

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

REPORT NO. 50-461/96002

FACILITY

Clinton Power Station

License No. NPF-62

LICENSEE

Illinois Power Company  
500 South 27th Street  
Decatur, IL 62525


DATES

from February 6 through March 25, 1996

INSPECTORS

M. J. Miller, Senior Resident Inspector  
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APPROVED BY

  
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Reactor Projects Branch 5

4 APR 96  
Date

AREAS INSPECTED

A routine, unannounced inspection of operations, engineering, maintenance, and plant support was performed. Safety assessment and quality verification activities were routinely evaluated. Follow-up inspection was performed for non-routine events and for certain previously identified items. Special inspection was performed in the areas of access authorization (Temporary Instruction 2515/127) and motor operated valve testing (Generic Letter 89-10). The results of both of these inspections are included as attachments to this report. Mr. Madeda's inspection in the area of security was performed from January 22-26, 1996.

Results: Two cited violations and one non-cited violation were identified in the areas inspected. Three inspection follow-up items and two unresolved items were identified in the attachments.

## Executive Summary

### Plant Operations

- Operator performance improved following the issuance of management expectations.
- The response to a recent steam leak in the drywell by both operations and engineering was effective and well coordinated.

### Maintenance

- Lack of understanding of the safety tagging program expectations resulted in an industrial safety "near miss" during work on the control rod drive rebuild room crane.

### Engineering

- While the overall work quality during a recent emergency diesel generator outage was good, the inspector was concerned in regards to the evaluation used to justify the non-repair of a repetitive bearing oil leak.
- GL 89-10 program documentation and test data provided an adequate basis to conclude that all GL 89-10 program MOVs would perform their intended safety functions under worst-case design-basis conditions.

### Plant Support

- Security program performance was good and the program continued to provide the necessary level of facility protection.
- Program strengths were noted in security equipment effectiveness, maintenance support and tactical response related drill activities.
- The security program was maintained at an effective level of readiness.
- Poor work practices and weak attention to detail, on the part of security personnel, resulted in the issuance of two violations.

### Safety Assessment/Quality Verification

- Self-assessments in the MOV area provided good technical findings and were beneficial in improving the MOV program.
- Although the licensee was developing corrective actions to address personnel errors and safety tagging concerns identified in a recent inspection report, additional examples continued to be identified during this inspection period.

Summary of Open Items

Violations: identified in Sections 4.1.1 and 4.1.2.

Unresolved Items: identified in Attachment 1, Section 4.

Inspection Follow-up Items: identified in Attachment 1, Sections 2, 5, and 8.

Non-cited Violations: identified in Section 1.3.

## DETAILS

### 1.0 OPERATIONS

NRC Inspection Procedure 71707 was used in the performance of an inspection of ongoing plant operations. While the issuance of management expectations resulted in improved operator performance, expectations in some areas needed improvement. The questioning attitude demonstrated by operators while evaluating a steam leak in the drywell was excellent. In addition, engineering support to operations was both prompt and effective.

#### 1.1 Management Expectation Effected Operator Performance

Improvements in control room communications were noted following the issuance of management expectations for operations personnel. On February 20, 1996, management expectations for the conduct of operations were issued, which included specific items for each operating position and general expectations for the entire crew. As a result, the inspectors observed some improvements in the conduct of operations. For example, three-way communication between the reactor operators (RO) and line assistant shift supervisor (LASS) was used more consistently. Additionally, operator response to annunciators has improved with the ROs calling out the annunciator alarms and the LASS acknowledging the information. The inspectors also noted that non-work related discussions, in the main control room, were reduced.

Although the inspectors considered the scope of these managements expectations to have been thorough, the inspectors noted that expectations concerning operation at or near licensed power levels were not clearly defined. Operators controlled thermal power level based on 10 minute thermal power averages which are based on multiple thermal calculations and are continuously updated. Operators were also provided 1 hour and 8-hour power histories based on hourly calculations which were less accurate. Trending of the ten minute averages were not provided on a 1 hour and 8-hour basis. No operator guidance was provided concerning potential conflicts between the two power indications.

On March 6, 1996, the hourly calculations exceeded the licensed thermal limit by 1 to 2 MW<sub>e</sub> for four consecutive hours and the 8-hour power history marginally exceeded the licensed limit. The operators did not respond to the trended information, since they considered the 10 minute averages more accurate.

The licensee later proved that the licensed limit had not been exceeded over an 8-hour period, based on the 10 minute averages; however, management had expected operators to control power based on the most conservative information available to them. A condition report was written and a review of power history tracking methods was in progress. Operators were provided interim guidance until the review could be completed. Although expectations were not clear in this case, this issue demonstrated a lack of attention to detail by the operators.

Based on the licensee's data no violation occurred and the inspectors had no further concerns in this area.

### 1.2 Effective Actions Taken in Response to Steam Leak in the Drywell

Both operations and engineering took effective actions in resolving a steam leak in the drywell which occurred on March 20, 1996. At approximately 6:10 a.m. operators received the fission product particulate and gas monitor high alarms concurrent with an increase in drywell pressure, temperature and leakage. The operators reviewed the work performed during the midnight shift and determined that the probable cause for the change in operational parameters was due to a steam leak in the drywell following stroking of a main steam line drain inboard isolation valve (1B21-F016). The operators teamwork provided sufficient data from available instrumentation to promptly identify a step change in drywell leakage prior to the change being detected by the drywell floor drain sump leakage indication. The inspectors considered the operators questioning attitudes and prompt entry into the limiting condition of operation (LCO) to be excellent.

Upon recognition of entry into the LCO, operations promptly informed engineering that an evaluation would be required within the next 4 hours. Engineering effectively reviewed the conditions and provided an appropriate course of action. Both the inboard and outboard main steam line drain isolation valves were closed which resulted in the leak being isolated. Following the isolation, drywell leakage returned to within normal limits. A maintenance work request was updated to work this valve in the upcoming Fall refueling outage. The inspectors had no other concerns.

### 1.3 Follow-up on Non-Routine Events

(Closed) LER 96001: "Failure to Perform Technical Specification Required Testing of the Trip and Isolation of the Mechanical Vacuum Pumps on a Main Steam Line High Radiation Signal." While planning work to be performed on the main steam line (MSL) radiation monitors the licensee identified a note in the Operations Requirements Manual (ORM), Table 3.2.16-1, which stated that a MSL high radiation trip would trip and isolate the mechanical vacuum pumps. Licensee personnel were unable to identify a surveillance that tested this trip function. Subsequently, a condition report was written to evaluate if this function was required to be tested and to track any necessary corrective actions.

Further review of this event determined that the testing of the condenser vacuum pump trip and isolate function was required to be performed every 18 months as part of the logic system functional testing (see ORM testing requirement 4.2.16.4). Testing records determined that the mechanical vacuum pump trip and isolation function was tested on August 9, 1985, as part of the preoperational test program; however, no other testing records were located. The MSL high radiation trip and isolation of the mechanical vacuum pumps was declared inoperable on January 10, 1996, and successfully tested later the same day. From

April 17, 1987, to January 1, 1995, this note was part of technical specification (TS) table 3.3.2-1. On January 1, 1995, the licensee implemented improved TS which moved many items, including this table, to the ORM. The failure to perform testing in accordance with the TS and the ORM prior to January 10, 1996, was a violation of NRC requirements. This licensee-identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII of the NRC Enforcement Policy (50-461/96002-01(DRP)).

One non-cited violation was identified in this area.

## 2.0 MAINTENANCE

NRC Inspection Procedures 62703 and 61726 were used to perform an inspection of maintenance and testing activities. Poor understanding of safety tagging program expectations resulted in power being restored to a piece of equipment while work was being performed. Although no one was physically injured, this was an additional example of safety tagging concerns identified in IR 95015.

### 2.1 Industrial Safety "Near Miss" Due to Poor Understanding of Safety Tagging Program

Lack of knowledge of the safety tagging program by electrical maintenance (EM) personnel resulted in a recent industrial safety "near miss." On March 6, 1996, EM personnel requested that the control rod drive rebuild room crane be repositioned (out of a high radiation area) in order to perform preventive maintenance tasks. To relocate the crane, a temporary lift of a danger tag was requested by maintenance to restore power to the crane. Maintenance personnel continued to work on the crane since they believed they would be informed to stop work prior to the tag being lifted. Operations personnel notified an EM supervisor in advance of lifting the danger tag. However, this information was not communicated to the workers before the tag was lifted and the breaker was closed. An electrician had a screwdriver engaged on one phase and in contact with a second phase of the three phase 480 volt overhead power rails when power was restored. The screwdriver was damaged and small particles of molten metal were imbedded in the worker's safety glasses. No physical injury to the worker occurred.

Due to previous safety tagging problems, new safety tagging training plans were being developed. Following this near miss, the electrical maintenance supervisor had a stand down to ensure that electricians understood certain basics in safety tagging until formal training could be accomplished. Specifically, electricians were counselled that once a temporary lift was requested, the electricians must consider the circuit energized and take appropriate precautions or stop work. The inspectors consider this event to be another example of personnel errors and safety tagging problems.

No violations or deviations were identified.

### 3.0 ENGINEERING

NRC Inspection Procedure 37551 was used to perform an onsite inspection of the engineering function. While the quality of work during the recent Division III emergency diesel generator (EDG) outage was good, the evaluation written to justify the non-repair of a repetitive oil leak was a concern. During the inspection period, the GL 89-10 close-out inspection was performed. The results of this inspection are included as Attachment 2 to this report.

#### 3.1 Actions Taken to Address Recurring Oil Leak Were a Concern

From March 12-14, the licensee performed a scheduled system outage on the Division III EDG. While the overall quality of the work performed was good, the inspector questioned the licensee's decision to not repair a recurring leak on the generator inboard bearing. The inspector reviewed the engineering evaluation which provided the justification for not repairing the leak during the most recent outage. Although the evaluation addressed many issues, additional items which contributed to a Division III EDG bearing failure in March 1995 were not addressed. Specifically, the evaluation did not address whether the severity of the leak had been analyzed during EDG operation. In addition, the licensee stated that periodic checks of both oil level and leakage would be performed; however, the periodicity was not specified. Lastly, the evaluation did not discuss the course of action to be taken if leakage increased. This issue was discussed with licensee personnel; however, the information needed to address the inspector's concerns was not available at the conclusion of the inspection. Additional inspection will be performed in this area and tracked under the actions related to violation 461/95003-01A.

#### 3.2 Follow-up on Non-Routine Events

(Closed) LER 96002: "Spurious High Reactor Water Level Trip Signal Causes High Pressure Core Spray System to be Inoperable." This LER was a minor issue and was closed.

(Closed) Inspection Follow Up Item 461/93010-01: Possible inadequate qualification of Electrical Connectors. Replacement electrical connectors were environmentally qualified following the identification of this issue; however, submerging of the connector was not addressed. During the inspector's discussion with licensee personnel, it was stated that the environmental qualification would be updated to address submerging.

(Closed) Violation 461/93026-01: Inadequate corrective action related to undersizing of circuit breaker overloads for the high pressure core spray (HPCS) water leg pump. In response to this violation, the licensee performed an engineering evaluation which allowed the upsizing and installation of the overloads on the HPCS water leg pump motor. Based upon these actions, and actions taken to address previous concerns related to the HPCS discharge check valve, this item is closed.

(Open) Violation 461/95003-01A: Inadequate corrective action. The failure to repair a long term bearing oil leak on the inside generator bearing for the Division III EDG resulted in insufficient lubrication and subsequent failure of the bearing.

The inspector reviewed the action taken to correct this problem. The defective bearing was replaced, the leak was repaired and other contributing conditions, such as the correct method for measuring oil level, were corrected. In observing the Division III EDG outage (see Section 3.1), the inspector noted that oil exited under the bearing and the bearing appeared to be leaking. The inspector reviewed the licensee's evaluation which justified continued operation of the diesel. While several items were evaluated, several issues were not addressed as discussed in Section 3.1. Due to the need for additional review in this area this item will remain open.

No violations or deviations were identified.

#### 4.0 PLANT SUPPORT

NRC Inspection Procedures 71750 and 83750 were used to perform an inspection of plant support activities. The results of a recent security inspection determined that security equipment effectiveness, maintenance support, and tactical response drill activities were considered program strengths. However, additional attention was needed in the area of personnel errors. An Access Authorization inspection was performed during this inspection period. The results of that inspection are included in Attachment 1 to this report.

#### 4.1 SECURITY

The licensee's physical security program was effective and continued to provide the necessary level of facility protection required by the NRC. Security equipment effectiveness, maintenance support, and tactical response drill activities were considered program strengths. However, continuing personnel errors (due to lack of attention to detail and poor work practices) resulted in two violations of NRC requirements.

##### 4.1.1 Security Staffing Fell Below the Minimum Required Due to Lack of Attention to Detail

On August 25, 1995, two senior security supervisors failed to recognize and implement required security response and staffing requirements prior to responding to a car accident approximately seven miles from the Clinton Power Station (CPS). When security personnel became aware of the accident, they contacted local law officials and volunteered to provide medical assistance which was subsequently accepted. A security shift supervisor (SSS) and some members of the armed response force then left Illinois Power Company property for a period of approximately 36 minutes in order to respond to the accident. While partial communications were maintained during the time the security personnel were off site (those that responded to the accident were still able to



receive transmissions from the alarm station), they were unable to directly communicate with the alarm stations if necessary.

The licensee's review of this event determined that the SSS who responded to the accident and another SSS believed that all armed response commitments were being met since those security force members who were off site were still able to respond to the site in a timely manner, if needed. However, the failure to maintain minimum security force staffing and to maintain a security shift leader on site at all times is a violation of the CPS security plan (50-461/96002-02(DRS)).

The inspector considered this event to be significant in that two senior security personnel failed to recognize the consequences of their actions. In response to this event, all security supervisors were briefed on the importance of maintaining adequate staffing requirements. In addition, the respective procedures were also clarified to affirm security staffing and response requirements. The inspector verified the licensee's corrective actions were reasonable and complete. No further concerns were identified.

#### 4.1.2 Poor Knowledge of Vehicle Search Requirements Resulted in Violation

On January 24, 1996, the inspector observed a security force member (SFM) perform a number of vehicle searches. On one occasion the SFM failed to perform an adequate search of two areas of a semi-truck due to poor knowledge of search requirements. Specifically, both the bunk bed area within the passenger cab and a battery box located on the undercarriage of the vehicle were not searched in accordance with the licensee's security plan.

The inspector immediately notified the SFM of the search deficiencies. Upon this notification, the SFM acknowledged that he had not searched the bunk bed area during the initial search. This area was subsequently inspected and no problems were identified. The SFM stated that the battery box was recognized during the search; however, he felt that an inspection of this area was not necessary since the vehicle was to be escorted while in the protected area. The inspector discussed the battery box discrepancy with security management personnel and confirmed that the SFM's actions in regard to the battery box were incorrect. The battery box was later inspected and no problems were identified. A review of drill records and interviews of other SFMs determined that the improper search appeared to be an isolated incident.

The failure to perform searches in accordance with the site security plan is a violation of NRC requirements (50-461/96002-03(DRS)). While the improper search was caused by poor knowledge of search requirements, personnel error (due to poor work practices and attention to detail) was also a contributing factor. In response to this event, the search officer was suspended until additional training was completed in vehicle search techniques. All security force officers were briefed on the event and advised of management's expectations in this area. The vehicle search training program was also reviewed and found to be

appropriate. The inspector verified the licensee's corrective actions were reasonable and complete. No further concerns were identified.

#### 4.2 Followup on Previously Opened Items

(Open) Inspection Follow-up Item 50-461/95008-02: This item was opened to track the licensee's corrective actions in response to increased personnel errors by security force supervisors. Prior to opening this item, the licensee's security management identified an increasing trend in security related personnel errors and was in the process of implementing corrective actions. Subsequent inspection results determined that the number of personnel errors by security supervisors dropped dramatically. However, the number of errors by security force officers increased significantly. While the security organization had implemented some corrective actions previously, an ongoing concern related to site-wide personnel error problems resulted in the development of a site-wide action plan concerning personnel error. The security organization planned to develop their corrective actions in accordance with the site-wide action plan.

Two violations were identified.

#### 5.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION

The licensee's development of corrective actions to address the safety tagging and personnel error trends discussed in Inspection Report 95015 were progressing well. However, additional examples in each area were identified during the inspection period. When hourly calculations of reactor thermal power exceeded the licensed limit for approximately four hours, operators failed to respond to the more conservative indication available to them (Section 1.1). While personnel errors by security supervision declined, there was an increase in errors by security force members. The licensee was in the process of correcting this concern at the conclusion of the inspection (Section 4.2). In addition, insufficient understanding of safety tagging expectations resulted in an industrial safety "near miss" (Section 2.1).

#### 6.0 REVIEW OF UFSAR COMMITMENTS

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant practices, procedures and/or parameters to the UFSAR descriptions. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The inspectors verified that the UFSAR wording was consistent with the observed plant practices, procedures and/or parameters.

## 7.0 PERSONS CONTACTED AND MANAGEMENT MEETINGS

### 7.1 Region III and CPS Management Personnel Met in Regional Office

John Cook, Senior Vice President-Energy Supply, and Wilfred Connell, Vice President-CPS, visited Hub Miller, Regional Administrator, Region III, and other regional management on March 15, 1996. The purpose of this meeting was to introduce Mr. Connell as the new Vice President of Clinton and to discuss recent plant issues.

### 7.2 Preliminary Inspection Findings (Exit)

The inspectors contacted various licensee operations, maintenance, engineering, and plant support personnel throughout the inspection period. Senior personnel are listed below.

At the conclusion of the inspection on March 25, the inspectors met with licensee representatives (denoted below) and summarized the scope and findings of the inspection activities. The licensee did not identify any of the documents or processes reviewed by the inspectors as proprietary.

W. Connell, Vice President - Clinton Power Station  
R. Morgenstern, Manager - Clinton Power Station  
D. Thompson, Manager - Nuclear Station Engineering Department  
R. Phares, Manager - Nuclear Assessment  
J. Palchak, Manager - Nuclear Training and Support  
M. Lyon, Director - Licensing  
D. Morris, Director - Radiation Protection  
A. Mueller, Director - Plant Maintenance  
K. Moore, Director - Plant Operations  
D. Antonelli, Acting Director - Plant Support Services  
C. Elsasser, Director - Planning & Scheduling  
M. Stickney, Supervisor - Regulatory Interface

## 8.0 DEFINITIONS

### 8.1 Violations for Which a "Notice of Violation" will Not Be Issued

The NRC uses the Notice of Violation as a standard method for formalizing the existence of a violation of a legally binding requirement. However, because the NRC wants to encourage and support licensee's initiatives for self-identification and correction of problems, the NRC will not generally issue a Notice of Violation for a Severity Level IV violation that meets the tests of the NRC Enforcement Policy (NUREG-1600) Section VII. A violation of regulatory requirements identified during this inspection for which a Notice of Violation will not be issued was discussed in Section 1.3 of this report.

### 8.2 Inspection Follow-up Items

Inspection follow-up items are matters which have been discussed with the licensee, which will be reviewed further by the inspector, and which

involve some action of the part of the NRC or licensee or both. Inspection follow-up items disclosed during the Access Authorization inspection are discussed in Sections 2,5, and 8 of Attachment 1 to this report.

### 8.3 Unresolved Items

Unresolved items are matters which more information is required in order to ascertain whether they are acceptable items, violations, or deviations. Unresolved items disclosed during the Access Authorization inspection are discussed in Section 4 of Attachment 1 to this report.

Attachment 1: Results of TI 2515/127 Access Authorization Program Inspection  
Attachment 2: Results of GL 89-10 Close-out Inspection

ATTACHMENT 1

TEMPORARY INSTRUCTION (TI) 2515/127 "ACCESS AUTHORIZATION PROGRAM"

This attachment addresses the on site inspection conducted by Messrs. T. Madeda and J. Belanger of this office between February 26 - March 1, 1996. The inspection included an evaluation to determine whether Access Authorization Program requirements identified in your Clinton Security Plan were adequately implemented.

Areas examined during the inspection included all relevant aspects of the access authorization program as identified in TI 2515/127. Within these areas, the inspection consisted of a selective examination of procedures and representative records, interviews with personnel, and observations of activities in progress.

No violation of NRC requirements were identified during this inspection. Two unresolved items pertaining to individual access to psychological evaluation records and audits of psychological vendors were noted and are addressed in Section 4. Within the scope of this inspection, the Access Authorization Program adequately met the regulatory requirements of 10 CFR 73.56 and provided reasonable assurance that individuals who were authorized unescorted access to the licensee's nuclear plant were trustworthy and reliable, and did not constitute an undue risk to the health and safety of the public as a result of their unescorted access to the nuclear facility.

The following items were considered program strengths:

Management support for the program and the knowledge and level of professionalism of the licensee's access authorization support staff (Section 2).

Review of security investigation case files by site access authorization staff after receipt of the files from the contractor security agency (Section 3).

Management/Supervisory training element of the behavioral observation program (Section 5).

The need for increased attention to detail for certain aspects of the licensee's access authorization program was noted based upon:

A deficiency in the review and approval of a contractor access authorization program (Section 2).

The need to proceduralize the physical protection program for the control and protection of personal information. Access control vulnerabilities were identified in the personal information protection program (Section 8).

## 1. Background

On April 25, 1991, the Commission published the Personnel Access Authorization Requirements for Nuclear Power Plants, 10 CFR 73.56 (the rule) which required each licensee to implement an Access Authorization Program by April 27, 1992, and comply with the requirements of 10 CFR 73.56. The program was also required to be incorporated into the licensee's Physical Security Plan.

This inspection, conducted in accordance with NRC Inspection Manual Temporary Instruction 2515/127, "Access Authorization," assessed the licensee's Access Authorization Program and its implementation to determine if regulatory requirements were being met.

## 2. Access Authorization Program - Administration and Organization

Overall program implementation was good. The knowledge and competence of the support staff was excellent. Management support was effective and management implementation of the program was good. More attention to detail was required in the licensee's reviewing of one contractor access authorization program. This finding was identified as an inspection follow up item. The licensee committed in their security plan to implement all elements of Regulatory Guide 5.66 to satisfy the requirements of 10 CFR 73.56. The licensee had prepared, reviewed, and revised procedures which were generally good.

Staffing levels were sufficient to implement program requirements. The access control staff at the Clinton facility consisted of a Supervisor, Personnel Processing and four access personnel specialists. The supervisor reported to the Director, Administration. During outages, the staff was augmented by personnel trained to perform specific personnel processing tasks. Staff support personnel were interviewed and were very knowledgeable of program responsibilities and procedures. This aspect of the program was a strength.

The licensee's performs all background investigation (BI) functions except for two contractors (self-screening) that complete BIs for their employees and one vendor that acts as an agent to the licensee in conducting some BIs during outages. The inspector's reviewed the licensee's written specifications and purchase orders for background investigation and found them to be sufficient. No deficiencies were identified with one of the "self-screeners" investigation program. The other self-screener did not identify in their written specifications the specific elements of their investigative and psychological activities to assure that these functions are conducted in conformance with the licensee's program requirements. Specifically, the contractor agreed to follow licensee requirements, but did not provide specific detail on how that objective would be met. This issue however was not addressed when the program was reviewed and approved by the licensee's personnel processing supervisor. The licensee agreed to evaluate the inspector's finding and is an inspection follow-up item (461/96002-04(DRS)).

### 3. Background Investigations

The licensee's background screening investigation program was being implemented in a good manner and regulatory requirements were being met. A program strength was identified in the area of case file review.

The inspectors reviewed records and conducted interviews to verify the adequacy of the licensee's program to verify true identity of an applicant and to develop information concerning employment, education, credit, and criminal histories, military service, and the character and reputation of an individual prior to granting them unescorted access to protected and vital areas.

The inspectors reviewed the results of the background investigation (BIs) files of 35 licensee and contractor employees.

Inspection results showed the scope and depth of background investigations (BIs) satisfied NRC regulatory requirements and provided an adequate level of background information on which to base a determination for access authorization. Reviewed BI files showed a "best effort" to obtain and document required information to address an applicant's employment history, education history, credit history, criminal history, military service, and the applicant's character and reputation. The BIs covered the specified time period and number of required contacts for each element referenced above. The licensee verified identity by social security number or photo driver's license prior to granting unescorted access and issuing a badge. In those cases where derogatory information had been developed, the licensee adequately, and in a timely manner, reviewed and evaluated the derogatory information. At a minimum this included an interview with the employee concerning the adverse information.

During a review of BIs, the inspectors verified that when the licensee received BIs conducted by a vendor, a licensee's access control specialists reviewed and evaluated each BI before granting access authorization. This review significantly reduced the chance of error and was a program strength.

### 4. Psychological Evaluations

Psychological tests were being controlled, administered, and proctored adequately. Two unresolved items were noted: (1) individuals did not have direct access to their psychological evaluation records and (2) audits of psychological evaluation services were limited in scope. These items are addressed below.

The inspectors reviewed the licensee's procedure and practices for completing the required psychological testing and evaluations. The licensee contracted psychological evaluation services to satisfy access authorization program requirements. The purchase order for the psychological evaluation services was reviewed and considered adequate.

The licensee used the Minnesota Multiphasic Personality Inventory (MMPI) II for initial psychological evaluations. The inspector observed MMPI-2 test

booklets were adequately protected. The psychological test booklets were controlled by the access authorization staff and test administration was proctored by designated licensee personnel. Tests results for personnel are evaluated by a licensed psychological assessment service company. If necessary, follow-up evaluations were completed by clinical interviews by psychologist licensed to perform such services.

The inspectors verified that the examinations had been controlled and protected in an adequate manner. Record review and interviews showed that identity of the person was confirmed before taking the test.

Section 6.1 of Regulatory Guide (RG) 5.66, which was a part of the licensee's site security plan states that an applicant has a right to review information to assure its accuracy and completeness (in reference to the access authorization program). For psychological evaluations however, the psychological evaluation service contractor will release the documents pertaining to the individual's evaluation only to a psychologist or psychiatrist, and not directly to the individual concerned. This practice requires the individual involved to retain a psychologist or psychiatrist for the sole purpose of receiving, and possibly evaluating the test results. The expense for this service was to be paid by the individual involved and if the person was not willing or able to pay the fees involved, the documents would not be provided. This practice may be contrary to the provisions of Section 6.1 of RG 5.66. This issue is considered an unresolved item and resolution of this issue will be addressed by separate correspondence (461/96002-05(DRS)).

The licensee had not audited the contractor that performed psychological evaluation services. The licensee's position was that sufficient information and documentation from the vendor was available on site by the licensee and subject to audit by their quality assurance group to fulfill the audit requirements identified in RG 5.66. Documentation consisted primarily of letters advising the licensee of psychological evaluation results and certification that individuals conducting the evaluations are state licensed. The licensee's position may be contrary to 10 CFR 73.56 (g)(1) which requires a licensee's program to be audited at least every 24 months to ensure that program requirements are satisfied. This issue is considered to be an unresolved item and resolution of this issue will be addressed by separate correspondence (URI 461/96002-06 (DRS)).

#### 5. Behavior Observation Program (BOP)

The management/supervisory training aspect of the BOP program was considered a program strength. However, the portion of the BOP pertaining to reporting arrests that may impact upon trustworthiness needs clarification.

Inspection conclusions were based upon monitoring a Supervisors' training class, a review of the student handbook titled "Supervisor's Fitness for Duty," and interviews with six supervisors (licensee and contractor) and four non supervisors (licensee and contractor). The inspectors also ▶



confirmed that personnel recently assigned as supervisors received the required behavior observation training within the 90 days.

The training provided for supervisors was considered excellent. The training was provided on an annual basis and consisted of attending a class and receiving handbook of approximately fifty pages. The handbook was complimentary to the class and provides an excellent reference resource. The class was presented by an instructor from the training department, was an hour and a half long, and was well presented. The class focused on various scenarios involving the recognition of behavioral changes that may be precursors of a decrease in the employee's performance. The class, rather than a strict lecture, encouraged group discussion in addressing the roles of supervisors in various behavior observation issues.

Interviews with supervisors disclosed all of the supervisors were aware of employee assistance program (EAP) elements that were available to their personnel. Several of the supervisors who stated that they themselves utilized the EAP program, or had referred an employee to the program, had favorable experiences and stated that confidentiality was maintained. Supervisors understood their responsibilities for behavior observation and stated that they knew their personnel well enough to be able to identify aberrant behavior.

Non-supervisor personnel received training to program responsibilities as part of the General Employee Training. Those personnel interviewed were also aware of EAP assistance available to them and believed that assistance would be provided in a confidential manner.

The licensee had also developed a method to monitor those personnel who have not been under a behavioral observation program during the 30 or more day period. A report including the last date/time a keycard was used is sent to each supervisor on a monthly basis. The supervisors are required to review this report to assure that individuals who have not accessed the protected area during the previous 30 days have remained under an approved continual observation program, (the licensee's or an approved contractor's fitness for duty program). If an individual has not remained under an approved CBOP, the supervisor is required to initiate an Exit Processing Form. Interviews with fitness for duty staff indicated that the procedure was complied with.

Interviews with the supervisors and non supervisors disclosed some confusion regarding self-reporting of arrests that could impact on their trustworthiness.

Section 9.0 of NUMARC 89-01 (an attachment to RG 5.66) states individuals with unescorted access authorization must report any arrest that may impact upon his/her trustworthiness. The General Employee Training Student Handbook, page 8-9, states that "All personnel with unescorted access to the Protected and Vital Areas must tell Personnel Processing personnel. This does not include minor traffic violations, but does include DWI and DUI arrests." This reporting channel was developed by the licensee to provide a degree of confidentiality for reporting arrests. Only two of ten supervisors and non supervisors interviewed were aware of the proper

reporting contact. Most of the individuals stated that they would advise their supervisor or plant security. The designated contact for reporting arrests was not well understood by personnel interviewed. The licensee had reached the same conclusion as a result of a surveillance conducted by the licensee's Nuclear Assessment Department approximately one month prior to this inspection. In response to this surveillance, the issue was included in the plant's daily newsletter. At the exit, the licensee agreed that additional measures were needed to strengthen the proper reporting channel. This finding was considered to be an inspection follow-up item (461/96002-07(DRS)).

6. Unescorted Access Authorization - Grandfathering, Reinstatement, Transfer, and Temporary

Licensee's access control records were reviewed to determine if they were correctly "grandfathering," reinstating, transferring, and granting temporary access authorization.

Inspection results showed these provisions were being appropriately utilized by the licensee. The inspectors reviewed the case files for four individuals from each of the categories noted above.

Licensee's records were reviewed to ascertain that personnel who did not meet the criteria for "grandfathering," i.e., those who did not have uninterrupted unescorted access authorization for at least 180 days on April 25, 1991, had not been granted unescorted access authorization without having satisfied the elements of the program. The licensee's procedures and practices for reinstatement, transfers, and temporary access authorization met program requirements.

7. Denial/Revocation of Unescorted Access

No violations were noted. Licensee actions concerning decisions to deny unescorted access met their program requirements and NRC regulatory requirements. Appeal case files were complete and addressed matters appropriate to the appeal decision.

The inspector reviewed several case files involving revocation of unescorted access. Each case file was adequately documented as to the reason access was denied or revoked, contained the required notification of access denial, and the right to appeal identified in the letters to the individuals. Appropriate background and supportive documentation was within each reviewed appeal case file whereby a decision could be rendered based upon the content of the files. The decision to deny unescorted access, upon appeal, is reviewed by the Manager, Nuclear Assessment. The determination from this review is final. Unescorted access was not granted during the appeal review process.

8. Protection of Personnel Information

No violations were noted. The licensee had implemented an adequate system to provide for the protection of personal information and to prevent unauthorized disclosure of sensitive information. However, procedural

guidance describing the licensee's program for the physical protection of personal information was very limited in scope. In addition, access control vulnerabilities that could compromise the licensee's protection of personal information were identified by the inspectors. These findings were considered as an inspection follow-up item (461/96002-08(DRS)).

Personnel were aware of the need to protect private and personal information obtained during the access authorization process. The listing of personnel denied access was adequately controlled. Consent forms were completed by personnel prior to initiation of the access authorization process. During the inspection, it was confirmed that required access authorization records were maintained at one location in the licensee's owner controlled area. These records are maintained at a centralized location within the access authorization office area. Physical protection practices were reviewed. During normal working hours, all file containers are unlocked and access control was the responsibility of cognizant personnel in the area. During nonworking hours all file containers are locked, access to the building is controlled by locks, and building surveillance is maintained by security patrols.

Inspector observation identified two concerns with the personal information protection program. The protection program was not proceduralized and inspector observations during work hours showed on several occasions inspectors were able to enter the record file storage area unchallenged/undetected and were able to stand unobserved next to file cabinets containing access authorization personal information. The licensee acknowledged our findings and took immediate action to strengthen physical security to the area and will further evaluate the inspector's concerns.

Personal information maintained in computers is protected by password protection and files are not maintained on computer "hard" drives. The access authorization staff was very sensitive to the control and distribution of access authorization case files and assured that the files were reviewed at designated locations and returned for security storage.

Individuals applying for unescorted access are advised about the type of records that are produced and retained, the duration of such records, their right to review and correct any information that may be incorrect, and the right to withdraw consent for obtaining records and conducting background investigations. The inspectors confirmed by random selection of records that no elements of the background investigation were initiated prior to the appropriate consent form(s) being signed.

#### 9. Audits

The inspectors reviewed the audits of the licensee's Access Authorization Program to determine that the minimum audit requirements were being met. Although the licensee's audit of their program was very good in scope and documentation, an unresolved item was identified in reference to program audits. Specifically, the licensee had not conducted an audit within the past two years of the contractor that provided psychological evaluation services. (See Section 4, Psychological Evaluations)

The inspectors confirmed that annual audits were completed for the two contractor/vendors approved by the licensee to complete background investigations for their personnel and of the contractor (Equifax, Inc.) that performed some of the licensee's background investigations. The audits were either performed by the licensee or by the utility group NEI. The scope of the audits equalled or exceeded the minimum audit requirements identified in Section 13 and Attachment A to NUMARC 89-01, an attachment to RG. 5.66. For those contractor audits performed by NEI, the licensee evaluated the audit results, corrective actions were adequate, and evaluated the impact of the audit results on their program. Such evaluations were adequately documented.

#### 10. Record Retention

The inspectors reviewed the licensee's record retention activities to ensure required records were being retained for the appropriate time frame. The licensee's access authorization procedure and the procedure for contractors whose program had been determined to be acceptable correctly identified the record retention period for access authorization records.

During the inspection, access authorization related records were maintained at two on site locations, one of which was located within the protected area; the other outside the protected area. Records relating to background investigations previously performed by Burns International Security Services, Inc. for security personnel were located within the protected area. The record storage location for all other access authorization records was at the Personnel Processing Center building located outside the protected area.

Individuals applying for unescorted access authorization were advised about the type of records that are produced and retained, the duration of such records, their right to review and correct any information that may be incorrect, and the right to withdraw consent for obtaining records and conducting background investigations. All of the above information was identified in a consent form. The inspectors noted that there was no mention on the consent form of where the records were normally retained. The licensee indicated that they had planned to revise the consent form for other reasons but indicated that they would include the location of where the records were maintained in this revision.

ATTACHMENT 2

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

FACILITY

Clinton Power Station

License No. NPF-62

LICENSEE

Illinois Power Company  
500 South 27th Street  
Decatur, IL 62525

DATES

February 12 - 16, 1996

INSPECTORS

S. Burgess  
A. Dunlop  
J. Guzman

R. Cain, INEL

Inspection Summary

Inspection conducted February 12-16, 1996 (Report No. 50-461/9.002(DRP))

Areas Inspected: Announced safety inspection of the licensee's response to Generic Letter (GL) 89-10, "Safety-Related Motor-Operated Valve (MOV) Testing and Surveillance," (2515/109) and the licensee's self-assessment in this area.

Results: All significant issues related to Clinton's MOV program have been resolved, therefore, the GL 89-10 program review will be closed. Program documentation and test data provided an adequate basis to conclude that all GL 89-10 program MOVs would perform their intended safety functions under worst-case design-basis conditions. Self-assessments in the MOV area provided good technical findings and were beneficial in improving the MOV program.

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## DETAILS

### 1.0 Persons Contacted

#### Illinois Power Company (IP)

- \* W. Connell, Vice President
- \* K. Baker, Engineer, Nuclear Station Engineering Department (NSED)
- \* J. Funston, Engineer, NSED
- \* S. Hong, Engineer, NSED
- \* K. E. Moore, Engineer, NSED
- \* K. S. Moore, Manager, Operations
- \* J. Puzauskas, MOV Coordinator, NSED
- \* D. Thompson, Manager, NSED

#### Nuclear Regulatory Commission

- \* K. Stoedter, Resident Inspector

\* Denotes those attending the exit meeting on February 16, 1996.

### 2.0 Generic Letter 89-10 Program Implementation

The focus of this inspection was to evaluate the process for qualifying the design-basis capability of MOVs and closure of GL 89-10. The inspection concentrated on evaluating MOVs that were tested under static or low differential pressure (dP) conditions. A valve sample that included several program closure methods used by Clinton was selected to verify design-basis capability. The inspectors reviewed design-basis documents, thrust calculations, test packages, and engineering evaluations for the following MOVs:

1B21-F019	Main Steam Line Outboard Drain Isolation Valve
1E12-F024A	RHR Pump 1A Test Return to Suppression Pool Valve
1E12-F053B	RHR Shutdown Cooling Injection Valve
1E22-F012	Suppression Pool Minimum Flow Bypass Valve
1G33-F001	RWCU Pump Suction Inboard Isolation Valve
1SM-001A	Suppression Pool Make-up Shutoff Valve

### 2.1 Program Scope Changes

Two containment fire pump outboard isolation valves, 1FP051 and 1FP054, were appropriately removed from the program after changing the safety position from open to close, which removed their active close safety function. The valves now have no design-basis open or close safety function.

With the removal of these valves, the program scope consisted of 168 MOVs (111 gate valves, 38 globe valves and 19 butterfly valves).

### 2.2 Design-Basis Capability Verification

Program documentation and test data provided an adequate basis to conclude that safety-related MOVs would perform their intended safety functions under worst-case design-basis conditions. The valve factors (VFs) applied to the

non-testable MOVs appeared to be well supported, and overall the current switch settings and MOV thrust margins appeared to be adequate.

Verification of the design basis capability of main steam isolation valve leakage control system MOVs was appropriately completed using existing MOVATs test data adjusted for diagnostic uncertainty and evaluated for potential overloading using the Kalsi LTAFLA software.

### 2.2.1 MOV Sizing and Switch Settings

Clinton's thrust and torque calculations utilized the standard industry equations with the valve mean seat diameter used to calculate valve seat area. Minimum required thrust in the close direction was adjusted for diagnostic system uncertainties, torque switch repeatability, load sensitive behavior, and stem lubricant degradation. The maximum thrust limit in the close direction was adjusted for diagnostic system uncertainties, torque switch repeatability, and load sensitive behavior. The minimum required thrust in the open direction was adjusted for diagnostic system uncertainties and stem lubricant degradation.

Actuator run efficiency was used to calculate closing output torque for ac MOVs, which made valves vulnerable to potential nonconservatism in the Limitorque equation. The licensee previously performed a calculational screening using reduced efficiencies and identified marginal MOVs. Engineering evaluations and proposed modifications were ready to be implemented when the potential reduced efficiency issue was resolved. The inspectors considered this action to be adequate for program closure.

### 2.2.2 Misapplication of Application Factor

Procedure ME-04.00, "Stem Thrust/Torque Evaluation for MOVs," contained a statement that was contrary to guidance provided in Limitorque's Technical Update 93-03. The procedure stated that an application factor of 1 should be used in conjunction with the temperature effect factor. The Technical Update stated that an application factor of 1 may be used when the degraded voltage was less than 90% full voltage. The discrepancy did not affect Clinton's methodology because the degraded voltage factor was applied as soon as the voltage went below 100%. The licensee stated that the procedure would be corrected.

### 2.2.3 Valve Factor and Grouping

Valve factors and groupings for non-tested MOVs were well supported from Clinton's dynamic test program and information obtained from 127 industry tests. With the exception of one Anchor-Darling double disc gate, all gate valves at Clinton were Anchor-Darling flex wedges with the majority in the 150# ANSI pressure class. The majority of VF data from industry tests agreed with the Clinton data, with outliers adequately evaluated. From this testing, MOVs were divided into eight groups based on valve manufacturer, valve type, and size. The inspectors reviewed the licensee's data to see if more valve groups were needed to account for ANSI pressure class ratings; however, the VF assumptions for Clinton's Anchor-Darling flexwedge gate valves were adequate to bound fluctuation caused by pressure rating.



Current torque switch settings supported the applied group VFs, with the exception of 14 MOVs, which had interim operability justifications. In some cases, the justifications relied on weakly supported "conservatism" such as generalizations that VFs tended to be lower for high temperature applications. However, based on the available VF data, and because of the pending corrective action on these valves, the inspectors did not disagree with the final conclusions. Final resolution for these valves included a combination of actions, such as relying on the actual tested VFs, valve replacement, or increasing the torque switch settings. These actions were to be completed during the upcoming refueling outage (Fall 1996).

#### 2.2.4 Globe Valves

The inspectors considered the grouping of globe valves adequate for program closure. Three globe valve groups consisted of five Edwards Hermavalves, 18 Yarway, and 15 Anchor-Darling valves.

Although Clinton had no plant dynamic test data for the Edwards Hermavalves, the licensee was able to demonstrate the vendor calculations were conservative based on the valve company's dP testing and review/comparison of industry test data. The Yarway rising, rotating stem globe valves could not be practicably tested; however, all had low design-basis dP and thrust margins in excess of 790%.

#### 2.2.5 Load Sensitive Behavior

The methodology for addressing load sensitive behavior (LSB) was adequate for program closure. Data from 31 tests concluded that LSB appeared to be random; therefore, Clinton selected a random error of 10%, which bounded all but two of Clinton's LSB tests. These two outlier tests, as well as two other valves, had a static stem friction coefficient less than or equal to 0.08, which exhibited high LSB when compared to other valves. Industry data reviewed by Clinton personnel supported the observation that MOVs with stem friction coefficients equal to, or less than 0.08, tended to exhibit higher LSB. To address this, a 10% bias margin was added in addition to the 10% random margin, to all MOVs with a static stem friction coefficient that was less than 0.09.

#### 2.2.6 Deficiencies in Open Stroke Evaluations

Two concerns raised with evaluation of open safety function valves indicated shortcomings in the thoroughness of review of technical details. First, in determining actuator thrust capabilities, instead of using open stroke stem friction coefficient (SFC) data, the SFC from the closing static test (at C14) was applied. A review of dP tests indicated 1 of 5 reviewed tests had a higher SFC during the open stroke. The use of the lower SFC could overestimate thrust capability. Second, margin for potential load sensitive behavior was not included in the open stroke thrust requirements.

These concerns were highlighted by four MOVs with open margins of less than 5%. To address this, Clinton re-reviewed the torque traces and degraded voltage calculations to verify sufficient torque and thrust was available for these valves. In all cases, the valves were demonstrated to be capable after including margin for open stroke load sensitive behavior and applying the more conservative SFC.

The licensee maintained that, based on data interpretation, use of closing stroke C14 SFC was typically more conservative but agreed to re-evaluate this position as more data was acquired during periodic verification testing. Similarly, Clinton agreed to programmatically account for potential load sensitive behavior during the open stroke.

#### 2.2.7 Stem Lubricant Degradation

The margin included for stem lube degradation (SLD), which was obtained by adding 0.02 to the static SFC, was considered acceptable for program closure. The acceptability was based on Clinton's available SLD data and on the plans to monitor, and adjust as appropriate, the SLD as part of the trending program.

#### 2.2.8 Butterfly Valve Testing

The seating and unseating torques had not been verified for 14 butterfly valves because diagnostic static testing was not complete. However, the program was adequate for GL 89-10 program closure based on the following: (1) design-basis capability was appropriately based on nine dynamic diagnostic tests with the untested valves grouped with sister valves, (2) adequate margin was available for the untested valves, (3) established plans were in place to complete the remaining testing within the next three refueling outages with the risk significant valves tested during the current fuel cycle, (4) the untested valves were either in very low dP water conditions (less than 25 psid) or in air systems (less than 10 psid), (5) each non-tested butterfly valve was quarterly stroked under design-basis conditions, and (6) sufficient analytical margin existed between required torques and actuator or valve weak links.

#### 2.3 Pressure Locking and Thermal Binding (PL/TB)

Twelve valves were documented as potentially susceptible to PL in the licensee's 180-day response to GL 95-07. Unmodified valves were considered operable for the short term based on analytical calculations. Although modifications were planned for the remaining ten valves found to be potentially susceptible to PL, the licensee was considering basing long-term corrective actions for six valves with a low safety significance on an analytical methodology.

The inspectors noted that the licensee's 180-day response to the GL did not identify the low pressure coolant injection (LPCI) pump suction valves from the suppression pool as being potentially susceptible to thermally induced PL. These valves experienced a PL event at Grand Gulf, which is of a similar plant design. The valves, which are normally open, are closed to accomplish shutdown cooling. Hot coolant in the vicinity of these valves caused thermally induced PL, such that the valves would not reopen when exiting shutdown cooling. The licensee previously reviewed this issue and considered them potentially susceptible to PL, however, the scenario to induce PL was considered outside the design basis and beyond the GL scope. The inspectors noted, however, that Clinton Technical Specifications (TS) allowed the LPCI system to remain operable while in shutdown cooling. As such, the LPCI train could be considered operable when a PL event would render the train inoperable. Based on the licensee's initial evaluation of the GL, standing orders were developed to declare the LPCI train in shutdown cooling to be

inoperable. By declaring the system inoperable, an additional emergency core cooling system (ECCS) would be required to be operable to meet TS requirements. Although this may alleviate the PL concern, the issue of whether the valves should have been identified in the response to the GL remains open. This issue and the area of PL/TB will be reevaluated in the future under the guidance of GL 95-07.

#### 2.4 Periodic Verification of Design-Basis Capability

Plans for periodic verification (PV) of MOV design-basis capability were satisfactory for program closure. As currently planned, the PV program would meet the intent of the ASME OMN-1 Code Case where the static test frequency would not exceed 10 years. However, the licensee was not aware that, where the selected test interval extended beyond five years, information obtained from valve testing conducted during the first five-year time period must validate assumptions made to justify the longer test interval. The licensee indicated that the PV program would be revised to ensure that the five-year evaluation was performed prior to allowing the extended PV interval.

The program combined risk considerations and valve margin in determining the periodic test type and frequency. Although some dynamic diagnostic testing would be performed, the majority of PV testing would be completed using static diagnostic tests on low margin valves and motor power monitoring on higher margin valves.

The staff is preparing a GL on the PV of MOV design-basis capability and will review the PV program in greater detail following issuance. Clinton should review its program and consider the benefits (such as identification of decreased thrust output and increased thrust requirements) and the potential adverse effects (such as accelerated aging or valve damage) when determining appropriate PV testing for each MOV.

#### 2.5 Post-Maintenance Testing (PMT)

Guidelines for post-maintenance testing of MOVs were considered appropriate for program closure. The guidelines required the performance of static diagnostic testing to demonstrate that each MOV remained capable of operating under design-basis conditions following packing replacement/adjustment or after valve or operator maintenance. However, the inspectors were concerned that, as worded, the procedure could allow work on valve internals (which may invalidate the VF determined from baseline testing) that may not require post maintenance dynamic testing to ensure operability. In response, Clinton revised the PMT procedure to ensure that work performed on valve internals of any safety related testable valve was evaluated on the need for post maintenance dynamic testing.

#### 2.6 Adequate Response to IN 92-18

The site's 1992 response to NRC Information Notice (IN) 92-18 "Potential For Loss Of Remote Shutdown Capability During a Control Room Fire," adequately documented how this scenario would not prevent safe reactor shutdown; however, potential damage to MOVs or to system pressure boundaries due to spurious MOV actuation stemming from hot electrical shorts was not fully addressed in the response. The licensee had generated stall calculations to confirm that the loads imposed by spurious valve actuations, with no protective devices in the

circuit, would not endanger the reactor pressure boundary. The licensee intended to revise the IN response in order to consolidate this information and fully address the issue. No further questions were raised.

#### 2.7 MOV Trending and Corrective Actions

The trending program appeared capable of adequately tracking and evaluating data to maintain MOV design-basis capability. A computerized data base was used to track valve degradation and/or failures. This would include concerns with lubrication, switch settings, gearing, valve and motor hardware. This system could then be used to trend repetitive problems or to initiate reviews of other MOVs for similar problems. A computerized data base for diagnostic test results was established with baseline information; however, the trending software was not yet in place. MOV deficiencies found through the trending program would be documented to management on a quarterly basis with a trending analysis report produced after each refueling outage.

#### 3.0 Self Assessment

The MOV program self assessment assisted in identifying significant issues that may have hindered closure and overall was considered a strength in the program. The use of technical personnel involved with MOV programs at other sites allowed for a rigorous assessment and although certain concerns were still raised during the NRC inspection, the self assessment flagged potentially significant issues such as a lack of margin enhancement, testing procedure shortcomings, and weaknesses in operability reviews. The licensee's response to issues raised by the self assessment was also positive as all issues were reviewed and addressed via completed or planned corrective action.

#### 4.0 Review of UFSAR Commitments

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant practices, procedures and/or parameters to the UFSAR descriptions. While performing this inspection, the applicable portions of the UFSAR that related to the MOVs highlighted in Section 2.0 were reviewed. The inspectors verified that the UFSAR wording was consistent with the observed plant practices, procedures and/or parameters.

#### 5.0 Exit Meeting

The inspectors met with licensee representatives (denoted in Section 1.0) on February 16, 1996. The inspectors summarized the inspection's purpose and scope and the findings. Also discussed was the likely informational content of the inspection report with regards to documents or processes reviewed during the inspection.