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

Report No.: 50-424/88-44

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

Docket No.: 50-424 License No.: NPF-68

Facility Name: Vogtle 1

Inspection Conducted: October 1 - October 28, 1988

Inspectors: C.A. Patterson 11/25/88
for J. F. Rogge, Senior Resident Inspector Date Signed

C.A. Patterson 11/28/88
for R. J. Schepens, Senior Resident Inspector Date Signed

C.A. Patterson 11/28/88
for C. W. Burger, Resident Inspector Date Signed

Accompany Personnel: R. F. Aiello, Resident Inspector

Approved By: M.V. Sinkule 11/28/88
M. V. Sinkule, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine, unannounced inspection entailed resident inspection in the following areas: plant operations, radiological controls, maintenance, surveillance, fire protection, security, outage, and quality programs and administrative controls affecting quality.

Results: Two violations were identified. One violation was in operations. (Failure to Implement Log Taking Procedures for the Diesel Generator). One violation which was not cited was in maintenance. (Failure to Establish Appropriate Training to Preclude the Misuse of Tools).

One strength was noted in the outage area regarding the coordination and planning of outage activities.

DETAILS

1. Persons Contacted

Licensee Employees

*G. Bockhold, Jr., General Manager Nuclear Operations
*R. M. Bellamy, Plant Manager
*T. V. Greene, Plant Support Manager
*J. E. Swartzwelder, Nuclear Safety & Compliance Manager
*W. F. Kitchens, Manager Operations
*W. N. Marsh, Deputy Operations Manager
*M. A. Griffis, Maintenance Superintendent
*C. C. Echert, Manager Chemistry and Health Physics
*A. L. Mosbaugh, Assistant Plant Support Manager
H. M. Handfinger, Assistant Plant Support Manager
F. R. Timmons, Nuclear Security Manager
R. E. Lide, Engineering Support Supervisor
*G. A. McCarley, ISEG Supervisor
*G. R. Frederick, Quality Assurance Site Manager - Operations
W. E. Mundy, Quality Assurance Audit Supervisor
R. M. Odom, Plant Engineering Supervisor
*J. B. Beasley, Outage and Planning Manager

Other licensee employees contacted included craftsmen, technicians, supervision, engineers, operations, maintenance, chemistry, quality control inspectors, and office personnel.

*Attended Exit Interview

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

2. Licensee Action on Previous Enforcement Matters - (92702)

(Closed) Violation 50-424/87-44-01 "Failure To Properly Implement A Temporary Modification To The Train "A" Electrical Tunnel Ventilation System." The licensee response dated September 28, 1987, was reviewed. The inspector reviewed the corrective actions which changed the manner in which the supply fans would be operated. The review package indicated that the setpoint for autostarting of the fan was changed from 17°F to 90°F.

3. Operational Safety Verification - (71707)(93702)

The plant began this inspection period in Power Operation (Mode 1) maintaining a near constant boron concentration and reducing power to maintain criticality. On October 7, the unit commenced a planned shutdown to begin the first refueling outage from 80% power. On October 8, the reactor was manually tripped, placing the plant in Hot Standby (Mode 3). Plant cooldown was conducted and cold shutdown (Mode 5) was achieved on October 9. The primary was placed in mid-loop operation to support

reactor coolant pump seal work and installation of loop dams into #1 and 4 steam generators. Refueling (Mode 6) was entered on October 14. On October 17, the reactor vessel head was removed. Fuel offload commenced on October 18 and was completed on October 23. On October 20, one assembly had canted over approximately ten inches and was recovered. On October 23, the unit was defueled. On October 24, the primary system was drained to mid-loop for accumulator check valve work and removal of steam generator nozzle dams while the reactor was defueled. On October 27, the primary water level was raised for refueling. Refueling commenced on October 27 and was in progress at the end of this period.

Two ESFAS occurred during this inspection period. On October 16, a SI occurred during the performance of an engineering procedure. On October 4, a containment ventilation isolation (CVI) occurred as a result of an improper procedure.

a. Control Room Activities

Control Room tours and observations were performed to verify that facility operations were being safely conducted within regulatory requirements. These inspections consisted of one or more of the following attributes as appropriate at the time of the inspection.

- Proper Control Room staffing
- Control Room access and operator behavior
- Adherence to approved procedures for activities in progress
- Adherence to TS LCO
- Observance of instruments and recorder traces of safety related and important to safety systems for abnormalities
- Review of annunciators alarmed and action in progress to correct
- Control Board walkdowns
- Safety parameter display and the plant safety monitoring system operability status
- Discussions and interviews with the On-Shift Operations Supervisor, Shift Supervisor, Reactor Operators, and the Shift Technical Advisor (when stationed) to determine the plant status, plans, and to assess operator knowledge
- Review of the operator logs, unit log and shift turnover sheets

No violations or deviations were identified.

b. Facility Activities

Facility tours and observations were performed to assess the effectiveness of the administrative controls established by direct observation of plant activities, interviews and discussions with

licensee personnel, independent verification of safety systems status and LCOs, licensee meetings and facility records. During these inspections the following objectives are achieved:

(1). Safety System Status - Confirmation of system operability was obtained by verification that flowpath valve alignment, control and power supply alignments, component conditions, and support systems for the accessible portions of the ESF trains were proper. The inaccessible portions are confirmed as availability permits.

(2). Plant Housekeeping Conditions - Storage of material and components and cleanliness conditions of various areas throughout the facility were observed to determine whether safety and/or fire hazards existed.

(3). Fire Protection - Fire protection activities, staffing and equipment were observed to verify that fire brigade staffing was appropriate and that fire alarms, extinguishing equipment, actuating controls, fire fighting equipment, emergency equipment, and fire barriers were operable.

(4). Radiation Protection - Radiation protection activities, staffing and equipment were observed to verify proper program implementation. The inspection included review of the plant program effectiveness. Radiation work permits and personnel compliance were reviewed during the daily plant tours. Radiation Control Areas were observed to verify proper identification and implementation.

(5). Security - Security controls were observed to verify that security barriers were intact, guard forces were on duty, and access to the Protected Area was controlled in accordance with the facility security plan. Personnel were observed to verify proper display of badges and that personnel requiring escort were properly escorted. Personnel within Vital Areas were observed to ensure proper authorization for the area. Equipment operability or proper compensatory activities were verified on a periodic basis.

(6). Surveillance (61726)(61700) - 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 inspectors observed portions of the following surveillances and reviewed completed data against acceptance criteria:

Surveillance No./ Rev. No.	Title
12007 Rev. 8	Refueling Entry Mode 5 To 6 (Decay Time Determination)
14230 Rev. 4	Verification Of Offsite To On-Site Class 1E AC Distribution System
14406 Rev. 2	Boron Injection Flow Path Verification
14423 Rev. 4	Source Range Analog Channel Operability Test
14552 Rev. 3	Monthly Nuclear Service Cooling Water System Flow Path Verification
14710 Rev. 2	Remote Shutdown Panel Transfer Switch And Control Center. (18 Month Surveillance)
14980 Rev. 13	Diesel Generator (DG) Operability Test
24663 Rev. 1	18 Month Effluent System Flow Rate Device (AF 0014) Channel Calibration
34218 Rev. 7	18 Month Main Stream Line Radiation Monitor RE 13119 Channel Calibration
54055 Rev. 4	Loss Of Offsite Power In Conjunction With An ESF Actuation Test Signal

While observing portions of surveillance 14980, Diesel Generator Operability Test, the inspector noted that MWO 18806933 was written (at approximately 0:45am on 10/03/88) to clean/replace the duplex fuel filters on DG 1A. At 08:10am, approximately 7.5 hours later, the MWO was implemented which subsequently reduced fuel filter D/P below the alarm setpoint. This prompted the

inspector to conduct an audit of previous DG logs (Operations Procedure 11855-C). The results of the audit were as follows:

TIME	DATE	EDG	COMMENT
11:45am	12/22/86	A	No fuel filter or oil filter D/P data was recorded
11:30am	0.\/28/87	B	No fuel filter or oil filter D/P data was recorded
9:30pm	09/.\0/87	A	Fuel filter D/P Out Of Specification hi, no documentation/annotation
0:46am	02/06/88	A	Fuel filter D/P Out Of Specification hi, no documentation/annotation
3:30am	02/25/88	A	Fuel filter D/P Out Of Specification hi, no explanation provided
9:45am	03/07/88	A	Fuel filter D/P Out Of Specification hi, no explanation provided
1:49am	09/22/88	B	The fuel filter differential pressure slowly increased until Out Of Specification readings started occurring at time 4:05am.
3:15am	"		
4:05am	"		The operator waited until the readings were Out Of Specification to take action. Further, the operator waited until 4:59a (next set of
4:59am	"		of logs) b re swapping out the filters.
0:45am	10/03/88	A	Fuel filter D/P Out Of Specification hi. MWO initiated for filter maint.

TIME cont	DATE	EDG	COMMENT
1:45am	10/03/88		No logs taken for this hour
2:45am	"		Fuel filter still Out Of Specification hi
3:45am	"		" " " " " " "
4:45am	"		" " " " " " "
5:45am	"		" " " " " " "
6:45am	"		No logs taken for this hour
7:25am	"		Fuel filter still Out Of Specification hi
8:10am	"		D/P back in specification

The above items were identified to be not in accordance with either Technical Specification 6.7.1a, Operations Procedure 10001-C section 3.0, or Operations Procedure 11885-C. The procedure violation did not result in a TS LCO violation, however, it was representative of a failure to implement a procedure required by TS 6.7.1a to take operating logs, to document or annotate out of specification conditions, to notify the Unit Shift Supervisor of abnormal log readings, and to implement corrective maintenance when required.

The item is identified as Violation 50-424/88-44-01, "Failure to Implement Operations Procedures 10001-C and 11885-C Required by TS 6.7.1a To Monitor DG Performance."

(7) Maintenance Activities (62703) - The inspector observed maintenance activities to verify that correct equipment clearances were in effect; work requests and fire prevention work permits, as required, were issued and being followed; quality control personnel were available for inspection activities as required; retesting and return of systems to service was prompt and correct; TS requirements were being followed. Maintenance Work Order backlog was reviewed. Maintenance was observed and MWO packages were reviewed for the following maintenance activities:

MWO No.	Work Description
A8802125	Investigate, Replace, Rework ARV-0014 (Waste Gas Monitor) Due To Erratic Indication
18710345	Steam Generator Feedwater Differential Temperature Calibration

MWO No. cont.	Work Description
18802881	Perform Operational Test On Smoke Detectors Behind Control Room Operating Panels
18806933	Replace DG 1A Duplex Fuel Filters
18807286	Simulate Opening The RTB 33b Contact In An Effort To Reset The P-4 Interlock By Lifting Wire RTA-23 At Terminal Strip TB 5-1 At The "A" Train Reactor Trip Switchgear
18807377	Investigate/Correct Radiation Monitor Channel 12444C (Containment Air Radiation Monitor)

While observing MWO 18807286, the inspector noted that the licensee (engineering) failed to initially recognize that wire 1B5 would be lifted along with wire RTA-23 due to the nature of its construction. This procedure (MWO) was developed to simulate opening the reactor trip breaker 33b contact in order to reset the P-4 interlock to allow completion of train "A" DG and ESFAS test. As a result, the on-shift operations supervisor elected to discontinue this procedure. Instead, the licensee racked in the reactor trip breakers which achieved the same result as lifting the RTA-23 lead. Further investigation showed that lifting 1B5 would have only removed voltage indication from the reactor trip switchgear panel.

(8). Refueling Activities (60705) (60710) - New Fuel receipt, core alterations and fuel shuffle evolutions were observed to verify program effectiveness, approved procedures were being used and personnel were qualified. The inspector observed portions of the following evolutions:

93300-C, Rev. 3 Conduct of Refueling Operations
93330-C, Rev. 2 Development and Implementation of the Fuel Shuffle Sequence Plan
93010-C, Rev. 4 Unloading, Inspection and Storage of New Fuel
93020-C, Rev. 3 Technical Inspection of New Fuel

While observing fuel offload and transfer to the spent fuel pool, the inspector observed that the refueling machine computer failed when fuel assembly 5C42 was lifted approximately 6" from the lower core support plate. The fuel assembly was lowered back into position P-5. A procedure was subsequently written to troubleshoot and repair the refueling machine. This procedure required the refueling machine to be ungrappled and lifted off

of assembly 5C42. When the refueling machine was lifted up, assembly 5C42 canted over to approximately the R-6 and R-7 core location and rested up against the core baffle plate for a top end displacement of ten inches. A temporary procedure was written to upright and remove assembly 5C42 from the reactor. Engineering and vendor evaluations were performed to verify there was no damage to the core baffle plate, adjacent fuel assembly, and fuel assembly 5C42. Particular attention was given to assembly 5C42 due to the fact that it is to be reloaded back into the reactor. Management attention in resolving this issue was considered noteworthy. The inspectors were confident and noted that the recovery proceeded in a safe and controlled manner. The licensee was however, not able to inform the inspectors of their evaluation for reportability.

The licensee's preparation and execution of placing the unit into mid-loop operation was accomplished in a safe and pre-planned manner. Prior to the evaluation, the licensee responded to two comments regarding the tygon tube level instrument. When level discrepancies occurred during the evolution, the licensee was conservative in stopping the evolution until agreement was achieved. During a separate evolution with the vessel defueled however, operators were not prompt in resolving level discrepancies which resulted in primary water rising and discharging thru the steam generator manway. During this event, about 200 gallons was discharged to the containment floor before proper levels were established.

The licensee demonstrated the ability to make proper safety decisions regarding the failure of the primary system snubbers. The licensee suspended testing after two on the twenty installed snubbers failed. Following consultation with Paul Monroe and Westinghouse, the licensee proceeded to change the oil in all twenty snubbers to remove particulates. Retest of eight repaired snubbers have been satisfactory.

The inservice testing of the steam generators proceeded in a efficient manner. The plugging of only one tube was indicative of good chemistry practices.

The overall scheduling and coordination was noted as being a strength of the outage. Meetings were conducted on a frequent basis with appropriate levels of management in attendance.

4. Review of Licensee Reports (90712)(90713)(92700)

a. In-Office Review of Periodic and Special Reports

This inspection consisted of reviewing the below listed reports to determine whether the information reported by the licensee was technically adequate and consistent with the inspector knowledge of the material contained within the report. Selected material within the report was questioned randomly to verify accuracy and to provide a reasonable assurance that other NRC personnel have an appropriate document for their activities.

Monthly Operating Report - The reports dated September 15 and October 11, 1988, were reviewed. The inspector had no comments.

(Open) Special Report 88-02, Rev. 2 - The inspector reviewed the information in this report. This report will receive further regional based inspection.

(Open) 50-424/P21-88-03 "TDI Diesel Left Intercooler Inlet Adapter Defect." On October 5, 1988, the NRC received notification from Imo Delaval Inc., that a defect in the left inlet adapter weld resulted in jacket water cooling tubes leaking at Grand Gulf station. During inspection of the Unit 1 diesels no defects were identified. The right intercooler inlet adapter, however, on the "B" diesel was noted to have cracking on the stiffener of the inlet flange to the adapter and to the stiffener inside the adapter. The licensee initiated DC 1-88-3105 on this condition and is in the process of evaluating the condition for 10 CFR 21 reportability. The welds were repaired. The inspector examined external the repaired area with the foreman responsible for the work and determined that this was not the defect of this part 21 report. The licensee has plans for reexamination of the "A" diesel prior to startup and will forward the information to TDI. The inspector noted that no intake manifold drain was installed on the Vogtle diesels. Further inspection followup will result if this new defect is determined reportable.

b. Licensee Event Reports and Deficiency Cards

LER and (DC) were reviewed for potential generic impact, to detect trends, and to determine whether corrective actions appeared appropriate. Events which were reported pursuant to 10 CFR 50.72, were reviewed as they occurred to determine if the technical specifications and other regulatory requirements were satisfied. In-office review of LERs may result in further followup to verify that the stated corrective actions have been completed, or to

identify violations in addition to those described in the LER. Each LER is reviewed for enforcement action in accordance with 10 CFR Part 2, Appendix C. Review of DCs was performed to maintain a realtime status of deficiencies, determine regulatory compliance, follow the licensee corrective actions, and assist as a basis for closure of the LER when reviewed. Due to the numerous DCs processed only those DCs which result in enforcement action or further inspector followup with the licensee at the end of the inspection are listed below. The LERs and DCs denoted with an asterisk indicates that reactive inspection occurred at the time of the event prior to receipt of the written report.

(1) Deficiency Card reviews:

*DC 1-88-2765 "Inadvertent FSFAS Actuation." On October 4, a technician placed the Containment Low Range Radiation Monitor in bypass and powered down Digital Process Monitor (DPM) 1RX-003 for the purpose of implementing design change package (DCP) 88V1N007. This involves the changeout of an electronic part in the plant radiation and effluent monitors to increase their

reliability. Operators in the control room, aware of the work in progress, verified that the 1RE-003 bypass light was lit as expected when they received annunciator ALB05 B04 "Bypass CVI Hi Rad Test." Approximately 15 seconds later, when the technician powered down the DPM, a CVI occurred. Upon resetting the CVI, operators noted that procedure 11886-1, "Recovery from ESF Activations" was difficult to use in that operators had to hunt for steps that applied just to CVI actuations. The electronic part changeout was done under MWO 1880621. Previously, the changeout had been successfully completed on the redundant monitor 1RE-002. During the changeout, the technician realized that leads to the Solid State Protection System must be lifted prior to powering down the monitor to include the requirement to lift the leads in the MWO work instructions. He did not state that the leads had to be lifted prior to powering down the monitor, however. A different technician performed the work for 1RE-003. The technician assumed that this monitor was the same as 1RE-2565, with which he was familiar, due to the fact that the leads also must be lifted on 1RE-2565 to prevent a CVI actuation. In actuality 1RE-2565 can be powered down without lifting any leads as long as they are lifted before the monitor is powered back up. In the case of 1RE-003, the leads must be lifted before powering down.

DC 1-88-2882 "Contaminated Neutron Embrittlement Specimens Cask In Excess Of Department Of Transportation Limits." On October 11, the licensee received a shipment of radioactive material which included an empty neutron embrittlement specimen

cask from Westinghouse Research and Development Center in Pittsburgh, PA. Surveys performed upon receipt of the cast identified removal contamination levels in excess of the department of transportation's limit of 2,200 DPM/100 CM2. Contamination levels ranged up to 22,000 DPM/100 CM2. The principal isotopes identified were Co-60, Co-50, Mn-54, Cs-137 and Cs-134. The cask was carried by Forest Hills Transfer and Storage, Inc. in a nonexclusive use vehicle. Vogtle was the first stop for this carrier after the cask was loaded on the trailer. No contamination was found in the tractor or on the driver. Westinghouse and the carrier were notified by the licensee. The 3,000 DPM/CM2 were found. This issue was turned over to Region II inspectors for further followup.

*DC 1-88-2985 "Unplanned Safety Injection Signal." On October 16, 1988, the licensee received an unplanned safety injection signal while performing step 5.4.12 of engineering procedure 54055 (Train "A" Diesel Generator and ESFAS test). The actuation was originally attributed only to a faulty procedure execution. However, further investigation showed that regardless of the personnel error the unplanned ESF actuation would have occurred as a result of spurious grounds generated during the alignment steps 5.4.12a & 5.4.12b. To prevent this from reoccurring, the licensee revised their procedures to allow placing the SSPS mode selector switch in the operate position subsequent to performing step 5.4.12 thus precluding an undesirable SI from actuating any equipment. Prior to resuming the test, SI had to be reset. This involved either racking in the RTBs or simulating racking in the RTBs (see MWO 18807286 for details). Further test procedure revising deleted step 5.4.12 as a means for generating the required SI signal and an alternate method was used as authorized by engineer procedure 54055 paragraph 4.0, subparagraph 1.0 to complete the test satisfactorily.

DC 1-88-2903"Internal Whole Body Contamination." On October 11, 1988, an individual working in the fuel handling building transfer canal, was found to be contaminated when he exited the Auxiliary Building Control Point IPM-7. A whole body count was performed, as a result, a 5% body burden was detected after the individual took a second shower. Subsequent analysis appears to show internal contamination. The cause of the contamination was due to poor radiological work practices and working beyond the scope of the radiation work permit. The issue has been turned over to the Region II Health Physics Department for further investigation.

DC 1-88-2938 "Inadvertent Diesel Generator Trip." On October 14, diesel generator 1A tripped during the performance of a functional test for DCP 88-VIN 0049. The DG was operating at

1500kw when the operator noticed the MVAR meter had gone offscale high. The operator unloaded the DG and subsequently opened the output breaker. The DG continued to idle when, suddenly, it tripped with no apparent cause. The disposition of this DC is pending the completions of the engineering investigation for the cause of the trip. Meanwhile, the functional test was reperformed satisfactorily.

(2) The following LERs were reviewed and are ready for closure pending verification that the licensee's stated corrective actions have been completed.

(a) 50-424/88-26, Rev 0 "Use Of Improper Tool Leads To Containment Ventilation Isolation." On September 7, an electrician was in the process of reinstalling shorting bars into fuse holders following the completion of an electrical switch replacement. The electrician unintentionally created a short between two 120 volt AC circuits. Various alarms and indicators actuated, including those for a CVI. The appropriate CVI valves and dampers actuated. Control room personnel verified that no abnormal radiation condition existed by observing redundant monitors. The control room personnel and the electrician immediately confirmed that the electrical short had initiated the CVI. The cause of this event is the use of an improper tool by the electrician. Fuse pullers provided to the electrician would not fit between the inserted shorting bars, so he used needle-nose pliers to perform the insertions. These pliers made the electrical short by simultaneously contacting two shorting bars. Appropriate personnel will be advised to avoid the use of needle-nose pliers or makeshift tools for installation of fuses or shorting bars and the proper size fuse pullers will be made available.

This item represents a violation of NRC requirements which meets the criteria for non citation. In order to track this item, the following licensee identified item (LIV) is established.

LIV 50-424/88-44-01 "Failure To Establish Appropriate Training To Preclude The Misuse Of Tools - LER 88-26"

(3) The following LERs were reviewed and closed.

(a). 50-424/87-44, Rev 1 "Control Room HVAC Design Violates Single Failure Criteria." This event was reviewed in NRC report 50-424.87-56 and completion of corrective action remained. Based on discussions with the responsible engineering supervisor, this item is closed.

(b). 50-424/87-52, Rev. 0 "Inadvertent Containment Ventilation Isolation During Source Check Of Radiation Monitor." Previous inspection was performed regarding this LER in NRC Rpt. 50-424-88-02. 50-424/87-60, Rev. 0 "Control Room Isolation Actuation Due To An Inadequate Procedure." Chemistry and Health Physics Procedures were reviewed to verify that the corrective actions had been incorporated. Training lesson plan number CH-LP-41001-03-C, dated November 11, 1987, was reviewed. The inspector reviewed training adequacy with the chemistry manager.

5. Followup on Previous Inspection Items - (92701)

(Closed) Inspector Followup Item 50-424/88-15-01 "Review Maintenance Program For Flood Level Switch And Watertight Doors To Verify Component Operability." The inspector reviewed the licensee package assembled to present the watertight door and level switch test program. Procedure 25038-C, Rev. 1 "General Checkout Of Watertight Door Seals" and Procedure 22328-C, Rev. 1 "Level Switch Functional Test And Calibration" were also reviewed. A survey of equipment utilizing the licensee's maintenance planning computer was utilized to verify maintenance was performed planned for the sampled equipment.

6. Exit Interviews - (30703)

The inspection scope and findings were summarized on October 28, 1988, with those persons indicated in paragraph 1 above. The inspector described the areas inspected and discussed in detail the inspection results. No dissenting comments were received from the licensee. The licensee did not identify as proprietary any of the materials provided to or reviewed by the inspector during this inspection. Region based NRC exit interviews were attended during the inspection period by a resident inspector. This inspection closed one Violation, one Inspector Followup Item, and three Licensee Event Reports. The items identified during this inspection were:

Violation 50-424/88-44-01, "Failure to Implement Operations Procedures 10001-C and 11885-C Required by TS 6.7.1 To Monitor DG Performance" - paragraph 3.b.(6)

LIV 50-424/88-44-01 "Failure To Establish Appropriate Training To Preclude The Misuse Of Tools - LER 88-26" - paragraph 4.b.(2)

7. Acronyms And Initialism

CFR	Code of Federal Regulation
CVI	Containment Ventilation Isolation
DC	Deficiency Cards
DCP	Design Change Package
DG	Diesel Generator
DPM	Digital Process Monitor
ESF	Engineered Safety Features
ESFAS	Engineered Safety Features Actuation System
HVAC	Heating, Ventilation and Air Conditioning
IFI	Inspector Followup Item
LIV	Licensee Identified Violation
LCO	Limiting Conditions for Operations
LER	Licensee Event Reports
MWO	Maintenance Work Order
MVAR	Mega Volt Amp Reactive
NPF	Nuclear Power Facility
NRC	Nuclear Regulatory Commission
RTB	Reactor Trip Breaker
SI	Safety Injection
SSPS	Solid State Protection System
TS	Technical Specification