



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

Report No.: 50-400/95-13

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

Docket No.: 50-400

License No.: NPF-63

Facility Name: Harris 1

Inspection Conducted: August 6 - September 2, 1995

Inspectors: S. Elrod, Senior Resident Inspector 9-28-95
 Date Signed

Other Inspector: D. Roberts, Resident Inspector

Approved by: D. Verrilli, Chief 9/28/95
 Date Signed
 Reactor Projects Branch 1A
 Division of Reactor Projects

SUMMARY

Scope:

This routine inspection was conducted in the areas of operations, maintenance, surveillance, engineering, plant support, review of licensee event reports, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed.

Results:

Plant Operations

The inspectors noted one instance of operator inattention to procedural detail. This resulted in the wrong steam generator being fed during a auxiliary feedwater full flow surveillance test, paragraph 3.b. Otherwise, performance in this area was satisfactory. The inspectors identified no violations or deviations in the plant operations area.

Maintenance

In general, the performance of work was satisfactory with proper documentation of removed components and independent verification of the reinstallation. Additionally, the licensee adequately resolved battery maintenance and surveillance issues, paragraph 4. The inspectors identified no violations or deviations in this area.

Engineering

The licensee identified a deficiency concerning emergency core cooling system components located outside of the Reactor Auxiliary Building Emergency Evacuation System ventilation boundary, paragraph 5. The inspectors identified no violations or deviations in the engineering area.

Plant Support

The inspectors found plant housekeeping and material condition of components to be satisfactory. An unresolved item was identified concerning the possible falsification of health physics surveys, paragraph 6.b. Otherwise, the licensee's adherence to radiological controls, security controls, fire protection requirements, emergency preparedness requirements, and TS requirements in these areas was satisfactory. Nuclear Assessment Section assessments were thorough. The inspectors identified no violations or deviations in the plant support area.

REPORT DETAILS

1. PERSONS CONTACTED

Licensee Employees

- D. Batton, Superintendent, On-Line Scheduling
- *D. Braund, Manager, Security
- *J. Collins, Manager, Training
- *J. Dobbs, Manager, Outage and Scheduling
- *J. Donahue, General Manager, Harris Plant
- *R. Duncan, Superintendent, Mechanical Systems
- *W. Gautier, Manager, Maintenance
- M. Hamby, Supervisor, Regulatory Compliance
- *M. Hill, Manager, Nuclear Assessment
- *D. McCarthy, Superintendent, Outage Management
- *R. Prunty, Supervisor, Licensing and Regulatory Programs
- W. Robinson, Vice President, Harris Plant
- *G. Rolfson, Manager, Harris Engineering Support Services
- *S. Sewell, Superintendent, Design Control
- *T. Walt, Manager, Regulatory Affairs
- *B. White, Manager, Environmental and Radiation Control
- *A. Williams, Manager, Operations

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

NRC Personnel

- *S. Elrod, Senior Resident Inspector, Harris Plant
- *D. Roberts, Resident Inspector, Harris Plant

*Attended exit interview

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

2. PLANT STATUS AND ACTIVITIES

a. Operating Status of the Plant Over the Inspection Period.

The plant continued in power operation (Mode 1) until September 2, 1995. On that day, the unit was shutdown for a scheduled refueling outage (RFO 6). The unit had operated in Mode 1 for 297 days since startup on November 8, 1994. The unit ended the period in hot shutdown (Mode 4) with RCS temperature and pressure at approximately 335 DEGF and 350 psig, respectively.

b. Other NRC Inspections or Meetings at the Site.

There were no other NRC inspections conducted at Harris this month.

3. OPERATIONS

a. Plant Operations (71707)

(1) Shift Logs and Facility Records

The inspector reviewed records and discussed various entries with operations personnel to verify compliance with the TS and the licensee's administrative procedures. In addition, the inspector independently verified clearance order tagouts.

The inspectors found the logs to be legible and well organized, and to provide sufficient information on plant status and events. The inspectors found clearance tagouts to be properly implemented. The inspectors identified no violations or deviations in the shift logs and facility records area.

(2) Facility Tours and Observations

Throughout the inspection period, the inspectors toured the facility to observe activities in progress, and attended several licensee meetings to observe planning and management activities. The inspectors made some of these observations during backshifts.

During these tours, the inspectors observed monitoring instrumentation and equipment operation. The inspectors also verified that operating shift staffing met TS requirements and that the licensee was conducting control room operations in an orderly and professional manner. The inspectors additionally observed several shift turnovers to verify continuity of plant status, operational problems, and other pertinent plant information. Licensee performance in these areas was satisfactory.

Licensee personnel performed a controlled plant shutdown on September 1 in accordance with procedure GP-006, Rev. 7.2, Normal Plant Shutdown from Power Operation to Hot Standby. This procedure was performed smoothly. Secondary systems were secured in accordance with the procedure with no unexpected trips. Reactor protection system permissives and nuclear instrumentation responded to reactor power changes as expected. Operations personnel appropriately used self-verification techniques before turning switches. Operators generally acknowledged the control room annunciators and alarms as they came in. The inspector noted one case when operators were slow in responding to a radiation monitoring system alarm, but this did not detract from the operators overall good performance in this area. Management oversight



was provided in that both licensee management and NAS personnel were in the control room observing the shutdown.

The inspector also observed portions of the cooldown from Mode 3 to Mode 4. Operators performed this evolution in accordance with procedure GP-007, Rev. 8, Normal Plant Cooldown (Mode 3 to Mode 5). The RCS and pressurizer were both cooled within cooldown limits specified by technical specifications and attachments to the general procedure. Cooldown rates were appropriately tracked by the STA in accordance with the procedure. The inspector concluded that both the shutdown and the cooldown evolutions were performed successfully.

The inspectors identified no violations or deviations in the facility tours and observations area.

b. Effectiveness of Licensee Control in Identifying, Resolving, and Preventing Problems (40500)

Condition Reports (CRs) were reviewed to verify that TS were complied with, corrective actions and generic items were identified, and items were reported as required by 10 CFR 50.73.

CR 95-1917 was initiated when an operator fed the wrong steam generator during an AFW system surveillance test. Test procedure OST-1087, Rev. 5, Motor Driven Auxiliary Feedwater Pumps Full Flow Test Quarterly Interval, allowed operators to feed the steam generators in any order. The test coordinator had decided prior to the test that the "B" and "C" steam generators would be fed with the "A" motor-driven AFW pump and the "A" SG would be fed with the "B" pump. During the test, after feeding the "B" SG with the "A" pump running, the BOP operator announced that he was opening the "C" motor-operated isolation valve to feed the "C" SG. He instead opened the "A" SG motor-operated isolation valve and subsequently announced to the control room that he had opened the "C" valve. Another operator in the MCR noticed the error and alerted the operator who later corrected it.

Although the "A" SG experienced an extra thermal cycle because of the error, the safety significance was minor because all of the SGs were to eventually be cycled during the test. The error pointed to the need to devote more attention to detail in the area of operations.

c. Review of LERs (92700)

- (1) (Closed) LER 94-002-00: Technical Specification Surveillance Violation Due to Failure to Perform Required Radiation Monitoring System Compensatory Measures.

This LER documented a July 1994 TS violation which occurred when operators did not perform compensatory measures for an inoperable turbine building ventilation stack flow rate monitor. Another violation was reported on the same LER for two turbine building exhaust fans that were not included in the TS compensatory flow estimation procedure. The inspector reviewed the licensee's corrective actions for this event which included enhancements to procedures containing operating and surveillance requirements for vent stack samplers and flow rate monitors. Operators also received training on the newly revised procedures.

This LER is closed.

- (2) (Closed) LER 95-005-00: Technical Specification Violation Due to Missed Compensatory Vent Stack Flow Rate Estimate.

This LER documented a July 1995 TS violation which occurred when operators did not perform compensatory measures for an inoperable waste processing building ventilation stack (WPB Stack 5A) flow rate monitor. The violation initially appeared to be similar to the one discussed in LER 94-002-00 because it also involved a vent stack flow rate monitor. However, there were significant differences. The 1994 violation involved a combination of poor work practices and inadequate procedure/process controls. The 1995 violation involved a single human failure to follow the same procedures which had been corrected following the 1994 event.

The safety significance of the 1995 incident was minimal. No abnormal increases in radioactivity levels were indicated by either the 12-hour grab samples or the auxiliary sampler. These alternate sampling methods were compensatory measures taken to replace the inoperable WPB Stack 5A PIG and WRGM detectors. The inspector concluded that the similarities between the two events were overshadowed by the differences and did not warrant a violation citation. The LER adequately described the event, its causes, the safety significance, and the licensee's corrective actions.

This LER is closed.

- d. Followup - Operations (92901)

(Closed) URI 400/95-12-02: Determine Adequacy of Corrective Actions for Violations Involving Vent Stack Flow Monitors.

The inspector verified that corrective actions for a 1994 event involving the turbine building vent stack flow monitor were adequate. Additionally, the inspector concluded that a similar 1995 event involving waste processing building vent stack 5A was

not caused by inadequate corrective actions for the 1994 event, but by personnel error. For more discussion of each event, see paragraphs 3.c.(1) and 3.c.(2) of this report.

The inspector has closed this unresolved item.

The inspectors noted one instance of operator inattention to procedural detail. Otherwise, performance in this area was satisfactory. The inspectors identified no violations or deviations in the plant operations area.

4. MAINTENANCE

a. Maintenance Observation (62703)

The inspector observed the maintenance and reviewed the work packages for the following maintenance activity to verify that correct equipment clearances were in effect, work requests were issued, and TS requirements were being met.

- (1) The inspector observed the fire protection staff hydrostatically testing spare fire hoses intended for installation in the containment during the upcoming refueling outage. The staff had connected 7 runs of hose with 300 feet of hose each and had reached the 300 psig test pressure at the time of this observation. The test was being performed per OPT-3010, Rev. 6, Fire Hose Service Test. The inspector observed layout, gage calibration records, safety precautions, and conduct of the pressure test. These items were satisfactory.

The procedure had two prerequisites requiring signatures - neither was signed. One signature was for granting permission to perform the test. The other indicated that the prerequisites were completed. The prerequisites were actually completed even though a signature had not been obtained. This was a non-safety related procedure and the work was on spare hose rather than installed plant equipment. This was identified to the licensee who initiated a detailed review of management controls in this area.

- (2) The inspector observed an alteration equivalent to a repair being performed on the "B" containment hydrogen monitor control panel. The alteration consisted of swapping control cards to a new drawer that contained an upgraded power supply, then installing and testing the drawer. This was significantly easier than disassembling the drawer to replace the power supply alone. The maintenance shop staff, vice the construction crew, was performing the alteration. The inspector observed good workmanship practices,

documentation of lifted leads, and on-site assistance by both the design engineer and the system engineer.

The inspector observed that the planners had inserted into the work package (without explanation, reference, or direction) some forms normally used by the construction staff. The first page contained signature blocks marked "NA," seeming to imply that the forms were not to be used. The back side of the forms contained step-by-step documentation requirements including several mandatory QC hold points. When questioned by the inspector, the shop staff stopped work, resolved the purpose of the forms, then continued. Since work had not progressed far, the form signatures could be legitimately signed. Hold points had not been bypassed yet. The inspector considered this to be a weakness in organizational communication and control of work processes. The maintenance staff used this instance as an example in a study designed to simplify work planning and control.

b. Followup - Maintenance (92902)

- (1) (Closed) VIO 400/94-23-02: Failure to Maintain Emergency Battery Bank 1B-SB Operable.

This violation resulted primarily because procedure MST-E0011, 1E Battery Quarterly Test, contained steps that misled the technicians to believe the battery to be fully operable when it was actually conditionally operable pending restoration of one cell's voltage within the next week. The voltage was not restored as required. Subsequent to discovery during the next surveillance, the licensee found several instances where this condition had occurred previously but had remained undetected.

The licensee responded to this violation in letters HNP-95-002 of January 6, 1995, and HNP-95-007 of January 16, 1995. The licensee promptly restored the battery to operable status in November 1994. The inspector reviewed the battery restoration in IR 400/94-23. Subsequent actions to prevent recurrence included training and human factors changes to procedures MST-E0011 and also MST-E0010, 1E Battery Weekly Test. Both were significantly improved in providing directions to operators concerning prompt evaluation and correction of adverse conditions; quantification of battery water level when it is above the full mark; clarity of items needing independent verification; removal of administrative limits that added confusion; and added clarity of required corrective actions and timing. Training records of lesson plan TS-LP-6.2 showed widespread training on this subject in the first quarter of 1995. This violation is closed.

- (2) (Closed) URI 400/94-21-03: Determine Intent of TS 4.8.2.1c.3 and Review Licensee's Operability Determination for the 1A Emergency Battery.

This item involved the meaning of the phrase "The resistance of each cell-to-cell and terminal connection is less than or equal to 150×10^{-6} ohm." Specifically, the inspectors questioned whether the resistance limit included tier-to-tier or tier-to-spare cell jumper cables or did it only include the battery post-to-cable terminal resistance. A side issue was the technique of measuring cell-to-cell resistance when the cells each have two positive and two negative posts. While clear written NRC guidance could not be found, the inspector determined that the NRR technical intention was to include the cable resistance if cables were involved. As documented in IR 400/94-21, a utility calculation found the battery physically operable in the as-found condition with spare cell jumpers exceeding 150×10^{-6} ohm. The utility did, however, find that the cables could be shortened, thus reducing the cell-to-cell resistance to a value less than 150×10^{-6} ohm. This was accomplished last spring. The utility also settled on a technique of measuring cell-to-cell resistance between the most separated posts on the four-post batteries. This decision was supported by an analysis of multiple current flow paths. The inspector concluded that this was a moot issue because the original requirements were not clearly stated; de facto operability existed; and the licensee modified the installation such that the cable resistance was within the specification. This item is closed.

In general, the performance of work was satisfactory with proper documentation of removed components and independent verification of the reinstallation. Additionally, the licensee adequately resolved battery maintenance and surveillance issues. The inspectors identified no violations or deviations in this area.

5. ENGINEERING - Effectiveness of Licensee Control in Identifying, Resolving, and Preventing Problems (40500)

CR 95-1862 discussed a construction deficiency which resulted in portions of the ECCS recirculation system located in the RAB being outside of the RAB emergency exhaust system boundary.

FSAR section 6.5.1.1.2 described the design basis for the RAB emergency exhaust system (RABEES). It stated that the RABEES serves to limit the post-accident radiological releases from the potentially contaminated portions of the RAB. These areas include the charging pump, RHR heat exchanger, containment spray, and RHR pump rooms; mechanical, electrical and HVAC rooms; and mechanical, electrical, and HVAC penetration areas. It thus implied that rooms containing CSIP suction and discharge piping,

seal injection piping, normal and alternate miniflow piping, and associated valves were enveloped in the RABEES boundary. Instead, the as-built portions of the ECCS system, primarily located in a mezzanine area above the charging/safety injection pumps, were not enclosed in the RABEES boundary but were in areas ventilated via the normal, non-emergency, RAB ventilation system.

This condition was actually discovered by the licensee before 1990. However, licensee personnel then determined through calculations, that the unfiltered leakage from the affected components during an accident would not result in offsite doses in excess of 10 CFR 100 limits. Licensee personnel determined in August 1995 that the 1990 evaluation was in error and that this discrepancy would introduce non-conservative factors into the original FSAR analysis performed to determine dose rates resulting from ECCS leakage outside containment. Specifically, the original FSAR dose analysis (described in FSAR section 15.6.5.4.2) assumed that effluent released from ECCS systems would first be processed through the RABEES filtration units prior to being released to the atmosphere. It did not factor in the potential increased dose resulting from the unfiltered leakage from that part of the system not within the RABEES boundary.

At the close of this inspection period, licensee personnel were still investigating the cause of this condition and were performing calculations to determine expected onsite and offsite doses. Compensatory measures were established to help minimize the potential for unfiltered leakage from the ECCS system for the postulated LOCA scenario. These included an administrative leakage limit of two gallons per hour from this portion of the ECCS system, which would be monitored twice daily by auxiliary operators. Additionally, compensatory actions were established to maintain control of the RAB boundary such that it would be intact during an accident. This included placing prohibitive signs on doors accessing the general RAB. These signs alert personnel not to block open the doors without shift supervisor approval. Certain doors for rooms enclosed within the RABEES boundary were already under this administrative requirement. However, doors accessing the general RAB were not.

Licensee personnel made a related 1-hour non-emergency report to the NRC on August 24 per 10 CFR 50.72. A 30 day written LER was expected to follow. The inspectors will continue to follow this issue under the LER.

The inspectors identified no violations or deviations in the engineering area.

6. PLANT SUPPORT

- a. Plant Housekeeping Conditions (71707) - The inspectors reviewed storage of material and components, and observed cleanliness conditions of various areas throughout the facility to determine whether safety hazards existed. The inspector concluded that



plant housekeeping was satisfactory and no safety hazards were apparent.

- b. Radiological Protection Program (71750) - The inspectors reviewed radiation protection control activities to verify that these activities were in conformance with 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.

On August 2, 1995, licensee management informed the inspector that an HP technician had possibly falsified a radiological survey form. This form, dated July 28, 1995, documented a monthly survey for a room on the 236 foot elevation of the Waste Processing Building. HP survey forms were permanent plant records required by licensee procedure HPP-625, Rev. 2/1, Performance of Radiological Surveys. Although not required by the procedure, a lead technician and an HP supervisor typically reviewed survey forms before sending them to Document Control for permanent storage.

Between July 28 and August 1, a lead technician reviewed WPB survey records generated by the technician in question. The reviewer questioned similarities between the then-current surveys and those from the previous month. After questioning the survey results, licensee personnel reviewed security access records for two vital area doors accessing one of the affected areas. From this review, the licensee concluded that the individual had not accessed the affected area during the month of July, and therefore never performed the survey.

When initially confronted with this finding, the individual denied any wrongdoing and stated that the security system must have been faulty for not detecting his/her access to the vital area. The individual maintained that a radiological survey had been performed on July 28. E&RC management challenged the individual by conducting a joint walkdown of the affected room and asking the technician to identify certain specific survey attributes without the benefit of the form. The individual apparently had difficulty identifying such elements as a hot spot and other radiological items. Based on the individual's difficulty in recalling the survey's attributes, and following a more detailed investigation into the security system, plant management placed the individual on administrative leave and on August 11 terminated his/her employment and access to the site.

There were no adverse radiological consequences resulting from the falsified survey. Licensee personnel performed new surveys for all of the areas surveyed by the individual during that week. The new results were only slightly different from the numbers documented on the individual's surveys. Additionally, the

licensee's QC organization (under NAS) conducted an independent review of security records, radiological surveys, and chemistry surveillances to determine if a widespread organizational problem existed. Although the QC organization identified some minor inconsistencies involving survey times vs. access times for vital areas, none of the inconsistencies were determined to have wrongdoing implications.

The inspector reviewed the affected survey records, the results of the QC assessment, and actions taken by E&RC management to correct this situation. The corrective actions included stand-down meetings conducted by management to stress the importance of maintaining the integrity of the radiological control program. Licensee management reiterated that such acts of wrongdoing were taken seriously by plant management, as indicated by the strong actions taken against the involved individual.

The inspectors' review of the licensee's program requirements for HP surveys, including requirements for documenting time of survey, was continuing at the end of the inspection.

Unresolved Item 400/95-13-01: Potential Falsification of Radiological Survey Forms.

- c. Security Control (71750) - During this period, the inspectors toured the protected area and noted that the perimeter fence was intact and not compromised by erosion or disrepair. The fence fabric was secured and barbed wire was angled. Isolation zones were maintained on both sides of the barrier and were free of objects which could shield or conceal an individual. The inspectors observed various security force shifts perform daily activities, including searching personnel and packages entering the protected area by special purpose detectors or by a physical patdown for firearms, explosives, and contraband. Other activities included vehicles being searched, escorted, and secured; escorting of visitors; patrols; and compensatory posts. In conclusion, the inspectors found that selected functions and equipment of the security program complied with requirements.

The inspector noted an example of good performance on behalf of security personnel when they detected alcohol on the breath of a contractor employee reporting to work on August 18. The individual subsequently tested positive for alcohol with blood alcohol content readings of 0.057 and 0.060 percent. The licensee's FFD limit is 0.040 in accordance with 10 CFR 26, Appendix A requirements. The individual's employment and plant access were terminated almost immediately after the positive test results were confirmed. The individual had been recently hired to support RFO 6 activities. Licensee personnel reported this incident in accordance with requirements contained in 10 CFR 50.72. The licensee exhibited good performance in the fitness for duty area.

- d. Fire Protection (71750) - The inspectors observed fire protection activities, staffing, and equipment to verify that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable. During plant tours, the inspector looked for fire hazards. The inspector concluded that the fire equipment and barriers inspected were in proper physical condition.
- e. Emergency Preparedness (71750) - The inspectors toured emergency response facilities to verify availability for emergency operation. Duty rosters were reviewed to verify appropriate staffing levels were maintained. No emergency preparedness exercises or drills were conducted during the month.
- f. Licensee Self Assessment (40500)

The licensee's Nuclear Assessment Section completed two assessments this month, as listed below. The inspectors reviewed the assessments and concluded that the assessments were thorough and resulted in substantive findings. Areas assessed were:

- Report H-TQ-95-01, "Training and Qualification of the Training Staff;" and
- Report H-SP-95-03, "Shutdown Risk Management Assessment."

The inspectors identified no violations or deviations in the Nuclear Assessment area.

The inspectors found plant housekeeping and material condition of components to be satisfactory. An unresolved item was identified concerning the possible falsification of health physics surveys. Otherwise, the licensee's adherence to radiological controls, security controls, fire protection requirements, emergency preparedness requirements, and TS requirements in these areas was satisfactory. Nuclear Assessment Section assessments were thorough. The inspectors identified no violations or deviations in the plant support area.

7. EXIT INTERVIEW

The inspectors met with licensee representatives (denoted in paragraph 1) at the conclusion of the inspection on September 1, 1995. 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 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. No dissenting comments from the licensee were received.

<u>Item Number</u>	<u>Status</u>	<u>Description and Reference</u>
95-013-01	Open	URI Potential Falsification of Radiological Survey Forms, paragraph 6.b.
94-002-00	Closed	LER Technical Specification Surveillance Violation Due to Failure to Perform Required Radiation Monitoring System Compensatory Measures, paragraph 3.c.(1).
94-021-03	Closed	URI Determine Intent of TS 4.8.2.1c.3 and Review Licensee's Operability Determination for the 1A Emergency Battery, paragraph 4.b.(2).
94-023-02	Closed	VIO Failure to Maintain Emergency Battery Bank 1B-SB Operable, paragraph 4.b.(1).
95-005-00	Closed	LER Technical Specification Violation Due to Missed Compensatory Vent Stack Flow Rate Estimate, paragraph 3.c.(2).
95-012-02	Closed	URI Determine Adequacy of Corrective Actions for Violations Involving Vent Stack Flow Monitors, paragraph 3.d.

8. ACRONYMS AND INITIALISMS

AFW - Auxiliary Feedwater
 CFR - Code of Federal Regulations
 CM - Corrective Maintenance [procedure]
 CP&L - Carolina Power & Light
 CR - Condition Report
 CSIP - Charging/Safety Injection Pump
 DEGF - Degrees Fahrenheit
 E&RC - Environmental and Radiation Control
 ECCS - Emergency Core Cooling System(s)
 encl - Enclosure
 ESW - Emergency Service Water
 FFD - Fitness for Duty
 FSAR - Final Safety Analysis Report
 GP - General Procedure

HNP - Harris Nuclear Plant
HPP - Health Physics Procedure
HVAC - Heating, Ventilation, and Air Conditioning
IR - [NRC] Inspection Report
LER - Licensee Event Report
LOCA - Loss of Coolant Accident
MCR - Main Control Room
MST - Maintenance Surveillance Test [procedure]
NAS - Nuclear Assessment Section
NPF - Nuclear Production Facility [a type of license]
NRC - Nuclear Regulatory Commission
NRR - Nuclear Reactor Regulation
OST - Operations Surveillance Test [procedure]
PIG - Particulate, Iodine, and Gas [monitor]
psig - Pounds per Square Inch, Gauge
QC - Quality Control
RAB - Reactor Auxiliary Building
RABEES- RAB Emergency Exhaust System
RCS - Reactor Coolant System
RFO - Refueling Outage
RHR - Residual Heat Removal
SG - Steam Generator
STA - Shift Technical Advisor
TS - Technical Specification [part of the facility license]
URI - Unresolved Item
VIO - Violation [of NRC requirements]
vs - Versus
WPB - Waste Processing Building
WRGM - Wide Range Gas Monitor

