

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
 CLINTON

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/12/2000	1999018	<b>Pri:</b> OPS <b>Sec:</b>	Self	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Poor coordination within the operations department results in a radioactive spill.</b>  Poor coordination within the operations department resulted in the initiation of work on a waste collector tank prior to the draining of its contents. This led to an overflow of the floor drain system and the spill of a water/resin mixture in the ultrasonic resin cleaner tank room.
<b>Dockets Discussed:</b> 05000461 Clinton						
01/12/2000	1999018	<b>Pri:</b> OPS <b>Sec:</b> PLTSUP	Licensee	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Y2K Preparations</b>  During the Year 2000 rollover, no grid disturbances, plant transients, or equipment problems occurred. Two minor Year 2000 related software problems, which were not previously anticipated, were identified on January 2, 2000. One problem involved a graphics program and the other affected the automatic channel-check function for the area and process radiation monitoring system. Neither problem had an operational impact on the plant and the licensee promptly corrected both problems.
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> OPS <b>Sec:</b>	NRC	WK	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Unplanned Technical Specification entry</b>  An unplanned Technical Specification entry occurred due to a system knowledge deficiency on the part of the licensee and a lack of attention-to-detail. Specifically, operations personnel did not question the operability impact on reactor water cleanup (RT) system pump room monitoring and isolation instrumentation from leaving the "A" RT pump room door open.
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> OPS <b>Sec:</b>	NRC	WK	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>Shift management did not fully evaluate the potential impacts associated with installing a logic analyzer in t</b>  Initiatives to address operator performance weaknesses were developed and implemented prior to the plant restart in May 1999. This resulted in improved operator performance which has been sustained to this point. However, the failure to fully evaluate rod control and information system troubleshooting activities indicated that improvement is still needed in the command and control of plant activities
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Improper main control room atmosphere</b>  The inspectors determined that the communication methods used during the calibration of a radiation monitor (specifically shouting in the MCR) did not meet the licensee's conduct of operations standards. Control room supervision did not correct this issue until they were questioned by the inspectors.
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Allowed outage times during online maintenance effectively managed.</b>  The inspectors concluded that the licensee effectively managed allowed outage times during Division III planned maintenance activities. Delays were encountered following a high pressure core spray system breaker trip due to the need to acquire testing equipment from another facility. The inspectors determined that one of the licensee's work week critiques did not provide sufficient details of problems encountered during the work week. As a result, the value of the critiques was limited
<b>Dockets Discussed:</b> 05000461 Clinton						

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11/17/1999	1999020-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3B <b>Sec:</b> 1C <b>Ter:</b>	<b>Failure to notify the NRC within 30 days of learning of the diagnoses of a medical condition not meeting requi</b>  The inspectors identified a non-cited violation involving the failure of the licensee to notify the NRC in five separate instances of permanent changes in licensed operators' medical conditions regarding hypertension contrary to the requirements of 10 CFR 55.21. Therefore, the NRC was not given the opportunity to evaluate the medical status and condition of the licensees if appropriate. The safety significance was low because the affected licensed operators would normally be on shift with other licensed operators and solo operation was of low probability.
<b>Dockets Discussed:</b> 05000461 Clinton						
10/18/1999	1999015-01	<b>Pri:</b> OPS <b>Sec:</b> PLTSUP	NRC	NCV	<b>Pri:</b> 3C <b>Sec:</b> 1C <b>Ter:</b>	<b>Failure to control the operator aid program in accordance with procedures and to have an adequate procedu</b>  The inspectors identified that operator aids tracking was inconsistent, recommendations to replace long-standing operator aids were either not provided or were untimely, and an unauthorized operator aid was in use on a main control room panel. The inspectors identified an inadequate procedure for removing chemistry equipment from service.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Referencing wrong main control room instrumentation channel.</b>  The inspectors' query prompted the licensee to identify that control room operators were referencing the wrong channel for off-gas system release rates. Initially, operations management only addressed the issue internally with all operators. Later, a condition report was written for trending purposes. Based on discussions with the inspectors, the licensee decided that the classification would be raised to a higher level to ensure the extent of condition of this issue was evaluated.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Failure to place OOS switch in INOP</b>  Operations personnel generally responded to plant annunciators in a timely manner, referenced the appropriate annunciator response procedures, made sufficiently detailed log entries, and appropriately referenced Technical Specifications and Limiting Conditions for Operation when necessary. However, the inspectors identified a Non-Cited Violation for a discrepant control board indication which had gone unnoticed by control room operators for 7 hours.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 4B <b>Ter:</b> 2A	<b>Prompting was needed to ensure operability determination completion.</b>  Inspector prompting was needed for operations and engineering personnel to recognize that an operability determination should have been completed to evaluate the impact of increased valve weight on the operability of the high pressure core spray system. This indicated a need to further improve the operability determination program and engineering support to operations.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b>	<b>Out-of-service annunciators.</b>  The inspectors determined that although the total number of out-of-service annunciators had slowly increased since plant restart, improvements had been made in the management of the out-of-service annunciator program.
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07/28/1999	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> 3A <b>Ter:</b>	<b>Operators did not use good judgement when exiting TS LCOs</b> The inspectors determined that operators did not provide sound technical justification before exiting four Technical Specification Action Statements associated with the unexpected opening of a turbine bypass valve.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Operators frequently used Technical Specificaitons</b> The inspectors concluded that operations personnel frequently referenced the Technical Specifications (TS) and independently assessed issues with the potential to impact TS requirements.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 5A <b>Ter:</b>	<b>Failure to critically review work schedule &amp; barricade access to protected equipment during high risk</b> One Non-Cited Violation was identified for the failure to follow procedural requirements to post and/or barricade access to plant areas containing equipment considered necessary to maintain on-line safety at an acceptable level. Specifically, plant areas containing equipment associated with the high pressure core spray system were not posted to inform workers that work was not allowed on this equipment while the RCIC system was inoperable. A sample would most likely have been obtained from the Division III emergency diesel generator (EDG) expansion tank while the RCIC system was inoperable had the inspectors not informed plant management that a technician was in the process of collecting samples from all three EDGs.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b> 3C	<b>Operations personnel did not understand expectations for control room supervisor oversight</b> The inspectors determined that operations personnel did not understand management expectations for control room supervisor oversight during changes in reactivity.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>Management expectations for documenting unexpected annunciators were vague</b> The inspectors determined that management expectations for documenting unexpected annunciators were vague and not completely understood by operations personnel.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>Licensee did not identify and correct the root causes of the first of two valve failures</b> Operators reacted well to challenges encountered during the failure of valve 1FW004 on two occasions. However, the licensee did not identify and correct the root causes of the first valve failure which resulted in an unnecessary challenge to operators during restart activities when the valve failed a second time. This was indicative of a need to improve the effectiveness of the corrective action program
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06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Plant operators methodically and cautiously conducted plant restart activities</b>  Plant operators methodically and cautiously conducted plant restart activities and, in most cases, exhibited conservative decision-making when challenging situations were encountered. For example, operators manually scrambled the plant after a startup feedwater flow control valve malfunctioned and stopped their approach to criticality when unusual reactor period readings were observed.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>Overall operator performance was acceptable</b>  While overall operator performance during the plant restart was acceptable, NRC inspectors identified several instances where plant management's expectations for the conduct of operations were not clearly understood by all operators, occasions where suspect plant conditions were either not recognized or were not thoroughly evaluated by the operators, and instances where procedural requirements were not followed
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3B <b>Sec:</b> 5A <b>Ter:</b>	<b>Operators failed to recognize that conditions existed which required entry into Technical Specification</b>  The failure of operators to recognize that conditions existed which required entry into Technical Specification (TS) limiting condition for operations on three occasions was indicative of the need to improve operators' knowledge of TS requirements. One Non-Cited Violation with three examples was identified associated with this issue. (NCV 50-461/99010-01)
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b>	<b>Operations personnel exhibited a conservative safety focus in deciding to insert the control rods</b>  The inspectors determined that operations personnel exhibited a conservative safety focus in deciding to insert the control rods following an unexplained period indication. However, engineering support to operations was poor during this event in that the abnormal period meter indications were not explained and the fact that the reactor was critical was either not recognized or not effectively communicated to the operators
<b>Dockets Discussed:</b> 05000461 Clinton						
04/21/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 1C <b>Ter:</b>	<b>Long term corrective actions were not scheduled</b>  The licensee implemented or planned several interim corrective actions designed to sustain adequate performance in the operations functional area through restart. However, long-term corrective actions described in the Plan-For-Excellence had not been scheduled for completion following restart of the facility
<b>Dockets Discussed:</b> 05000461 Clinton						
04/21/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b> 1C	<b>Correct actions to resolve deficiencies in the work control process were adequate</b>  The licensee's planned corrective actions to resolve deficiencies in the work control process were considered adequate to support closure of this aspect of NRC Manual Chapter 0350 Case-Specific Checklist (CSC) Restart Item II.1, "Establish and Implement Continuing Operator Training Emphasizing Technical Specification Adherence/Knowledge and Recognition of Degraded Conditions." However, the effectiveness of the licensee's planned corrective actions to sustain improvement is considered an Inspection Follow-up Item. Licensee actions to address the other aspects of this CSC restart item were documented in NRC Inspection Report 50-461/99006. Based on the inspection results documented in that report and this report relative to CSC Restart Item II.1, this item is considered closed
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04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 2B <b>Ter:</b>	<b>Lack of rigor in the work control supervisors' review of work packages</b>  A lack of rigor in the work control supervisors' review of work packages and questioning of work group personnel resulted in the approval of poor work packages and the failure to communicate ongoing work activities to the operators and subsequently, frequent challenges to the operators. As a result, the main control room operators were not always aware of expected alarms and research was necessary to answer their questions regarding plant activities. After the inspectors identified this concern to licensee management, the screening of work packages and the questioning of work group personnel improved.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b> 5B	<b>Operators responded effectively to equipment failures</b>  The operators responded appropriately to malfunctioning equipment. The licensee properly identified and classified action requests as main control room deficiencies when appropriate.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Operators properly implemented safety system tagout activities.</b>  Operators properly implemented safety system tagout activities. However, the inspectors identified some problems with the procedural guidance contained in Procedure CPS No. 1014.01, "Safety Tagging," and with operator understanding of the procedural guidance. These included a lack of guidance for disabling vane-type air operated valves without accumulator air bleed valves; a lack of procedural understanding by operators for safety tag placement on electrical breakers; a lack of procedural guidance for on/off electrical breakers with non-functioning mechanical interlocks; and a lack of administrative guidance for documenting an annual field verification of active safety tagouts.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Main control room personnel correctly and consistently used three-part communication techniques</b>  Main control room personnel correctly and consistently used three-part communication techniques with very few exceptions. When communications errors occurred, main control room personnel promptly corrected them to ensure that communications standards were met. Formal and consistent pre-job briefings contained pertinent information necessary for the safe operation of the plant. However, the inspectors noted that one of the eight pre-job briefings observed did not include specific actions for malfunctions and unexpected conditions, and licensee personnel did not clearly state termination criteria during the briefing.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>The main control room operators' narrative logs were complete and accurate.</b>  The main control room operators' narrative logs were complete and accurate. However, the inspectors also concluded that the log taking process was cumbersome and required the "B" reactor operator to spend the majority of the shift making log entries.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>Shift staffing consistently met procedural requirements.</b>  Shift staffing consistently met procedural requirements. In general, the main control room operators conducted informative individual turnovers and briefings in a formal manner with all participants attentive to the information presented.
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04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 4B <b>Ter:</b>	<b>The licensee's operability determinations and evaluations provided sufficient detail</b>  The licensee's operability determinations and evaluations provided sufficient detail to support the conclusion that the associated equipment was operable. However, in one instance, the operators did not promptly pursue an operability question with the only operable emergency diesel generator and performed other unrelated work before conducting a surveillance test on the emergency diesel generator. The safety impact of this situation was minimal because the licensee eventually declared the emergency diesel generator operable based on an appropriate operability determination.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>The inspectors concluded that the operator workarounds would not significantly complicate the startup</b>  The inspectors determined that the operator workarounds, operator challenges, and the main control room deficiencies that would not be resolved prior to unit startup would not significantly complicate plant operations. The inspectors concluded that the licensee had established an adequate program to identify, track, and resolve operator workarounds and main control room deficiencies. Consequently, NRC Manual Chapter 0350 Case Specific Checklist Restart Item IV.1, "Establish Program to Reduce and Maintain Main Control Room Deficiencies," was closed by the NRC Oversight Panel.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 1A <b>Ter:</b>	<b>The control room supervisors and operations shift management controlled the surveillance test</b>  The control room supervisors and operations shift management reviewed, approved, and controlled the surveillance test result packages in accordance with the surveillance test control program procedures.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 1A <b>Ter:</b>	<b>The main control room operators understood the reasons for all lit annunciators</b>  The main control room operators understood the reasons for all lit annunciators on the main control room panels. However, the inspectors noted inconsistent operator response to expected alarms, including failures to properly announce alarms, during the first week of the inspection. After the inspectors identified this concern to licensee management, alarm response performance improved and was appropriate during the second onsite week of the inspection.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 1A <b>Ter:</b>	<b>Control room personnel and work control supervisors were knowledgeable of TS requirements</b>  The control room supervisors, main control room operators, and work control supervisors were knowledgeable of technical specification requirements for various plant operational modes. These individuals correctly interpreted technical specifications associated with alternating current power sources and the availability of shutdown cooling. The operators promptly recognized degraded plant conditions and correctly implemented technical specifications following identification of several emergent equipment problems.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Control room supervisor failed to observe reactivity manipulations</b>  In general, the operators properly used and adhered to procedures. However, during a control rod venting evolution, the inspectors identified that, contrary to procedure, a control room supervisor failed to directly supervise reactivity manipulations for several minutes. This failure to follow procedure was a non-cited violation.
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04/07/1999	1999004-02	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Two instances in which the licensee did not maintain non-narrative operations records</b>  The inspectors identified two instances in which the licensee did not maintain non-narrative operations records rigorously. A non-cited violation was identified concerning a failure to perform a quarterly temporary modification audit and the licensee would have been untimely in performing a quarterly out-of-service annunciator audit had the inspectors not intervened.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004-03	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 2B <b>Ter:</b> 3C	<b>Examples of inadequate procedures</b>  The inspectors determined that the operations procedures reviewed, with only a few exceptions, were adequate to perform the intended tasks. These exceptions included a control rod scram time surveillance test procedure which failed to direct the withdrawal of subsequent control rods under the existing plant configuration and an emergency diesel generator surveillance test procedure which failed to ensure that acceptable frequency and voltage requirements could be met. The inspectors considered these inadequate procedures to constitute non-cited violations. The licensee addressed the issue in the corrective action program as Condition Report No. 1-99-03-236, dated March 17, 1999.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>The licensee's review of procedures to support CSC Restart Item II.3, was narrowly scoped</b>  The inspectors determined that the licensee's review of procedures to support CSC Restart Item II.3, "Review and Revise Abnormal Operations Sections of Operating Procedures," was narrowly scoped in that only 3 of 47 procedures were reviewed following the licensee's determination that a significant number of operating procedures required revision prior to restart. Following additional inspector prompting, the licensee completed the review and revision of the remaining procedures. The inspectors determined that the licensee had resolved the concerns associated with CSC Restart Item II.3
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 3A <b>Ter:</b> 2A	<b>The inspectors identified an example of a previously identified violation concerning compensatory actions</b>  The inspectors identified another example of a previously identified violation for the failure to ensure that the completion of compensatory actions for degraded equipment was documented in the control room journal. The previous violation was identified as a NCV. (NCV 50-461/98020-02).
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 3B <b>Ter:</b>	<b>Initial documentation provided to support closure of CSC Restart Item II.1, was narrowly focused</b>  The inspectors concluded that the initial documentation provided to support closure of Case Specific Checklist (CSC) Restart Item II.1, "Establish and Implement Continuing Operator Training Emphasizing Technical Specification Adherence/Knowledge and Recognition of Degraded Conditions," was narrowly focused and did not contain the supporting information for the actions the licensee had indicated were taken to resolve this item. Subsequently, operations and training department personnel provided supplemental information to the inspectors to support resolution of each issue associated with this item except those related to work control. Consequently, CSC Restart Item II.1 will remain open pending the review of corrective action documentation related to various aspects of the work control process
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04/07/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Operations personnel had improved performance in areas of communications and shift turnovers</b> The inspectors determined that operations personnel had improved performance in the areas of communications, shift and relief turnovers. Technical Specification and procedure implementation, and peer checks were frequently used in the control room.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>Failure to provide adequate oversight to maintain professional atmosphere in MCR</b> The inspectors identified one non-cited violation with five examples due to the inadequacies in the conduct of control room activities. The violation examples involved the failure to minimize distractions and loitering in the control room; inappropriately conducting training in the at-the-controls area; the failure to understand the expected plant response before proceeding with a unit substation bus outage; the failure of a management member to be present for a significant, infrequently performed test or evolution brief; and the failure to monitor control room panels.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Several weaknesses identified by the Integrated Safety Assessment (ISA) continued to exist</b> Several weaknesses identified by the Integrated Safety Assessment and Special Evaluation Team Inspections, such as log keeping, safety tagging and equipment status control continued to exist.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 5B <b>Ter:</b>	<b>Some, root causes were narrow in scope and corrective actions did not address the root causes.</b> In a number of instances, the root causes for significant conditions adverse to quality were narrow in scope and the associated corrective actions did not effectively address the root causes.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>The threshold for documenting conditions adverse to quality was conservatively low</b> The threshold for documenting conditions adverse to quality was conservatively low and the Operations Department personnel exhibited a self-critical attitude.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>The Operations Department effectively assessed, used, and disseminated industry operating experience</b> The Operations Department effectively assessed, used, and disseminated information pertaining to industry operating experience events.
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 1A <b>Ter:</b>	<b>Operations Department personnel were implementing the operability determination program in an appropriate and effective manner.</b> Operations Department personnel implemented the operability determination program in an appropriate and effective manner.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b> 1A	<b>The Operations Department adequately implemented changes to the CPS Corrective Action Program</b> The Operations Department adequately implemented changes to the Corrective Action Program. However, further improvement is needed in areas such as root cause analysis, corrective action development, and trending.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Overall, the Operations Department was effective in resolving problems</b> Overall, the Operations Department was effective in resolving problems
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b>	<b>Failure to have the shift manager position report to an individual off-shift with a CPS SRO license.</b> The licensee failed to properly implement the requirement of Technical Specification (TS) 5.2.2.f by having the Shift Manager position report to an individual who did not hold a senior reactor operator license. One Non-Cited Violation was identified.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001-02	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5C <b>Sec:</b> 5A <b>Ter:</b>	<b>Failure to properly assign a corrective action due date commensurate with its safety significance.</b> Weaknesses were identified in the implementation of the management staff member role and the Corrective Action Review for Effectiveness Program. The licensee failed to implement corrective actions to address a concern regarding the review of condition reports. One NCV was identified.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3B <b>Sec:</b> 1A <b>Ter:</b>	<b>1998 licensed operator performance during requalification examination was poor.</b> The licensee determined that licensed operator performance during the 1998 licensed operator requalification examination was poor. The licensee identified a large number of operator errors and operators demonstrated weaknesses with Emergency Operating Procedure usage, system and equipment control manipulation, communications, teamwork, and emergency action level classification.
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02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5A <b>Sec:</b> 1A <b>Ter:</b> 3B	<b>The licensee identified a number of problems with the Licensed Operator Requalification Training</b>  The licensee identified a number of problems with the Licensed Operator Requalification Training (LORT) program, including inadequate use of available feedback to improve the LORT program, insufficient simulator training time, poor change management, poor examination results documentation, lack of a sample plan for the 1998 examination, and a lack of operator performance trending in the simulator. However, the licensee did not realize the extent of the problems until a large number of operator performance issues surfaced during the annual licensed operator requalification examination.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Improvements in communications</b>  The inspectors observed continuous improvement in crew communications, teamwork, and event diagnosis during the multiple dynamic simulator training exercises. The licensee's training staff conducted these exercises to address the poor operator performance noted during the 1998 licensed operator requalification examinations.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Licensed operator medical records were complete</b>  The inspectors identified that the licensed operator medical records were complete, physicals were timely, and required medical restrictions had been incorporated into associated individual licenses.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b>	<b>Performance during the dynamic simulator scenario re-examinations had improved</b>  Overall operator performance during the dynamic simulator scenario re-examinations had improved when compared to the operator performance observed during the 1998 licensed operator requalification examination.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b>	<b>Operator performance during the dynamic simulator scenario re-examinations was acceptable.</b>  Overall, the licensee's process for administering examinations and evaluating both crew and individual operator performance during the dynamic simulator scenario re-examinations was acceptable.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b> 3C	<b>The licensee developed a fairly comprehensive program for remediation and re-evaluation</b>  The licensee developed a fairly comprehensive program for remediation and re-evaluation of unsatisfactory crew and individual performance following the 1998 licensed operator requalification examination. The use of various remediation and re-evaluation techniques, which depended upon the nature of the failures, was appropriate. The licensee's use of video reviews and simulator exercises appeared to be effective in remediating poor operator performance.
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02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Licensee's simulator staff effectively identified and corrected simulator discrepancies</b> The inspectors concluded that the licensee's simulator staff effectively identified and corrected simulator discrepancies in a timely manner. The licensee's plant specific control room simulator generally provided consistent and realistic plant response under normal, abnormal, and emergency conditions.
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02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> 1A <b>Ter:</b>	<b>The licensee's investigation and root cause for high operator requalification failure rate was thorough.</b> The licensee's investigation and root cause report associated with condition report number 1-98-09-281, "Unacceptably High Number of Failures in the 1998 Licensed Operator Annual Requalification Examinations," was thorough, resulting in the licensee's identification of a number of licensed operator requalification training program deficiencies.
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02/17/1999	1998029	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 1A <b>Ter:</b> 5B	<b>The licensee developed and implemented appropriate corrective actions for requalification problems</b> The licensee developed and implemented appropriate corrective actions for the Licensed Operator Requalification Training program based on the root cause analysis for the unsatisfactory operator performance identified during the 1998 licensed operator requalification examination.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Operations personnel did not meet the guidance for timely declaration of Unusual Event</b> The inspectors determined that operations personnel did not meet the guidance in NRC Emergency Preparedness and Radiation Protection Branch Position (EPPOS) No. 2, "Timeliness of Classification of Emergency Conditions," for declaration of the January 6, 1999, notice of unusual event (NOUE). Specifically, operations personnel declared the NOUE 26 minutes after the initiation of the LOOP even though the guidance in NRC EPPOS No. 2 specified that event declaration should occur within 15 minutes. Additionally, expectations for the timeliness in declaring emergency action levels in response to events were not specified in procedures for preparing and conducting emergency exercises
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>The licensee's annunciator response procedures did not reference the TS associated with the alarming condi</b> The inspectors determined that in most cases, the annunciator response procedures did not reference the Technical Specifications associated with the alarming condition
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 1B <b>Ter:</b> 3B	<b>The inspectors determined that the licensee's critique of the LOOP and NOUE was not sufficiently critical</b> The inspectors determined that the licensee's critique of the LOOP event was not sufficiently critical to identify issues involving operator knowledge weaknesses, procedure discrepancies, timeliness of event declaration, and delays in the shift turnover process. Following discussions with the inspectors, the licensee initiated an event review team and conducted an effective assessment of the issues and concerns to identify issues involving operator knowledge weaknesses, procedure discrepancies, timeliness of event declaration, and delays in the shift turnover process.
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02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> 3C <b>Ter:</b>	<b>The licensee's review of procedures to support closure of CSC Restart Item II.3 was ineffective</b>  The inspectors determined that the licensee's review of procedures to support closure of Case Specific Checklist (CSC) Restart Item II.3, "Review and Revise Abnormal Operations Sections of Operations Procedures," was ineffective in that the assessment did not determine that approximately 244 procedure changes associated with 113 operations procedures involved technical issues which needed to be addressed prior to restart or prior to the next time the procedure was used
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Operations personnel responded appropriately to a loss of offsite power</b>  The inspectors determined that operations personnel responded appropriately to a loss of offsite power (LOOP) involving a Notice of Unusual Event (NOUE) declaration in that procedures were used in-hand, peer checks were frequently conducted, three-way communication techniques were good, and off-shift personnel were effectively utilized without becoming a distraction to the operating crew
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	WK	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Operator knowledge of the interlocks associated with the 4160V bus feeder breakers was a weaknesses</b>  The inspectors identified operator knowledge weaknesses regarding the interlocks associated with the 4160V vital bus feeder breakers
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1B <b>Sec:</b> 3C <b>Ter:</b> 4A	<b>Non-Cited Violation for the failure to translate design requirements into annunciator response procedures.</b>  The inspectors identified one Non-Cited Violation for the failure to translate design requirements into annunciator response procedures. Specifically, the design requirements for the operation of the 4160V 1A1 main and reserve feeder breakers following a trip of the emergency diesel generator was incorrectly translated into Procedure 5060.01, "Alarm Panel 5060 Annunciators - Row 1"
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002-02	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b> 5B	<b>The licensee did not log EDG starts or formally track lightly-loaded run times for each EDG</b>  The inspectors concluded that the licensee did not log EDG starts or formally track lightly-loaded run times for each EDG, which could result in the licensee failing to take necessary actions to ensure EDG reliability. One Non-Cited Violation was identified concerning this issue
<b>Dockets Discussed:</b> 05000461 Clinton						
01/12/2000	1999018	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 1A <b>Ter:</b>	<b>Preventive maintenance impact on plant operations not consistently addressed.</b>  The inspectors determined that engineering and maintenance personnel did not have a common understanding of the preventive maintenance review process. As a result, personnel were not consistently identifying and addressing the impact of equipment concerns on plant operations, specifically how out of tolerance results could affect annunciator operation.
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10/18/1999	1999015-02	<b>Pri:</b> MAINT <b>Sec:</b> OPS	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to conduct adequate post maintenance testing following diesel generator maintenance.</b>  The inspectors concluded that the failure to conduct adequate post-maintenance testing following a Division II emergency diesel generator outage resulted in the failure to identify that a small diesel fuel leak to the lube oil existed. Subsequently, oil analysis results were not reviewed in a timely manner which resulted in the failure to promptly identify this significant condition adverse to quality. Two Non-Cited Violations were identified (Section M8.1).
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 4B <b>Ter:</b>	<b>Maintenance procedure deficiencies.</b>  The inspectors and the licensee have identified multiple examples of deficiencies with maintenance procedures over the last 3 months. The procedure deficiencies have caused equipment problems and plant transients that have unnecessarily challenged operations personnel. A broad scope review of maintenance procedures had not been initiated and was not planned to be completed until the end of 1999.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014-03	<b>Pri:</b> MAINT <b>Sec:</b> OPS	Licensee	NCV	<b>Pri:</b> 2A <b>Sec:</b> 1C <b>Ter:</b>	<b>Providing inadequate instructions for FIN Team safety tagouts</b>  One Non-Cited Violation was identified regarding inadequate procedures which were used for equipment control during fix-it-now (FIN) team activities. Specifically, Procedure 1014.01, "Safety Tagging," Revision 27, was inadequate in that it did not provide clear equipment control instructions for FIN team safety tagouts.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 1A <b>Ter:</b>	<b>Maintenance personnel did not provide TS required data to operators in a timely manner resulting in an LCO</b>  The failure of maintenance personnel to deliver surveillance test results in a timely manner to operators resulted in an unnecessary TS Limiting Condition for Operation entry, and poor communications by operators led to the failure to initiate channel checks on a radiation monitor following its calibration. These examples were indicative of the need to further improve the control of work affecting adherence to TS requirements.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 5B <b>Ter:</b>	<b>Inadequate use of risk analysis during surveillance testing</b>  The licensee failed to promptly implement recommendations developed by the probabilistic risk assessment group to minimize plant risk during standby liquid control system surveillance testing even though the testing configuration and methodology placed the plant in an unacceptable risk condition and increased the containment failure frequency by a factor of 180.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 5B <b>Ter:</b>	<b>Work management did not recognize impact of other activities on equipment operability</b>  The inspectors concluded that the failure of work management personnel to recognize that several activities that were not part of the surveillance test or preventive maintenance task programs, such as RCIC system cold start testing, should have been evaluated for potential operability impacts, was a weakness in the licensee's operability determination program.
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07/28/1999	1999013-02	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> 5A <b>Ter:</b> 5B	<b>Failure to ensure that a TS entry was not required during the performance of minor maintenance</b>  Three examples of a Non-Cited Violation were identified for electrical maintenance and controls and instrumentation personnel using the minor maintenance process to conduct work which required entry into a TS Limiting Condition for Operation or operational requirements manual required action and/or resulted in disabling the safety function of the component.
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06/15/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b>	<b>Improvements were needed in the licensee's nuclear instrument surveillance and calibration programs</b>  The licensee encountered problems during plant restart activities with source range monitor (SRM) surveillance tests, SRM channel checks, SRM calibrations, SRM and intermediate range monitor overlap, and intermediate range monitor correlation. Based on these issues, the inspectors concluded that improvements were needed in the licensee's nuclear instrument surveillance and calibration programs.
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06/15/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Fix-It-Now (FIN) team continued to unnecessarily challenge main control room operators</b>  The inspectors determined that maintenance activities conducted by the Fix-It-Now (FIN) team continued to unnecessarily challenge main control room operators in that FIN team personnel started two work activities without first notifying operations personnel, and the work activities caused unexpected annunciators to alarm in the main control room. Inspector prompting was necessary to ensure FIN team-related human performance deficiencies were entered into the corrective action program.
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06/15/1999	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3B <b>Ter:</b>	<b>Inspector prompting was necessary during turbine testing to ensure prerequisites met</b>  During turbine testing, inspector prompting was necessary to ensure that operations personnel did not proceed until lamp test results were understood, that prerequisites were completed, and that acceptance criteria were met
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010-02	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> 2A <b>Ter:</b>	<b>Non-Cited Violation for the failure to implement a tagout while administratively controlling TS equipment.</b>  The inspectors identified one Non-Cited Violation for the failure to implement a tagout while administratively controlling TS equipment
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010-03	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> 2A <b>Ter:</b>	<b>Non-Cited Violation for the failure to conduct a 20-minute maintenance run on the RCIC turbine</b>  The inspectors identified one Non-Cited Violation for the failure to conduct a 20-minute maintenance run on the reactor core isolation cooling system turbine at greater than 1500 revolutions per minute as required by the licensee's procedure.
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06/15/1999	1999010-04	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b>	<b>Failure to provide an adequate procedure for shutdown service water pump motor maintenance</b> The inspectors determined that a violation occurred involving an inadequate procedure for establishing the proper air gap on the motor bearing for shutdown service water Pump 1SX01PB. The licensee appropriately identified the cause of the failure and implemented corrective actions which should preclude recurrence. The violation was not cited.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 1A	<b>Poor communications resulted in confusion between operations and FIN team personnel</b> Poor communications resulted in confusion between operations and Fix-It-Now team personnel and created an unnecessary distraction in the control room.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006-02	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to provide oversight to maintain professional atmosphere in the main control room.</b> The inspectors identified one non-cited violation for the failure to conduct adequate post-maintenance testing after completing work on air-operated containment isolation valve
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006-04	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3C <b>Sec:</b> 2B <b>Ter:</b>	<b>Excessive use of FIN overtime</b> The inspectors identified one non-cited violation due to the failure to maintain adequate Fix-It-Now team shift coverage without the heavy use of overtime. In addition, the licensee did not have an effective program for limiting excessive overtime for team individuals working on safety-related activities
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999004-04	<b>Pri:</b> MAINT <b>Sec:</b> OPS	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> 1A <b>Ter:</b>	<b>EDG test procedure inadequate</b> Emergency diesel generator surveillance test procedure was inadequate in that it did not ensure that acceptable frequency requirements could be met. The licensee addressed this issue in the corrective action program as Condition Report No. 1-99-03-426, dated March 31, 1999.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 5A <b>Ter:</b>	<b>Overall, the Maintenance Department had incorporated performance improvement into practices.</b> Overall, both the Maintenance and Work Management Departments had incorporated a continuous performance improvement program into department practices. However, the inspectors identified examples of missed preventive maintenance items and missed surveillance tests, indicating that the licensee was not achieving the desired results in those areas through implementation of the continuous performance improvement program.
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03/25/1999	1999001	<b>Pri: MAINT</b> <b>Sec:</b>	NRC	POS	<b>Pri: 5A</b> <b>Sec:</b> <b>Ter:</b>	<b>The licensee's program to address industry operating experience events was acceptable.</b>  The licensee's program to address industry operating experience events was acceptable. Maintenance management recognized a weakness in retrievability of operating experience files and implemented appropriate corrective actions.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri: MAINT</b> <b>Sec:</b>	NRC	POS	<b>Pri: 5A</b> <b>Sec: 5B</b> <b>Ter:</b>	<b>Maintenance Department self-assessments were of sufficient scope</b>  Maintenance Department self-assessments were of sufficient scope and were an effective means of identifying deficiencies and proposing corrective actions. In some instances, performance indicators showed improving trends, indicative of effective corrective actions. Generally, audits and assessments were probing and critical resulting in the identification of program and process deficiencies.
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03/25/1999	1999001	<b>Pri: MAINT</b> <b>Sec:</b>	NRC	POS	<b>Pri: 5B</b> <b>Sec: 5A</b> <b>Ter:</b>	<b>Facility Review Group were sufficiently critical of root cause evaluations</b>  Overall, the Facility Review Group and Independent Assessment Group organizations were sufficiently critical of root cause evaluations and through their interactions with licensee staff, improved the quality of the final product.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri: MAINT</b> <b>Sec:</b>	NRC	POS	<b>Pri: 5C</b> <b>Sec:</b> <b>Ter:</b>	<b>The Maintenance Department adequately implemented changes to the corrective action program.</b>  The Maintenance and Work Management Departments adequately implemented changes to the corrective action program. Although further improvement was needed in root cause analysis and trending, changes to the corrective action program had improved effectiveness of both departments in identifying, analyzing, and resolving problems.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001-04	<b>Pri: MAINT</b> <b>Sec:</b>	Licensee	NCV	<b>Pri: 2B</b> <b>Sec:</b> <b>Ter:</b>	<b>Failure to check for and remove accumulated water from the Div II fuel oil storage tank every 92 days.</b>  The failure to check for, and remove accumulated water from the Division II fuel oil storage tank was an example where the requirement of TS 3.8.3.5 was not met and was a violation. However, this Severity Level IV violation is being treated as a Non-Cited Violation,
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001-05	<b>Pri: MAINT</b> <b>Sec:</b>	NRC	NCV	<b>Pri: 2B</b> <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform surveillance testing within the specified frequency of the technical specification</b>  The failure to perform the Division II degraded voltage relay channel functional test was an example where the requirement of TS 3.3.8.1.2 was not met and was a violation. However, this Severity Level IV violation is being treated as a Non-Cited Violation
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/25/1999	1999001-06	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform surveillance testing on Division II 4.16kV Bus undervoltage relay</b>  Licensee identified that a surveillance test was not performed within the specified TS frequency due to inadequate software change management. The failure to perform the Division II degraded voltage relay channel functional test was a violation of TS 3.3.8.1.2. This Severity Level IV violation was treated as a Non-Cited Violation.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-01	<b>Pri:</b> MAINT <b>Sec:</b> ENG	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to Revise TS Surveillance Acceptance Criteria</b>  The licensee failed to revise Technical Specification acceptance criteria associated with RCIC surveillance procedures to incorporate system head losses and other factors.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-11	<b>Pri:</b> MAINT <b>Sec:</b> ENG	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> 4B <b>Ter:</b>	<b>Failure to Correct Battery Cell Specific Gravities for Temperature</b>  During a review of battery maintenance and surveillance procedures, licensee personnel identified that the specific gravity measurement of safety-related battery cells was not properly temperature-corrected. The licensee conducted a root cause investigation and determined that the event was due to a misinterpretation of the requirements of Technical Specification Surveillance Requirement 3.8.6.2.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> 2B <b>Ter:</b>	<b>Molded case circuit breaker test not properly performed</b>  The inspectors determined that training and oversight of new molded case circuit breaker test personnel did not ensure that expectations for using the smallest gage wire during testing were implemented
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>The licensee's assessment of corrective action effectiveness for CSC Restart Item V.1 was not adequate</b>  The inspectors determined that the licensee's assessment of corrective action effectiveness for CSC Restart Item V.1, "Develop Process to Review Deferrals of Preventive Maintenance Items," was not sufficiently critical to identify deficiencies associated with implementation of the deferral process for late preventive maintenance items.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>The licensee conducted a thorough evaluation and inspection of the Division IV NSPS battery</b>  The inspectors determined that the licensee conducted a thorough evaluation and inspection of the Division IV nuclear system protection system battery after electrical maintenance personnel caused an accidental short circuit during maintenance on this battery
<b>Dockets Discussed:</b> 05000461 Clinton						

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02/16/1999	1999002-03	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform preventive maintenance items</b>  The inspectors identified one violation, for which enforcement discretion was exercised, concerning the failure to perform late preventive maintenance items tasks or process deferral requests prior to returning systems and components to an available status
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002-06	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform required channel calibrations</b>  Failure to perform required channel calibrations on the drywell and containment hydrogen and oxygen analyzers
<b>Dockets Discussed:</b> 05000461 Clinton						
01/12/2000	1999018-01	<b>Pri:</b> ENG <b>Sec:</b>	Self	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Failure to correctly translate design information into specifications.</b>  One Non-Cited Violation was identified concerning the failure to establish measures to ensure that design basis information was correctly translated into specifications for the high pressure core spray (HPCS) system minimum flow valve molded case circuit breaker. Specifically, the original specifications did not provide sufficient trip setting margins to ensure that the molded case circuit breaker did not trip during HPCS system operation. .
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Temporary Modification Program potential vulnerability.</b>  The inspectors identified a potential vulnerability in the licensee's temporary modification and troubleshooting processes in that malfunctions related to connecting troubleshooting equipment to operable plant components were not evaluated before commencing troubleshooting activities. The licensee revised its maintenance work order process to address this vulnerability. The revised process included steps to ensure that potential failure mechanisms were evaluated before connecting troubleshooting equipment to operable plant components.
<b>Dockets Discussed:</b> 05000461 Clinton						
10/18/1999	1999015-06	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>AOV program adverse trend not recognized</b>  The inspectors concluded that although numerous AOV and SOV surveillance test failures had occurred during the past several years, the licensee failed to identify the root causes of the failures and implement effective corrective actions to prevent recurrence of these failures. As a result, five of eight AOVs tested in the early part of this inspection period did not meet stroke time acceptance criteria. One example of a Non-Cited Violation was identified
<b>Dockets Discussed:</b> 05000461 Clinton						
10/18/1999	1999015-03	<b>Pri:</b> ENG <b>Sec:</b> MAINT	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 5A <b>Ter:</b>	<b>Untimely corrective actions to address fuel oil dilution issue on the Division II emergency diesel generator.</b>  The inspectors concluded that the failure to conduct adequate post-maintenance testing following a Division II emergency diesel generator outage resulted in the failure to identify that a small diesel fuel leak to the lube oil existed. Subsequently, oil analysis results were not reviewed in a timely manner which resulted in the failure to promptly identify this significant condition adverse to quality. Two Non-Cited Violations were identified.
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07/28/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Operability determination did not provide adequate detail</b> The inspectors determined that the initial operability determination/evaluation conducted after a high temperature alarm was received for the reactor core isolation cooling (RCIC) system gland seal compressor, lacked detail in that it did not consider the impact of increased steam leakage on standby gas treatment system operability, main control room dose, or the program for minimizing primary coolant leakage sources outside containment. Following inspector prompting, engineering personnel completed an additional review of the potential operability impacts and revised the operability determination/evaluation.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	WK	<b>Pri:</b> 4A <b>Sec:</b> 5B <b>Ter:</b> 5A	<b>Weakness in the licensee's program to control primary coolant leakage sources outside containment.</b> The inspectors identified one weakness in the licensee's program to control primary coolant leakage sources outside containment. Specifically, the licensee had not defined limits for maintaining leakage "as low as practicable" for those portions of systems outside containment that could contain highly radioactive fluids during a transient or accident (a Technical Specification requirement). As a minimum, operations and engineering personnel were not verifying continued compliance with 10 CFR Part 100 and GDC 19 dose limits following testing or the identification of new leakage sources.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b> OPS	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Engineering and training provided support during CW pump and a reactor recirculation system flow anomaly</b> Engineering and training personnel provided effective support to plant operators by providing timely evaluations and explanations for a degraded circulating water pump and a reactor recirculation system flow anomaly.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>ECP procedure was vague</b> Following the inspectors' questions, reactor engineers decided to revise an estimated critical position calculation (ECP) to account for an approximate 75 degree reduction in moderator temperature from the value used in the original calculation. The inspectors determined that the applicable procedure was vague in that it did not clearly state what a significant moderator temperature change was and, in turn, when a new ECP calculation was required.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Information provided for operability evaluation for the jet pump was not sufficient</b> Engineering personnel generally provided sufficient information to demonstrate compliance with TS surveillance test requirements. However, the information provided as part of an engineering operability evaluation for the jet pump, which was accepted by operators, was not sufficient to support the operability determination. This indicated a need for improvement in engineering personnel's rigor in performing operability evaluations and in operator's questioning attitude.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/15/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 5C <b>Ter:</b>	<b>The failure of engineering personnel to provide timely resolution of several technical issues</b> The failure of engineering personnel to provide timely and/or adequate resolution of several technical issues encountered during plant restart activities unnecessarily challenged operations personnel and indicated that engineering staff support to operations needed to be improved.
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04/21/1999	1999011	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Corrective actions resolved degraded grid conditions</b>  The inspectors concluded that the electrical distribution system design changes would resolve degraded voltage concerns and would restore Clinton Power Station to the original design basis by having an automatic degraded voltage detection scheme. Consequently, NRC Manual Chapter 0350 Case Specific Checklist Restart Item IV.4, "Resolve Degraded Voltage and Electrical Distribution," is considered closed
<b>Dockets Discussed:</b> 05000461 Clinton						
04/21/1999	1999011	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Operability evals adequate</b>  The inspectors concluded that the operability determinations, operability evaluations, and safety evaluations adequately addressed all modes of plant operation with current setpoint field settings. In addition, the inspectors concluded, based on their evaluation of sixteen instrument setpoint review packages, that the licensee had adequately demonstrated that sufficient margin existed between the field settings and their respective allowable value and analytical limit. Consequently, NRC Manual Chapter 0350 Case Specific Checklist Restart Item VI.3, "Validate the Adequacy of the Setpoint Program," is considered closed
<b>Dockets Discussed:</b> 05000461 Clinton						
04/21/1999	1999011-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	VIO IV	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b>	<b>Design basis information was not translated into a safety-related calculation.</b>  One violation was identified due to the failure of the engineering staff to assure that design basis information regarding the horsepower rating for the hydrogen mixing compressors was correctly translated into emergency diesel generator loading calculation 19-AK-05, despite having considered this issue closed in the corrective action system
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 2B <b>Ter:</b>	<b>The testing of the reserve auxiliary transformer static var compensator was well controlled.</b>  The inspectors observed that testing of the reserve auxiliary transformer Static VAR Compensator was well controlled. Potential coordination issues were minimized through the use of effective briefs and just-in-time training
<b>Dockets Discussed:</b> 05000461 Clinton						
04/07/1999	1999006-03	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform required post maintenance testing on containment isolation valve following maintenance.</b>  The inspectors identified one non-cited violation for the failure to complete an adequate safety evaluation prior to revising Procedure 1029.03, "Implementation of the Fix-it-Now Process," as required by 10 CFR 50.59
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Engineering performance indicators were not stand-alone</b>  Engineering performance indicators were not stand-alone and were not easy to understand. At the end of the inspection, corrective actions were being developed to address this issue.
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03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Inadequate corrective actions - several examples</b>  The NRC identified a number of examples where engineering personnel failed to ensure that problems were adequately resolved through the implementation of effective corrective actions.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<b>Modifications were adequately designed and installed.</b>  The NRC team reviewed a number of modifications and determined that the modifications were adequately designed and installed. However, two deficiencies related to post-modification testing were identified. One pertained to a failure to specify required post-modification testing (See NCV 50-461/99003-06) and a minor violation where a step to conduct a post-modification megger test of a transformer was removed from the modification package without documenting and evaluating the change.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b> 2A	<b>Established reasonable assurance that SSCs would perform their intended safety functions</b>  The team concluded that based on the review of System Design and Function Validation project findings, as well as an independent review of the reactor core isolation cooling system, the licensee had established reasonable assurance that safety-related structures, systems, and components would perform their intended safety functions as described in the design and licensing basis.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>Planned electrical distribution system changes were well-implemented.</b>  The team concluded that planned electrical distribution system changes and other initiatives to address degraded voltage concerns were well-implemented.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>Remote shutdown procedure incorporated the assumptions in the revised safe shutdown analysis</b>  The team concluded that the remote shutdown procedure adequately incorporated the assumptions in the revised safe shutdown analysis and that the procedure could be adequately implemented. In addition, the team concluded that all modifications to prevent fire induced valve damage to critical safe shutdown valves, as required by fire protection regulations, were completed. Finally, the team concluded that the program to address the fire-resistive technical concerns associated with Thermo-Lag was adequate.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>The quality of 10 CFR 50.59 screenings and safety evaluations had improved.</b>  The team concluded that the quality of 10 CFR 50.59 screenings and safety evaluations had improved. In addition, the program for ensuring that trained and qualified personnel prepared and reviewed 10 CFR 50.59 screenings and safety evaluations was adequate.
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03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Resolution of significant hardware deficiencies, the performance of engineering personnel was good</b>  The team concluded that with regard to the resolution of significant hardware deficiencies, the performance of engineering personnel was good. However, the team identified a number of examples where engineering personnel failed to ensure that less significant problems were adequately resolved through the implementation of effective corrective actions.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 4A <b>Ter:</b>	<b>Controls to ensure setpoint calculations were satisfactory</b>  The team concluded that the licensee had implemented satisfactory controls to ensure setpoint and design calculations would be properly controlled and were performing appropriate reviews to ensure safety-related setpoints and design calculations were conservatively set in the field.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-02	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Bypass Leakage Flowpaths Not Included in TS Surveillance</b>  The licensee failed to include all potential bypass leakage flowpaths into the total bypass leakage into specifications.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-04	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Failure to Revise Procedures to Reflect Maximum Valve Leakage</b>  The licensee failed to revise procedures to reflect the accurate maximum leakage of isolation valves in emergency core cooling system piping to storage tanks vented to atmosphere.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-06	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Failure to Prescribe Post-Modification Testing for VC Chillers</b>  The licensee failed to prescribe adequate safety-related chiller post-modification testing.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-08	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>Failure to Seismically Qualify Circuit Breakers</b>  The licensee failed to translate requirements for maintaining the seismic qualification of circuit breakers into procedures
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/18/1999	1999003-09	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5C <b>Sec:</b> 4B <b>Ter:</b>	<b>Operation at Less Than Minimum Required Grid Voltage</b> The licensee failed to immediately restore inoperable offsite circuits to an operable status during degraded voltage conditions. In April 1992, engineers raised a concern that the setpoints for the second level undervoltage relay in the auxiliary power system may not be correctly set. Subsequently, the licensee identified that since initial plant startup, if a loss-of-coolant-accident had occurred while grid voltage was low, sufficient voltage may not have been available for proper safety system operation. A review of previous bus voltage data determined that offsite voltage had gone below minimum grid voltage for several periods in the past.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003-10	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Failure to Prescribe Adequate Circuit Logic Testing</b> The licensee failed to prescribe adequate testing for suppression pool makeup system instrumentation, primary containment and drywall isolation instrumentation, and a portion of the logic circuitry for the thermal overload bypass circuit for the suppression pool dump valves.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/18/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 2B <b>Ter:</b>	<b>Improvement in engineering and maintenance activities</b> The team concluded that licensee efforts to address NRC concerns regarding circuit breakers had been effective. The team observed measurable improvement in engineering and maintenance activities relative to circuit breakers. The team concluded that the licensee adequately addressed each of the commitments in Confirmatory Action Letter RIII-97-009.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 4A <b>Ter:</b> 4B	<b>The licensee had resolved the concerns associated with CSC Restart Item IV.7</b> The inspectors determined that the licensee had resolved the concerns associated with CSC Restart Item IV.7, "Resolve Emergency Diesel Generator Concerns"
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002-04	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Design basis requirements had not been translated into maintenance procedures</b> The inspectors identified one Non-Cited Violation pertaining to the licensee's identification that design basis requirements had not been adequately translated into maintenance procedures and instructions involving the replacement of the Division I and II shutdown service water pump oil coolers. The licensee's corrective actions to review the generic implications of the Division I shutdown service water pump bearing failure on other large safety-related motors was timely and conservative
<b>Dockets Discussed:</b> 05000461 Clinton						
02/16/1999	1999002-05	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Failure to make a required 10 CFR 50.72(b)(2)(iii) report to the NRC within 4 hours of discovery</b> The inspectors identified one Non-Cited Violation for the failure to make a required 10 CFR 50.72(b)(2)(iii) report to the NRC within 4 hours of discovery that the shutdown service water system would not have performed its intended safety functions
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01/12/2000	1999018	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 1A <b>Ter:</b>	<b>Radiation protection personnel performance deficiencies.</b> The inspectors determined that radiation protection personnel performance deficiencies, such as failing to recognize and inform management of unusual radiological conditions and not maintaining a questioning attitude, existed in connection with a resin spill in the ultrasonic resin cleaner tank room.
<b>Dockets Discussed:</b> 05000461 Clinton						
01/12/2000	1999018	<b>Pri:</b> PLTSUP <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 1A <b>Ter:</b>	<b>Contamination control during maintenance effective was effective.</b> The inspectors determined that activities associated with lowering the upper containment pool level and controlling changing radiological conditions were effective as reflected in the licensee's accomplishing the evolution with a minimal increase in area dose rates and no changes in airborne contamination levels.
<b>Dockets Discussed:</b> 05000461 Clinton						
12/01/1999	1999016	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Emergency response drill performance adequate.</b> Based on observations during a recent emergency preparedness drill, the inspectors concluded that the licensee adequately demonstrated that its emergency response staff could assemble in a timely manner and take appropriate actions in response to plant accident conditions.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Radioactive material program weakness</b> The inspector identified weaknesses in the licensee's designation of personnel authorized to ship radioactive materials. For example, the inspector identified that an individual prepared and certified shipments prior to the written designation authorizing them for the activity. Although these inconsistencies were not a violation of regulatory requirements, they represented a potential for unqualified personnel to perform shipping activities.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Packing and shipping radioactive waste effective</b> The RP staff properly packaged and classified radioactive material and waste shipments in accordance with regulatory requirements. The shipping documentation and low level waste manifests contained the information required by 49 CFR Part 172 and 10 CFR Part 20.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Quality assurance reviews of radioactive waste program effective</b> The quality assurance and RP staffs performed effective reviews of the radioactive waste processing and radioactive material shipping program. Generally, assessment findings were adequately corrected by the RP staff.
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09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Storing radioactive waste in accordance with requirements.</b>  The licensee controlled and labeled stored containers of radioactive materials, and wastes were in accordance with the requirements contained in 10 CFR Part 20. In addition, the licensee had begun to implement corrective actions to address program weaknesses identified by the licensee's self assessments of this area.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Classifying radioactive waste effective</b>  The licensee established and implemented an effective program for the classification of radioactive wastes. The RP staff's methodologies for determining the waste classification of radioactive waste shipments were technically sound.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Radioactive waste handling training program adequate.</b>  The licensee's training program was consistent with U.S. Department of Transportation and NRC requirements and was sufficient to ensure that the staff was properly prepared to handle, package, and ship radioactive material.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/17/1999	1999019-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to follow radiation work permit for entry into a high radiation area.</b>  The licensee identified that an individual entered a posted high radiation area, while performing work on a radiation work permit which did not allow entry into a high radiation area. This failure to follow procedures was determined to be a Non-Cited Violation of regulatory requirements. The inspector concluded that the licensee had performed an appropriate review of the incident and had implemented corrective actions, which were commensurate with the error.
<b>Dockets Discussed:</b> 05000461 Clinton						
09/08/1999	1999014	<b>Pri:</b> PLTSUP <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 2B <b>Ter:</b>	<b>ALARA practices effective.</b>  The inspectors determined that licensee management effectively used As Low As Reasonably Achievable techniques to minimize radiation dose during the cleaning of the condenser water boxes. Specifically, an additional 5 percent reactor power reduction resulted in about 30 percent dose savings.
<b>Dockets Discussed:</b> 05000461 Clinton						
07/28/1999	1999013	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Licensee controllers and evaluators provided an accurate assessment</b>  Licensee controllers and evaluators provided an accurate assessment of activities during the June 16, 1999, emergency preparedness training drill. The licensee's observations and post-drill critiques were effective in recognizing strengths, weaknesses, and areas for continued improvement.
<b>Dockets Discussed:</b> 05000461 Clinton						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/11/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Chemistry technicians demonstrated effective procedure adherence</b> Chemistry technicians demonstrated effective procedure adherence while obtaining and analyzing chemistry samples. With one exception, concerning the quantitative transfer of materials, technicians prepared and handled samples with proper analytical techniques, which reduced the potential for cross contamination or for loss of materials.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>The chemistry staff effectively implemented the instrument quality control program</b> The chemistry staff effectively implemented the instrument quality control program to ensure the accuracy of chemistry analyses. The inspector observed that the staff properly identified instrument performance trends and out-of-tolerance data and that the staff had completed and planned actions to improve instrument performance.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b>	<b>The quality assurance department provided thorough assessments of chemistry performance</b> The quality assurance department provided thorough assessments of chemistry performance which were effective in identifying performance problems, including procedure adherence and contamination controls. The inspector noted that the chemistry staff completed corrective actions to address the identified problems.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b> 5A	<b>Chemistry department self assessments were critical and effective at identifying problems</b> Chemistry department self assessments were critical and effective at identifying problems and weaknesses in the chemistry program and in personnel performance. The chemistry staff was also properly identifying performance issues and documenting those issues in the station's corrective action system.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5C <b>Ter:</b>	<b>Chemical impurities in reactor water were generally maintained well within specifications</b> During the unit startup, the levels of chemical impurities in reactor water were generally maintained well within specifications. The licensee took appropriate actions to reduce elevated levels of sulfate and iron impurities, which had been above its administrative action levels. The inspector concluded that the startup water chemistry was similar to previous unit startups and that the level of impurities would not have resulted in any long-term acceleration of system corrosion rates.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Implementation of the access authorization program was acceptable</b> Implementation of the access authorization program was acceptable. Sufficient information was included in the process to allow clear determination of trustworthiness and reliability. Developed derogatory information was reviewed timely and evaluations assured safety.
<b>Dockets Discussed:</b> 05000461 Clinton						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/11/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Personnel, vehicle and package searches were professional and thorough.</b>  Personnel, vehicle and package searches conducted at entry points into the protected area were professional and thorough.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Communications within the security organization and among maintenance support organizations was good.</b>  Communications within the security organization and among maintenance support organizations was good. Observed meetings demonstrated the staff's open and informative expression of views.
<b>Dockets Discussed:</b> 05000461 Clinton						
06/11/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2A <b>Ter:</b>	<b>Maintenance for security systems was timely and effective</b>  Maintenance for security systems was timely and effective. The maintenance program effectively supported plant protection by ensuring that security equipment was operable and effective. The vehicle barrier system was properly maintained and met security plan commitments. The barriers were well maintained and capable of performing their function.
<b>Dockets Discussed:</b> 05000461 Clinton						
04/21/1999	1999011-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b>	<b>Failure to provide temporary protection to reduce a plant vulnerability to a fire</b>  One non-cited violation was identified due to the failure to stage alternate fire protection equipment following the removal of hydrant house 31 from service. The failure of operations personnel to communicate the status of disabled fire protection equipment to fire brigade members was considered a weakness
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5A <b>Sec:</b> 1C <b>Ter:</b>	<b>A lack of management attention resulted in RP assessments that were late and narrow in scope.</b>  A lack of management attention concerning the radiation protection departments' self-assessment process resulted in assessments that were late and narrow in scope. Several self-assessments lacked external team members and peer reviews and were performed by individuals directly involved with the task being assessed. Quality Assurance audits were critical and adequately addressed deficiencies. The QA audits served as a barrier to prevent large issues from being overlooked.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>The Plant Radiation Protection Department's communication practices sustained improvements</b>  The licensee's communication practices and As-Low-As-Reasonably-Achievable (ALARA) Program reflected sustained improvements.
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>RP personnel effectively implemented the CR process</b> The Condition Report (CR) statistics and results of personnel interviews indicated that radiation protection personnel were actively participating and accepting the CR process and exhibiting a willingness to self-identify and document problems.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b>	<b>The RP Departments' root cause and apparent cause evaluations (ACEs) were generally adequate</b> The RP Departments' root cause and apparent cause evaluations (ACEs) were generally adequate with corrective actions appropriate to the problem identified.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>The RP Departments effectiveness in identifying and resolving problems was considered adequate.</b> The plant radiation and chemistry departments effectiveness in identifying and resolving problems was considered adequate. The quality of root cause evaluations steadily improved over the last 6 months. The quality of apparent cause evaluations had improved, but in some cases, greater detail was required to support a conclusion that no unresolved safety questions existed.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 1C <b>Ter:</b>	<b>The PR&amp;C Departments' operating experience program was well-implemented.</b> The plant radiation and chemistry departments' operating experience program was well-implemented. Relevant industry and internal information was disseminated in a timely manner and effectively communicated to all levels of the organization.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 1C <b>Ter:</b>	<b>Supervisory and management personnel were adequately enforcing management expectations</b> The inspectors concluded that supervisory and management personnel in the plant radiation and chemistry (PR&C) departments were adequately enforcing management expectations to the workers. PR&C department staff participated in the management observation program and took steps to derive full benefit from field observations. Adequate numbers of PR&C department management had received leadership development training and the inspectors found evidence that elements introduced by this program were still in use. The PR&C departments' performance indicators were event-based and adequately reflected station performance. Recent initiatives by the PR&C departments were effective in sorting and analyzing condition report data on a statistical basis which was an improvement from the event-based performance indicators.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 1C <b>Ter:</b>	<b>The PR&amp;C Departments had adequately implemented changes to the corrective action program.</b> The inspectors determined that the plant radiation and chemistry (PR&C) departments had adequately implemented changes to the corrective action program. The threshold for personnel documenting problems in the PR&C departments was sufficiently low to ensure that problems would be identified and adequately addressed at early stages. Sufficient corrective action program training was provided to PR&C department personnel and licensee self-assessments of the correction action program had been completed.
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/25/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Corrective actions for significant CRs assigned to the PR&amp;C Departments were broad and well-focused</b>  Corrective actions for significant condition reports (CRs) assigned to the radiation protection departments were broad and well-focused on preventing problems from recurring. For less significant CRs, the licensee focused on near-term instead of long-term corrective actions. The licensee's CARE items did not always address the root cause identified and, in some cases, were not properly tracked in the licensee's database.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/25/1999	1999001-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 1C	<b>Failure to implement Section 2.7.1 of the offsite does calculation manual</b>  The failure to perform the grab samples on the shutdown service water effluent radiation monitor was an example where the requirements of Technical Specifications were not met
<b>Dockets Discussed:</b> 05000461 Clinton						
03/12/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Overall licensee performance during the 1999 Emergency Plan exercise was adequate</b>  Overall licensee performance during the 1999 Emergency Plan exercise was adequate, and had improved considerably from the evaluated exercise, conducted November 18, 1998. An Exercise Weakness was identified relative to knowledge of the status of inplant repair teams.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/12/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Performance in the Simulator Main Control Room was acceptable</b>  Performance in the Simulator Main Control Room was acceptable; no problems were noted in implementation of the Emergency Operating Procedures. During the rapidly moving scenario, control room shift personnel properly diagnosed reactor events at the Notification of Unusual Event, and Alert levels. Notifications were promptly made to offsite officials.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/12/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The Technical Support Center staff's performance was effective</b>  The Technical Support Center staff's performance was effective; the facility activated efficiently, and use of priorities was very good. Plant event analysis, event classification, notifications, and briefings were competently performed by the staff.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/12/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Performance in the Emergency Operations Facility was acceptable.</b>  Performance in the Emergency Operations Facility was acceptable. Status board maintenance and definition of what constitutes a release were identified as inspection followup items.
<b>Dockets Discussed:</b> 05000461 Clinton						

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03/12/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Communication was acceptable with some overall problems noted</b>  Communication was acceptable with some overall problems noted; licensee staff indicated they plan to perform a review of communications between facilities.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/05/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Protected area assessment and detection aids were functional and effective</b>  Protected area assessment and detection aids were functional and effective based on observations of field testing. These systems provided the security organization with the ability to identify an external design basis threat attack on the facility
<b>Dockets Discussed:</b> 05000461 Clinton						
03/05/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The licensee appropriately analyzed, tracked and resolved security events.</b>  The licensee appropriately analyzed, tracked and resolved security events. For example, the licensee identified a trend of computer related problems that reduced protection measures and was in the process of resolving the issue.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/05/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Tactical response table top drills were an effective training tool</b>  Tactical response table top drills were an effective training tool, provided a good mechanism for the evaluation of individual performance, and demonstrated an effective contingency response capability.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/05/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>The security organization was effective in identifying, analyzing, and correcting problems</b>  The security organization was effective in identifying, analyzing, and correcting problems through a combination of audits, self-assessments, and tracking and trending programs.
<b>Dockets Discussed:</b> 05000461 Clinton						
03/05/1999	1999007-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Failure to report use of medication that could affect job performance.</b>  The inspector identified that derogatory information relating to fitness-for-duty and access authorization reporting requirements regarding a contract employee was not provided to the appropriate staff for evaluation and resolution. In addition, the inspector identified that the licensee had not established any guidance or policy that required the information to be forwarded to the Fitness-for-Duty and Access Authorization staff for evaluation relative to continued unescorted protected area access. Two Non-Cited Violations were identified regarding the reporting requirements. (NCVs 1999007-01 & 1999007-02) NOTE: A second PIM entry for 1999007-02 was not made.
<b>Dockets Discussed:</b> 05000461 Clinton						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/16/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Radiation protection personnel demonstrated conservative decision making by using a video camera</b>  The inspectors determined that radiation protection personnel demonstrated conservative decision making by using a video camera and robot to minimize exposure to only 9 millirem during recovery of a radiography source
<b>Dockets Discussed:</b> 05000461 Clinton						
02/12/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Licensee made improvements in the ALARA program</b>  The inspector noted improvements in the ALARA program. Increasing the resources for the ALARA program contributed to more timely and critical work planning reviews and to effective monitoring of department and station dose performance. The 1999 annual dose goals more accurately reflected the licensee's planned scope of work and were effectively monitored by the plant departments.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/12/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>RP technicians demonstrated acceptable techniques and clearly communicated radiological conditions</b>  During routine contamination surveys and work coverage, radiological protection technicians demonstrated acceptable techniques and clearly communicated radiological conditions to plant personnel. In addition, the licensee properly calibrated area radiation monitors at the frequency specified in plant procedures.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/12/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The licensee included an acceptable level of ALARA instructions in general employee training</b>  The licensee included an acceptable level of ALARA instructions in general employee and RP technician training, which included the use of mock-ups. The ALARA staff also participated in bench-marking to increase its awareness of successful industry practices.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/12/1999	1999005-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Inadvertent entry of two individuals into a posted high radiation area</b>  The licensee identified an inadvertent entry of two individuals into a posted high radiation area (HRA). The individuals were not on a radiation work permit which authorized the entry into the HRA, contrary to procedural requirements. This failure to follow procedure was considered a Non-Cited Violation. The inspector concluded that the licensee had performed an appropriate review of the incident and had implemented corrective actions, which were commensurate with the error.
<b>Dockets Discussed:</b> 05000461 Clinton						
02/12/1999	1999005-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	VIO IV	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Repetitive problem concerning the adequacy and thoroughness of radiological surveys</b>  The inspector concluded that the licensee had not adequately corrected a repetitive problem concerning the adequacy and thoroughness of radiological surveys. As a result of this ongoing problem, the licensee identified a failure of the RP staff to perform an adequate radiological survey incident to the changes in operation of the residual heat removal system. This inadequate survey was determined to be a violation of 10 CFR Part 20. Specifically, the RP staff failed to identify and post an HRA, which resulted from known operational changes within the facility.
<b>Dockets Discussed:</b> 05000461 Clinton						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

## Legend

### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.