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

Report Nos.: 50-424/95-24 and 50-425/95-24

Licensee: Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425 License Nos.: NPF-68 and NPF-81

Facility Name: Vogtle 1 and 2

Inspection Conducted: September 17 through October 21, 1995

Inspector: FOR R. W. Wright 11/13/95
C. R. Ogle, Senior Resident Inspector Date Signed

FOR R. W. Wright 11/13/95
P. C. Hopkins, Resident Inspector Date Signed

FOR R. W. Wright 11/13/95
M. T. Widmann, Resident Inspector Date Signed

Approved by: Paul H. Skinner 11/13/95
P. H. Skinner, Chief Date Signed
Reactor Projects Branch 2
Division of Reactor Projects

SUMMARY

Scope: This routine, inspection entailed inspection in the following areas: plant operations, surveillance, maintenance, onsite engineering, plant support, and follow-up. Backshift inspections were performed on September 17, 20, 26, and 28, 1995; and on October 3, 8, 9, 11, 12, and 19, 1995.

Results: One violation, two non-cited violations and an unresolved item were identified.

Operations:

- A slight perturbation in pressurizer level occurred following restoration of an isolated seal water return filter to service. A subsequent investigation revealed deficiencies associated with the control of the filter status. This was identified as a non-cited violation (paragraph 2d).

- The second non-cited violation involved a mispositioned AFW system valve discovered by the inspectors. Though the mispositioning was of minimal safety significance, it represents the third incorrectly positioned valve found by the inspectors in the last two inspection report periods (paragraph 2e).

- Operators responded well to a transient involving a malfunctioning feedwater pump control circuit. The operators actions are identified as a strength (paragraph 2g)

Maintenance:

- A weakness was identified in the work planning process in that an incorrect solenoid operated valve was installed in a BTRS system valve. As a result of this misapplication, the solenoid valve ultimately failed resulting in a minor letdown system transient. Operations personnel responded well to the transient. The operator actions are identified as a strength (paragraph 2f).

Engineering:

- The licensee identified that OP$\Delta$T trip setpoints were set less conservatively than the values specified for the nominal trip setpoints in TS. However, no as found setpoints exceeded the allowable TS values. Pending inspector review of licensee followup actions, this item is unresolved (paragraph 5c).

Plant Support:

- The violation addressed the licensee's discovery of a unattended vehicle in the protected area with the keys in the ignition. This occurrence was similar to two previous violations identified in Inspection Reports 50-424,425/94-22 and 95-06 (paragraph 6b).

# REPORT DETAILS

1. Persons Contacted

Licensee Employees

J. Beasley, General Manager Nuclear Plant
S. Bradley, Reactor Engineering Supervisor
W. Burmeister, Manager Engineering Support
*C. Christiansen, SAER Supervisor
C. Coursey, Maintenance Superintendent
*R. Dorman, Manager Training and Emergency Preparedness
*W. Dunn, Unit 2 Superintendent
J. Gasser, Assistant General Manager Plant Operations
*M. Griffis, Manager Plant Modifications
T. Hargis, Maintenance Superintendent
*K. Holmes, Manager Maintenance
*D. Huyck, Manager Nuclear Security
*W. Kitchens, Assistant General Manager Plant Support
I. Kochery, Health Physics Superintendent
R. LeGrand, Manager Health Physics and Chemistry
G. McCarley, ISEG Supervisor
*R. Moye, Plant Engineering Supervisor
T. Parton, Health Physics Superintendent
*M. Sheibani, Nuclear Safety and Compliance Supervisor
C. Stinespring, Manager Plant Administration
*J. Swartzwelder, Manager Outage and Planning
*C. Tippins, Nuclear Specialist, NSAC
R. Waters, Material Supervisor, Plant Administration

Other licensee employees contacted included technicians, supervisors, engineers, operators, maintenance personnel, quality control inspectors, and office personnel.

Oglethorpe Power Company Representative

*J. Sharpe, Site Representative

NRC Inspectors

C. Ogle, Senior Resident Inspector
*P. Hopkins, Resident Inspector
*M. Widmann, Resident Inspector

*Attended Exit Interview

An alphabetical list of abbreviations and acronyms is located in the last paragraph of the inspection report.

2. Plant Operations (71707)

a. General

The inspection staff reviewed plant operations throughout the reporting period to verify conformance with regulatory requirements, TSs, and administrative controls. Control logs, shift supervisors' logs, shift relief records, LCO status logs, night orders, standing orders, and clearance logs were routinely reviewed. Discussions were conducted with plant operations, maintenance, chemistry, health physics, engineering support and technical support personnel. Daily plant status meetings were routinely attended.

Activities within the control room were monitored during shifts and shift changes. Actions observed were conducted as required by the licensee's procedures. The complement of licensed personnel on each shift met or exceeded the minimum required by TS. Direct observations were conducted of control room panels, instrumentation and recorder traces important to safety. Operating parameters were verified to be within TS limits.

Plant tours were taken during the reporting period on a routine basis. They included, but were not limited to the auxiliary building, control building, electrical equipment rooms, cable spreading rooms, NSCW towers, DG buildings, AFW buildings, MSIV rooms, turbine building and the low voltage switchyard. During plant tours housekeeping and equipment status were observed.

b. Unit 1 Summary

The unit operated at full power until September 27, when power was reduced to approximately 30% to add oil to the motor for RCP number 2. The unit returned to full power on September 28, and remained there throughout the inspection period.

c. Unit 2 Summary

The unit operated at full power throughout the inspection period.

d. Control of Equipment Status on RCP Seal Return Filter

On September 19, 1995, while investigating an alarm on the backflushable filter control panel, the operations shift discovered that the CVCS seal return filter, 1-1208-F4-002, was bypassed. The seal return filter was restored to service. However, approximately one hour later, a low flow alarm for RCP number 2 seal injection flow occurred. In response, charging header backpressure was increased to direct more flow to the RCP seals. Following this increase in seal flow, a high seal injection filter differential pressure alarm was received on

filter number 4. Seal injection filter number 5 was placed in service and number 4 filter was backflushed and placed in standby. Later in the shift, a PZR low level deviation alarm (5% high/low) annunciated and the shift entered AOP 18004-C, Reactor Coolant System Leakage. A second charging pump was started to restore PZR level. Ultimately, seal injection needle valves were adjusted thereby restoring proper seal flows to each of the RCPs. The inspectors were advised that the probable cause of the reduced seal injection flow was debris introduced into the seal injection system following backflushing of the seal return filter. When the seal return filter was restored to service it released this debris resulting in the observed perturbation in the seal injection system. The licensee further identified that the seal return filter was probably bypassed since the completion of the last Unit 1 refueling outage in October 1994.

In response to this event, the inspector reviewed system diagrams; procedures for system operation, valve lineups, and filter backflushing; USS and RO log entries; a sequence of events developed by the licensee; an ISEG analysis of the event; and RER 92-0052 on known problems with backflushable filter nitrogen supply system. Interviews were also conducted with operations personnel regarding the material condition of the nitrogen system and procedural controls of the seal return filter system.

The backflushable filter system is used to remove debris from certain process systems to the backflushable filter crud tank system. Nitrogen is used to backflush the dirt and debris on the filters to the crud tank. The nitrogen is supplied to the backflushable filter system accumulator by the auxiliary gas system. Chemistry sampling performed in 1992, indicated that the nitrogen system contained particulate contaminants at the nitrogen header. RER 92-0052 was initiated to address the need for filters in the system to alleviate these particulates. DCP 92-V2M156 was initiated to install a five micron filter in the nitrogen system and was accomplished on Unit 2 during 2R4. A similar modification to Unit 1 was delayed pending an evaluation of the effectiveness of the modification on Unit 2. (Since the September 19 event, the licensee has initiated the DCP for Unit 1's filter modification.) While several operating shift supervisors interviewed by the inspectors were aware of the particulate problem in the nitrogen system, no procedural controls, preventive measures, or warnings were developed or incorporated into system operating procedures to alert operators to the potential of introducing contaminates into the RCS from the nitrogen system.

The inspectors also determined that during performance of daily rounds, PEOs or RWOs did not routinely verify system operating status for the backflushable filters or record their differential pressure readings. This information was also not tracked in the control room. Following the event, the licensee revised the PEO rounds sheets to include a verification that the seal return

filter is in service and to document the filter differential pressure on each shift.

The inspectors concluded that all of the operating shifts were not cognizant of the seal return filter status. This is a violation of procedure 10000-C, Conduct of Operations, which requires shift personnel to be aware of equipment component status and system lineups. This is identified as NCV 50-424/95-24-01, Failure To Be Cognizant Of Seal Return Filter System Status, consistent with section VII of the NRC Enforcement Policy.

e. Mispositioned AFW System Valve

On September 26, 1995, during a routine tour of the Unit 2 Train B MDAFW pump room, the inspectors observed that the AFW Chemical Injection to MDAFW Pump B Discharge valve, 2-1302-U4-078, was incorrectly positioned. The inspectors noted that this normally closed valve was open. This discrepancy was identified to the Shift Superintendent and following confirmation of the inspectors' observation, the valve was shut. The inspectors were informed that a follow-up valve lineup of all AFW valves in the Unit 2 Train B MDAFW pump room by the licensee revealed no other mispositioned valves.

The inspectors reviewed the DC generated in response to the event. They also reviewed the last clearance involving the valve and portions of a procedure used for adding chemicals to the steam generators. Additionally, the inspectors interviewed cognizant operations management regarding the licensee's investigation of the issue.

The inspectors were advised that the valve probably had been mispositioned since the end of the last outage on Unit 2 some seven months earlier. The licensee attributed this to a failure to properly implement the AFW system restoration valve lineup specified in procedure VEGP 35535, Operation of the Condensate Chemical Injection System, following the last chemical addition to the SGs during the outage. Overall, the inspectors concluded that the licensee's explanation was plausible. Further, the inspectors noted that a check valve immediately upstream of the valve, minimizes the safety significance of the mispositioning.

As corrective action, the licensee stated their intention to enhance VEGP 35535 to more positively ensure that all valves are properly repositioned following a chemical addition.

The inspectors concluded that the mispositioned AFW System valve was contrary to the requirements of the system valve lineup procedure, VEGP 11610, Auxiliary Feedwater System Alignment. This is identified as NCV 50-425/95-24-02, AFW System Valve Mispositioned, consistent with Section IV of the NRC Enforcement Policy.

f. Letdown Transient

On September 28, shortly after the BTRS System was returned to service following maintenance on Unit 2, a letdown heat exchanger outlet high pressure alarm occurred. Letdown pressure spiked at approximately 520 psig and a relief valve in the system opened to control pressure. Due to the pressure buildup in the letdown system, approximately 60 gallons of water was discharged from several diaphragm valves into the auxiliary building. VCT level decreased approximately three percent and leak detection alarms on auxiliary building level 1 and level A were received. Approximately two minutes later, the RO isolated BTRS from service to correct the high pressure condition in the letdown system. Letdown pressure and VCT level then stabilized. The letdown system transient resulted from valve 2-HV-7022, BTRS heat exchanger outlet isolation valve, failing closed following the fuses opening in the valve's power supply.

In response, the inspectors reviewed letdown flowpath system drawings, electrical elementary diagrams, MWO 29502382 accomplished to replace the solenoid on valve 2-HV-7022 immediately prior to the transient, interviewed the mechanics that performed the maintenance, and reviewed the method used to select and issue parts for maintenance. The inspectors also reviewed a selected list of completed MWOs for safety and non-safety system installations to verify that AC/DC solenoids were installed per design.

Immediately prior to the transient on September 28, maintenance personnel replaced the solenoid valve on the air supply to BTRS valve 2-HV-7022. When BTRS was returned to service the heat exchanger outlet isolation valve failed as a result of the solenoid electrically failing and then opening a supply fuse. A review of MWO 29502382 and the material equipment request revealed that the solenoid issued was a 120 VAC electrical rated component whereas the solenoid power supply is 125 VDC. This misapplication resulted in the solenoid failing approximately one hour after being placed in service. A review of the vendor drawing of valve 2-HV-7022 revealed that two solenoids are specified for use in this style valve, one AC and one DC. Based on discussions with work planning personnel the inspectors concluded that the work planner did not thoroughly review the vendor drawing thus contributing to the planner specifying the incorrect solenoid. Furthermore, the mechanic involved in the maintenance indicated to the inspectors that he did not review the electrical elementary diagram supply power prior to the solenoid installation.

The inspectors concluded that the wrong solenoid was specified, issued, and installed due to personnel error. The inspectors identified that the misapplied solenoid was on a non-safety related system. However, the inspectors concluded that this failure represented a weakness.

The inspectors identified that the operator actions in response to the letdown pressure transient were timely and effective. The operators' actions are identified as a strength.

g. Unit 1 Feed Flow Transient

At 5:56 p.m. on September 24, 1995, Unit 1 experienced feed flow oscillations as a result of a degraded MFP A Hagan controller. The control room operators took manual control of the MFP and feed flow was returned to normal by 6:06 p.m.. Following replacement of a failed card in the controller, the MFP was returned to automatic at 11:00 p.m. that evening.

At 4:49 p.m. on September 25, 1995, the licensee made a 24-hour notification to the NRC in accordance with the requirements of License Condition 2.H. This notification was based on the licensee's conclusion that reactor power exceeded 102% for a few seconds during the transient. The licensee reported a peak power of 102.08% based on information obtained from the secondary heat balance.

In response to the event, the inspectors reviewed trend plots of key plant parameters for the transient. The inspectors also interviewed one of the reactor operators on-shift during the transient. Additionally, the inspectors reviewed TS and the operating license.

Based on this review, the inspectors concurred with the licensee's assessment of the magnitude and duration of the transient. The inspectors also noted that no discernible increase in indicated nuclear instrument power occurred coincident with the transient. The inspectors noted that no safety limits were violated. Overall, the inspectors concluded that the operators did an effective job in mitigating the transient. This is identified as a strength.

Two non-cited violations were identified.

3. Surveillance Observation (61726)

General

Surveillance tests were reviewed by the inspectors to verify procedural and performance adequacy. The completed tests were examined for necessary test prerequisites, instructions, acceptance criteria, technical content, data collection, independent verification where required, handling of deficiencies, and review of completed work. The tests witnessed, in whole or in part, were inspected to determine that approved procedures were available, equipment was calibrated, prerequisites were met, tests were conducted according to procedure, test results were acceptable, and system restoration was completed.

The inspectors witnessed or reviewed the following surveillance activities:

| SURVEILLANCE NO. | TITLE |
|---|---|
| 14400-2 | Control Room Emergency Filtration Actuation Logic Test |
| 14415-C | Fuel Handling Building Ventilation Actuation Logic Surveillance Test |
| 14663-1 | SSPS Slave Relay K743, 744, & 745 Train B Test, Feedwater Isolation |
| 14664-1 | SSPS Slave Relays K649 Train A Test Safety Injection |
| 14803-1 | CCW Pumps and Discharge Check Valves ISI Test |
| 14825-2 | Quarterly Inservice Valve Test, Steam Generator 2 Feedwater Bypass Valve 2-LV-5244, Train A & B |
| 14980-1 | Diesel Generator Operability Test |
| 18004-C | Reactor Coolant System Leakage |
| 24710-1 | Nuclear Instrumentation System Power Range Channel 1N43 Calibration |
| 24812-1 | Delta T/T Average Loop 3 Protection Channel III 1T-431 Analog Channel Operational Test |
| 92025-C | Fire Protection Surveillance Program |

The inspectors did not identify any problems or concerns during the observation of these surveillance activities.

No violations or deviations were identified.

4. Maintenance Observation (62703)

General

Maintenance activities were observed or reviewed during the reporting period to verify that work was conducted in accordance with approved procedures, TSs, and applicable industry codes and standards. Activities, procedures, and work orders were examined to verify proper authorization to begin work, fire hazard provisions, cleanliness, and exposure controls, proper return of equipment to service, and adherence to limiting conditions for operation were met.

The inspectors witnessed or reviewed the following maintenance activities:

| MWO NOS. | WORK DESCRIPTION |
|---|---|
| 19502611 | Investigate Repair Lead Lag Card in Slot (0241-ITY8432A) Out of Calibration High |
| 19502614 | RCP Seal Return Filter Differential Pressure Transmitter Calibration, 1-1208-F4-002 |
| 19502647 | DG 1B Moisture Check in Starting Air Pressure Gauge (Right and Left Banks) |
| 19502665 | Perform Adjustment to Power Range High Level Trip Bistables During Power Assertion |
| 19502695 | NSCW System Pump Number 3 Discharge Isolation Valve, 1-HV-11606, Troubleshoot |
| 19502706 | CCW Pump Number 4 Motor Cooler; Remove Orifice and Backflush Piping |
| 19502761 | DG 1B Dew Point Check Air Start Receiver Tanks, Trains A & B |
| 29501973 | Replace the Train B SSPS Memory Resent Push Button on Unit 2 and Functional Test |
| 29502378 | DG 2A Moisture Check in Starting Air Pressure Gauge (Right and Left Banks) |
| 29502452 | Calibrated OP$\Delta$T Setpoints and Performed ACOTS for Loops 411, 421, 431 and 441 |
| 29502438 | DG 2A Dew Point Check Air Start Receiver Tanks, Trains A & B |

The inspectors did not identify any problems or concerns during the observation of these maintenance activities.

No violations or deviations were identified.

5. Onsite Engineering (37551)

a. General

During the inspection period, the inspectors assessed the effectiveness of onsite engineering processes by reviewing engineering evaluations, root cause determinations, modifications, and engineering testing. The inspectors also reviewed DCs to determine whether the licensee was appropriately documenting problems and implementing corrective actions.

b. Unit 1 Train B ESF Chiller Inoperable

At 12:13 a.m. on October 2, 1995, the Unit 1 Train B ESF Chiller supply breaker tripped while starting the chiller during the performance of surveillance 14400-1, Control Room Emergency Filtration Actuation Logic Test. The chiller was declared inoperable and since the Train A Chiller was in stop as required by the surveillance procedure, the Unit entered TS 3.0.3. The Train A ESF Chiller was subsequently started and TS 3.0.3 was exited approximately 3 minutes later. With only one chiller operable, the unit was in TSs 3.7.6 and 3.7.11. Troubleshooting commenced and at 8:50 p.m. on October 3, 1995 following revisions to the overcurrent relay setpoints, the Train B ESF Chiller was returned to service and TSs 3.7.6 and 3.7.11 were exited.

Another, voluntary entry into TS 3.0.3 was made by the licensee at 5:42 p.m. on October 2, 1995 while placing the Unit 1 Train A ESF Chiller in standby. This evolution required that the chiller unit be placed in stop as part of the sequence for placing the machine in a standby lineup. The TS was exited approximately 8 minutes later.

The inspectors reviewed the log entries and deficiency cards generated in response to the event. The inspectors also witnessed a portion of the licensee's troubleshooting efforts as well as part of the post-troubleshooting operation of the chiller. Additionally, the inspectors reviewed a design change undertaken to increase the setting of the overcurrent relays for the chiller motors.

The ESF Chiller motor supply breaker tripped as a result of the actuation of the phase C overcurrent relay on the supply breaker. The licensee identified no electrical malfunctions or faults during the troubleshooting. The overcurrent relay setpoints were within specified tolerance. The licensee did detect that the starting currents for the machine, though consistent with another machine, were higher than the nameplate rating. Based on this, the licensee revised the overcurrent relay setpoints on the machine from 600 amps to 800 amps. The licensee also intends to revise the same setpoints for the other machines. The overcurrent relay and a current transformer were also replaced.

Overall, the inspectors concluded that the licensee's actions were adequate. The TS entries, including the voluntary entry in TS 3.0.3 were appropriate. The inspectors also noted from a review of approximately a year and a half of past surveillance results, that the ESF chillers have not exhibited similar failures, hence the actuation of the overcurrent relay was most probably the result of an unexpected nuisance trip. The inspectors have no further questions on this issue.

After the end of the inspection report period, the licensee is evaluating the need to enter TS 3.0.3 in this situation. The inspectors will monitor the outcome of this evaluation.

c. The following items were reviewed using licensee reports, inspections, record reviews, and discussions with licensee personnel, as appropriate:

OPΔT Non-Conservative Set Point

On October 6, 1995 at approximately 5:15 p.m., Unit 1 received a Loop 1 OPΔT alarm in the Control Room on the Main Control Board. Instrument and Control technicians determined that the OPΔT set point generator card TY412H had failed. The card was replaced and calibrated.

To assist in troubleshooting efforts, the licensee decided to develop two "troubleshooting guides" that would detail nominal voltage readings expected at circuit board test points throughout the OPΔT loops. The first troubleshooting guide assumed that the plant was at 100% power and the other would mimic conditions set up by ACOT performance procedures.

While developing the field troubleshooting guide, the licensee identified less conservative values for the OPΔT Reactor Protection System nominal trip setpoints specified in TS Table 2.2.1. However, the setpoints determined during development of the troubleshooting guidance were more conservative than the allowable value in the TS table. The licensee entered TS 2.2.1.a. on October 10, 1995 at 5:10 p.m. to evaluate the OPΔT trip set points.

The licensee's preliminary evaluation revealed that the algorithm used in the software program did not properly calculate the OPΔT setpoint under all conditions. Specifically, the algorithm failed to properly adjust the setpoint for changes in average coolant temperature.

The licensee initiated immediate corrective actions to clear the LCO condition on October 12, 1995 at 4:08 p.m.. This included the revision of the software program. Other work included field work performed to record as found data for all OPΔT loops for both units to determine any operability issues and to perform ACOT recalibration activities to restore the OPΔT Reactor Protection System Function to within the nominal and allowable values.

The inspectors reviewed the licensee's calculation of OPΔT set points and ACOT procedures and agreed with the licensee's trip setpoint calculations. The inspectors also observed a portion of the collection of as found data, the recalibration activities for Units 1 and 2, and restoration of the OPΔT Reactor Protection System function to nominal values. No as found values exceeded the allowable values for OPΔT specified in TS Table 2.2-1.

The licensee had not completed their formal review of this issue prior to the end of the inspection period. This is identified as

Unresolved Item, URI 50-524,425/95-24-04, OPΔT Non-Conservative Setpoints, pending NRC review of this effort and any other corrective actions.

No violations or deviations were identified.

6. Plant Support (71750)

a. General

Plant support activities were observed and reviewed to ensure that licensee programs were implemented in conformance with facility policies and procedures and in compliance with regulatory requirements. Activities reviewed included radiological controls, physical security, emergency preparedness, and fire protection.

b. Designated Vehicle Unsecured Inside the Protected Area

On September 21, 1995, at approximately 2:45 p.m., the licensee security patrol identified maintenance designated vehicle number 12 in the protected area near the Unit 2 NSCW B Train Tower unattended with the keys in the ignition. Upon discovery, security immediately removed the vehicle from the protected area.

The inspectors reviewed the Physical Security Plan, applicable security procedures, vehicle records, and interviewed security management and the individuals involved in the unattended vehicle.

Based on this, the inspectors determined that at the time of the incident, the responsible individuals were in the process of unloading welding materials to be used on a modification being performed on the Unit 2 B Train NSCW Tower. Both individuals advised the inspectors that they were deeply involved in this effort and as a result neglected to remove the keys when they left the vehicle.

Most PA vehicles have a key alarm installed that will alarm when the door is opened with the key in the ignition. However, the inspectors were advised that the alarm in this vehicle did not always operate. The inspectors noted that this event was similar to two prior occurrences documented in recent inspection reports (NCV 50-424,425/94-22-02, VIO 50-424,425/95-06-02).

The Plant Physical Security Plan requires that designated vehicles be secured inside the PA. Furthermore, VEGP Procedure 00653-C, Protected Area Entry/Exit Control specifies that vehicle keys be in the possession of an authorized individual when the vehicle is left unattended. Employees are briefed during General Employee Training on the requirements for ensuring these requirements are met.

The failure to remove the keys and properly secure the unattended

vehicle is identified as VIO 50-424,425/95-24-03, Failure to Follow Protected Area Entry/Exit Procedure with Regard to PA Designated Vehicles.

One violation was identified.

7. Exit Meeting

The inspection scope and findings were summarized on October 23, with those persons indicated in paragraph 1. The inspector described the areas inspected and discussed in detail the inspection findings. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the material provided to or reviewed by the inspectors during the inspection.

| Item No. | Status | Description and Reference |
|---|---|---|
| NCV 50-424/ 95-24-01 | Closed | Failure To Be Cognizant Of Seal Return Filter System Status (paragraph 2d) |
| NCV 50-425/ 95-24-02 | Closed | Mispositioned AFW System Valve (paragraph 2e) |
| VIO 50-424,425/ 95-24-03 | Open | Failure to Follow Protected Area Entry/Exit Procedure with Regard to PA Designated Vehicles (paragraph 6b) |
| URI 50-524,425/ 95-24-04 | Open | OP$\Delta$T Non-Conservative Setpoints (paragraph 5c) |

8. Abbreviations

| | |
|---|---|
| AC | - Alternating Current |
| ACOT | - Analog Channel Operational Test |
| AFW | - Auxiliary Feedwater System |
| BTRS | - Boron Thermal Regeneration System |
| CCW | - Component Cooling Water |
| CFR | - Code of Federal Regulations |
| CVCS | - Chemical and Volume Control System |
| DC | - Deficiency Card |
| DC | - Direct Current |
| DCP | - Design Change Package |
| DG | - Diesel Generator |
| ESF | - Engineered Safety Feature |
| ISEG | - Independent Safety Engineering Group |
| LCO | - Limiting Condition for Operation |
| MDAFW | - Motor Driven Auxiliary Feedwater |
| MFP | - Main Feedwater Pump |
| MSIV | - Main Steam Isolation Valve |
| MWO | - Maintenance Work Order |
| NCV | - Non-Cited Violation |
| NPF | - Nuclear Power Facility |
| NRC | - Nuclear Regulatory Commission |
| NSAC | - Nuclear Safety and Compliance |
| NSCW | - Nuclear Service Cooling Water System |
| NUREG | - Nuclear Regulations |
| OP$\Delta$T | - Over Power Differential Temperature |
| PA | - Protected Area |
| PDR | - Public Document Room |
| PEO | - Plant Equipment Operator |
| psig | - Pounds Per Square Inch Gauge |
| PZR | - Pressurizer |
| RCP | - Reactor Coolant Pump |
| RCS | - Reactor Coolant System |
| RER | - Request for Engineering Review |
| RO | - Reactor Operator |
| RWO | - Radwaste Operator |
| SAER | - Safety Audit And Engineering Review |
| SG | - Steam Generator |
| SSPS | - Solid State Protection System |
| TS | - Technical Specifications |
| URI | - Unresolved Item |
| USS | - Unit Shift Supervisor |
| VAC | - Volts Alternating Current |
| VCT | - Volume Control Tank |
| VDC | - Volts Direct Current |
| VEGP | - Vogtle Electric Generating Plant |
| VIO | - Violation |
| 2R4 | - Unit 2 Fourth Refueling Outage |