

Clinton

4Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: FIN Finding

AUTOMATIC SHUTDOWN SIGNAL GENERATED DUE TO PERSONNEL ERROR

The inspectors identified a finding of very low safety significance concerning poor operator performance following a reactor scram on December 2, 2003. The primary cause of this finding was related to the cross-cutting area of Human Performance, in that, poor performance by operations personnel resulted in a momentary loss of reactor pressure vessel level control. This loss of level resulted in a second reactor scram signal being generated. No violations of NRC requirements occurred.

This finding was more than minor because the finding affected the Reactor Safety/Initiating Event objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding did not contribute to the likelihood of a Primary or Secondary system loss of coolant accident initiator, did not contribute to both the likelihood of a reactor trip AND the likelihood that mitigation equipment or functions will not be available, and did not increase the likelihood of a fire or internal/external flood. Therefore, the finding was determined to be of very low safety significance.

Inspection Report# : [2003009\(pdf\)](#)

Mitigating Systems

Significance:  Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY IMPLEMENT CORRECTIVE ACTIONS.

The inspectors identified a non-cited violation of 10 CFR 50 Appendix B Criterion XVI involving the licensee's failure to promptly enter an identified condition adverse to quality into their corrective action program. This finding related to the cross-cutting area of Human Performance, in that, engineering personnel were aware of a discrepant condition on the 4160 volt Bus 1C1 Reserve Feed potential transformer cubicle door but did not correct the condition for several days.

The inspectors determined that this issue was more than minor because the finding could be reasonably viewed as a precursor to a significant event if left uncorrected because the station personnel could fail to evaluate non-conforming conditions which could render safety related equipment inoperable. This issue was design/seismic qualification deficiency that was determined to not cause a loss of function by the licensee's evaluation. Based on this conclusion, this finding was determined to be of very low safety significance using the Phase 1 worksheets.

Inspection Report# : [2003009\(pdf\)](#)

 **Significance:** May 23, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW OPERABILITY EVALUATION PROCEDURE FOR A THROUGH-WALL LEAK IN ASME CLASS III PIPING.

A finding of very low safety significance was identified by the inspectors for failure to follow procedures as required by technical specification. This failure to following procedure resulted in an inadequate operability evaluation being performed by the licensee. This issue also resulted in the licensee failing to declare the affected system inoperable as required by NRC regulatory guidance documents and licensee procedures.

This issue was more than minor because an inadequate operability evaluation could affect the mitigating system cornerstone objective as it relates to the availability of the Division I service water system and emergency diesel generator. This issue was of very low safety significance because this qualification deficiency did not result in loss of function per GL 91-18. This issue was a non-cited violation of Technical Specification 5.4 which required the implementation of written procedures in NRC Regulatory Guide 1.33, Appendix A.

Inspection Report# : [2003004\(pdf\)](#)

Significance: SL-III Jan 24, 2003

Identified By: NRC

Item Type: VIO Violation

FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION TO THE NRC WHICH IMPACTED A LICENSING DECISION.

Clinton Station management personnel informed NRC Region III by letter dated September 24, 2002, that two operators who had been examined for their operator licenses in August 2002 had long standing medical conditions that warranted reporting to the NRC for review. Both operators were issued a license by the NRC on August 30, 2002. The licensee originally sent NRC Form 396s for both operators to Region III on June 26, 2002, without including their medical records and did not recommend any license restrictions. One operator had a history of myocardial infarction and the other had a history of coronary heart disease. The medical conditions described above are considered potentially disqualifying in accordance with American Nuclear Standards Institute/American Nuclear Society (ANSI/ANS) 3.4, 1983, and should have been reported to the NRC with a request for issuance of a license with a "no solo" restriction. When the licensee informed the NRC on September 24, 2002, of the medical conditions of the two operators there still was no request for an amended "no solo" license for either operator.

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The finding was determined to be of low safety significance because the operators had not acted in a solo capacity prior to having their license's amended. However, the regulatory significance was important because the incorrect information was provided under sworn statement to the NRC and impacted a licensing decision for the two individuals. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

Inspection Report# : [2003002\(pdf\)](#)

Barrier Integrity

 **Significance:** Dec 31, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PERFORM A TS REQUIRED SURVEILLANCE

The inspectors identified a finding of very low safety significance (Green) concerning the licensee's failure to verify heatup and cooldown rates in accordance with Technical Specification (TS) following a scram on December 2, 2003. This was determined to be a NCV of TS surveillance requirement 3.4.11.1.

This finding was more than minor because if left uncorrected, failure to perform a TS surveillance could become a more safety significant issue. This finding was not suitable for SDP evaluation but has been reviewed by NRC management and was determined to be a finding of very low safety significance. This issue may have been greater than Green if the TS temperature limitations had been exceeded and if subsequent evaluation showed a degradation of the reactor coolant system integrity.

Inspection Report# : [2003009\(pdf\)](#)

Significance:  Feb 20, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO ISOLATE AN INOPERABLE PRIMARY CONTAINMENT ISOLATION VALVE WITHIN THE ALLOWED ACTION TIME

A finding of very low safety significance was identified through a self-revealing event when operators failed to close a motor operated valve prior to de-energizing it when taking the valve out of service. The open valve resulted in an inoperable containment isolation pathway. The primary cause of this finding was related to the cross-cutting area of human performance. This finding is more than minor because it involved the attribute of configuration control under the Barrier Integrity Cornerstone. The finding is of very low safety significance because actual containment integrity was not breached. The failure to isolate an inoperable containment penetration was identified as a Non-cited Violation of Technical Specification 3.6.1.3.

Inspection Report# : [2003003\(pdf\)](#)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

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