July 30, 2002

Mr. Ted C. Feigenbaum
Executive Vice President and Chief Nuclear Officer
Seabrook Station
North Atlantic Energy Service Corporation
c/o Mr. James M. Peschel
P.O. Box 300
Seabrook, NH 03874

SUBJECT: SEABROOK STATION - NRC INSPECTION REPORT 50-443/02-04

Dear Mr. Feigenbaum:

On June 29, 2002, the NRC completed an inspection at the Seabrook nuclear power station. The enclosed report documents the inspection findings which were discussed on July 8, 2002, with Mr. G. St. Pierre and other members of your staff.

This inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

Based on the results of this inspection, the inspectors identified one finding of very low safety significance (Green). The finding was determined to be a violation of NRC requirements, involving corrective actions to preclude repetition of a significant condition adverse to quality. However, because of its very low safety significance and because it has been entered into your corrective actions program, the NRC is treating this issue as a Non-Cited violation, in accordance with Section VI.A of the NRC's Enforcement Policy. If you deny the Non-Cited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region I, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-001, and the NRC Resident Inspector at the Seabrook facility.

The NRC has increased security requirements at Seabrook Station in response to terrorist acts on September 11, 2001. Although the NRC is not aware of any specific threat against nuclear facilities, the NRC issued an Order and several threat advisories to commercial power reactors to strengthen licensees' capabilities and readiness to respond to a potential attack. The NRC continues to monitor overall security controls and will issue temporary instructions in the near future to verify by inspection the licensee's compliance with the Order and current security regulations.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at http://www.nrc.gov/reading-rm.html

Sincerely,

/RA/

Brian J. McDermott, Chief
Projects Branch 6
Division of Reactor Projects

Docket No. 50-443
License No: NPF-86

Enclosure: NRC Inspection Report No. 50-443/02-04
Attachments: Supplemental Information

cc w/encl:
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J. M. Peschel, Manager - Regulatory Programs
G. F. St. Pierre, Station Director - Seabrook Station
D. G. Roy, Nuclear Training Manager - Seabrook Station
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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No.:	50-443
License No.:	NPF-86
Report No.:	50-443/2002-04
Licensee:	North Atlantic Energy Service Corporation
Facility:	Seabrook Generating Station, Unit 1
Location:	Post Office Box 300 Seabrook, New Hampshire 03874
Dates:	May 26 - June 29, 2002
Inspectors:	Glenn Dentel, Senior Resident Inspector Javier Brand, Resident Inspector Kenneth Jenison, Senior Project Engineer Paul Frechette, Security Specialist
Approved by:	Brian McDermott, Chief Projects Branch 6 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000443-02-04, on 5/26-6/29/02; North Atlantic Energy Service Corporation; Seabrook Station; Unit 1. Identification and Resolution of Problems.

The inspection was conducted by resident inspectors, a regional senior project engineer, and a regional security specialist. The inspection identified one Green finding which was a Non-Cited violation. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using IMC 0609 "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "no color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at http://www.nrc.gov/NRR/OVERSIGHT/index.html

A. Inspector Identified Findings

Cornerstone: Mitigation Systems

- **GREEN**. On April 17, 2002, following maintenance activities, the licensee experienced an air intrusion event into the "A" emergency diesel generator (EDG) lubrication oil system. The inspectors identified that the licensee had inadequate corrective actions to prevent recurrence of air intrusion in the EDG lubrication oil system. A prior air intrusion event caused the December 2000 failure of the "B' EDG.

  This finding affected the mitigating systems cornerstone because it increased the probability for disrupting oil flow to the "A" EDG main bearings which could have resulted in failure of the EDG, impacting the reliability of the "A" EDG. The finding was determined to be of very low safety significance (Green), since the air intrusion into the lubricating oil system did not result in damage to the "A" EDG. The failure to implement effective corrective actions was a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." (Section 4OA2)

B. Licensee Identified Violations

There were no violations identified by the licensee during this inspection.

Report Details

SUMMARY OF PLANT STATUS: The plant was in the eighth refueling outage at the start of the inspection period. On May 31, the operators placed the turbine online. On June 1, the operators reduced power and the turbine was taken offline to perform addition cleaning of the secondary system following increases in sodium and chlorides in the steam generators. Later on June 1, the unit was placed back online. On June 4, the unit reached 100 percent power. Later on June 4, The operator decrease power to 51 percent to repair a steam leak on a drain line near the non-safety related heater drain tank. On June 6, the plant was returned to 100 percent power and remained near full power for the remainder of the period.

1. REACTOR SAFETY
Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R04 Equipment Alignment

Partial System Walkdown - "A" Emergency Diesel Generator (EDG)

a. Inspection Scope

On June 25, the inspectors performed a partial system walkdown of the "A" EDG prior to and after the "B" EDG was made inoperable for quarterly slave relay surveillance testing. The inspectors performed verification of major equipment alignment in the essential switchgear rooms and in the main control room. The inspectors also examined the material condition of major components in the areas of inspection and discussed specific minor material condition discrepancies with operators, maintenance technicians, and engineers.

b. Findings

No findings of significance were identified.

1R05 Fire Protection

a. Inspection Scope

The inspectors reviewed the fire protection analyses and examined the following risk significant areas:

- Primary Auxiliary Building - PCCW Pump Area - 25' elevation
- West Steam chase - All elevations
- Essential Switchgear Rooms- 21'6" elevation

Specific fire protection conditions examined included control of transient combustibles, material condition of fire protection equipment, and the adequacy of any fire impairments and compensatory measures. In addition, the inspectors reviewed the pre-fire strategies for these areas.

b. Findings

No findings of significance were identified.

1R11 Licensed Operator Requalification

a. Inspection Scope

On June 6, the inspectors observed operator training focusing on human performance of time critical tasks. The inspectors reviewed the operators ability to correctly evaluate the training scenario and implement the emergency plan. The inspectors also evaluated whether deficiencies were identified and discussed during critiques.

b. Findings

No findings of significance were identified.

1R12 Maintenance Rule Implementation

a. Inspection Scope

The inspectors evaluated the implementation of the maintenance rule, 10 CFR 50.65, as it pertained to the 125 volt DC, Containment Spray, Emergency Feedwater, Residual Heat Removal, and Radiation Monitoring systems. Conditions described within the below indicated CRs, were reviewed to determine if systems and components were accurately scoped within the Seabrook Maintenance Rule Program and that failures were appropriately evaluated against applicable maintenance rule functional failure criteria. For the selected systems, the inspectors also evaluated the current system performance reports and those corrective actions described therein. Finally, those plans and actions described to improved system availability and/or reduce maintenance related functional failure rates were also reviewed to ensure adherence to NRC requirements, Seabrook Maintenance Rule processes and the specifics indicated in PEG-45, “Maintenance Rule Program Monitoring Activities,” Revision 0.

The below indicated Condition Reports (CRs), as well as numerous other documents and historically related CRs comprised a portion of the resource material related to the systems of interest.

- CR - 02 - 03528, Equalizing Charge Problem
- CR - 01 - 04871, Failed Equalizing Charge
- CR - 01 - 05045, Battery Charger Selector Switch
- CR - 01 - 01268, Single Cell Charger
- CR - 01 - 03754, Equalizing Charge Alarmed Condition
- CR - 00 - 11852, Thermograph Inspection Found Hot Spot
- CR - 02 - 02407, Refueling Water Storage Tank
- CR - 02 - 03603, Containment Spray System Body to Bonnet Leaks
- CR - 02 - 09300, Containment Spray System Leaks
- CR - 02 - 08592, Emergency Feedwater System (EFS)
- CR - 02 - 02686, EFS system availability
- CR - 02 - 02258, EFS Motor Driven Pump Air Binding
- CR - 02 - 01503, EFS Motor Driven Pump Air Binding
- CR - 02 - 08617, Radiation Monitoring System Alarm

- CR - 00 - 13097, Radiation Monitor Detector Failure
- CR - 01 - 09249, Containment Air Monitor gas Channel Failures

b. Findings

No findings of significance were identified.

1R14 Personnel Performance During Non-routine Plant Evolutions

.1 Freeze Seal on the Primary Component Cooling Water System

a. Inspection Scope

On June 10 to 11, the inspectors reviewed the activities associated with the replacement of check valves for the radiation monitor in the primary component cooling water (PCCW) system. The replacement required the use of a freeze seal. The inspectors examined the controls for the freeze seal by reviewing the online maintenance plan, procedure MS 0526.07, "Freeze Sealing of Piping," Rev. 6, and by interviewing the operators, maintenance engineers, and maintenance technicians. The inspectors examined the licensee's plan against the NRC Inspection Manual, Part 9900: Technical Guidance, "Mechanical - Freeze Plugs." The inspectors reviewed the acceptance criteria and the contingency actions and ensured operators and maintenance technicians were aware of their responsibilities. The inspectors also performed field walkdowns of the system lineup and freeze seal controls.

b. Findings

No findings of significance were identified.

.2 Online Realignment of the Turbine due to Increased Vibrations

a. Inspection Scope

Following the eighth refueling outage, operators identified increased vibration on the Alterex exciter bearing #12. The licensee formed an equipment challenge team to evaluate actions to address the high vibration. The inspectors observed various activities including changes to the Alterex temperature and an online realignment. The inspectors reviewed the online realignment work package (WO 0220698 and the online maintenance assessment) to ensure adequate instructions, assessments, acceptance criteria, and contingency actions were specified. In addition, the inspectors attended the preevolution briefing, interviewed operators, system engineers and maintenance technicians, and performed field walkdowns of the activities.

b. Findings

No findings of significance were identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors reviewed several operability determinations (OD's) in order to assess that the identified conditions did not adversely affect safety system operability or plant safety. In addition, where a component was determined to be inoperable, the inspectors verified the TS limiting condition for operation implications were properly addressed. The inspectors performed field walkdowns, interviewed personnel, and reviewed the following items:

- CR 02-09717, oil leak discovered on the "A" emergency diesel generator (EDG) crankshaft seal on June 7. The inspectors evaluated the impact of the loss of oil, the effect of the leak on a running EDG, and the extent of condition to the other EDG.

- CR 02-09939, broken spring inside the "A" EDG speed adjust control switch identified on June 12. The inspectors reviewed the preliminary operability evaluation and the seismic evaluation.

- CR 02-10224, unexpected level drop in "B" component cooling water (PCCW) head tank. The inspectors reviewed the effect of the level drop and extent of condition to the other PCCW head tank. The inspectors also reviewed adverse condition report ACR 99-1015, which evaluated a similar condition in 1999.

b. Findings

No findings of significance were identified.

1R17 Permanent Plant Modifications

.1 AMSAC Setpoint Change

a. Inspection Scope

The inspectors reviewed plant modification MMOD 02-0517, which was issued to change the existing automatic transient without a scram mitigation system actuation circuitry (AMSAC) actuation setpoint. The AMSAC actuation setpoint was changed from 5% of steam generator narrow range level to 13%, to account for indicated level discrepancies created by steam flow past the mid-deck plate in the moisture separator section of the SG. The modification and evaluations were completed in response to an operating experience report and generic vendor information. The inspector also interviewed the design engineer responsible for the setpoint change and reviewed applicable documentation including the updated final safety analysis report (UFSAR).

b. Findings

No findings of significance were identified.

.2 Startup Feedwater Pump Undervoltage Interlock

a. Inspection Scope

The inspectors reviewed plant modification MMOD 01-0549, which was issued to provide a bus undervoltage interlock in the startup feedwater pump Bus 4 control circuit. This modification was required to prevent repeated cycling of the circuit breaker as it attempts to close upon receiving a pump auto start signal after a plant trip with Bus 4 de-energized. The inspector also reviewed applicable documentation including the UFSAR and the technical specifications.

b. Findings

No findings of significance were identified.

1R19 Post-Maintenance Testing

a. Inspection Scope

The inspectors reviewed several post-maintenance testing (PMTs) activities to ensure: 1) the PMT was appropriate for the scope of the maintenance work completed; 2) the acceptance criteria were clear and demonstrated operability of the component; and 3) the PMT was performed in accordance with procedures. The following PMTs were reviewed:

- On June 11, the operators placed the service water system from the ocean to the cooling tower following service water vacuum breaker changeout completed under WO 0204176. The inspectors ensured that the valve was verified to perform its design function. The inspectors evaluated CR 02-09881 to ensure inspector identified work planning issues were captured and that the issues did not result in an inadequate PMT.

- On June 13, the operators performed OX 1456.81, “Operability Testing of IST Valves,” Rev. 5 and OX 1430.04, Main Steam Valve Operability Test, “ Rev. 3 following replacement of the valve positioner for the “D” steam generator atmospheric steam dump valve ASDV-3004. The inspectors reviewed the work documentation (WO 0220148) and interviewed the control room operators.

- On June 19, the operators performed OX 1426.01, “DG 1A Monthly Operability Surveillance,” Rev. 8 following replacement of the “A” EDG speed adjust load switch completed per WO 0219397.

- On June 26, operators completed a maintenance run of the “B” EDG following repairs to a leaking jacket water cooling flange. The inspectors reviewed the documentation (WO 0220820) and interviewed the system engineer and operators.

b. Findings

No findings of significance were identified.

1R22 Surveillance Testing

a. Inspection Scope

The inspectors observed portions of several surveillance testing activities of safety related systems to verify that the system and components were capable of performing their intended safety function, to verify operational readiness, and to ensure compliance with required TSs and surveillance procedures.

The inspectors attended some of the pre-evolution briefings, performed system and control room walkdowns, observed operators and technicians perform test evolutions, reviewed system parameters, and interviewed the system engineers and field operators. The inspectors also reviewed the actions taken by the maintenance technicians and operators to address minor equipment deficiencies identified during the surveillance, and verified that these minor deficiencies did not affect the surveillance test results. The following surveillance procedures were reviewed.

- On May 29, OX146.02 , "Turbine Driven Emergency Feedwater Pump Quarterly and 18 Month Surveillance Test and Monthly Valve Alignment, " Rev. 8

- On June 25, OX1413.03, "'B' Train RHR Quarterly Flow and Valve Stroke Test, and 18 Month Valve Stroke Observation, " Rev. 3

b. Findings

No findings of significance were identified.

1R23 Temporary Plant Modifications

a. Inspection Scope

The inspectors reviewed open temporary modifications (TMs) to assess the potential for their collective impact on plant operations. The inspectors also reviewed TM 02-0008 and associated implementing documents to verify the plant's design basis and affected system or component operability were maintained. Maintenance Manual, MA 4.3A, "Temporary Modifications," Rev. 16, specified requirements for development and installation of TMs.

TM 02-0008 resulted in the disconnection of five incore detectors and one core exit thermocouple. The inspectors verified that Technical Specification 3.3.3.6 and Technical Requirement 20-3.3.3.2 were satisfied for the minimal fixed incore detectors and core exit thermocouples. The inspectors reviewed main plant computer points and interviewed operators and reactor engineers during the inspection.

b. Findings

No findings of significance were identified.

3. Safeguards (Cornerstone Physical Protection)

3PP1 Access Authorization Program (71130.01)

a. Inspection Scope

The following activities were conducted to determine the effectiveness of the Seabrook Station behavior observation portion of the personnel screening and fitness-for-duty (FFD) programs, as measured against the requirements of 10CFR26.22 and the Seabrook Station Fitness for Duty Program documents.

Five supervisors representing the Maintenance, Instrumentation and Controls, Operations, Engineering and Nuclear Oversight departments were interviewed, on June 26, 2002, regarding their understanding of behavior observation responsibilities and the ability to recognize aberrant behavior traits. Two (2) Access Authorization/Fitness-for-Duty self-assessments, two (2) semi annual FFD testing data reports, an audit, and event reports and loggable events for the four previous quarters were reviewed, during June 24-28, 2002. On June 26, 2002, five (5) individuals who perform escort duties were interviewed to establish their knowledge level of those duties. Behavior observation training procedures and records were reviewed on June 27, 2002.

b. Findings

No findings of significance were identified.

3PP2 Access Control (71130.02)

a. Inspection Scope

The following activities were conducted during the period June 24-28, 2002 to verify that Seabrook Station has effective site access controls, and equipment in place designed to detect and prevent the introduction of contraband (firearms, explosives, incendiary devices) into the protected area as measured against 10CFR73.55(d) and the Physical Security Plan and Procedures.

Site access control activities were observed, including personnel and package processing through the search equipment during peak ingress periods on June 24, 25, and 26, 2002, and vehicle searches, on June 24 and 25, 2002. On June 24, 2002, testing of all access control equipment; including metal detectors, explosive material detectors, and X-ray examination equipment, was observed. The Access Control event log, an audit, and three (3) maintenance work requests were also reviewed.

b. Findings

No findings of significance were identified.

4. OTHER ACTIVITIES [OA]

4OA1 Performance Indicator Verification (IP 71151)

a. Inspection Scope

The inspector reviewed the Seabrook Station program for gathering and submitting data relative to Fitness-for-Duty, Personnel Screening, and Protected Area Security Equipment Performance Indicators. The review included the licensee's tracking and trending reports, personnel interviews and security event reports for the Performance Indicator data collected from the 1st quarter of 2001 through the 2nd quarter of 2002.

b. Findings

No findings of significance were identified.

4OA2 Identification and Resolution of Problems

a. Inspection Scope

The inspectors reviewed actions taken in response to an unexpected air intrusion into the "A" emergency diesel generator (EDG) lubrication oil system on April 17, 2002 and a prior air intrusion event which resulted in failure of the "B" EDG on December 3, 2000. The inspectors evaluated whether the conditions adverse to quality were promptly identified, the cause was determined, and corrective actions were taken to prevent recurrence in accordance with 10 CFR 50, Appendix B, Criterion XVI "Corrective Action." The inspectors interviewed the maintenance supervisor, the system engineer, the root cause team leader, and other team members. The following documents were reviewed:

- CR 02-05315, root cause evaluation for the April 17, 2002 "A" EDG Air Intrusion;
- CR 00-13685, root cause evaluation for the December 3, 2000 "B" EDG Failure.

b. Findings

Introduction

The inspectors identified that North Atlantic Energy Service Corporation (NAESCO) took inadequate corrective action measures to prevent recurrence of an air intrusion event that caused the failure of the "B" EDG in December 2000. This resulted in air intrusion in the "A" EDG lubrication oil system on April 17, 2002, following maintenance activities. This issue was assessed as having very low safety significance (Green) and was determined to be a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion XVI "Corrective Action."

Description

On April 17, 2002, while starting the "A" EDG for an unloaded maintenance run, an air void resulted in low lubricating oil pressure and a start of the auxiliary oil pump. The low oil pressure condition caused an EDG alarm and an operator manually shutdown the EDG. The maintenance run was a post maintenance test following replacement of the lubricating oil temperature control valve.

The inspectors determined that inadequate venting of the lubricating oil piping was the cause of the air intrusion into the "A" EDG lubricating oil system. The inspectors also determined that corrective actions from prior events were inadequate to prevent recurrence of this problem. The opportunities were as follows:

- In 1996 and 1997, partial draining of the EDG lubricating oil system resulted in low oil pressure alarms, followed by auxiliary oil pump starts. Engineers failed to recognize that air intrusion was the cause for the low oil pressure and auxiliary oil pump start and misdiagnosed the cause as being associated with the oil pressure switches.

- On December 3, 2000, following repairs of the “B” EDG to address a damaged #7 piston and associated liner, and while conducting a post-maintenance break-in test run, the EDG engine had a failure of the No. 5 main bearing. The root cause team determined that inadequate bearing crush during bearing installation or loss of bearing lubricant film during post-repair engine break-in test runs were the two probable causes for the bearing failure. The corrective actions were targeted to develop program guidance for performing significant first time evolutions rather than prevention of air intrusion.

- On May 15, 2001, the diesel vendor completed a review of the December 2000 EDG failure and concluded it was due to an oil flow interruption caused by inadequate venting of the main lubricating oil pump discharge piping following maintenance. The system engineer issued CR 01-04893 to incorporate the vendors conclusion into the corrective action process. However, the actions implemented did not adequately address all maintenance activities with the potential to introduce air into the lubricating oil piping.

The inspectors reviewed the corrective actions resulting from the root cause evaluation (CR 02-05315) following the April 17 event, and determined that they were adequate to ensure proper venting of the lubricating oil system and prevent future air intrusion events.

Analysis

NAESCO missed several prior opportunities to properly identify and implement corrective actions to prevent recurrence of an event that had previously resulted in a failure of an EDG. This issue affected the mitigating systems cornerstone because it increased the probability for disrupting oil flow to the “A” EDG main bearings which could have resulted in failure of the EDG, impacting the reliability of the “A” EDG.

Using Appendix A of MC 0609, the finding was determined to be of very low safety significance (Green) since the air intrusion into the lubricating oil system did not result in damage to the “A” EDG. In addition, the out of service time was not significantly extended as a result of the air intrusion.

Enforcement

10 CFR 50, Appendix B, Criterion XVI “Corrective Action” requires for a significant condition adverse to quality, measures shall be taken to assure that the cause of the condition is determined and corrective actions are taken to preclude repetition. Contrary to the above, NAESCO failed to implement effective corrective actions to prevent recurrence of air intrusion into the EDG lubrication oil system. Because this violation was of very low safety significance and NAESCO entered this finding into its corrective action program (CR 02-05315), this violation is being treated as a Non-Cited Violation consistent with section VI.A.1 of the NRC Enforcement Policy **(NCV 50-443/02-04-01)**.

4OA6 Meetings, including Exit

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. G. St. Pierre on July 8, 2002, following the conclusion of the period. The licensee acknowledged the findings presented. The licensee did not indicate that any of the information presented at the exit meeting was proprietary.

ATTACHMENT

a. **Key Points of Contact**

Licensee:

G. St. Pierre, Station Director
B. Plummer, Operations Manager
T. Nichols, Plant Engineering Manager
D. Sherwin, Maintenance Manager
J. Pandolfo, Security Manager
R. Hickok, NRC Coordinator
M. O'Keefe, Regulatory Compliance Supervisor
P. Stroup, Station Director
P. Ryan, Security Operations Supervisor

b. **Items Opened, Closed, and Discussed**

Opened and Closed:

05000443/02-04-01	NCV	Inadequate Corrective Actions Resulted in Air Intrusion in the "A" Emergency Diesel Generator Lubricating Oil System. (Section 4OA2).

c. **Inspection Procedures Used**

71130 - Physical Protection
71151 - Performance Indicator Verification

d. **List of Documents Reviewed**

Plant Accessing Training - Fitness for Duty
Security/Fitness for Duty Semi-Annual Report, June, 2002 (Draft)
Security/Fitness for Duty Semi-Annual Report, December, 2001
Nuclear Oversight Audit Report No. 01-A12-01
Nuclear Oversight Audit Report No. 02-A04-01
Security Loggable event report, 06/01-06/02
Security Controlled Locks and Keys Audit Report, 2nd Quarter, 2002

e. **List of Acronyms Used**

CR	Condition Report
DCR	Design Change Request
DRPI	Digital Rod Position Indication
EDG	Emergency Diesel Generator
EFW	Emergency Feedwater
NCV	Non-Cited Violation
OA	Other Activities
PRT	Pressurizer Relief Tank
psig	pounds per square inch gage
PZ	Pressurizer
RCS	Reactor Coolant System
RHR	Residual Heat Removal System
RO	Reactor Operator
SRA	Senior Reactor Analyst
SDP	Significance Determination Process
SSC	Structure, System, or Component
TCV	Temperature Control Valve
TS	Technical Specifications
TM	Temporary Modifications
UFSAR	Updated Final Safety Analysis Report