



UNITED STATES  
 NUCLEAR REGULATORY COMMISSION  
 REGION II  
 101 MARIETTA STREET, N.W., SUITE 2900  
 ATLANTA, GEORGIA 30323-0199

Report No.: 50-400/94-17

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

Docket No.: 50-400

Licensee No.: NPF-63

Facility Name: Harris 1

Inspection Conducted: August 6 - September 2, 1994

Lead Inspector: *J. Tedrow* 9/14/94  
 J. Tedrow, Senior Resident Inspector Date Signed

Other Inspectors: D. Roberts, Resident Inspector  
 S. Rudisail, Reactor Inspector

Approved by: *H. Christensen* 9/14/94  
 H. Christensen, Section Chief Date Signed  
 Division of Reactor Projects

SUMMARY

Scope:

This routine inspection was conducted by the resident inspectors and a regional inspector in the areas of plant operations, review of nonconformance reports, maintenance observation, surveillance observation, system engineering, plant housekeeping, radiological controls, security, fire protection, emergency preparedness, and review of licensee event reports. Numerous facility tours were conducted and facility operations were observed. Some of these tours and observations were conducted on backshifts.

Results:

Two violations were identified: Failure to properly test emergency diesel generators at the required frequency, paragraph 3.b(1); Failure to maintain respirator qualifications in accordance with emergency plan procedures, paragraph 5.e.

Housekeeping deficiencies were identified in the reactor auxiliary building, paragraph 5.a.

The licensee's corrective action for self-identified problems was insufficient to prevent recurrence of problems, paragraph, 3.b(1) and 5.e.

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## REPORT DETAILS

### 1. Persons Contacted

#### Licensee Employees

- \*D. Batton, Manager, Work Control
- D. Braund, Manager, Security
- \*B. Christiansen, Manager, Maintenance
- J. Collins, Manager, Training
- J. Dobbs, Manager, Outages
- \*J. Donahue, General Manager, Harris Plant
- \*R. Duncan, Manager, Technical Support
- \*M. Hamby, Manager, Regulatory Compliance
- D. McCarthy, Manager, Regulatory Affairs
- \*R. Prunty, Manager, Licensing & Regulatory Programs
- W. Robinson, Vice President, Harris Plant
- \*G. Rolfson, Manager, Harris Engineering Support Services
- H. Smith, Manager, Radwaste Operation
- \*B. White, Manager, Environmental and Radiation Control
- \*A. Williams, Acting Manager, Operations

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

#### \*Attended exit interview

H. Christensen, Section Chief, Reactor Projects; was on site August 26, 1994, to tour site and meet with the Resident Inspectors.

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

### 2. Operations

#### a. Plant Operations (71707)

The plant continued in power operation (Mode 1) for the duration of this inspection period.

##### (1) 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; grounding device 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. No violations or deviations were identified.

(2) Facility Tours and Observations

Throughout the inspection period, facility tours were conducted to observe 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 (RAB); 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, observations were made regarding monitoring instrumentation which included equipment operating status, electrical system lineup, reactor operating parameters, and auxiliary equipment operating parameters. Indicated parameters were verified to be in accordance with the TS for the current operational mode. The inspectors also 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. The licensee's performance in these areas was satisfactory. No violations or deviations were identified.

b. Review of Nonconformance Reports (71707)

Adverse Condition Feedback Reports (ACFRs) were reviewed to verify the following: TS were complied with, corrective actions and generic items were identified and items were reported as required by 10 CFR 50.73.

3. Maintenance

a. 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 were issued and TS requirements were being followed. Maintenance was observed and work packages were reviewed for the following maintenance activities:

- Grease motor to pump coupling on "A" AFW pump in accordance with procedure PM-M0011, Equipment Lubrication Schedule.
- Perform limitorque operator inspection on the "A" AFW pump service water isolation valve 1SW-121, in accordance with procedure PM-I0020, Limitorque Operator Inspection.
- Replace all PSU-111 terminals in the 1SW-121 breaker cubicle with NU-2 terminals in accordance with PCR-7167.
- Troubleshoot TDAFW pump control panel and electronic governor for cause for pump overspeed trip.
- Calibration of the TDAFW steam pressure switch PS-431SB in accordance with procedure PIC-I100, Pressure and Differential Pressure Switch Inspection and Calibration.
- Disassemble TDAFW pump servo and replace oil seal.

In general, the performance of work was satisfactory with proper documentation of removed components and independent verification of the reinstallation. No violations or deviations were identified.

b. 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 test was reviewed:

- OST-1111 Auxiliary Feedwater Pump 1X-SAB Operability Test

The performance of this procedure was found to be satisfactory with proper use of calibrated test equipment, necessary communications established, notification/authorization of control room personnel, and knowledgeable personnel having performed the tasks.

- (1) Three ACFRs were written to document problems associated with emergency diesel generator surveillance testing. As discussed in NRC Inspection Report 50-400/94-15, the two EDGs experienced random failures requiring that maintenance and surveillance tests be performed to return the diesels to an operable status. Both EDGs were declared operable following successful tests on July 22 and 23, 1994.

ACFR 94-2622 was written on August 5 following the discovery by a licensee system engineer that the problems experienced by the "B" EDG on July 21 and 22 constituted two valid failures. Specifically, it was determined on August 5 that

the problem with a fuse block on July 21 and problems associated with an electronic governor on July 22 constituted two failures in as many valid tests. Technical Specification Table 4.8-1 requires that the EDGs be tested once per seven days if the number of failures in the last 20 valid tests is greater than or equal to two. The August 5 discovery came approximately three days after the "B" EDG should have been tested in accordance with the increased test frequency. As a result of the missed surveillance, the "B" EDG was declared inoperable and subsequently tested satisfactorily at 3:05 p.m. on August 5, 1994.

ACFR 94-2624 was also written on August 5 when the same engineer discovered that the "A" EDG should also be placed on an increased test frequency based on its failure on July 22 and four previous failures in 1992. The combination of these five failures, all of which occurred within the last 100 valid tests, satisfied the requirement in TS Table 4.8-1 for placing the "A" EDG on a weekly test schedule. The "A" EDG had been run on July 22, July 25, and August 2 for post-maintenance testing, troubleshooting, and a regular scheduled monthly test, respectively. Therefore, the licensee fortuitively met the weekly requirement for testing the "A" EDG. It was run again on August 6 to comply with Action b of TS 3.8.1.1 after the "B" EDG was declared inoperable on August 5.

The inspectors discussed the above ACFRs with cognizant licensee personnel to determine the cause for the missed requirements. In addition, the licensee formed an event review team to address the above situations and recommend corrective actions. It was determined that the requirements for increased test frequency were missed because the system engineers, who were normally responsible for making such a determination, were slow in reviewing test data associated with the diesel runs on July 21 and July 22. Following diesel tests, a system engineer usually enters the most recent test data in Attachment 1 to procedure TMM-400, Emergency Diesel, Reactor Trip Breaker and Response Time Results Evaluation, and then reviews previous data to determine whether or not any of the criteria outlined in TS Table 4.8-1 is satisfied. This action did not occur until August 5. Operating personnel also normally keep track of the number of start demands and failures for each diesel on a daily basis in accordance with procedure OPT-1510, Emergency Diesel Generators Daily Inspection/Checks. However, that procedure only defined valid start failures as those failures which occur when the diesel is actually started. Those instances which include a deficiency identified prior to the diesel receiving a start signal would not be included as a valid failure; only those following discovery of a condition which would have

prevented the diesel from starting or loading properly. This was the case for the "B" EDG on July 21 with the fuse holder problem. Furthermore, neither operations nor technical support procedures directed responsible parties to review the diesel's test history following a failure to determine future test frequency requirements. This action had occurred with previous tests because the prior system engineer was cognizant of this requirement.

The licensee's corrective actions for both of the above conditions included placing the diesel generators on increased test frequencies. Future corrective actions will include revising operations and technical support procedures to clarify EDG test pass/fail criteria in accordance with Regulatory Guide 1.108, Periodic Testing of Diesel Generator Units Used as Onsite Electric Power Systems at Nuclear Power Plants, and to include requirements for determining the need for increased testing within 72 hours of test failure notification.

ACFR 94-2663 was written on August 13 following the discovery by licensee personnel that the two diesel generators, which were both now on an increased test frequency, were not being tested on a staggered test basis as required by TS 4.8.1.1.2.a. The "B" and "A" EDGs had been tested on August 5 and 6, respectively; and then again on August 12 and 13, respectively. Based on the definition of staggered test basis in TS 1.36, each diesel should have been tested at the beginning of a sub-interval determined by dividing the specified weekly interval by two (the number of diesels being tested). That meant the diesels should have been tested alternately at 3 1/2-day intervals. Instead, more than six days elapsed between the time the "A" EDG was tested on August 6 and the "B" EDG was run on August 12. The licensee exceeded the TS required surveillance interval for demonstrating EDG operability by approximately two days after considering the 25 percent grace period allowed.

Although licensee personnel identified the testing deficiencies noted above, the inspectors considered the licensee's preliminary corrective action to be deficient for not identifying the correct staggered test basis frequency. Therefore, this violation will be cited.

Violation (400/94-17-01): Failure to test the EDGs in accordance with TS Table 4.8.1 on a staggered test basis.

#### 4. Engineering

##### a. System Engineering (37551)

ACFR 94-2668 reported that on August 15 approximately 50 Asiatic clams were found in a strainer basket associated with the emergency service water intake traveling screen at the main reservoir. During a followup inspection at the auxiliary reservoir intake structure the licensee discovered more of the species.

The clams were all determined to be less than 4 years old. Licensee personnel could not determine the origin of the species or how long they had been in the area, but indicated that the freshwater intake reservoirs provide a good environment for spawning during the spring and fall seasons.

Following the licensee's discovery, the inspector reviewed the licensee's actions to satisfy commitments made in response to NRC Generic Letter 89-13, Service Water System Problems Affecting Safety-Related Equipment. Generic Letter 89-13 requested that licensees establish programs to monitor and control the incidence of service water flow blockage due to biofouling. In addition, the letter requested that licensees conduct a test program to verify the heat transfer capability of all safety-related heat exchangers cooled by service water. The generic letter requested that a routine inspection and maintenance program be established for service water piping and components to look for corrosion, erosion, protective coating failure, silting and biofouling. Final actions requested by the generic letter included performance of a single active failure analysis for the ESW system and ensuring that maintenance practices, operating and emergency procedures, and training involving the service water system, were adequate. The results of all of the above requested actions were to be documented and retained in appropriate plant records. The licensee responded to GL 89-13 via letters, dated January 26, 1990, and June 17, 1991, indicating that the requested programs had been established and implemented.

The inspector's discussions with the licensee system engineer indicated that the requested maintenance, testing, and control programs had been conducted appropriately. Various engineering procedures were developed for testing ESW-supplied heat exchangers (i.e., containment fan coolers, CCW heat exchangers, and the ESCWS heat exchangers) to determine cooling capacities. The licensee indicated that these procedures had been performed but that, in some cases, the completed procedures were not documented in plant files. Procedure EPT-163, Raw Water Systems Inspection and Documentation, was developed for inspecting the material condition of ESW components. This procedure was performed on a routine basis and the licensee was able to provide documentation of results.

A semi-annual monitoring program conducted by the licensee identified only a single clam in the intake channel prior to August 15. It was determined prior to that time that no significant biofouling potential existed in the ESW system and thus a continuous chlorination process was unnecessary. The licensee had already implemented a continuous chlorination process for the circulating water and normal service water systems, and the cooling tower basin.

Concerning the recent discovery of 50 Asiatic clams, the licensee is re-evaluating the need for continuous chlorination of the ESW system and the potential for biofouling to occur in the ESW system. The inspector requested that the licensee produce documentation of completed testing for the safety-related heat exchangers in accordance with GL 89-13. This item will be tracked as an inspector followup item pending the licensee's completion of the above activities.

Inspector Follow-up Item (400/94-17-02): Follow the licensee's actions to address potential for biofouling in the ESW system.

b. Licensee Action on Previously Identified Engineering Inspection Findings (92903)

(Closed) Inspector Followup Item 400/94-13-05: Examine the licensee's design review of the ESW system cooling water supply to the CSIP oil coolers and development of a better test method.

This item was previously discussed in NRC Inspection Report 50-400/94-15. The licensee has received preliminary results of the nuclear steam system supplier's evaluation of the failure of the ESW header "A" return valve (1SW-270) to open. These results indicated that with the prior cross-connected ESW cooling water flow alignment to the CSIPs, all three CSIPs would fail within approximately 12 minutes if a safety injection signal was initiated concurrently with a loss of offsite power. However, if manual operator intervention within five minutes was considered, the CSIPs would not fail. The inspector requested details of any manual operator actions required to prevent pump damage and was informed that action to secure the "A" EDG, thereby stopping the "A" ESW pump, was considered to be necessary.

Although the present ESW cooling water flow alignment to the CSIPs precludes this event from happening now, this item is administratively closed and will be tracked as Unresolved Item (400/94-17-04) pending receipt and review of the final written evaluation.

c. The inspector reviewed the root cause investigations completed for the EDG failures which resulted in an Unusual Event on July 22, 1994. The event and the licensee's corrective actions for the failed EDGs were documented in NRC Inspection Report 50-400/94-15.



Root Cause Investigation Report 94-2535 for EDG A was reviewed. The licensee concluded that the voltage regulation problems were caused by the loose nuts on the linear reactors. The loose nuts were tightened and the EDG successfully passed surveillance testing. A review of the Automated Maintenance Management System identified the loose nuts on the linear reactors as a reoccurring problem. The licensee plans to apply "lock tight" to the nuts prior to September 30, 1994. Additionally, the licensee is considering replacement of the linear reactors during the next refueling outage.

For EDG B, Root Cause Investigation Report 94-2530 and 2533 were reviewed. The licensee replaced a fuse holder and the EG-A controller for EDG B. The inspector considered the identification of the root cause for the EDG B governor control problem well supported and the corrective actions adequate for resolution of the EDG problem.

#### 5. Plant Support

- a. Plant Housekeeping Conditions (71707) - 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.

During a tour of the RAB on August 15, the inspector observed several examples of poor housekeeping. The inspector found a step ladder on the floor behind the "A" component cooling water pump. Other items that were found by the inspector included a high voltage power cord on the floor outside the "B" CSIP room, a blue surgeon glove on the "B" CSIP baseplate near the speed increaser, and two oil collection cloths on the floor in the "B" CSIP room under service water piping. The cloths were typically used to monitor oil leaks from suspect components, but there was no annotation on the cloths as to why they were placed under the service water piping. The inspector also noted increased boric acid buildup on the outboard seals for the "A" and "B" CSIPs. These items were brought to the shift supervisor's attention who initiated actions to get each one resolved. These examples indicate that the declining performance noted in the area of housekeeping in NRC Inspection Reports 50-400/93-24 and 50-400/93-22 continues.

- b. Radiological Protection Program (71750) - Radiation protection control activities were observed to verify that these activities were in conformance with the facility policies and procedures, and in compliance with regulatory requirements. The inspectors also verified that selected doors which controlled access to very high radiation areas were appropriately locked. Radiological postings were likewise spot checked for adequacy.

- c. Security Control (71750) - 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.
- d. Fire Protection (71750) - 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. During plant tours, areas were inspected to ensure fire hazards did not exist.
- e. Emergency Preparedness (71750) - Emergency response facilities were toured to verify availability for emergency operation. Duty rosters were reviewed to verify that appropriate staffing levels were maintained. As applicable, emergency preparedness exercises and drills were observed to verify response personnel were adequately trained.

The inspector reviewed respirator qualifications for various plant employees to determine if personnel assigned to the emergency response organization (ERO) met requirements in the emergency plan. During this review, the inspectors identified eight licensed and non-licensed operators whose respirator fit tests had expired. These included three licensed SROs, and five non-licensed auxiliary operators. According to the official Emergency Response Organization Roster effective July 11, 1994, these individuals were required to be qualified on a full-face respirator and a self-contained breathing apparatus. In addition, several other licensed and non-licensed operators had not been fit tested in the previous twelve months, but were in the 25 percent grace period which allowed them to continue using respirators for three months after fit test expiration. According to health physics personnel, the eight individuals outside of the grace period would not have been issued respirators during an emergency situation. During an emergency, the licensed SROs are assigned the positions of site emergency coordinator-control room and operations leader. The auxiliary operators are assigned to the position of emergency communicator in the main control room.

Respirator qualification had previously been identified as a problem by the licensee. ACFR 94-0031 was generated at the beginning of the year following a practice emergency drill in which respirator-related delays occurred while dispatching damage control personnel from the OSC. The ACFR was dispositioned as a feedback report and tracked via the regulatory affairs corrective

action subprogram of which the emergency preparedness unit is a part. However, as of August 29, 1994, the ACFR had not been resolved and corrective actions had not been adequate to prevent the most recent examples identified by the inspector.

The inspector discussed this finding with licensee management who initiated an investigation into the deficiency. It was discovered that one of the eight individuals had actually been fit-tested within the required time frame, but the associated paperwork had not been updated. The other seven operators' status was not affected by that anomaly.

Plant Procedure, PLP-510, Respirator Protection Program, Section 5.13.2, and Plant Emergency Procedure, PEP-407, Maintenance of the HNP Emergency Response Organization, Section 9.4 both require that personnel in the ERO shall complete all the necessary requirements for respirator issue (including respirator fit) if required for their position. The failure to maintain the appropriate qualifications for ERO personnel is contrary to this requirement and therefore is considered to be a violation of TS 6.8.1.d.

Violation (400/94-17-03): Failure to maintain respirator qualifications in accordance with emergency plan procedures.

The inspectors note the fact that earlier identification of the problem by the licensee did not prevent the situation from recurring. This indicates a weakness in the licensee's resolution of minor deficiencies.

With the exceptions noted above, the inspectors found plant housekeeping and material condition of components to be satisfactory. The licensee's adherence to radiological controls, security controls, fire protection requirements, and TS requirements in these areas was satisfactory.

#### 6. Review of Licensee Event Reports (LERS) (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. (Open) LER 94-01: This LER reported a TS violation in which a slave relay test was not adequately performed for an engineered safety features component. This deficiency was identified by licensee operating personnel during a review of the test procedure. Specifically, valve 1ED-121 is a containment isolation valve on the discharge of the reactor coolant drain tank pumps which receives a shut signal on a containment phase "A" isolation signal via relay K623. The performance of test procedure OST-1044, ESFAS Train "A" Slave Relay Test, which was developed to satisfy TS surveillance requirements, has verified that the relay



functions, but never verified that the valve closed as required. This would have been accomplished by performing a continuity check for specific relay contacts for valve 1ED-121 and associated wiring to the valve's termination cabinet. While this condition has existed since plant startup, the safety significance of the omission was minimal since the valve is cycled daily during RCS leakrate calculations. Additionally, the relay has been verified to function properly by actuation of its other components during the quarterly test. Finally, continuity checks for 1ED-121 relay contacts and associated wiring are performed at 18-month intervals during ESF response time testing. These items were last verified to operate properly in April 1994 during the last refueling outage. The licensee determined the root cause for this error to be a deficiency in procedure OST-1044, ESFAS Train "A" Slave Relay Test, caused by an inadequate technical review. Corrective actions included a revision to the procedure and a review of other ESF output relays to ensure that TS required testing was being performed. Appropriate personnel will also be trained on this event. This LER will remain open pending completion of this action.

- b. (Open) LER 94-02: This LER reported the failure to perform TS required channel checks and flow estimates for turbine building vent stack radioactive gaseous effluent monitoring instrumentation on July 16 and July 17, 1994. The turbine building wide range gas monitor (WRGM) had been declared inoperable on July 16 at 7:30 a.m. due to a communication loss with the process computer (RM-11) in the main control room. While performing daily surveillance checks, licensee personnel did not perform the required channel check on the turbine building vent stack flow rate monitor because it was assumed that the flowrate monitor was also inoperable due to the communication problem between the WRGM and the RM-11. The flow rate monitor was in fact operable and should have been channel checked at a 24 hour interval. Flow rate monitor channel checks were not performed again until operators on a different shift discovered the condition at 11:00 p.m. on July 17. At that time the stack flow rate monitor was declared inoperable and the compensatory four hour flow estimate was commenced. Later on July 19, 1994, an omission of two fans was discovered in the stack flow rate estimate log book which was used for the compensatory flow estimates performed by operators. This condition resulted in inaccurate stack flow rate estimates.

The license determined the cause for the above incidents to be a combination of poor work practices and inadequate procedural controls. Corrective actions will include revisions to applicable procedures and training/counseling for appropriate personnel. This LER will remain open pending completion of this action.

- c. (Open) LER 94-03: This LER reported the potential effect that the single failure of an auxiliary reservoir discharge isolation valve would have on CSIP cooling water flow. This issue was discussed



in NRC Inspection Report Nos. 50-400/94-15 and 50-400/94-13 and is being tracked as Inspector Followup Item 50-400/94-13-05. The LER discussed that the engineering analysis for the CSIPs was not complete and a supplemental LER would be issued or LER 94-03 would be rescinded depending upon the CSIP operability determination. This LER will be left open pending the results of the licensee's engineering analysis.

- d. (Closed) LER 94-04: This LER reported the TS violation due to failure to perform EDG testing at the required frequency as discussed in paragraph 2.b(1) of this report. For record purposes, the licensee's corrective action will be tracked with the violation and the LER will be closed.

#### 7. Exit Interview (30703)

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on September 2, 1994. 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. During this meeting, licensee management requested that the EDG testing violation be considered as a non-cited violation based on the corrective actions that had been taken and identification of the problem by licensee personnel.

<u>Item Number</u>	<u>Description and Reference</u>
400/94-17-01	Violation: Failure to test the EDGs in accordance with TS Table 4.8-1 on a staggered test basis, paragraph 3.b(1).
400/94-17-02	Inspector Followup Item: Follow the licensee's actions to address potential for biofouling in the ESW system, paragraph 4.a.
400/94-17-03	Violation: Failure to maintain operator respirator qualifications in accordance with emergency plan procedures, paragraph 5.e.
400/94-17-04	Unresolved Item: Single failure in ESW system results in CSIP failure, paragraph 4.b.

#### 8. Acronyms and Initialisms

ACFR	-	Adverse Condition Feedback Report
AFW	-	Auxiliary Feedwater
CCW	-	Component Cooling Water
CFR	-	Code of Federal Regulations
CSIP	-	Charging Safety Injection Pump

EDG - Emergency Diesel Generator  
ERO - Emergency Response Organization  
ESCWS - Essential Services Chilled Water System  
ESFAS - Engineered Safety Feature Actuation System  
ESW - Emergency Service Water  
GL - Generic Letter  
LER - Licensee Event Report  
NRC - Nuclear Regulatory Commission  
OSC - Operational Support Center  
PCR - Plant Change Request  
RAB - Reactor Auxiliary Building  
RCS - Reactor Coolant System  
SRO - Senior Reactor Operator  
TS - Technical Specification  
WRGM - Wide Range Gas Monitor