September 13, 2000

EA-00-103

Mr. Oliver D. Kingsley
President, Nuclear Generation Group
Commonwealth Edison Company
ATTN: Regulatory Services
Executive Towers West III
1400 Opus Place, Suite 500
Downers Grove, IL 60515

SUBJECT: BYRON INSPECTION REPORT 50-454/00-12(DRP); 50-455/00-12(DRP)

Dear Mr. Kingsley:

On August 21, 2000, the NRC completed an inspection at the Byron 1 and 2 reactor facilities. The enclosed report presents the results of that inspection. The results of this inspection were discussed on August 18, 2000 with Mr. Levis and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to safety and to compliance with the Commission's rules and regulations and with the conditions of your license. Within these areas the inspection consisted of a selective examination of procedures and representative records, observations of activities, and interviews with personnel.

Based on the results of this inspection no findings were identified.

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

We will gladly discuss any questions you have concerning this inspection.

Sincerely,

/RA/

Michael J. Jordan, Chief Reactor Projects Branch 3

Docket Nos. 50-454; 50-455 License Nos. NPF-37; NPF-66

Enclosure: Inspection Report 50-454/00-12(DRP);

50-455/00-12(DRP)

cc w/encl: D. Helwig, Senior Vice President, Nuclear Services

C. Crane, Senior Vice President, Nuclear Operations

H. Stanley, Vice President, Nuclear Operations R. Krich, Vice President, Regulatory Services

DCD - Licensing

W. Levis, Site Vice President R. Lopriore, Station Manager

B. Adams, Regulatory Assurance Manager M. Aguilar, Assistant Attorney General

State Liaison Officer

State Liaison Officer, State of Wisconsin Chairman, Illinois Commerce Commission

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DATE	09/10/00		09/13/00		09/13/00		09/ /00	

ADAMS Distribution: DFT

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U. S. NUCLEAR REGULATORY COMMISSION REGION III

Docket Nos: 50-454; 50-455 License Nos: NPF-37; NPF-66

Report No: 50-454/00-12(DRP); 50-455/00-12(DRP)

Licensee: Commonwealth Edison Company

Facility: Byron Generating Station, Units 1 and 2

Location: 4450 N. German Church Road

Byron, IL 61010

Dates: July 1 - August 21, 2000

Inspectors: B. Kemker, Resident Inspector

J. Adams, Resident Inspector

C. Thompson, Illinois Department of Nuclear Safety

Approved by: Michael J. Jordan, Chief

Reactor Projects Branch 3 Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000454-00-12, IR 05000455-00-12, on 07/01-08/21/2000; Commonwealth Edison Company; Byron Generating Station; Units 1 & 2. Resident Operations Report.

The baseline inspection was conducted by resident inspectors. No findings were identified in any of the cornerstones.

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety

Radiation Safety

Safeguards

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Occupational
 - Public
- Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

Report Details

Summary of Plant Status

The licensee operated Unit 1 at or near full power for the duration of this inspection period.

The licensee operated Unit 2 at or near full power until July 26, 2000, when the unit experienced an automatic reactor trip as a result of a failure of a feedwater regulating valve controller. On July 27, 2000, the licensee conducted a reactor startup and synchronized the unit to the grid. The unit was operated at or near full power for the remainder of the inspection period.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity

1R04 Equipment Alignment

a. <u>Inspection Scope</u>

The inspectors verified the system alignment of the 2A containment spray (CS) system train while the 2B CS system train was out-of-service for maintenance. The inspectors performed a walkdown of the accessible portions of the system and verified the system lineup. In addition, the inspectors performed a complete system walkdown of the Unit 2 diesel generators. The inspectors reviewed the system drawings and the procedures listed below to determine the correct system alignment. The inspectors also reviewed applicable portions of the Updated Final Safety Analysis Report and Technical Specifications.

- Byron Operating Procedure (BOP) CS-E2A, "Containment Spray System Train 'A' Electrical Lineup Unit 2," Revision 1
- BOP CS-M2A, "Containment Spray System Train 'A' Valve Lineup Unit 2," Revision 1
- BOP DG-1, "Diesel Generator Alignment to Standby Condition," Revision 7
- BOP DG-E2A, "Train 'A' Diesel Generator System Electrical Lineup," Revision 2
- BOP DG-E2B, "Train 'B' Diesel Generator System Electrical Lineup," Revision 2
- BOP DG-M2A, "Train 'A' Diesel Generator System Valve Lineup," Revision 6
- BOP DG-M2B, "Train 'B' Diesel Generator System Valve Lineup," Revision 5

As part of the complete system walkdown of the Unit 2 diesel generators, the inspectors reviewed a listing of open maintenance work request tasks and verified that all equipment problems observed by the inspectors during the walkdown had been identified by the licensee and were entered into the licensee's corrective action program. The inspectors also evaluated the individual and cumulative affects of identified problems, operator work-arounds, existing temporary modifications, and outstanding modifications on the diesel generators' ability to perform their design safety functions.

In addition, the inspectors reviewed the licensee's root cause evaluation and corrective actions for an equipment alignment issue documented in the following problem

identification form to verify that identified problems were being entered into the corrective action program with the appropriate characterization and significance.

 PIF B2000-01842 No Boric Acid Flow During Normal Makeup of the Unit 2 VCT [Volume Control Tank]

b. <u>Findings</u>

There were no findings identified.

1R05 Fire Protection

a. <u>Inspection Scope</u>

The inspectors toured the plant areas listed below to observe conditions related to fire protection.

- Auxiliary Building General Area 426' Elevation (Zone 11.6-0)
- Unit 1 Lower Cable Spreading Room Non-segregated Bus Duct Area (Zone 3.2.A-1)
- Unit 2 Lower Cable Spreading Room Non-segregated Bus Duct Area (Zone 3.2.A-2)

These areas were selected for inspection because they were identified as risk significant in the Byron Station Individual Plant Examination of External Events. The inspectors reviewed applicable portions of the Byron Station Fire Protection Report and assessed the licensee's control of transient combustibles and ignition sources, material condition, and operational status of fire barriers and fire protection equipment. During this inspection, the inspectors interviewed engineering department personnel and the station's fire marshal.

In addition, the inspectors evaluated the licensee's assessment of degraded fire seals identified between the Unit 1 Lower Cable Spreading Room and Auxiliary Electrical Equipment Room, which were documented in the following condition reports.

CR B2000-02019 Fire Seal Not Installed Per Design

CR B2000-02096 Degraded Fire Seal Found in Floor of Unit 1 Auxiliary Electrical Equipment Room

b. Findings

There were no findings identified.

1R11 <u>Licensed Operator Requalification</u>

a. Inspection Scope

The inspectors assessed licensed operator performance and the training evaluators' critique during a licensed operator evaluated training session in the Byron Station operations training simulator on August 9, 2000. The inspectors focused on alarm response, command and control of crew activities, communication practices, procedural adherence, and implementation of emergency plan requirements.

b. <u>Findings</u>

There were no findings identified.

1R12 <u>Maintenance Rule Implementation</u>

a. Inspection Scope

The inspectors evaluated the licensee's implementation of the maintenance rule, 10 CFR Part 50.65, as it pertained to identified performance problems with the 1A feedwater (FW) pump, the 1B condensate/condensate booster (CD/CB) pump, and the 2B diesel generator (DG) that had been documented in the following problem identification forms.

•	PIF B2000-01204	1A FW Pump Emergency Availability Lost (Loss of
		Production Concern)
•	PIF B2000-01516	1B CD/CB Pump Required Tripping During PMT [Post
		Maintenance Test] Run
•	PIF B2000-01523	Foreign Material Causes High Motor Bearing Temperature
•	PIF B2000-01524	Unit 1 Entered Action Level II for Dissolved Oxygen
•	PIF B2000-01575	2B DG Inoperable Due to JW [Jacket Water] Flange Leak
•	PIF B2000-01584	1/3 of O-ring Extruded Into the 2B DG JW Lower Cooler

During this inspection, the inspectors evaluated the licensee's monitoring and trending of performance data, verified that performance criteria were established commensurate with safety, and verified that the equipment failures were appropriately evaluated in accordance with the maintenance rule. The inspectors also interviewed the station's maintenance rule coordinator and reviewed Nuclear Station Procedure ER-3010, "Maintenance Rule," Revision 0.

In addition, the inspectors evaluated the licensee's corrective actions for maintenance rule program issues associated with the 0B essential service water (SX) system makeup pump documented in the following problem identification forms to verify that identified problems were entered into the corrective action program with the appropriate characterization and significance.

 PIF B2000-00196 Unplanned LCOAR [Limiting Condition for Operation Action Requirement] Entry on OB SX Makeup Pump PIF B2000-01057 Unplanned LCOAR Entry - 0B SX Makeup Pump Failed to Start and Run With Auto Start Signal

• PIF B2000-01074 Maintenance Rule SX3 Makeup Function (a)(1)/(a)(2)

Review

• PIF B2000-01119 Re-entered 0BOL [Byron Operating Limit] 7.9 Due to

Another Failure of the OB SX Makeup Pump

b. <u>Findings</u>

There were no findings identified.

1R13 <u>Maintenance Risk Assessments and Emergent Work Evaluation</u>

a. Inspection Scope

The inspectors reviewed the licensee's evaluation of plant risk for planned maintenance activities on the 2B essential service water system train, the 1B residual heat removal system train, and the 120 volt alternating current instrument power inverter 212. The inspectors selected these maintenance activities because they involved systems which were risk significant in the licensee's risk analysis. The maintenance activity associated with the 212 inverter was considered emergent work to make repairs.

During this inspection, the inspectors assessed the operability of redundant train equipment and evaluated the licensee's implementation of planned contingency actions to minimize plant risk, where appropriate. The inspectors verified that the licensee's planning of the maintenance activities minimized the length of time that the plant was subject to increased risk. The inspectors also interviewed operations and work control department personnel and reviewed Nuclear Station Procedure WC-AA-103, "On-Line Maintenance," Revision 0.

b. <u>Findings</u>

There were no findings identified.

1R14 Personnel Performance During Non-routine Plant Evolutions

a. <u>Inspection Scope</u>

On July 26, 2000, Unit 2 experienced an automatic reactor trip from full power due to a steam generator (SG) low level for the 2C SG. The condition was the result of the reactor operator's response to the failure of the 2C SG feedwater regulating valve controller. The inspectors evaluated the operators' response to the reactor trip as well as the response of plant safety systems designed to mitigate the consequences of the transient. This evolution was selected for observation and evaluation to determine if operator actions in response to the trip were appropriate and in accordance with the licensee's emergency response procedures and training.

b. <u>Findings</u>

There were no findings identified.

1R15 Operability Evaluations

a. Inspection Scope

The inspectors evaluated the licensee's basis that the issues identified in the following operability evaluations did not render the involved equipment inoperable or result in an unrecognized increase in plant risk.

- Operability Assessment 99-011, "1A Diesel Generator Motor Jacket Water Pump Leaking"
- Recordable Indication Record 00-2-002, "2A Centrifugal Charging Pump Discharge Bypass Check Valve Leaking"

The inspectors interviewed engineering department personnel and reviewed Nuclear Station Procedure CC-3001, "Operability Determination Process," Revision 0 and the applicable portions of the Updated Final Safety Analysis Report and the Technical Specifications.

b. <u>Findings</u>

There were no findings identified.

1R16 Operator Work-Arounds

a. <u>Inspection Scope</u>

The inspectors evaluated the operator work-arounds (OWAs) listed below to identify any potential affect on the functionality of mitigating systems or on the operators' response to initiating events.

- OWA 232, "RM-11 Malfunctions"
- Condition Report B2000-01787, "Potential Operator Work-Around 2B FW [Feedwater] Pump Recirculation Valve Control Switch in Close Condition"

The inspectors selected OWA 232 because the recurring RM-11 computer malfunctions have been a significant distraction to control room operators. The inspectors selected the 2B FW pump recirculation valve control switch problem because the valve will not automatically open as designed on a low flow condition (i.e., following a reactor trip where a feedwater isolation occurs but the feedwater pumps do not trip). The inspectors interviewed operating and engineering department personnel and reviewed Nuclear Station Procedure OP-AA-101-303, "Operator Work-Around Program," Revision 0.

In addition, the inspectors performed the semiannual review of the cumulative effects of OWAs. During this review the inspectors considered the cumulative effects of OWAs on the following:

- the reliability, availability and potential for misoperation of a system;
- the ability of operators to respond to plant transients or accidents in a correct and timely manner; and
- the potential to increase an initiating event frequency or affect multiple mitigating systems.

b. <u>Findings</u>

There were no findings identified.

1R19 Post Maintenance Testing

a. <u>Inspection Scope</u>

The inspectors evaluated the licensee's post maintenance testing activities for maintenance conducted to replace a valve stem on the 1B residual heat removal (RH) heat exchanger (HX) component cooling water (CC) outlet isolation valve (1CC9412B); to replace the 2B essential service water (SX) pump discharge check valve (2SX002B); and to replace a rectifier bank and filter capacitors in instrument power inverter 212. These activities included the following work requests.

•	WR 980062042-01	2B SX Pump 2SX01PB Discharge Check Valve -
		Remove/Replace Check Valve With New
•	WR 990138672-02	1B RH HX 1RH02AB CC Outlet Isolation Valve Stem
		Replacement
•	WR 990047522-01	Inverter Instrument Bus 212 - Contingency General
		Troubleshooting Instructions
•	WR 990047522-02	In Support of Troubleshooting 212 Inverter Verify Output of
		DPT [Differential Potential Transformer]

The inspectors selected these post maintenance testing activities because they involved systems which were risk significant in the licensee's risk analysis.

The inspectors reviewed the above work requests to determine the scope of the work performed and evaluated the adequacy of the specified post maintenance testing. The inspectors verified that the post maintenance tests were performed in accordance with the procedures, that the procedures clearly stated acceptance criteria, and that the acceptance criteria was met. During these inspection activities, the inspectors interviewed operations, maintenance and engineering department personnel and reviewed the completed post maintenance testing documentation.

b. Findings

There were no findings identified.

1R22 Surveillance Testing

a. <u>Inspection Scope</u>

The inspectors evaluated the surveillance testing activities listed below to verify that the testing demonstrated that the equipment was capable of performing its intended function.

•	1BVSR 5.2.4-6	Unit 1 Train B ASME [American Society of Mechanical
		Engineers] Surveillance Requirements for Centrifugal
		Charging Pump 1B and Chemical and Volume Control
		System Valve Stroke Test
•	2BOSR 7.5.3-2	Unit 2 Diesel Driven Auxiliary Feedwater Pump Quarterly
		Surveillance
•	2BVSR 5.5.8.AF.1-2	Unit 2 ASME [American Society of Mechanical Engineers]
		Surveillance Requirements for the Diesel Driven Auxiliary
		Feedwater Pump

The inspectors selected these surveillance tests activities because the systems were identified as risk significant in the licensee's risk assessment and the components were credited as operable in the licensee's safety analysis to mitigate the consequences of a potential accident. The inspectors interviewed operations and engineering department personnel, reviewed the completed test documentation and applicable portions of the Updated Final Safety Analysis Report and the Technical Specifications, and observed the performance of these surveillance testing activities.

In addition, the inspectors evaluated the licensee's corrective actions for a surveillance testing issue documented in the following problem identification form.

 PIF B2000-01027 Breaker Mis-positioning During SSPS [Solid State Protection System] Bi-monthly Surveillance

b. Findings

There were no findings identified.

4. OTHER ACTIVITIES (OA)

4OA1 Performance Indicator Verification

Unplanned Power Changes per 7000 Critical Hours

a. Inspection Scope

The inspectors verified the Unplanned Power Changes per 7000 Critical Hours performance indicator for both units. The inspectors reviewed power history data for both operating units since April 1997, determined the number of power changes greater than 20 percent full power that occurred, evaluated each of those power changes

against the performance indicator definition, and verified the licensee's calculation of critical hours for both units. The inspectors also reviewed applicable portions of System Planning Operating Guide (SPOG) 1-3-F-1, "Station 6, Byron Operating Guidelines," Revision 1 and NEI [Nuclear Energy Institute] 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 0.

b. Findings

There were no findings identified.

Safety System Functional Failures

a. <u>Inspection Scope</u>

The inspectors verified the Safety System Functional Failures performance indicator for both units. The inspectors reviewed events or conditions reported in Licensee Event Reports (LERs) since April 1, 1999 that prevented, or could have prevented, the fulfillment of a safety function. The inspectors reviewed the LERs listed below for applicability to this performance indicator.

•	LER 50-454/99-001-00	Depressing Both Feedwater Isolation Reset Pushbuttons Leads to LCO [Limiting Condition for Operation] 3.0.3 Entry
•	LER 50-454/99-002-00	Design Package Fails to Classify Feedwater Vent Valves as Containment Isolation Valves and Results in Missed Technical Specification Surveillance
•	LER 50-454/99-003-00	Automatic Reactor Trip Due to Human Error During Surveillance Procedure
•	LER 50-454/00-001-00	Inservice Testing Not Performed on Several Valves Due to Inadequate Program Scope Development
•	LER 50-455/99-001-00	Six of 20 Main Steam Safety Valve Relief Tests Exceeded Required Tolerance Due to Disk to Nozzle Metallic Bonding
•	LER 50-455/99-002-00	Inadvertent Reactor Protection and Engineered Safety Feature Systems Actuations in Mode 5 Due to Unexpected Steam Generator Level Response When Stroking a Feedwater Isolation Valve
•	LER 50-455/00-001-00	Automatic Reactor Trip System Actuation Due to Off-Site Power Line Fault and Failed Air Circuit Breaker Load Rejection Contact
•	LER 50-454/455-99-004-00	Solid State Protection System (SSPS) Slave Relay Response Time Untested Due to Inadequate Procedures

b. Findings

There were no findings identified.

<u>Safety System Unavailability - Residual Heat Removal (RH) and High Pressure Safety Injection (HPSI) Systems</u>

a. <u>Inspection Scope</u>

The inspectors verified the Safety System Unavailability performance indicators for the RH and HPSI systems for both units. The inspectors reviewed operating logs, maintenance history and surveillance test history for unavailability information for these systems since January 1, 2000. The inspectors also reviewed Unit 1 Byron Technical Surveillance Requirement Procedure (1BVSR) 5.5.8.CC.1-1, "ASME [American Society of Mechanical Engineers] Surveillance Requirements for Component Cooling (CC) Pump 1CC01PA," Revision 3 and applicable portions of NEI [Nuclear Energy Institute] 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 0.

b. <u>Findings</u>

During review of performance indicator data for the Unit 1 "A" RH train, the inspectors identified that the licensee had not accounted for unavailability time associated with the performance of 1BVSR 5.5.8.CC.1-1 on May 2, 2000. As a result, 67 minutes of unavailability time was omitted by the licensee in the reporting of safety system unavailability for the 1A RH train.

The inspectors noted that the performance of this ASME surveillance test procedure usually reduces CC flow to an RH heat exchanger by throttling the heat exchanger discharge valve. The ASME surveillance test procedure can also be performed using an alternate flow path to the spent fuel pool cooling heat exchanger so not all performances of the surveillance test procedure are counted as RH train unavailability. The licensee had previously determined that throttling the CC flow to an RH heat exchanger for this test makes the RH train unavailable because the design basis heat removal flow is not available to the RH train. The performance of 1BVSR 5.5.8.CC.1-1 on May 2, 2000 utilized the 1A RH heat exchanger flow path and should have been counted as unavailability time.

The inspectors determined that the addition of 67 minutes to the unavailability of the 1A RH train would not affect a change in the performance indicator color and therefore this deficiency is considered minor. Because the error in reporting the performance indicator data was not willful, the NRC is exercising enforcement discretion consistent with existing enforcement policy and no enforcement action will be taken for this minor violation. This issue was entered into the licensee's corrective action program as condition report B2000-02151.

4OA5 Other

<u>Performance Indicator Data Collecting and Reporting Process Review Temporary</u> Instruction (TI 2515/144)

a. Inspection Scope

The inspectors reviewed the licensee's performance indicator data collecting and reporting process for the performance indicators listed below.

- Unplanned Power Changes per 7000 Critical Hours
- Safety System Functional Failures
- Safety System Unavailability Residual Heat Removal System
- Safety System Unavailability High Pressure Safety Injection System

The inspectors reviewed indicator definitions, data reporting elements, calculational methods, definitions of terms, and clarifying notes used by the licensee for consistency with industry guidance contained in applicable portions of NEI [Nuclear Energy Institute] 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 0.

b. Findings

There were no findings identified.

(Closed) Unresolved Item (URI) 50-454/455-99020-02: "Review of the Licensee's Investigation and Resolution of Inspector Identified Discrepancies with a Fire Protection System Surveillance Test Procedure." This issue was reviewed by the NRC staff and determined to be a violation of NRC requirements as documented in a letter from the NRC to the licensee dated July 21, 2000. This unresolved item is closed to violation 50-454/455-00011-01.

(Closed) URI 50-454/455-00009-01: "NRC to Review Additional Information on Split Trains of Component Cooling (CC)." The condition represented a nonconformance with the current design basis as described in the Updated Safety Analysis Report (UFSAR). The licensee acknowledged that the UFSAR will have to be corrected. In addition, the licensee acknowledged that until the nonconformance is corrected, the applicable Technical Specification limiting condition for operation would have to be entered or the CC system operability would have to be appropriately assessed whenever the Unit 0 CC pump is aligned to a unit substituting for a "B" train pump. This issue was reviewed by the NRC staff and determined to be of minor significance. This unresolved item is closed.

4OA6 Meetings, including Exit

Exit Meeting Summary

The inspectors presented the inspection results to Mr. Levis and other members of licensee management at the conclusion of the inspection on August 18, 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.

PARTIAL LIST OF PERSONS CONTACTED

<u>Licensee</u>

- B. Adams, Regulatory Assurance Manager
- R. Deppi, Nuclear Oversight Manager
- S. Gackstetter, Shift Operations Superintendent
- D. Hoots, Operations Manager
- J. Kramer, Work Control Manager
- S. Kuczynski, Maintenance Manager
- W. Levis, Site Vice President
- R. Lopriore, Station Manager
- W. McNeill, Radiation Protection Manager
- G. Stauffer, Regulatory Assurance
- D. Wozniak, Engineering Manager

ITEMS OPENED, CLOSED, AND DISCUSSED

<u>Opened</u>		
50-454/455-00011-01	NOV	Disposition to URI 50-454/455-99020-02
Closed		
50-454/455-99020-02	URI	Review of the licensee's investigation and resolution of inspector identified discrepancies with a fire protection system surveillance test procedure
50-454/455-00009-01	URI	NRC to review additional information on split trains of component cooling

LIST OF BASELINE INSPECTIONS PERFORMED

The following inspectable-area procedures were used to perform inspections during the report period. Documented findings are contained in the body of the report.

Inspection Procedure

		Report
<u>Number</u>	<u>Title</u>	Section
71111-04	Equipment Alignment	1R04
71111-05	Fire Protection	1R05
71111-11	Licensed Operator Requalification	1R11
71111-12	Maintenance Rule Implementation	1R12
71111-13	Maintenance Risk Assessments and Emergent Work Control	1R13
71111-14	Personnel Performance During Non-routine Plant Evolutions	1R14
	and Events	
71111-15	Operability Evaluations	1R15
71111-16	Operator Work-Arounds	1R16
71111-19	Post Maintenance Testing	1R19
71111-20	Refueling and Outage Activities	1R20
71111-22	Surveillance Testing	1R22
71151	Performance Indicator Verification	40A1
2515/144	Performance Indicator Data Collecting and Reporting Process Review	40A5
	INCHICAN	