS limiting condition of operation.

One violation 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.

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

- Inspection and adjustment of the diesel generator speed sensors.

- Inspection of the diesel generator valve springs in accordance with a 10 CFR 21 Report.

- Troubleshooting and calibration of the diesel generator tachometer.

- Replacement of valve packing on an air start tank isolation valve.

- Troubleshooting and calibration of heat trace panel HT-18753B, in accordance with procedure PIC-E048, Heat Tracing Control Temperature and Readout Unit Calibration.

The inspectors found the performance of work to be satisfactory with proper documentation of lifted leads, adequate tagouts, and proper independent verification.

No violations or deviations were identified.

5. Safety Systems Walkdown (71710)

The inspector conducted a walkdown of the emergency boration system to verify that the lineup was in accordance with license requirements for system operability and that the system drawings and procedures correctly reflected "as-built" plant conditions. The inspection disclosed that although the system was found to be functional, various testing, operation, and maintenance deficiencies were noted. These deficiencies are detailed in the following paragraphs.

a. A review of the inservice testing program for the boric acid pumps found that both boric acid pumps were on increased testing frequency due to previously noted pump degradation. In accordance with the licensee's approved inservice testing program, ISI-203, ASME Section XI Pump and Valve Program Plan, normally the pumps would be tested every three months using only pump differential pressure unless the plant was shutdown and then pump flow and differential pressure would be measured. The increased testing requirement resulted in a required pump test every six weeks.

The "A" and "B" boric acid pumps were full flow tested on March 16, 1991 during plant shutdown at the start of refueling outage three. After startup from this outage the plant re-entered Mode 5, cold shutdown, on May 3 and May 16, 1991. Although the pumps were tested every six weeks for differential pressure, it was found that the boric acid pumps were not full flow tested every six weeks when the plant was shutdown. ASME Section XI, Subsection IGP, Inservice Testing of Pumps in Nuclear Power Plants, Section IGP 3230.(a), requires that the testing frequency shall be doubled until the cause of the deviation is determined or corrected. Contrary to this requirement, the boric acid pumps were not full flow tested on the increased testing frequency and this is considered to be a violation.

Violation (400/91-24-03): Failure to perform adequate boric acid pump testing.

Further review of the boric acid system work history found that flow control valve 1CS-551 was repacked on April 15-17, 1991. This valve was used to adjust the recirculation flow/discharge pressure for the boric acid pumps during the Mode 1 differential pressure testing. Slight movement in this valve would cause changes in the differential pressure, and since flow was not measured, this could result in changing the reference value used in the test. Following any valve movement, a full flow test of the system was necessary to ensure that the reference differential pressure remained valid. It was noted that the inservice testing group was not aware that the valve had been worked and therefore did not perform any testing. A detailed review of subsequent pump testing indicated that the flow control valve was probably not moved and test reference data did not change. However, the licensee's failure to recognize that reference data pump testing might have been required is considered to be a weakness.

b. During the walkdown of the boric acid system the system appeared to be clean, properly tagged and free of boric acid leaks. However, it was noted by the inspector that a pipe strut, designed to support the boric acid line going to the charging pump section header, was not attached. No work history was available to show when the strut had been disconnected. An engineering evaluation was performed and the licensee determined that the disconnected strut had not caused a safety concern because other supports were able to adequately support system piping. The licensee promptly reconnected the strut. Although this did not result in a safety concern, the licensee's failure to maintain design control in the system is considered to be a weakness.

c. Further observations noted that various sections of the boric acid system were not provided with heat tracing for maintaining piping temperatures. The FSAR, Section 9.3.4.1.3.7, specified that boric acid system room temperatures had redundant alarms and that the system's heat tracing, which is alarmed by design, was provided to ensure that the boric acid system temperatures, in various pipe chases and rooms, were maintained greater than 65 degrees F. Basically alarms were provided to alert the licensee that the heat trace system was not providing adequate support to the TS required emergency boration system.

While reviewing heat trace system alarms, it was noted that five of the six RAB heat trace panels were in alarm on the waste processing annunciator panel. The alarm status was discussed with the waste process control room operator who stated that when alarms come in the main control room is notified. He was unsure why the annunciators were presently in alarm. A detailed review of the

alarm response procedures was also performed. The following deficiencies were identified:

- Alarm response procedure ALB-111-10-4, HT-18753 L RAB Trouble, required the operator to go to the local control panels to check the temperature control circuits. Since panel HT-18753 L contains no control circuits, the procedure was inadequate because it did not identify the proper control circuits from heat trace panel HT-18753 B and only identified the backup control circuits from heat trace panel HT-18753 BB which was deenergized and not in use.

- Alarm response procedure ALB-111-11-4, HT-18753 M RAB Trouble, required the operator to go to the local control panels to check the temperature control circuits. This procedure was likewise found to be inadequate because it did not reference any panel locations or control circuits and it had no control/alarm modules for completion of the alarm response.

- Alarm response procedures ALB-111-8-4, HT-18753 B RAB Trouble, and ALB-111-8-5, HT-18753 C RAB Trouble, used for the "B" and "C" heat trace panels, were found to be in error because the listed module alarm setpoints for overtemperature and undertemperature were outside of the allowable calibration range found in calibration procedure PIC-E048 for 19 of 92 setpoints.

The alarm procedures direct the operator to take appropriate steps to maintain proper line temperature, by using redundant circuits located in standby panels HT-18753 BB and HT-18753 CC, which are identically installed spare heat trace lines and control panels. These panels were both found deenergized with all control circuits turned off. All of the alarm procedures required the operator to initiate a work request to correct indicated problems. It appeared to the inspector that so many alarm circuits were in alarm that the alarms were considered nuisance alarms and the alarm response procedure was ignored. Therefore, deficiencies were not identified and work requests were not generated to correct the various system deficiencies as required.

The following deficiencies were noted during the inspector's review of the heat trace system and during observation of heat trace panel calibration:

(1) Heat Trace Panel 18753 B

Circuit C2-3, which controlled the heat trace for the emergency boration flow transmitter, FT-110, and the emergency boration system piping to the suction of the charging pumps, was found to have an overtemperature alarm caused by an open RTD which

locked out the heat trace for these components. No documented work request or operator action was evident.

Circuit C1-3, which controlled the heat trace for radiation monitor REM 3502A, a TS required leak detection monitor, was found with the control circuit disabled and the line heaters deenergized and caution tagged. The circuit was caution tagged on July 9, 1990, due to alarm problems with REM 3502 A. The FSAR, Section 5.2.5.3.2, stated that the sample lines were heat traced to prevent condensation within the lines, which could bias the particulate portion of the air sample. No documented work request or operator action had been taken.

Circuit C1-13, which controlled the heat trace for a section of the emergency boration flowpath line, was found with improper setpoints for the heater "on" signal (56 degrees F) and the under temperature alarm (56 degrees F). The TS required that the minimum boric acid system temperature be maintained greater than 65 degrees F.

Circuit C2-11, which controlled the heat trace for the TS required hydrogen monitors, was found with improper setpoints for the heater "on" signal (30 degrees F) and the under temperature alarm (29 degrees F).

Circuit C1-8, which controlled the unit room heater for the boric acid valve room was found with an under temperature alarm locked in with no work request or operator action taken.

Circuits C2-9 and C2-13, which controlled the heat trace for the hydrogen monitor sample lines, were found with overtemperature alarms locked in with no work request or operator actions taken.

The central alarm on the power supply drawer was energized (in alarm) and had been identified by work request 90-AADY-1 which was initiated on January 3, 1990. The alarm could have been reset by using an alarm acknowledge button in the "B" cabinet following receipt of any circuit alarm, which would allow future adverse conditions to alarm on the waste process annunciator panel. It appeared that the operators did not know how to reset the alarm so the waste process control panel annunciators were constantly in alarm. The alarm response procedures correctly specified the actions necessary to reset the central alarm but these procedures were not followed.

The silence/reset switch on the "B" and "C" panels were both found in the silence/reset position although both alarm response procedures directed the operator to return the switch to normal following resetting an alarm.

(2) Heat Trace Panel 18753 C

Circuit C2-8, which controlled the heat trace for the plant vent radiation monitor, RM 3509, was found with the control circuit disabled. No documented work request or operator action was evident.

Circuit C2-12, which controlled the unit room heater for the boric acid tank room, was found with the control circuit disabled. No documented work request or operator action had been taken.

Circuits C2-1, C2-2, and C2-3, which controlled the heat trace for the boric acid tank recirc lines, the boric acid tank supply line to the boric acid pumps, and boric acid tank sample lines, were found with overtemperature alarms locked in with no work request or operator action taken.

10 CFR 50, Appendix B, Criteria XVI, requires that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective equipment and nonconformances, be promptly identified and corrected. The licensee's failure to respond to control board alarms by following appropriate alarm response procedures led to the licensee's inability to identify deficiencies (as noted above) associated with the heat trace system. The heat trace system, which is a support system for various safety related systems, therefore was not properly maintained and was not able to adequately perform its safety system support function. This is contrary to the requirements of 10 CFR 50, Appendix B, and is considered to be a violation.

Violation (400/91-24-04): Failure to adequately identify, document, and correct deficiencies with the boric acid heat trace system.

d. A review of the heat trace panel calibration procedure found that HT-18753 B had been calibrated on July 11, 1990, and that HT-18753 C had been calibrated on September 12, 1989. The manufacturer's technical manual, Thermon Manufacturing Company, recommended that the temperature alarm and control channels should be calibrated every six months and the cabinet power supply should be calibrated every year. The licensee's failure to implement the manufacturer's recommendations is considered to be a weakness.

e. In response to NRC questions regarding this system, licensee management directed the technical support staff to identify which circuits were related to meeting TS surveillance requirements. In response, technical support memorandum TMM-91-001 was issued which identified four circuits. After further discussion with maintenance personnel, another technical support memorandum (TMM-91-002) was issued which identified seven circuits. After additional review by the inspectors and maintenance personnel, three additional circuits

were then identified. A review by plant engineering was requested for the heat trace system associated with various TS required radiation monitors and TS required containment hydrogen monitors. The technical support staff's failure to adequately identify in a timely manner all circuits related to meeting TS surveillance requirements is considered to be a weakness.

f. Radiation monitor REM-3502 A, Leak Detection Monitor, which is required to be operable by TS 3.3.3.1, was found with its heat trace circuit disabled. Radiation monitor RM 3509, Plant Vent Stack Monitor, which is required by TS 3.3.3.11, was found with its heat trace circuit disabled. The containment hydrogen monitors, which are required to be operable by TS 3.6.4.1, were found with the heat trace system in alarm due to overtemperature on two circuits and with improper actual temperature alarm and control settings of 29 degrees F and 30 degrees F versus the required 100 degrees F and 110 degrees F, on another circuit. The operability of these monitors with associated inoperable heat tracing is considered to be an unresolved item pending a review by plant engineering.

Unresolved Item (400/91-24-05): Failure to maintain heat trace systems on various TS monitors.

Two violations and an unresolved item were identified.

6. 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 91-18: This LER reported that the surveillance test interval specified for the personnel air lock was exceeded. This matter was identified by the licensee during a review of testing history for the air lock. The licensee has revised the test schedule for the personnel air lock to eliminate the use of a 25 percent grace period and has reviewed other surveillance test intervals to ensure they were properly scheduled.

7. Review of Plant Nuclear Safety Committee Activities (40500)

The inspectors attended selected PNSC meetings to observe committee activities and verify TS requirements with respect to committee composition, duties, and responsibilities. Minutes from one meeting were also reviewed to verify accurate documentation. Items reviewed during this meeting included a proposed change to the Technical Specifications which would allow AFW flow to be throttled or shut off while in Modes 2 or 3 as necessary to maintain steam generator level. This change resulted from an issued raised in NRC Inspection Report 91-13 for having

AFW flow control valves throttled or shut during plant startup. Attached to the meeting minutes were copies of the applicable safety review and analysis sheets in addition to the attendance sheet which demonstrated the required number of attendees. The inspector considers the conduct of these meetings to be good and that committee actions/recommendations enhance the safe operation of the plant.

No violations or deviations were identified.

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

   a. (Closed) Violation 400/90-26-02: Failure to properly implement a radiochemistry procedure.

      The inspector reviewed and verified completion of the corrective actions listed in the licensee's response letter dated March 1, 1991. Licensee management counselled the chemistry technician and foreman involved and has reinforced procedural compliance with chemistry personnel. Further, as part of the coaching program, chemistry supervision have initiated spot checks of procedure performance. The corporate chemistry and nuclear assessment departments have likewise observed technician performance during sampling.

   b. (Closed) Violation 400/91-14-01: Failure to maintain failed fuel detector operable.

      The inspector reviewed and verified completion of the corrective actions listed in the licensee's response letter, dated August 23, 1991. The licensee has returned the detector to service, informed personnel of the significance of the failed fuel detector, and has provided a list of emergency plan equipment to system engineers.

9. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on November 15, 1991. 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 and unresolved 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
400/91-24-01	NCV: Failure to properly post required notices to workers, paragraph 2.d.

400/91-24-02	VIO: Failure to provide an adequate surveillance test procedure for boric acid system temperature, paragraph 3.
400/91-24-03	VIO: Failure to perform adequate boric acid pump testing, paragraph 5.a.
400/91-24-04	VIO: Failure to adequately identify, document, and correct deficiencies, paragraph 5.c.
400/91-24-05	URI: Failure to maintain heat trace systems on various TS monitors, paragraph 5.f.

10. Acronyms and Initialisms

ACR	-	Adverse Condition Report
AFW	-	Auxiliary Feedwater
AP	-	Administrative Procedure
ASME	-	American Society of Mechanical Engineers
CFR	-	Code of Federal Regulations
EST	-	Engineering Surveillance Test
F	-	Fahrenheit
FSAR	-	Final Safety Analysis Report
ISI	-	Inservice Inspection
LER	-	Licensee Event Report
MST	-	Maintenance Surveillance Test
NCV	-	Non-Cited Violation
NRC	-	Nuclear Regulatory Commission
OST	-	Operations Surveillance Test
PIC	-	Process Instrument Control
PNSC	-	Plant Nuclear Safety Committee
RAB	-	Reactor Auxiliary Building
RTD	-	Resistance Temperature Detector
TS		Technical Specification
URI	-	Unresolved Item
VIO	-	Violation
WR/JO	-	Work Request/Job Order