

May 1, 2000

Mr. Michael T. Coyle
Vice President
Clinton Power Station
AmerGen Energy Company, LLC
Mail Code V-275
P. O. Box 678
Clinton, IL 61727

SUBJECT: CLINTON POWER STATION INSPECTION REPORT 50-461/2000002(DRP)

Dear Mr. Coyle:

On April 1, 2000, the NRC completed an inspection at the Clinton Power Station. The enclosed report presents the results of that inspection.

During the period covered by this inspection, your staff's conduct of activities at the Clinton Power Station was generally characterized by safety-focused operations. In particular, following emergent problems associated with the Division III emergency diesel generator (EDG) event, your staff completed a thorough root cause analysis, replaced the generator, developed and installed a temporary modification to preclude recurrence of the event, and operationally tested the new generator, all within the Technical Specification allowed outage time. Through these efforts, the time that the plant was in a higher risk configuration once the EDG problems developed, was effectively minimized. However, the failure to correctly translate the design basis for the static VAR (volt ampere reactive) compensator (SVC) into specifications during the initial development and installation of the SVC contributed to the damage to the Division III EDG when it was paralleled out-of-phase with an offsite power source.

Based on the results of this inspection, the NRC has determined that two violations of NRC requirements occurred. The first violation involved the previously mentioned failure to correctly translate the design basis for the SVC into specifications during the design and installation of the SVC modification. The second violation involved the failure to properly classify maintenance rule (10 CFR 50.65) related condition reports to ensure that they received the appropriate level of evaluation and review. These violations are being treated as Non-Cited Violations (NCVs), consistent with Section VII.B.1.a of the Enforcement Policy. These NCVs are described in the subject inspection report. If you contest the violations or the severity level of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555-0001, with copies to the Regional Administrator, Region III, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

M. Coyle

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response, if you choose to respond, will be placed in the NRC Public Electronic Reading Room (PERR) link at the NRC homepage, <http://www.nrc.gov/NRC/ADAMS/index.html>.

Sincerely,

/RA/

Marc L. Dapas, Deputy Director
Division of Reactor Projects

Docket No. 50-461
License No. NPF-62

Enclosures: Inspection Report No. 50-461/2000002(DRP)

cc w/encl: P. Hinnenkamp, Plant Manager
M. Reandeu, Director - Licensing
G. Rainey, Chief Executive Officer
R. Moore, Manager-Quality Assurance
M. Aguilar, Assistant Attorney General
G. Stramback, Regulatory Licensing
Services Project Manager
General Electric Company
Chairman, DeWitt County Board
State Liaison Officer
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-461
License No: NPF-62

Report Nos: 50-461/2000002(DRP)

Licensee: AmerGen Energy Company, LLC

Facility: Clinton Power Station

Location: Route 54 West
Clinton, IL 61727

Dates: February 26 - April 1, 2000

Inspectors: P. L. Loudon, Senior Resident Inspector
K. K. Stuedter, Resident Inspector
C. E. Brown, Resident Inspector
G. W. Hausman, Reactor Inspector - Region III
D. E. Zemel, Illinois Department of Nuclear Safety

Approved by: Thomas J. Kozak, Chief
Reactor Projects Branch 4
Division of Reactor Projects

EXECUTIVE SUMMARY

Clinton Power Station NRC Inspection Report 50-461/2000002(DRP)

This inspection included aspects of licensee operations, maintenance, engineering, and plant support. The report covers a 5-week period of resident and regional inspection.

Operations

- The inspectors determined that operators responded correctly and efficiently to an event where the Division III emergency diesel generator (EDG) was paralleled out-of-phase with the emergency reserve auxiliary transformer. A thorough root cause analysis was completed, the generator was replaced, a temporary modification was developed and installed to preclude recurrence of the event, and the new generator was operationally tested, all within the Technical Specification allowed outage time. Through these efforts, the time that the plant was in a higher risk configuration was effectively minimized (Section O1.1).

Maintenance

- The inspectors determined that the licensee effectively planned and conducted a Division I residual heat removal system heat exchanger performance test. The test was efficiently completed, thereby reducing the time the plant was in a higher risk configuration (Section M2.1).
- The inspectors concluded that the licensee was effectively monitoring the performance of systems within the scope of the maintenance rule (MR). A MR system performance report provided plant management with concise information relative to these systems which allowed for easy identification of those systems not meeting performance goals. Performance improvement plans were developed as required (Section M2.2).

Engineering

- The inspectors concluded that the licensee's root cause determination for the Division III EDG out-of-phase event was technically sound. However, one Non-Cited Violation (NCV) was identified involving the licensee's failure to correctly translate the static Volt Ampere Reactive (VAR) compensator (SVC) design basis into specifications during the initial review and installation of the SVCs (Section O1.1).
- The inspectors determined that the quality and thoroughness of cause determinations that the licensee conducted to address condition reports (CRs) documenting equipment problems/failures for structures, systems, and components within the scope of the MR, were not always adequate to ensure that the appropriate cause was identified and that corrective actions were initiated to prevent recurrence. One NCV was identified for failing to properly classify MR-related CRs (Section E2.1).

Report Details

Summary of Plant Status

The licensee operated the plant at essentially 100 percent power during the inspection period with the exception of a power reduction to approximately 80 percent for a control rod sequence exchange on April 1-2, 2000.

I. Operations

O1 Conduct of Operations

O1.1 Emergency Diesel Generator Paralleled Out-of-Phase

a. Inspection Scope (61726 and 71707)

The inspectors assessed the licensee's actions following an event which involved the out-of-phase paralleling of the Division III emergency diesel generator (EDG) with the emergency reserve auxiliary transformer (ERAT). The inspectors observed licensee actions associated with evaluating and determining the cause of the problem, effecting needed repairs, installing a temporary modification to the static VAR (volt ampere reactive) compensator (SVC), and testing a newly installed generator.

b. Observations and Findings

Background

During refueling outage six in late 1998 and early 1999, the licensee installed SVCs on the 4,160 volt side of the reserve auxiliary transformer (RAT) and the ERAT. The SVCs were added to regulate the 4,160 volt supply to the safety-related auxiliary power (AP) system by compensating for potential degraded offsite electrical distribution system voltage conditions. The SVCs react to electrical bus voltage changes within approximately 5 milliseconds. The design of the SVCs included a "freeze" signal to prevent the SVCs from interacting with an EDG during EDG paralleling activities by holding (or freezing) the SVC output constant when the EDG output circuit breaker is closed. When integrating the SVC system into the overall AP system design, the licensee assumed that the SVC freeze signal would occur simultaneously with EDG output breaker closure.

Event

A routine Division III EDG monthly surveillance test was conducted on February 28, 2000. Offsite electrical power was being supplied to the Division III bus from the ERAT. The surveillance test required operators to start the EDG and parallel it to the offsite power source. When main control room (MCR) operators closed the Division III EDG output breaker during the test, it appeared to them that the Division III EDG was successfully paralleled with the ERAT. However, immediately after the MCR operators

closed the output breaker, non-licensed operators in the Division III EDG room reported hearing a loud noise and feeling the floor vibrate. Neither the MCR operators nor the local operators observed any other indications that a problem existed with the EDG. Approximately 3 minutes after the synchronization, a “bus hi-voltage” annunciator alarmed in the MCR. The operators entered the correct annunciator response procedure, opened the Division III EDG output breaker, and the electrical bus voltage immediately dropped to its normal value of 4200 volts.

Analysis

The results of electrical tests conducted on the generator after the event were acceptable; however, a visual inspection identified that the generator windings and stator were mechanically damaged to the extent that the generator needed to be replaced. In addition, due to a recommendation from the manufacturer, the licensee decided to replace the turbocharger. The licensee determined through an analysis of surveillance test data that the Division III EDG had been paralleled out-of-phase with the ERAT. The licensee also determined that a 50- to 200-millisecond (3- to 12-cycle) delay existed from the time the EDG output breaker closed until the SVC received a freeze signal.

A large current and voltage transient occurred when the EDG was paralleled out-of-phase with the ERAT. When the EDG output breaker was closed, the EDG initially drew electrical power from the Division III bus which caused the bus voltage to fall below its nominal value of 4,200 volts. Since a time delay existed between the closure of the EDG output breaker and receipt of a freeze signal by the SVC, the SVC generated an output signal to compensate for the decreased voltage on the Division III bus. The SVC output signal to increase bus voltage was held constant when the freeze signal was received by the SVC. This resulted in a slow increase in bus voltage until it reached 4,339 volts and the “bus hi-voltage” annunciator alarmed approximately 3 minutes after the EDG output breaker was closed. Based on the results of interviews with the five operators conducting or monitoring the paralleling operation, there were no apparent equipment anomalies or personnel errors which caused the event.

Although the exact magnitude of the out-of-phase condition could not be determined, the licensee concluded that the error was less than 20 degrees. During laboratory testing, the licensee identified that the synchroscope’s indicated phase relation between the Division III EDG and the ERAT lagged the actual phase relation by up to 20 degrees. The licensee concluded that a 20-degree out-of-phase error would not have caused the resultant generator damage. However, the out-of-phase condition coupled with the SVC response caused damage to the generator similar to that which would be expected if the two sources were paralleled with a much larger out-of-phase error. To eliminate the synchroscope error, the licensee replaced the synchroscope.

The licensee conducted a safety evaluation pursuant to 10 CFR 50.59 to review the activity of paralleling an EDG to an offsite power source during EDG surveillance testing and during the recovery from a loss of offsite power (LOOP) event. The licensee determined that the potential interaction of an SVC with an EDG in the time delay between the EDG output breaker closing and the receipt of a freeze signal by the SVC during EDG surveillance testing, constituted an unreviewed safety question (USQ). This

USQ applied to all three divisional EDGs. The licensee determined that a similar problem would not occur when synchronizing an offsite power source to an EDG because protective devices are in place for the electrical system and adequate controls are included in LOOP recovery procedures. After reviewing Procedures CPS 3501.01, "High Voltage Auxiliary Power System," Revision 22, and CPS 3506.01, "Diesel Generator and Support Systems (DG)," Revision 26b, and through discussions with engineering personnel, the inspectors independently verified that adequate controls were in-place to ensure a similar out-of-phase event would not occur during LOOP recovery operations.

Criterion III, of 10 CFR Part 50, Appendix B, "Design Control," states, in part, that measures shall be established to assure that the design bases for structures, systems, and components (SSCs) are correctly translated into specifications and that measures shall be established for the selection and review for suitability of application of materials, parts, equipment, and processes that are essential to the safety-related functions of the SSCs. Contrary to this, before March 1999, during the SVC system integration design phase, the licensee incorrectly translated into specifications the design basis of the SVCs. The licensee's analysis credited an SVC freeze signal simultaneously with the closing of the EDG output breaker when in fact a 50- to 200-millisecond (3- to 12-cycle) delay existed between the EDG output breaker closing and the receipt of a freeze signal by the SVC. The licensee's failure to correctly translate the SVC design basis into specifications is considered a violation of Criterion III of 10 CFR Part 50, Appendix B. However, this violation is being treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy (**NCV 50-461/2000002-01 (DRP)**). This item was entered in the licensee's corrective action program as CR 2-00-03-051.

Generator Replacement and Testing

The operations department staff effectively controlled the repair and testing evolutions. During the work, the inspectors observed close coordination between diverse station work groups and offsite contractors. The licensee's staff effectively addressed in-progress changes and completed the necessary repairs while minimizing rework and errors. Station management closely monitored the work to ensure a safety focus was maintained while minimizing the time that the Division III EDG was inoperable, thereby minimizing the time that the plant was in a higher risk configuration. The licensee installed a temporary modification to manually freeze the SVC before paralleling the Division III EDG to an energized electrical bus and successfully completed operability testing on March 12, 2000, which was within the Technical Specification allowed outage time for the Division III EDG. Temporary modifications similar to the one installed on the Division III EDG were installed on the Division I and II EDGs which were successfully tested on March 18 and March 25, 2000, respectively. All aspects of this complex evolution were conducted safely.

c. Conclusions

The inspectors determined that operators responded correctly and efficiently to an event where the Division III EDG was paralleled out-of-phase with the ERAT. A thorough root cause analysis was completed, the generator was replaced, a temporary modification

was developed and installed to preclude event recurrence, and the new generator was operationally tested, all within the Technical Specification allowed outage time. Through these efforts, the time that the plant was in a higher risk configuration was effectively minimized.

The inspectors concluded that the licensee's root cause determination for the Division III EDG out-of-phase event was technically sound. However, one Non-Cited Violation was identified involving the licensee's failure to correctly translate the SVC design basis into specifications during the initial review and installation of the SVCs.

II. Maintenance

M2 Maintenance and Material Condition of Facilities and Equipment

M2.1 Division Residual Heat Removal System Heat Exchanger Performance Test

a. Inspection Scope (61726, 37551, and 71707)

The inspectors reviewed the licensee's preparations for and the conduct of the Division I residual heat removal (RHR) system heat exchanger performance test.

b. Observations and Findings

On March 16, 2000, the licensee conducted performance testing under Procedure 2602.01, "Heat Exchanger Performance of Shutdown Water Coolers Covered by NRC Generic Letter 89-13," Revision 13. The inspectors determined that the test was well planned and also observed good communication and coordination between the operations, maintenance, and engineering staffs while preparing for and conducting the test. These planning and coordination efforts resulted in the test being completed earlier than planned, thereby reducing the time that the plant was in a higher risk configuration. The inspectors reviewed the test results and determined that the heat exchanger met the design basis heat transfer capability requirements.

c. Conclusions

The inspectors determined that the licensee effectively planned and conducted a Division I RHR system heat exchanger performance test. The test was efficiently completed, thereby reducing the time the plant was in a higher risk configuration.

M2.2 Maintenance Rule (10 CFR 50.65) System Performance

a. Inspection Scope (61707)

The inspectors reviewed the licensee's efforts in monitoring and correcting performance problems associated with systems within the scope of the maintenance rule (MR).

b. Observations and Findings

The inspectors reviewed a recent MR system performance report generated by the licensee which detailed MR system performance relative to established operating cycle performance criteria for system unavailability and reliability. The inspectors observed that the Division II automatic depressurization system (ADS) air bank unavailability time was considerably higher than the planned operating cycle unavailability estimates. The primary reason for the higher than expected Division II ADS air bank unavailability time was that several delays occurred during a recent Division II ADS air bank flow regulating valve repair. These delays were attributed to the failure of the post-maintenance test, the need to replace the valve seat, and parts availability which directly led to the excess unavailability time for the system. Due to the relatively poor performance of this system, as required by MR-implementing procedures, the licensee developed a system performance improvement plan to address the performance issue.

c. Conclusions

The inspectors concluded that the licensee was effectively monitoring the performance of systems within the scope of the MR. A MR system performance report provided plant management with concise information relative to these systems which allowed for easy identification of those systems not meeting performance goals. Performance improvement plans were developed as required.

III. Engineering

E2 Engineering Support of Facilities and Equipment

E2.1 Inconsistent Resolution of Maintenance Rule-Related Condition Reports

a. Inspection Scope (37551)

The inspectors reviewed the following maintenance rule (MR) - related CRs for technical adequacy.

CR 1-97-12-020	“Automatic Depressurization System [ADS] Backup Air Bottle Pressure Regulating Valve”
CR 1-98-04-261	“ADS Backup Air Bottle Pressure Regulating Valve”
CR 1-98-06-033	“Erratic Intermediate Range Monitor [IRM] Indication”
CR 1-98-12-269	“VX06CB Trips due to Inadequate Freon Charge following Maintenance”
CR 1-99-02-040	“Erratic IRM Indication”
CR 1-99-02-083	“ADS Backup Air Bottle Pressure Regulating Valve”
CR 1-99-02-284	“Incorrect Relays Installed”
CR 1-99-08-201	“Hydrogen/Oxygen (H ₂ /O ₂) Monitor Failed Daily Calibration Check”
CR 1-99-10-162	“Maintenance Rule Functional Failure of 1LSCM278”
CR 2-00-01-004	“Maintenance Rule Functional Failure of Leak Detection Channel”

b. Observations and Findings

The inspectors reviewed the cause determinations completed for selected CRs to assess if appropriate causes were determined and corrective actions implemented to prevent recurrence of the conditions. Step 8.9.1 of Procedure 1029.05, "Implementation of the Maintenance Rule at CPS," Revision 5, requires personnel to initiate a CR to document MR-related issues. Step 8.9.3 of Procedure 1029.05 states that the classification of CRs generated to address equipment problems/failures for structures, systems, and components within the scope of the MR is determined using Procedure 1016.01, "CPS Condition Reports," Revision 33. Appendix A to Procedure 1016.01, defines the type of issue/condition for which a Class B CR should be generated. A Class B CR should be initiated for a condition which represents a moderate challenge to the plant or organization such that a cause investigation will provide a learning opportunity. In addition, Procedure 1016.01 requires that an apparent cause investigation provide the licensee with sufficient information such that a reasonable degree of confidence exists that the cause of the issue/condition has been rectified and that generic implications have been evaluated. A Class C condition report is intended to document a condition where the cause is obvious such that no additional investigation is needed to identify corrective actions. Step 8.9.4 of Procedure 1029.05, requires a cause determination investigation to be completed for each MR-related issue assessed as a critical component failure or functional failure.

In an attempt to prevent a duplication of investigation efforts, the licensee began classifying most MR-related CRs as Class C. With this classification, Procedure 1016.01 does not require an investigation; therefore, only the investigation pursuant to Procedure 1029.05 was being completed for MR-related issues. The inspectors had two concerns with this policy. First, the approval process for investigations conducted pursuant to Procedure 1029.05 is not as rigorous as that associated with Procedure 1016.01, which has led to the approval of inadequate investigations for MR-related issues. Second, many of the MR-related CRs were associated with critical component failures or functional failures which required additional investigation to determine the apparent cause of the failures and develop corrective actions to prevent recurrence of the failures. Therefore, these MR-related CRs were required by Procedure 1016.01 to be classified as Class B rather than as Class C.

The inspectors identified the following specific examples where CRs for deficient conditions were inappropriately classified and inadequate cause determinations were conducted pursuant to the MR:

- In June 1998, the licensee initiated Class C CR 1-98-06-033 to assess a potential IRM functional failure due to erratic indications on IRM channels C and G. In the cause determination, the licensee concluded that workers chipping paint near cabling for IRM C and G caused the erratic indication. The licensee's corrective actions for this issue included using a briefing sheet to remind workers about the precautions need when working in the vicinity of cabling. The licensee's cause determination also stated that pre-job briefing standards had been improved to aid in identifying work that may impact sensitive equipment. However, the specific actions that were taken to improve the standards were not discussed.

Approximately 8 months later, the licensee initiated Class C CR 1-99-02-040 to document additional erratic performance with IRM channels C and G. Although the licensee conducted a cause determination pursuant to Procedure 1029.05 for the erratic IRM performance, no corrective actions were established. The inspectors identified that the licensee conducted an apparent cause evaluation for the erratic IRM channel performance and identified two weaknesses which may have contributed to the erratic IRM indications. The licensee also identified 10 additional CRs associated with problems which occurred due to conducting work near sensitive equipment. However, no actions were taken to address the weaknesses or the potential adverse trend (due to multiple CRs on work near sensitive equipment) because the CRs were classified at a level which did not require that corrective actions be developed.

- In May 1999, the licensee initiated Class C CR 1-99-05-152 to document a potential functional failure associated with the Division I H₂/O₂ monitor. Engineering personnel determined that the monitor failed due to burned out filaments and a blown fuse and that the probable cause of this condition was inadequate gas flow across the filaments due to depleting the H₂/O₂ equipment gas supply. However, the licensee's cause determination did not specify why this condition developed or initiate any corrective actions to prevent the gas supply from being exhausted in the future.

The inspectors reviewed the documentation associated with other MR-related CRs and identified similar concerns. The inspectors discussed these concerns with engineering personnel and were informed that the plant equipment performance improvement team (a recently established group) had also identified deficiencies in the cause determination process for MR-related equipment problems/failures. Following discussions with the inspectors, engineering management provided additional guidance to engineering personnel describing the type of information that should be included in a cause determination for MR-related equipment failures and how thorough the associated investigation should be. Engineering management was developing additional actions to address this issue as part of the Clinton Power Station 5-year strategic plan.

Criterion V to 10 CFR Part 50, Appendix B, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality be prescribed by documented instructions, procedures, or drawings of a type appropriate to the circumstances and be accomplished in accordance with these instructions, procedures, or drawings. Appendix A to Procedure 1016.01, defines a Class B CR as a CR which documents a condition which represents a moderate challenge to the plant or organization such that a cause investigation will provide a learning opportunity. In addition, Procedure 1016.07 requires that an apparent cause investigation provide the licensee with sufficient information such that a reasonable degree of confidence exists that the cause of the issue/condition has been rectified and that generic implications have been evaluated. The inspectors determined that the licensee's failure to classify MR-related CRs associated with erratic IRM indications and the failure of the Division I H₂/O₂ monitor as Class B, when additional investigation was required to provide a reasonable degree of confidence that the cause of the issue had been rectified and generic implications had been evaluated, is a violation of Criterion V to 10 CFR Part 50, Appendix B. However, this violation is being

treated as a Non-Cited Violation consistent with Section VII.B.1.a of the NRC Enforcement Policy (**NCV 50-461/2000002-02**). This item was entered in the licensee's corrective action program as Condition Report 2-00-03-116.

c. Conclusions

The inspectors determined that the quality and thoroughness of cause determinations that the licensee conducted to address condition reports documenting equipment problems/failures for structures, systems, and components within the scope of the MR, were not always adequate to ensure that the appropriate cause was identified and that corrective actions were initiated to prevent recurrence. One NCV was identified for failing to properly classify MR-related CRs.

E7 Quality Assurance in Engineering Activities

E7.1 Audit of the Effectiveness of System Managers (37551)

The inspectors reviewed Quality Assurance Assessment Report 2000-03-20-13 which documents the results of a licensee assessment of the adequacy and effectiveness of engineering system managers' activities as identified in Nuclear Station Engineering Department (NSED) Procedure A.18, "Conduct of System Manager." As a result of the assessment, quality assurance personnel initiated a Level 2, Class B CR (CR 2-00-03-064) to document that NSED system managers had not identified the critical parameters of their assigned systems as required by the guidelines in NSED A-18. This procedure had been revised to include the requirement of identifying critical parameters as a corrective action for a November 1999 Level 2, Class A condition report (CR 1-99-08-055) initiated to address downward trends in flash point and viscosity in EDG lube oil sample results. Licensee quality assurance personnel made recommendations on improving the consistency of system manager notebooks and the use of the "System Health Reports." The inspectors determined that the assessment was thorough and probing, and produced substantive results.

IV. Plant Support

R1 Radiological Protection and Chemistry (RP&C) Controls

R1.1 Plant Walkthrough of Radiological Areas (71750)

The inspectors conducted tours of the facility during normal activities. The inspectors observed that for the areas inspected, appropriate radiological postings were installed to warn plant personnel of the associated radiation hazard. Contamination levels were kept to a minimum in the rooms housing safety-related components, allowing operators uninhibited access to those components.

S1 Conduct of Security and Safeguards Activities

S1.1 Review of Security Area Lighting and Controls (71750)

The inspectors conducted a tour of the protected area during the evening hours to assess if sufficient lighting existed for security officers to observe potential intruders. The inspectors also assessed whether security force members appropriately controlled and monitored protected and vital areas of the plant. The inspectors concluded that sufficient lighting existed in the protected area to reveal potential intruders and that security force members effectively controlled protected and vital area access.

V. Management Meetings

X1 Exit Meeting Summary

The inspectors presented the inspection results to members of licensee management on April 6, 2000. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

X3 Management Meeting Summary

Clinton Power Station management and NRC Region III management held a meeting at Clinton Power Station on March 10, 2000. Discussion topics included the licensee's 5-year strategic plan and licensee efforts to continue improving personnel and equipment performance at CPS.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

G. Baker, Manager - Nuclear Support Services
S. Clary, Director - Plant Engineering
M. Coyle, Site Vice President
K. Gallogly, Director - Corrective Action
P. Hinnenkamp, Plant Manager - Clinton Power Station
W. Maguire, Director - Operations
R. Moore, Manager - Work Management
M. Reandean, Director - Licensing
R. Schenck, Manager - Maintenance
D. Smith, Director - Security and Emergency Planning
P. Walsh, Manager - Nuclear Station Engineering Department
E. Wrigley, Manager - Quality Assurance

INSPECTION PROCEDURES USED

IP 37550: Engineering Observations
IP 37551: Onsite Engineering Observations
IP 61726: Surveillance Observations
IP 62707: Maintenance Observation
IP 71707: Plant Operations
IP 71750: Plant Support and Observations

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-461/2000002-01	NCV	Failure to Correctly Translate the SVC Design Basis into Specifications Suitable for the Equipment Application and Processes
50-461/2000002-02	NCV	Failure to properly classify maintenance-rule condition reports to ensure adequate apparent cause determinations.

Closed

50-461/2000002-01	NCV	Failure to Correctly Translate the SVC Design Basis into Specifications Suitable for the Equipment Application and Processes
50-461/2000002-02	NCV	Failure to properly classify maintenance-rule condition reports to ensure adequate apparent cause determinations.

Discussed

None

LIST OF ACRONYMS

ADAMS	Agencywide Documents Access and Management System
ADS	Automatic Depressurization System
AP	Auxiliary Power
CFR	Code of Federal Regulations
CR	Condition Report
EDG	Emergency Diesel Generator
ERAT	Emergency Reserve Auxiliary Transformer
FF	Functional Failure
IRM	Intermediate Range Monitor
LOOP	Loss of Offsite Power
MCR	Main Control Room
MR	Maintenance Rule
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
NSED	Nuclear Station Engineering Department
PERR	Public Electronic Reading Room
PLC	Programmable Logic Controller
RAT	Reserve Auxiliary Transformer
RHR	Residual Heat Removal
SSCs	Structures, Systems, and Components
SVC	Static VAR Compensator
USQ	Unreviewed Safety Question
VAR	Volt Ampere Reactive