



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION III
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LISLE, IL 60532-4352

July 8, 2011

Mr. Michael J. Pacilio
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4300 Winfield Road
Warrenville IL 60555

**SUBJECT: CLINTON POWER STATION NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000461/2011008**

Dear Mr. Pacilio:

On June 3, 2011, the U.S. Nuclear Regulatory Commission (NRC) completed a Problem Identification and Resolution inspection at your Clinton Power Station. The enclosed report documents the results of this inspection, which were discussed on June 3, 2011, with Mr. K. Taber and other members of your staff.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, observed activities, and interviewed personnel.

The inspectors concluded that your staff was effective at identifying problems and incorporating them into the corrective action program (CAP). However, the NRC inspectors identified degradation in Clinton Power Station's evaluation of issues entered into the CAP. Operating Experience (OE) was appropriately screened and disseminated. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies, although there were a few instances where station audits had the opportunity, but failed to identify issues that were later found by the NRC inspection team. On the basis of interviews conducted during the inspection, workers at the site expressed freedom to enter safety concerns into the CAP.

Based on the results of this inspection, three NRC-identified findings of very low safety significance were identified. One of the findings identified during this inspection was related to the accuracy of an evaluation performed for an operability determination. The second Green finding identified during this inspection was related to an inadequate evaluation that led to a failure to maintain a quality record. The third finding identified during this inspection was related to a failure to measure the effectiveness of Corrective Actions to Prevent Recurrence (CAPRs) as required by station procedures. The findings involved violations of NRC requirements. However, because of their very low safety significance, and because the issues were entered into your corrective action program, the NRC is treating the issues as non-cited violations (NCVs) in accordance with Section 2.3.2 of the NRC Enforcement Policy.

If you contest the subject or severity of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the Resident Inspector Office at the Clinton Power Station. In addition, if you disagree with the cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Clinton Power Station.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Mark A. Ring, Chief
Branch 1
Division of Reactor Projects

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

Enclosure: Inspection Report 05000461/2011008;
w/Attachment: Supplemental Information

cc w/encl: Distribution via ListServ

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-561
License No: NPF-62

Report No: 05000461/2011008

Licensee: Exelon Generation Company, LLC

Facility: Clinton Power Station

Location: Clinton, IL

Dates: May 16 through June 3, 2011

Inspectors: R. Orlikowski, Project Engineer (Team Lead)
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Approved by: Mark A. Ring, Chief
Branch 1
Division of Reactor Projects

Enclosure

TABLE OF CONTENTS

SUMMARY OF FINDINGS.....	1
REPORT DETAILS.....	4
4. OTHER ACTIVITIES.....	4
4OA2 Problem Identification and Resolution (71152B).....	4
4OA6 Management Meetings.....	16
SUPPLEMENTAL INFORMATION.....	1
KEY POINTS OF CONTACT.....	1
LIST OF ITEMS OPENED, CLOSED AND DISCUSSED.....	1
LIST OF DOCUMENTS REVIEWED.....	2
LIST OF ACRONYMS USED.....	12

SUMMARY OF FINDINGS

IR 05000461/2011008, Clinton Power Station; Identification and Resolution of Problems.

This inspection was conducted by three region-based inspectors, the NRC Resident Inspector at the Clinton Power Station, and the onsite Illinois Emergency Management Agency (IEMA) inspector. Three Green findings were identified by the inspectors. The findings were considered non-cited violations (NCVs) of NRC regulations. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Identification and Resolution of Problems

On the basis of the samples selected for review, the team concluded that implementation of the corrective action program (CAP) at Clinton Power Station was generally effective, although there has been a degradation in Clinton's CAP over the past two years. The licensee had a low threshold for identifying problems and entering them in the CAP. Items entered into the CAP were screened and prioritized in a timely manner using established criteria and were generally implemented in a timely manner commensurate with their safety significance. However, the inspectors identified degradation in the licensee's evaluation of issues entered into the CAP. Specifically, there were several instances where the corrective actions associated with Action Requests (ARs) were not adequate or not appropriate for the circumstances. Additionally, the inspectors identified multiple instances where Effectiveness Reviews (EFRs) were not performed to assess the effectiveness of Corrective Actions to Prevent Recurrence (CAPRs). The team noted that the licensee reviewed operating experience for applicability to station activities. Audits and self-assessments were usually performed at an appropriate level to identify deficiencies, although there were a few instances where station audits had the opportunity, but failed to identify issues that were later found by the NRC inspection team. On the basis of interviews conducted during the inspection, workers at the site expressed freedom to enter safety concerns into the CAP.

A. NRC-Identified and Self-Revealed Findings

Cornerstone: Mitigating Systems

- Green. The inspectors identified a finding of very low safety significance with an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," related to calculational errors found in the licensee's operability determination. Specifically, on four separate operability determinations, the licensee failed to account for the cable resistance when determining the maximum allowable contact resistance associated with the second level undervoltage (UV) relays for the 4.16 kV Buses. The licensee entered this violation into its CAP as Action Requests (ARs) 1226340 and 1224313 and performed a preliminary calculation which determined that the error reduced the available margin in the circuit resistance but did not change the overall conclusions for the past operability calls made for the four different occasions.

The inspectors determined that this finding was more than minor because it was associated with the Mitigating Systems Cornerstone attribute of design control and

adversely affected the cornerstone objective of ensuring availability and reliability of systems that respond to initiating events to prevent undesirable consequences. This finding was of very low safety significance (Green) because the licensee was able to demonstrate that the operability calls that were previously made relating to the second level UV relays were still valid and acceptable. The inspectors concluded that this finding affected the cross-cutting aspect of human performance. Specifically, the licensee failed to use conservative assumptions in decision making related to immediate operability determinations of conditions adverse to quality. [IMC 0310 H.1(b)] (Section 4OA2.1.b(2)(1))

- Green. The inspectors identified a finding of very low safety significance with an associated NCV of 10 CFR Part 50, Appendix B, Criterion XVII, "Quality Assurance Records." Specifically, the licensee failed to maintain a quality record documenting a nondestructive examination (NDE) of a safety-related spreader beam lifting device. After losing the original NDE report, the licensee's corrective action (CA) was to recreate the report from memory and maintain the recreated report as the quality record. Upon review and questioning from the NRC, the licensee was able to locate the missing NDE report in the records archive. This issue was entered into the licensee's CAP as AR1223723.

The inspectors determined the finding was more than minor because, if left uncorrected, failure to maintain a quality record as evidence of an activity affecting quality of safety-related equipment due to inappropriate disposition of CAs pertaining to missing/lost quality records could become a more significant safety concern. This finding was of very low safety significance because this finding did not represent an actual loss of any safety function of the Mitigation Systems. The inspectors concluded that this finding affected the cross-cutting aspect of human performance. Specifically, the licensee did not ensure complete, accurate and up-to-date design documentation and work packages. [IMC 0310 P.1(d)] (Section 4OA2.1.b(2)(2))

Cornerstone: Initiating Events

- Green. The inspectors identified a finding of very low safety significance with an associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The licensee failed to perform an effectiveness review (EFR) to ensure that CAs taken to prevent recurrence of a significant condition adverse to quality were actually effective to preclude repetition. The licensee entered this violation into its CAP as ARs 1221616, 1221661, and 1223806 to investigate the cause and to identify appropriate CAs.

The finding was of more than minor significance because it was similar to Example 4a in IMC 0612, "Power Inspection Reports," Appendix E, "Examples of Minor Issues," in that, the licensee routinely failed to perform EFR evaluations on similar CAs related to significant conditions adverse to quality. The finding was a licensee performance deficiency of very low safety significance due to answering 'no' to all questions under the Initiating Events Cornerstone column of IMC 0609 Attachment 4, "Phase 1 - Initial Screening and Characterization of Findings." The inspectors concluded that this finding affected the cross-cutting aspect of problem identification and resolution. Specifically, the licensee failed to thoroughly evaluate problems to include conducting EFRs of CAs to ensure that problems were resolved. [IMC 0310 P.1(c)] (Section 4OA2.1.b(3)(1))

B. Licensee-Identified Violations

No violations of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Problem Identification and Resolution (71152B)

The activities documented in sections .1 through .4 constituted one biennial sample of problem identification and resolution as defined in Inspection Procedure (IP) 71152.

.1 Assessment of the Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's CAP implementing procedures and attended CAP meetings to assess the implementation of the CAP by site personnel.

The inspectors reviewed risk and safety-significant issues in the licensee's CAP since the last NRC Problem Identification and Resolution (PI&R) inspection in April 2009. The selection of issues ensured an adequate review across NRC cornerstones. The inspectors used issues identified through NRC generic communications, department self-assessments, licensee audits, operating experience (OE) reports, and NRC documented findings as sources to select issues. Additionally, the inspectors reviewed issue reports generated as a result of facility personnel's performance in daily plant activities. In addition, the inspectors reviewed ARs and a selection of completed investigations from the licensee's various investigation methods, which included root cause, apparent cause, equipment apparent cause, common cause, and quick human performance investigations.

The inspectors selected one high risk system, the Emergency Diesel Generator System, to review in detail. The inspectors' review was to determine whether the licensee staff were properly monitoring and evaluating the performance of this system through effective implementation of station monitoring programs. This five year review on the Emergency Diesel Generator System was undertaken to assess the licensee staff's efforts in monitoring for system degradation due to aging aspects.

During the reviews, the inspectors determined whether the licensee staff's actions were in compliance with the facility's CAP and 10 CFR Part 50, Appendix B requirements. Specifically, the inspectors determined if licensee personnel were identifying plant issues at the proper threshold, entering the plant issues into the station's CAP in a timely manner, and assigning the appropriate prioritization for resolution of the issues. The inspectors also determined whether the licensee staff assigned the appropriate investigation method to ensure the proper determination of root, apparent, and contributing causes. The inspectors also evaluated the timeliness and effectiveness of CAs for selected issue reports, completed investigations, and NRC findings, including NCVs.

b. Assessment

(1) Effectiveness of Problem Identification

Issues were generally being identified at a low threshold, evaluated appropriately, and corrected in the CAP. Workers were familiar with the CAP and felt comfortable raising

concerns. This was evident by the large number of CAP items generated annually; which were reasonably distributed across the various departments. A shared, computerized database was used for creating individual reports and for subsequent management of the processes of issue evaluation and response. These processes included determining the issue's significance, addressing such matters as regulatory compliance and reporting, and assigning any actions deemed necessary or appropriate.

The inspectors determined that the station was generally effective at trending low level issues to prevent larger issues from developing. The licensee also used the CAP to document instances where previous CAs were ineffective or were inappropriately closed.

As a result of an observation from the 2009 PI&R Inspection that found deficiencies in security officers' knowledge on initiating Issue Requests, the inspectors specifically asked security officers if they had received some form of training or instruction on entering issues into the licensee's computer-based CAP. All security officers interviewed responded that training/instruction had been provided. Additionally, the officers stated that there was a laminated instruction card available at each computer workstation with step-by-step instructions on how to initiate issue reports.

The inspectors noted that since the 2009 PI&R Inspection, the Security organization had generated approximately 2,100 Issue/Action Reports. From these 2,100 issues, 11 trend IRs were initiated. By comparison, the Training organization generated approximately 750 IRs and 13 trend IRs during the same period. The Training Department is about one fourth the size of the Security Department. Although the Security Department meets the requirements for quarterly trending (LS-AA-125-1005), the inspector felt that, based on numbers alone, the Security organization should be identifying/initiating more trend IRs. It may be prudent for all departments to examine their trending program to ensure trends or potential trends are being identified.

Observation

Failure to Follow Work Order Instructions

During review of work order (WO) 01277109 Task ID 1, "Replace Grounded 'B' RR [Reactor Recirculation] Pump Motor," referenced from action AR 00988866, "RR B Motor Change Out Spreader Beam NDE INSP Report Missing," the inspectors identified that contrary to WO 01277109 guidance, the licensee had inappropriately marked 'N/A' [Not Applicable] on step 4.2 of Task ID 1 and step 4.3 of Task ID 14 in WO 01277109. These procedure steps required inspection and supervisory oversight of rigging devices and should not have been marked 'N/A'. However, an earlier procedure step had accomplished the same function.

The inspectors determined that the licensee's failure to follow instructions in Step 4.2 of Task ID 1 and Step 4.3 of Task ID 14 in WO 01277109 is a violation of Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," which requires, in part, that activities affecting quality be performed in accordance with instructions, procedures, and drawings appropriate to the circumstance. Instructions, procedures or drawings shall include appropriate quantitative or qualitative acceptance criteria for determining that important activities have been satisfactorily accomplished.

The licensee subsequently addressed this issue of failure to follow WO instructions in the CAP as AR 1223512, "(NRC Identified) Issue Identified with WO Documentation."

This failure to comply with the requirements of Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," constitutes a violation of minor significance that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Findings

No findings were identified.

(2) Effectiveness of Prioritization and Evaluation of Issues

The inspectors concluded that the station was generally effective at prioritizing issues commensurate with their safety significance. The inspectors observed that the majority of issues identified were of low-level and were either closed to trend, closed to actions taken, or characterized at a level appropriate for a condition evaluation. Issues were being appropriately screened by both the Station Oversight Committee (SOC) and Management Review Committee (MRC). There were no items in the operations, engineering, or maintenance backlogs that were risk-significant, individually or collectively.

The inspectors concluded that the station's evaluation of issues was not always thorough and there had been degradation in this area of Clinton Power Station's CAP. Specifically, there were several instances where the CAs associated with ARs were not adequate or not appropriate for the circumstances. This was evidenced by two minor violations and two findings identified during this inspection.

Observations

Failure to Adequately Maintain Regulatory Requirements in Design Basis Procedures and Instructions

During review of AR No. 0092284, "NDE Inspection for Strongback Is Not Identified," the inspectors identified that the licensee's CA to resolve this AR was to revise Exelon procedure MA-AA-716-021, "Periodic Inspection of Rigging Equipment." The inspectors verified that procedure MA-AA-716-021(revision 2) was indeed revised to identify the special lifting device inspection requirements of ANSI N14.6-1978, "American National Standard for Special Lifting Devices for Shipping Containers Weighing 10,000 Pounds (4500 kg) or More for Nuclear Materials." However, subsequent to this revision, the licensee made another revision to procedure MA-AA-716-021 (revision 3), which essentially removed ANSI N14.6-1978 requirements for periodic inspection of special lifting devices from the procedure. The licensee maintained that upon evaluation at the time of revising MA-AA-716-021, Rev. 2, the licensee determined that the special lifting device periodic inspection requirements as described in ANSI N-14.6-1978 would be more appropriately captured in equipment specific documents such as Preventative Maintenance Requests (PMRQs) and vendor specific work orders. Upon review of these special lifting device (equipment specific) documents, the inspectors identified that the licensee had not adequately included the ANSI N14.6 requirements into these documents. Specifically, the inspection requirements and periodicity of inspection of special lifting devices was not adequately addressed in these equipment specific documents.

The inspectors determined that the licensee's failure to have adequate procedures/documents for inspection of special lifting devices per ANSI Code N14.6-1978 is a violation of Title 10 CFR 50, Appendix B, Criterion III, "Design Control," which requires, in part, that measures shall be established to assure that applicable regulatory requirements and the design basis, as defined in 10 CFR 50.2 and as specified in the license application, for those structures, systems, and components to which this appendix applies are correctly translated into specifications, drawings, procedures, and instructions.

The licensee generated AR 1224057, "Submit Service Requests to revise PMRQs 156877 & 156886 to be Consistent with the Requirements from ANSI N14.6. Document Service Request Approval and PMRQ Changes Results as Closure, and Create Additional Actions as Required," to revise the equipment specific documents, such that they adequately capture the appropriate ANSI N14.6 requirements for periodic inspection of special lifting devices.

This failure to comply with the requirements of Title 10 CFR 50, Appendix B, Criterion III, "Design Control," constitutes a violation of minor significance that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Failure to Demonstrate by Calculation Operability of Safety-Related Loads When Powered from the EDGs

The inspectors identified a minor violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to demonstrate by calculation that the Technical Specifications (TS) upper voltage limits for the emergency diesel generator (EDG) surveillance tests were adequate to support operability of all safety-related loads. Specifically, the licensee failed to provide adequate evaluation for AR 670088 "Non-Conservative TS for 4.16 kV Vital Bus Voltage," initiated in 2007 during a Component Design Basis Inspection (CDBI) self-assessment. The self-assessment raised a concern regarding the upper limit for the 4.16 kV safety-related bus voltage of 4580 volts as being non-conservative. The maximum analytical limit in the design calculation was 4454 volts due to potential overvoltage on the 120 volt components. The AR evaluation concluded that the current administrative limit of 4300 volts in the surveillance procedures was adequate to limit the safety-related bus voltages to ensure their safety function. However, the inspectors determined that the licensee's evaluation failed to correctly address the concern regarding the non-conservative TS voltage limits. The current design basis analysis did not support the TS upper voltage limit (4580 volts) for the safety-related buses. The licensee entered this issue into their CAP as AR 1226340, "Maximum Steady State Voltage for TS 3.8.1 Nonconservative."

This failure to comply with 10 CFR Part 50, Appendix B, Criterion III, "Design Control," constitutes a violation of minor significance that is not subject to enforcement action in accordance with the NRC's Enforcement Policy.

Findings

(1) Failure to Account for Cable Resistance in Operability Determinations

Introduction: The inspectors identified a finding of very low safety significance (Green) with an associated NCV of 10 CFR 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to account for the cable resistance in immediate operability

determinations. Specifically, on four different occasions, the licensee failed to account for the cable resistance when determining the maximum allowable circuit resistance to ensure that adequate minimum voltage was available for the trip coils associated with the 4.16 KV buses.

Description: On the following four different occasions, during the performance of CPS 9333.20 and CPS 9333.30, "4.16 kV Degraded Voltage Trip Functional Test," for Division I and Division II respectively, contact resistance for the undervoltage (UV) relays was found unacceptable. UV relays 227X1-21A1-2 and 227X1-21B1-2 were found to have higher than expected resistance readings across the closed contacts used to trip the Reserve Auxiliary Transformer (RAT) Feed Breaker upon initiation of a degraded voltage signal. Typically, closed contact readings should read significantly less than 1 ohm.

- During the performance of CPS 9333.30 on May 14, 2009, contacts between 4 and 5 on relay 227X1-21B1-2 read approximately 3.6 ohms. Immediate operability determined that the trip coil was operable and would perform its function. This issue was documented in AR 919673.
- During the performance of CPS 9333.30 on July 15, 2009, contact between 4 and 5 on relay 227X1-21B1-2 again showed higher contact readings; anywhere from 14 to 48 ohms. Immediate operability determined that the trip coil was inoperable and subsequently, the associated emergency diesel generator was also declared inoperable. This issue was documented in AR 947824.
- During the performance of 9333.20 on July 30, 2009, contact between 11 and 20 on relay 227X1-21A1-2 read approximately 2.43 ohms. Immediate operability determined that the trip coil was operable. This issue was documented in AR 947581.
- During the performance of CPS 9333.30 on December 17, 2009, contacts between 4 and 5 on relay 227X1-21B1-2 again showed higher contact resistance readings of 19.4 ohms across the contacts. Immediate operability determined that the trip coil was inoperable. This issue was documented in AR 1006888.

The operability determination in all four occasions listed above was based on a simplified calculation showing that as long as the resistance between the contacts was less than 13.1 ohms, then adequate voltage of greater than 70 Vdc would be available for the trip coil to perform its function in a worst case scenario. The inspectors noticed that this acceptance criterion for the maximum contact resistance was not listed in the surveillance procedure CPS 9333.20 or CPS 9333.30. The inspectors also noticed that the equation used in the simplified calculation that determined the maximum acceptable resistance between the contacts did not account for the cable resistance for the control cables associated with the trip coil control circuitry. Subsequent to the inspector identification of this deficiency, the licensee identified the length of the cables associated with these affected circuits as a total of 860 feet and 1114 feet for Division I and II respectively. The licensee recalculated the maximum acceptable resistance value using the cable length/resistance and determined that the original calculated value of 13.1 ohms was reduced by 2.07 ohms and 2.7 ohms for Division I and II respectively.

The inspectors determined that the new calculated values for the maximum resistance between the contact would not have changed the past operability determinations for the above four occasions. In addition, the licensee's two Equipment Apparent Cause Evaluations (EACEs), which were performed for AR 947581 and AR 1006888, also determined that the apparent cause of the high contact resistance readings was due to the improper measuring technique and not actual degraded relay contact.

Analysis: The inspectors determined that the failure to account for the cable resistance in four different operability determinations was a performance deficiency warranting a significance evaluation. The performance deficiency was determined to be more than minor because the finding was associated with the Mitigating Systems Cornerstone attribute of design control and adversely affected the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, on two of the four immediate operability determinations, the licensee failed to ensure that adequate voltage would be available for the trip coils when the contact resistance for the second level under-voltage relays was reading higher than expected. The inspectors performed a Phase 1 SDP review of this finding using the guidance provided in IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings." In accordance with Table 4a, "Characterization Worksheet for IE, MS, and BI Cornerstones," the inspectors determined that this finding was a design deficiency confirmed not to result in loss of operability or functionality. Specifically, the licensee was able to demonstrate that the operability calls that were previously made, when the operability of the second level under-voltage relays was in question, were still acceptable when the cable resistance was added.

Cross-Cutting Aspects

The inspectors concluded that this finding affected the cross-cutting aspect of human performance, Decision Making. Specifically, the licensee failed to use conservative assumptions in decision making affecting the operability of the second level under-voltage relays when conditions adverse to quality were identified. (IMC 0310 H.1(b)).

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion III, "Design Control," requires, in part, that measures shall be established to assure that applicable regulatory requirements and the design basis are correctly translated into specifications, drawings, procedures, and instructions.

Contrary to the above, in 2009, on four different occasions, the licensee failed to ensure that applicable regulatory requirements and design basis related to second level UV relay circuits were correctly translated into calculations used in immediate operability determinations. Specifically, the licensee failed to ensure that the cable resistance was accounted for when determining the maximum allowable circuit resistance to ensure that adequate minimum voltage was available for trip coils associated with the 4.16 kV buses. Because this violation was of very low safety significance and it was entered into the licensee's CAP as AR 01223508, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy.

(NCV 05000461/2011008-01, Failure to Account for Cable Resistance in Operability Determinations). The licensee entered this into their CAP as ARs 1226340 and 1224313.

(2) Failure to Maintain a Quality Record as Evidence of an Activity Affecting Quality of Safety-Related Equipment Due to Inappropriate Corrective Actions

Introduction

The inspectors identified a finding of very low safety significance and a NCV of 10 CFR 50, Appendix B, Criterion XVII, "Quality Assurance Records," for the licensee's failure to maintain sufficient quality records that provide evidence of activities affecting quality of safety-related equipment.

Description

During review of AR 00988866, "RR 'B' Motor Change out Spreader Beam NDE INSP Report Missing," the inspectors identified that the licensee did not have in their completed work order documents the NDE report that is required to qualify the spreader beam used to lift the reactor recirculation motor during the change out process in the drywell. The NDE of the critical welds of the spreader beam, which is considered a special lifting device, is required by ANSI N14.6-1978, "American National Standard for Special Lifting Devices for Shipping Containers Weighing 10,000 Pounds (4500 kg) or More for Nuclear Materials," prior to each use.

AR 00988866 dated November 4, 2009, states that the NDE was performed on the spreader beam prior to use in lifting the reactor recirculation 'B' motor, however no record of the NDE existed in the completed work order documents. The licensee proposed three recommended actions in AR 00988866 as resolution of this CR: 1) Personnel who were involved should search their working areas to locate the missing NDE inspection report, 2) Duplicate report may be generated based on recollection of the inspection, 3) Perform NDE inspection for the used spreader beam again and document the results per this AR (if #1 and #2 are not feasible). On November 23, 2009, the missing NDE report was recreated based on recollection from memory of the individual who conducted the examination and approved by licensee corporate NDE. Upon review and further questioning from the inspectors, the licensee attempted to find the missing original NDE report. After extensive searching, the licensee did find the missing original NDE report dated October 18, 2009, which differed in certain parameters from the recreated NDE report dated November 23, 2009.

Analysis

The inspectors determined that the licensee's failure to maintain a quality record documenting an NDE on safety-related equipment due to inappropriate CAs is a performance deficiency that impacted the Mitigation Systems Cornerstone.

The inspectors determined that this performance deficiency was more than minor because, if left uncorrected, failure to maintain a quality record as evidence of an activity affecting quality of safety-related equipment due to inappropriate disposition of CAs pertaining to missing/lost quality records, could become a more significant safety concern. Absent NRC identification, the licensee would deem it acceptable practice to recreate from memory, quality records of activities that affect quality of safety-related equipment in lieu of more appropriate CAs available to the licensee.

The inspectors completed a significance determination, in accordance with IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 - Initial Screening

and Characterization of Findings,” Table 4a for the Mitigation Systems Cornerstone. Based on answering 'no' to each of the Phase 1 screening questions identified in the Mitigation Systems Cornerstone column of Table 4a, the finding was determined to be of very low safety significance. Specifically, this finding did not represent an actual loss of any safety function of the Mitigation Systems.

Cross-Cutting Aspects

This finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not ensure complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components. (IMC 0310 P.1(d))

Enforcement

Title 10 CFR 50, Appendix B, Criterion XVII, “Quality Assurance Records,” requires, in part, that sufficient records shall be maintained to furnish evidence of activities affecting quality. The records shall include at least the following: Operating logs and the results of reviews, inspections, tests, audits, monitoring of work performance, and materials analyses. The records shall also include closely-related data such as qualifications of personnel, procedures, and equipment. Inspection and test records shall, as a minimum, identify the inspector or data recorder, the type of observation, the results, the acceptability, and the action taken in connection with any deficiencies noted. Records shall be identifiable and retrievable. Consistent with applicable regulatory requirements, the applicant shall establish requirements concerning record retention, such as duration, location, and assigned responsibility.

Contrary to the above requirements, on November 23, 2009, during resolution of AR 00988866, “RR B Motor Change out Spreader Beam NDE INSP Report Missing,” the licensee approved a decision to recreate from recollection of memory the missing NDE report and, therefore, failed to maintain a sufficient quality record providing evidence of the NDE. Failure to maintain a sufficient record that provides evidence of the NDE affecting quality of the safety-related spreader beam was a violation of 10 CFR 50, Appendix B, Criterion XVII. Because this violation was of very low safety significance and was entered into the CAP, this violation is being treated as an NCV consistent with Section VI.A.1 of the NRC Enforcement Policy.

(NCV 05000461/2011008-02 Failure to Maintain Quality Record as Evidence of Activity Affecting Quality of Safety-Related Equipment). The licensee entered this issue into the CAP as AR 1223723.

(3) Effectiveness of Corrective Actions

The effectiveness of corrective actions for the items reviewed by the inspectors was generally appropriate for the identified issues. Over the two year period encompassed by the inspection, the inspectors identified no significant examples where problems recurred. The inspectors did identify one weakness associated with the station’s use of EFRs to evaluate Corrective Actions to Prevent Recurrence (CAPR). While reviewing Root Cause Evaluations performed since the last biennial PI&R inspection in 2009, the inspectors identified six examples where Clinton Power Station failed to perform EFRs as required by the station’s CAP procedures.

Findings

(1) Failure to Perform Effectiveness Review

Introduction

Inspectors identified a finding of very low safety significance with an associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." The licensee failed to perform an EFR to ensure that CAs taken to prevent recurrence of a significant condition adverse to quality were actually effective to preclude repetition.

Discussion

Inspectors performed a review of the licensee's CAP with a focus, in particular, on how significant conditions adverse to quality are addressed. Exelon procedure LS-AA-120, "Issue Identification and Screening Process," defines a significant condition adverse to quality to include "severe operating abnormalities or large deviations from expected plant performance of safety-related structures, systems, or components; [and] "events" such as described in the plant Technical Specifications." 10 CFR 50 Appendix B Criteria XVI requires, in part, that "In the case of significant conditions adverse to quality the measures shall ensure that the cause of the condition is determined and CA taken to preclude repetition." LS-AA-125, Revision 15, "Corrective Action Program Procedure," Step 1.3 states that "significant conditions adverse to quality and conditions adverse to quality are resolved through direct action, the implementation of CAPRs and Corrective Actions (CAs)."

Inspectors then focused their review upon how the licensee identifies CAPRs to resolve significant conditions adverse to quality. The licensee's method to accomplish this was through its highest level of investigation, a Root Cause Analysis. During a general review of the licensee's Root Cause Reports completed within the previous two years, inspectors identified six examples where the licensee failed to follow its processes for correcting significant conditions adverse to quality.

On October 23, 2009, the licensee completed Root Cause Report (RCR) 972235, "Valve Packing Failure inside Drywell Resulted in Plant Shutdown Due to Increasing Unidentified Leakage Rate." The conclusion of the licensee's report was that there were two root causes for the plant shutdown event: 1) That the 1E51F063 valve stem was off center with the stuffing box with the potential to cause packing side loading and accelerated loss of packing load, and 2) Inadequate work instruction did not require the packing in 1E51F063 to be torqued to the as-left value from the original installation. The investigation also identified two CAPRs, one to address each root cause identified. Licensee procedure LS-AA-125-1001, "Root Cause Analysis Manual," Revision 8, Attachment 12 identifies the attributes of a CAPR; specifically, "CAPRs are intended to address the root cause(s) in a manner to prevent recurrence, therefore, CAPRs should have the following attributes: specific, measurable, accountable, reasonable, timely, effective, reviewable, actionable, linked to a root cause, [etc]." RCR 972235 was approved by the licensee with the EFR portion blank, other than the statement that "An Effectiveness Review to address the effectiveness of the Root Cause CA is not necessary. The root cause is limited to a single valve, 1E51F063, with an off center stem to stuffing box condition. The work order to investigate and correct the condition is sufficient assurance the condition is corrected and will no longer cause accelerated loss of packing load." This statement addresses only one of the two identified root causes

and also appears contrary to the licensee's procedural guidance that a CAPR should be measurable and reviewable. After questions from inspectors, the licensee determined that its MRC had approved this RCR with comments to be incorporated, one of which was to add EFRs for the CAPRs. This action was later closed without initiating any EFR.

Further review by inspectors identified five additional examples where the licensee failed to follow their procedures with respect to CAPRs and EFRs.

1. RCR 979700, "1B33C001B: RR B Trip - Resulting in Reactor Scram," identified a Special Plant Condition as a CAPR which included the instruction to generate additional actions as needed and include the identified Root Cause, Extent of Condition/Cause, CAPRs, and EFR. No EFR was ever created.
2. RCR 1017724, "Contract Employee Contaminated in Drywell," identified one root cause, one CAPR, and did include one EFR. However, this EFR was performed to address a separate CA and not the CAPR which was identified.
3. RCR 1023530, "Gate Seal Leakage during Containment Isolation Valve System Functional Test," identified two root causes and two CAPRs. An EFR was assigned to the first CAPR and none was assigned to the second. However, on April 19, 2011, AR 1204691 was written by the licensee's Nuclear Oversight (NOS) organization which identified this omission of a required EFR. In this AR, NOS stated that "failing to create and document individual EFRs could result in not identifying whether a single CAPR effectively resolved an identified cause." At the time of inspection the RCR was provided in final form to inspectors with no correction made for this identification from NOS.
4. RCR 1147568, "Re-Evaluation Exam Provided Did Not Meet Expectations," identified one root cause and two CAPRs. The licensee assigned two EFRs to one of the CAPRs, however the EFR was marked "N/A" for the other CAPR which was identified.
5. RCR 1157980, "WANO Identified Area for Improvement for Relays and Power Supplies," identified two root causes, one CAPR and assigned two EFRs to be completed. However, these two EFRs were assigned to CAs and not the identified CAPR. Notably, in the EFR section of this report a preface was added which stated "There is no specific EFR action for the CAPR," and "no specific effectiveness criteria can be developed. Therefore no specific EFR action is to be completed. This was reviewed with and approved by MRC."

Analysis

The inspectors determined that the licensee's failure to perform EFRs which verify that CAs taken for significant conditions adverse to quality successfully prevent their reoccurrence was a performance deficiency warranting a significance evaluation. The finding was of more than minor significance because it was similar to Example 4a in IMC 0612, "Power Inspection Reports," Appendix E, "Examples of Minor Issues," in that the licensee routinely failed to perform EFR evaluations of CAs taken to prevent recurrence of significant conditions adverse to quality. The inspectors performed a Phase 1 SDP review of this finding using the guidance provided in IMC 0609, Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings."

In accordance with Table 4a, "Characterization Worksheet for IE [Initiating Events], MS [Mitigating Systems], and BI [Barrier Integrity] Cornerstones," the inspectors determined that this finding was a licensee performance deficiency of very low safety significance (Green) due to answering 'no' to all questions under the Initiating Events Cornerstone column.

Cross-Cutting Aspects

Inspectors concluded that this finding affected the cross-cutting aspect of problem identification and resolution. Specifically, the licensee's CAP did not thoroughly evaluate problems to include, for significant problems, conducting EFRs of CAs to ensure that problems are resolved. (IMC 0310 P.1(c))

Enforcement

10 CFR 50, Appendix B, Criteria V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings. Licensee procedure LS-AA-125, "Corrective Action Program Procedure," Step 1.3 states that "significant conditions adverse to quality and conditions adverse to quality are resolved through direct action, the implementation of Corrective Actions to Prevent Recurrence and Corrective Actions." Step 4.4.8 of this procedure states "Perform Effectiveness Reviews in accordance with LS-AA-125-1004, Effectiveness Review Manual." Revisions 4 and 5 of LS-AA-125-1004, "Effectiveness Review Manual," in effect during this time period of review, contain requirements that "all CAPRs are to be evaluated in the EFR" and to "Initiate Attachment 1, 'Individual Effectiveness Review' for each of the CAPRs identified."

Contrary to the above, on the six separate occasions previously described, the licensee failed to perform EFRs in accordance with its procedures to verify that CAs taken for significant conditions adverse to quality successfully prevented their reoccurrence. Because of the very low safety significance, this violation is being treated as an NCV consistent with Section 2.3.2 of the NRC Enforcement Policy **(NCV 05000461/2011008-03, Failure to Perform Effectiveness Review)**. The licensee entered this violation into its CAP as ARs 01221616, 01221661, and 01223806.

.2 Assessment of the Use of Operating Experience (OE)

a. Inspection Scope

The inspectors reviewed the licensee's implementation of the facility's OE program. Specifically, the inspectors reviewed implementing operating experience program procedures, attended CAP meetings to observe the use of OE information, and completed evaluations of OE issues and events. The inspectors' review was to determine whether the licensee was effectively integrating OE experience into the performance of daily activities, whether evaluations of issues were proper and conducted by qualified personnel, whether the licensee's program was sufficient to prevent future occurrences of previous industry events, and whether the licensee effectively used the information in developing departmental assessments and facility audits. The inspectors also assessed if CAs, as a result of OE experience, were identified and implemented in an effective and timely manner.

b. Assessment

In general, OE was effectively used at the station. The inspectors observed that OE was discussed as part of the daily station and pre-job briefings. Industry OE was effectively disseminated across the various plant departments and no issues were identified during the inspectors' review of licensee OE evaluations. During interviews, several licensee personnel commented favorably on the use of OE in their daily activities.

Findings

No findings were identified.

.3 Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors assessed the licensee staff's ability to identify and enter issues into the CA program, prioritize and evaluate issues, and implement effective CAs, through efforts from departmental assessments and audits.

b. Assessment

The inspectors concluded that self-assessments, NOS audits, and other assessments were typically effective at identifying most issues. The inspectors concluded that these audits and self-assessments were generally completed in a methodical manner by personnel knowledgeable in the subject area. Corrective Actions associated with the identified issues were implemented commensurate with their safety significance.

There were a few issues identified by the inspectors that were not identified during station self-assessments and/or audits. NOS previously identified one of the RCE's that did not include EFRs for the CAPRs. However, NOS did not identify the other five instances where EFRs were not included to review CAPRs. Additionally, as preparation for this inspection, an assessment team comprised of Clinton employees along with one Quad Cities and one Robinson Nuclear Plant employee performed a focused self assessment (FASA) on Clinton's CAP. The FASA identified no strengths, 19 recommendations, and 21 standards deficiencies. However, the FASA did not identify any of the issues and weaknesses that were identified by the NRC inspection team. Additionally, the FASA did not identify the decline in performance of Clinton's CAP that was identified by the NRC inspection team.

Findings

No findings were identified.

.4 Assessment of Safety-Conscious Work Environment

a. Inspection Scope

The inspectors assessed the licensee's safety-conscious work environment (SCWE) through reviews of the facility's employee concerns program (ECP) implementing procedures, discussions with ECP coordinators, interviews with personnel from various

departments, and reviews of issue reports. The inspectors also reviewed the results of licensee safety culture surveys.

b. Assessment

The inspectors determined that the plant staff were aware of the importance of having a strong SCWE and expressed a willingness to raise safety issues. No one interviewed had experienced retaliation for safety issues raised or knew of anyone who had failed to raise issues. All persons interviewed had an adequate knowledge of the CAP process. These results were similar with the findings of the licensee's safety culture surveys. Based on these limited interviews, the inspectors concluded that there was no evidence of an unacceptable SCWE.

The inspectors determined that the ECP process was being effectively implemented. The inspectors noted that the licensee had appropriately investigated and taken constructive actions to address potential cases of harassment and intimidation for raising issues.

Findings

No findings were identified.

4OA6 Management Meetings

.1 Exit Meeting Summary

On June 3, 2011, the inspectors presented the inspection results to Mr. B. K. Taber, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

W. Knoll, Site Vice President
B. K. Taber, Plant Manager
A. Khanifar, Site Engineering Director
S. A. Gackstetter, Training Director
S. J. Fatora, Maintenance Director
R. E. Zacholski, Nuclear Oversight Manager (Acting)
B. W. Davis, Regulatory Assurance Manager
R. S. Frantz, Regulatory Assurance
K. Brown, Regulatory Assurance
J. M. Stovall, Radiation Protection Manager
T. P. Veitch, Chemistry Manager
J. E. Cunningham, Security Manager
T. R. Stoner, Outage Manager
R. A. Schenck, Manager Site Project Manager
D. J. Kemper, Sr. Manager Plant Engineering
C. D. Dunn, Shift Operations Superintendant

Nuclear Regulatory Commission

Mark A. Ring, Chief, Branch 1, Division of Reactor Projects

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened and Closed

05000461/2011008-01	NCV	Failure to Account for Cable Resistance in Operability Determinations (40A2.1.b(2)(1))
05000461/2011008-02	NCV	Failure to Maintain a Quality Record As Evidence of an Activity Affecting Quality of Safety-related Equipment Due to Inappropriate Corrective Actions (40A2.1.b(2)(2))
05000461/2011008-03	NCV	Failure to Perform Effectiveness Review (40A2.1.b(3)(1))

Discussed

None.

LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety, but rather, that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

PLANT PROCEDURES		
<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
CPS 9333.20	Division I 4.16 kV Bus Undervoltage Relay (Degraded Voltage) Functional Test	December 9, 2009
CPS 9333.30	Division II 4.16 kV Degraded Voltage Trip – Functional Test	December 9, 2009
PMRQ 159638-05	Perform Voltage Measurement at 1PL12JB	
PMRQ 158714-08	Perform Voltage Measurement at 1PL12JA	
HPP-1342-10	Procedure for Onsite Handling and Installation of Cask Pit Racks for the Clinton Nuclear Plant	Revision 1
MA-AA-716-022	Control of Heavy Loads Program	Revision 8
MA-CL-716-022-1001	Handling of Heavy Loads	Revision 0F
WC-AA-111	Predefine Process	Revision 3
EC 376454 R/0	Design Considerations Summary	
ANSI N14.6-1978	American National Standard for Special Lifting Devices for Shipping Containers Weighing 10,000 Pounds (4500 kg) or More for Nuclear Materials	February 15, 1978
MA-AA-716-021	Exelon Procedure; Rigging and Lifting Program	Revision 17
CPS 8106.03	Crane Inspection, Maintenance, and Testing (Including Special Lifts)	Revision 22e
MA-CL-716-021-1001	Periodic Inspection of Rigging Equipment	Revision 2
MA-CL-716-021-1001	Periodic Inspection of Rigging Equipment	Revision 3
LS-AA-120	Issue Identification and Screening Process	
LS-AA-125	Corrective Action Program Procedure	Revision 15
LS-AA-125-1001	Root Cause Analysis Manual	
LS-AA-125-1003	Apparent Cause Evaluation Manual	
LS-AA-125-1004	Effectiveness Review Manual	
LS-AA-126-1001	Focused Area Self-Assessments	
ANSI/ANS 56.8-2002	Containment System Leakage Testing Requirements	
NEI 94-01	Industry Guideline for Implementing Performance-based Option of 10 CFR Part 50, Appendix J	
Regulatory Guide 1.163	Performance-Based Containment Leak-Test Program	

PLANT PROCEDURES		
<u>Number</u>	<u>Description or Title</u>	<u>Date or Revision</u>
CPS 1305.01	Primary Containment Leakage Rate Testing Program	
CPS 1305.01F001	Type 'B' Local Leak Rate Summary Sheet	
CPS 9861.04	MSIV Local Leak Rate Test (MC-5,6,7,8)	
CPS 9861.04D002	MSIV B Local Leak Rate Test Data Sheet (1MC-8)	
EI-AA-101-1001	Employee Concerns Program Process	Revision 10
EI-AA-101	Employee Concerns Program	Revision 9
RP-AA-203-1001	Personnel Exposure Investigations	Revision 6
HU-AA-1004-101	Procedure Use and Adherence	Revision 4
RP-AA-301	Radiological Air Sampling Program	Revision 4
RP-AA-350	Personnel Contamination Monitoring, Decontamination, and Reporting	Revision 9

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
AR 0067088	Non-Conservative TS for 4.16 kV Vital Bus Voltage
AR 00947824	Division II Higher than Expected Ohmic Value on Second Level UV Relay
AR 00947581	Higher than Expected Ohmic Value on Second Level UV Relay
AR 0100688	High Ohmic Value on Second UV Relay
AR 00919673	Higher than Expected Ohmic Value on Second Level UV Relay
AR 00970557	Issue with Auto Start of Division 3 Diesel Following Manual Stop
AR 01155992	Division I DG 16 Cylinder Engine Heat Exchanger Coolant Leak
AR 00904590	UFSAR Statement Regarding Shunt Tripped Loads Incorrect
AR 01214578	Division II Diesel Generator Tripped During 9080.02
AR 00977050	NRC Information Notice 2009-16 Spurious Relay Actuations Cause Loss of Power
AR 00953437	NRC Information Notice 2009-10 Transformer Failures Recent Operating Experience
AR 01031112	NRC Information Notice Failure of MOVs Due to Degraded Stem Lubricant
EACE 947581	Higher than Expected Ohmic Value on Second Level UV Relay
EACE 1006888	High Ohmic Value on Second UV Relay
EACE 985349	Division I EDG did not go to rated Speed and Voltage During Monthly Surveillance Testing
EACE 969157	Incorrect Installation of K-8A and K-32 Relays in 1E22S001B
ACE 1113608	Evaluated Division II EDG Quick Start Time
RCI 916815-09	RCIC Tripped During Startup
RCI 1157980-10	WANO Identified Area for Improvement for Relays and Power Supplies
01032794-02	1DG01KA/B – Diesel Generators Fuel Oil Consumption, Revision 0
970557-02	Issue with Auto Start of Division 3 Diesel Following Manual Stop
670088-02	Non-Conservative TS for 4.16 kV Vital Bus Voltage

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
AR 01152745	Key Calculation Review Issue in an Instrument Calculation
AR 01158094	Fuel Handling Components Not Matching Design Configuration
AR 01152397	1DG02KE Replace DIV 3 EDG Governor Hydraulic Lines
AR 01151739	W/O Tasks for ASME Work Not Routed to ISI for Review/Approval
AR 01155992	1DG12AA: DIV 1 DG 16 CYL Engine Heat Exchanger Coolant Leak
AR 01155146	Inspection Results from 0TF01B-6" Boroscope
AR 01155313	Requesting Cantera to Reclassify CAT "D" Weld to CAT "A"
AR 01167888	Equivalency EC for H2 Igniter Did Not Identify Calc Impact
AR 01163955	CISI Work Order Closed Without Completing All Work
AR 01169808	NDE Did Not Perform UT for Accumulated Air on LPCS and LPCIA
AR 01176939	Flow Accelerated Corrosion Program Rated Yellow
AR 01183047	Non Conservative Analysis of Hanger Support Plate
AR 01197929	Excessive External Corrosion on Valve 1W0305
AR 00909586	Vibration Aging Not Performed Per Approved Test Procedure
AR 00925421	Safety-related ASME SEC. III Bolting vs. Quality Level 1
AR 00922844	NDE Inspection for Strongback is Not Identified
AR 00929815	FW Heater Shell Thickness Acceptance Criteria Based on INAPP
AR 00950308	Nonsafety O-Rings Installed in Safety-related/EQ Valves
AR 00954857	Potential Buried Line Leak Identified at NW Corner of TB
AR 00953213	Pipe 1WS11D below Acceptance Criteria for Wall Thickness
AR 00952602	Perform NDE Inspection of 1SXC3A
AR 00952609	Perform NDE Inspection of 1SXB9A
AR 00952621	Perform NDE Inspection of 1SXJ4A
AR 00952631	1WS09AA: Perform MT on Pipe to Evaluate Extent of Cracking
AR 00988866	RR B Motor Change out Spreader Beam NDE Inspection Report Missing
AR 01016954	Main Condenser Tube Bundle Supports Have Erosion Damage
AR 01023478	0SY09EA, MOD4508, Replacement Part Not Like for Like
AR 01082774	NRC CDBI Calculation Used Incorrect Cooling Capacity
AR 01014784	Leakage from Insulation at 6" Condenser Nozzle
AR 01019707	Minor Imperfections Discovered During NDE of MSIV Poppet
AR 01001385	Need Code Minimum Thickness Requirements for UTS
AR 01015209	South Main Condenser Waterboxes Have Patches of Corrosion
AR 01015184	Significant Rust on Both South CW Waterbox Expansion Joints
AR 01015202	Valves 1CD098B and D are Badly Corroded
AR 01020386	C1R12 – 1FP48S Nozzles Eliminated Without Site ENG Approval
AR 01020871	Potential NRC NCV for Weld Accessibility for Examination
AR 01020881	NRC Observation of NDE Activities in C1R12
AR 01017558	Degraded Coatings/Rust on Liner Plates Inside Containment
AR 01017544	Floor Coating Degraded Inside Drywell Near AZ 325, EL 723
AR 01062663	OE30955 - Clinton Could Have Vulnerabilities for Exposed Pipe
AR 01103870	0WS51-8" Piping Wall Thickness below Screening Criteria

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
AR 01107529	UT of 1SX93EA Finds 1 Location below the Calculated MIN
AR 01025446	1B21-F032B Fails LLRT Not Identified
AR 00947143	1WS45AA: Degraded Trend on WS Pipe Wall Thickness
AR 0106221	Alert Alarm Trend 1RIXPR023
AR 01039946	Non Low Carbon Welding Filler Material Needs Removed
ACE 1032794	Calculation 01DO06 Contained Non-Conservative Inputs
CCA 1164913	Potential Trend – Chemical Control
ACE 1026020	Issues Identified During C1R12 Drywell Close-Out
EACE 00951748	MCR Alarmed On SA Header Pressure Drop Due to a Failed Air Dryer Purge Check Valve
RCI 972235	Valve Packing Failure Inside Drywell Resulted in Plant Shutdown Due to Increasing Unidentified Leakage Rate
ACE 01024981	Restraining Device Placed on 1CW01PB Failed
AR 01224057	NRC Identified Issues with PMRQ
AR 01021241	Late Scope Addition Of 1B21F022C
AR 01148122	Bypassed QV Hold Point
AR 00910239	Newly Rebuilt Compensator Found With Damaged O-rings
AR 00949402	1E51N501 Procedure Deficiency 9432.49
AR 00969157	1E22S001B-K8A For DIV III D.G. Incorrect Installation
AR 01016173	1B33F067B - Discovered Cracked Limitorque Housing
AR 01016831	Multiple Eng. Issues With Perm Shielding Mod
AR 01024981	Restraining Device Placed on 1CW01PB Failed
AR 01048311	CCP 1SA01D: Dryer Inlet And Purge Valves Open At Same Time
AR 01069590	1AP75E1F: Inadvertent Loss of 1VX04CB
AR 01179979	Potential Trend On Rad Monitor Failures
AR 00907001	Procedure Adherence Fundamental As A Maint Focus Area
AR 01095255	CCA For Online Maintenance/Work Week Adverse Trend
AR 01066830	Review Of Human Performance Actions on Declining Performance
AR 01150089	ODCM Table 3.9.2-1 Item 1.F Deleted Without Updating 9432.42
AR 01152747	1SX027B 1VY006 System Test Cannot Be Completed In Full
AR 01159237	1SM001A: No HBC Lubrication Inspection Port
AR 01160216	Found Voltage Discrepancy In App B For 9080.21 And 9080.22
AR 01165412	PMRQ Scope Change Could Have Lead To Missed PMT
AR 01172939	Gaps Identified During EFR For Part Segregation Walkdowns
AR 01173198	Transmitter Installed Upside Down
AR 01182519	1DG12AA Packing Leak On DIV. 1 EDG Heat Exchanger
AR 01191512	1DG006C: Valve Failed As Found Pressure Test
AR 01035683	1GC01PB: Corrective Action Not Performed
AR 01122813	1DG01KA: Fuel Leak Discovered During Maint PMT
AR 01120781	1DG01KA16: Unable To Perform Section Of 8207.09 For Diesel
AR 01143877	Unexpected Readings On Voltage And Ripple For Temp P/S
AR 00972235	Drywell Pressure Rise/Floor Drain Leak Rate
AR 01194749	Division 1 DG Slow Start Time
AR 00925961	TDRFP 1B Unloaded When Placing TDRFP 1A In Service
AR 00922711	Data Missed In Operating Logs For 9080.03 DIV 3 DG Run

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
AR 00925880	RAT Tripped
AR 00939875	Secondary Containment LCO Action Not Entered When Required
AR 00938683	LCO Action Not Previously Identified
AR 00948468	1E12F064A: RHR[Residual Heat Removal] A Min Flow F064A Failed To Stroke Shut
AR 00959835	9000.02D001 SURVEILLANCE REQUIREMENTS
AR 00974412	Missed Opportunity To Identify TS Actions For Bypassed Rod
AR 01013399	C1R12 LL NRC Resident Observation Regarding FP Behaviors
AR 01017904	Double Blade Guide Removed With Rod Inserted
AR 01113608	DIV 2 EDG Quick-Start Time > 9080.02 STEP 9.1.6 Criteria
AR 01159858	Perform Reactivity Management CCA
AR 00958957	Perform CCA On Documented Gaps Within Operations
AR 01075686	Perform Reactivity Management CCA
AR 01092787	Adverse Trend In Fire Protection Barrier Impairment Process
AR 01152838	1DG01KB DIV 2 DG Oil Leak Needs Revisited
AR 01157160	CPS 3506.01 Needs Revised For Fuel Oil Sampling Criteria
AR 01173770	Inadequate Risk Perception Displayed By Crew D Supervision
AR 00926130	HPCS INOP due to DIV 4 DC Voltage Low
AR 00934528	Entered Abnormal Reactor Flow Offnormal
AR 00939898	Potential Adverse Trend In Operations Work Control
AR 00946058	Fuel Pool Cooling PMRQs Past Late Date Due To Failed 1FC004A
AR 00946549	1FC004A Continued To Stroke Open After Full Open Indication
AR 00959329	IRs Routinely Routed To OPS Not Per LS-AA-120
AR 00964540	NRC Identified Disposition IR Not Properly Documented
AR 01023864	Backup Bottle For Upper Pool Gates Cannot Be Verified
AR 01042194	IR Action Not Timely
AR 01104238	Ineffective Implementation Of Corrective Actions
RCR 917094	Perform A Root Cause Analysis on EHC Pump Quality Resolution
RCR 972235	Valve Packing Failure Inside Drywell Resulted in Plant Shutdown
RCR 979700	1B33C001B: RR B Trip - Resulting in Reactor Scram
RCR 1017724	Contract Employee Contaminated in Drywell
RCR 1021241	Late Identification of Work Scope for 1B21F022C, Inboard Main Steam Line C Isolation Valve
RCR 1023530	Gate Seal Leakage During Containment Isolation Valve System Functional Test
RCR 1147568	Re-Evaluation Exam Provided Did Not Meet Expectations
RCR 1157980	WANO Identified Area for Improvement for Relays and Power Supplies
EACE 490449	A' Electro-Hydraulic Control System Pump Erratic Pressure Control
ACE 802707	1EH01PB Has Pencil Size Leak From Compensator
ACE 910239	Recurrence of Inadequately Refurbished EHC Pump Compensators
EACE 1017464	Investigate Failure of 'B' MSIVs
AR 802707	1EH01PB Has Pencil Size Leak From Compensator
AR 900700	1EH01S: Declining Main EHC Header Pressure Trend
AR 905167	1EH01PA Pump Pressure Erratic During Pump Jog
AR 908262	1EH01PA Pressure Oscillating 1400 - 1500 psig
AR 910239	Newly Rebuilt Compensator Found With Damaged Orings

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED

<u>Number</u>	<u>Description or Title</u>
AR 914589	1EH01S: EHC Pump Test Results & Findings at Vendor Facility
AR 917094	Perform a Root Cause Analysis on EHC Pump Quality Resolution
AR 927530	Results of Effectiveness Review for AR 490449
AR 950746	1EH01PA: Main EHC Pump A Discharge Pressure Lowering
AR 950753	1EH01S: Main EH Pump Discharge Filter DP Increasing Trend
AR 983138	1EH01PA: Main EHC Pump A Making Occasional Abnormal Noise
AR 993685	1EH01PA: EH Pump A Discharge Pressure Degrading
AR 993974	1EH01PA: Pressure Compensator Needs Adjustment
AR 994192	EH 'B' Pump Local Discharge Pressure Gauge Reading Low
AR 997711	1EH01FB: EH Pump 'B' Discharge Pressure Has Decreasing Trend
AR 1020527	NOS ID MSIV LLRT Test Data Anomalies
AR 1021798	EHC 'A' Pump (1EH01PA) Not Operating Properly
AR 1056553	Received PPC Alarm on EH-DA201 Main EHC Pressure
AR 1060386	1EH01PA: Unexpected Low Pressure Main EHC (PPC Alarm)
AR 1160255	Steam Bypass EHC 'B' Pump Oscillating Pressure
AR 1165585	SB EHC Pump 'B' Oscillating Pressure
AR 1179468	Inadequate Response to NER NC-10-036
AR 1188640	Low Discharge Pressure 1EH01PB During Weekly Jog
AR 1193664	1C85D002PB: Bypass EHC Skid Pressure Oscillating
AR 1198169	EHC Pump Repair/Overhaul by Pump OEM to Reduce Problems
AR 1204691	NOS ID Root Cause Report Does Not Contain EFR or EFRS
AR 1211557	1H13-U703: Spurious Halon Alarms are a Distraction
AR 1017464	1B21F028A: 9861.04 LLRT on MSL A, B, and C Test Failure
AR 1059673	NOS ID MSIV As-Found Results Re-Evaluate Reportability
AR 1099320	CA 1033113-03 Extension Paperwork
AR 1207467	Potential Creep Away from Meeting Regulatory Requirements
AR 1207487	Depth of Investigation for NRC Findings and Violations
AR 1090813	Possible Gap ID'd During SOER 02-04 Effectiveness Review
AR 0792128	Potential Degrading Trend in Human Performance
AR 1046015	NOS ID Security Program Performance Rated Yellow
AR 1050574	NOS ID Elevation of Operations of Automatic Vehicle Barriers
AR 1185699	Identified Trend un Human Error Prevention Fundamental
AR 1089919	RP 2 nd Quarter HU Events
CCA 905077	Negative Trend in Human Performance Events in 2009
AR 0989128	Potential Low Level Internal Contamination
AR 1017853	Individual Contaminated in RT Hold Pump Room
AR 1167779	Identified Trend with Errors made by Security Supervision
AR 1099410	Security: Evaluate for CCA in Security Declining HU
CCA 913798	Trng-Potential Trend-Clock Reset
CCA 937393	Trng - Potential Trend Training Records Issues
CCA 1089222	Trng - Check-In Assess ID'd Deficiency In DTC Performance
CCA 1125966	Clinton Training Dept Performance Common Cause Analysis
CCA 1167605	Trng-Potential Trend ID'd During NTD Qtrly C&A
CCA 915153	Increase In HU Events Tracking IR
CCA 965371	Potential Trend-Security Regulation Violations
CCA 1037104	Security Identified Organizational Issues Requiring CCA

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
CCA 1167779	Identified Trend With Errors Made By Security Supervision
CCA 1120908	Trend IR: IR's Associated With Weapons And Ammunition
CCA 1051723	Security – Adverse Trend In Firearms Qualifications
CCA 1185699	Identified Trend In Human Error Prevention Fundamental
CCA 1185701	Identified Trend With Physical Security Fundamental
RCE 1101545	Trng- 5 Of 6 ILT Students Failed Comp Exam #2
ACE 935792	Trng - Final Exam Failures
ACE 1077324	Trng- Unqualified Instructor Performed Evaluation
ACE 1108724	Trng - Ineffective CA On Trng Records Quality
ACE 1122532	Trng: Consequential Exam Security Event While Performing JPM
ACE 1021622	Questions Regarding Search At Unitech Laundry Facility
ACE 1041649	Inadvertent AVB Manipulation
ACE 1052555	Potential Inattentive Security Officer
ACE 1077623	Violation Of Work Hour Rules (WHR)
CCA 969936	Trng - Analysis Of Exam Failures For A Common Cause
IR 924558	Trng: FASA Deficiency For Training Request Action Response
IR 937396	Trng - Peat Missing Disposition To Recommended Actions
IR 944094	Controlled Copy Number Not Marked On Controlled Copy Binder
IR 954980	Trng - CRC Meeting Cancelled Due To Illness
IR 967010	Trng - Ops Procedures Reference A Superseded Procedure
IR 978652	Trng Clearance Writer/Preparer TPE Template Error
IR 996224	Trng: Critical Task Wording Needs Improved
IR 1007200	Trng - Scenario Critical Step Enhancement
IR 1019320	Broken Tabs On 1E31-R551 Recorder
IR 1020492	HPCS Test Prep Switches
IR 1023625	C1R12 LI - Perform Auto Act/Isol Tests At Front Of Outage
IR 1026054	Trng Component Changed In Employee's LMS History Panel
IR 1036041	Trng - One EP Quiz Question Had Two Possible Answers
IR 1067400	Trng Chemistry Training Reschedule
IR 1083426	NTD - Category 2 Parts Found At Maint. Learning Center
IR 1093396	MRC Rejected NTD CCA On Question Quality
IR 1095615	Trng - Instructor Late For Class
IR 1152017	Contin Training ID Potential CPOS Bus Damage Vulnerability
IR 1178145	OIO - Benchmarking Accrediting Board Chairman Feedback
IR 1190426	Trng-PCRA- Cps 4004.01 Loss Of IA
IR 908802	Security PIDS Zone Is Locked On
IR 911659	Detect Lane MSO At Risk Of Inattentiveness At Nonpeak Times
IR 920462	1JB05-STI-2: STI02 Alarm Point Locked On
IR 922993	PZ 18/19 Malfunction Locked On
IR 930689	Gate Will Not Close
IR 936894	BRE #1 Interior Folding Wall Table Disconnected From The Wall
IR 954911	NSSS BOP Training Needed
IR 970224	Brake And Signal Light Out
IR 992652	Security X-Ray #3 Inoperable
IR 1005909	Enhancement For Intake At Screenhouse
IR 00939150	789' Ctmt Level 2 Personal Contamination Event

CORRECTIVE ACTION PROGRAM DOCUMENTS REVIEWED	
<u>Number</u>	<u>Description or Title</u>
IR 01012816	Level 1 PCE 2010-01
IR 01020244	Reforecast Of C1R12 Exposure Goal And Stretch Goals
IR 00968090	Potential Adverse Trend Identified
IR 01147953	USAR Table Needs Updated
IR 01158522	Procedure Change Needed For Cps 3822.07 C002
IR 01172431	IR Not Written For Ed Dose Alarm
IR 00923067	Reoccurring Loss Of Power
IR 01039689	Inadequate Closure Of EFR
IR 01039691	Inadequate Closure Of EFR
IR01083224	Water Backing Up In Floor Drains

OPERATING EXPERIENCE	
<u>Number</u>	<u>Description or Title</u>
910219	TRNG-CPS 3304.04 Requires Revision Per OpEx 25417 – OIO
1099404	Enhancement To SOER 02-4 (Davis-Besse) Continuing Training
1127685	EMD SOER 98-2 Training ID'D Unnecessary Work Performed
1102960	Security OpEx: Oyster Creek Schedule Concerns – OIO
1149784	OpEx Review: OE 32446 Security Drill SGI/Sensitive [Sic] Documents

AUDITS, ASSESSMENTS, SELF-ASSESSMENTS, AND EVALUATIONS		
<u>Number</u>	<u>Description or Title</u>	<u>Revision</u>
CL-2009-E-013	50.59 Evaluation – Deferral of Division 3 DG Fuel Oil Storage Tank Cleaning to September 2009 and a 25% Interval Extension to Regulatory Guide 1.137 10 Year FOST Cleaning Frequency for all 3 Division EDGs	Revision 0
CL-2010-S-029	50.59 Review – Temporary Modification to Lift Input from A10 Device to A11 Device for the Division I Diesel Generator	Revision 0
CL-2009-S-054	50.59 Review – Division III DG Auto Start Immediately Following LOOP [Loss of Offsite Power] After Manual Stop	Revision 0
CL-2009-S-004	50.59 Review – Replacement of the Existing A3 Speed Relay Switch Assembly for the Division I EDG	Revision 0
Report No. C1R12-078	Liquid Penetrant Examination Report for Weld CRDH-210%	January 24, 2010
ER-AA-335-003	Magnetic Particle Examination	Revision 3
ER-AA-335-004	Magnetic Particle Examination	Revision 4
RM-AA-101	Records Management Program	Revision 8
LS-AA-110	Commitment Management	Revision 7
Self Assessment (SA) 887965-02	Operations Burden Aggregate Process	

AUDITS, ASSESSMENTS, SELF-ASSESSMENTS, AND EVALUATIONS		
<u>Number</u>	<u>Description or Title</u>	<u>Revision</u>
SA 1056012-03	Pre-NRC PI&R Inspection FASA	
SA 1147578-21	MCR Deficiency & B Priority Work Process	
NOSA-CPS-10-06	Training & Staffing (AR# 995676)	June 8, 2010
NOSA-CPS-10-07	FFD, Access Authorization & Corporate Security (AR# 995688)	August 20, 2010
AR 699108	Ops Training Objectives 1, 2, 3, 4, 5, 6 FASA	June 2, 2009
AR 861208	Safeguards Control FASA	April 30, 2009
AR 860982	Equip Performance Testing & Maint & OCA FASA	August 4, 2009
AR 904733	Training – Admin & Records Check-In Report	September 22, 2009
AR 1106585	Training – Technical Human Performance Check-In Report	January 5, 2011
AR 1071455	DTC Roles & Responsibilities Check-In Report	March 10, 2011
AR 1011842	Firearms Practice & Range Check-In Report	December 21, 2010
AR 1132993	Turnover & Briefings Check-In Report	March 16, 2011
QHPI 971566	Trg - Consequential Exam Security Event	
QHPI 993075	Trng: Improper Instructor Use Of HU Tools During JPMs	
QHPI 1013316	NEIT Consequential Exam Security Event	
QHPI 909344	Handgun Fell From Holster During Arming Process	
QHPI 941815	Security First Aid Injury Elevated To OSHA Recordable	
QHPI 1041285	Dropped Handgun	
QHPI 1089400	AVB Inappropriately Lowered	
QHPI 1099266	Security Officer On Post Without Contingency Equipment	
QHPI 1140526	Security Training - Loss Of Exam Control	
FASA 1056012-03	Pre-NRC PI&R Inspection FASA	
976693-02	Check-In Self-Assessment: Site safety Culture	
861223-02	Check-In Self-Assessment: Safety Culture Procedure Implementation	

WORK ORDERS AND DRAWINGS		
<u>Number</u>	<u>Description or Title</u>	<u>Revision</u>
Work Order (WO) 01277109	Replace Grounded 'B' RR Pump Motor	
WO 00336929 /PMRQ 156877	MM Inspect System Dryer/Separator Strongback	
WO 00014659 /PMRQ 156886	MM Inspect Strongback Carousel Hoists, Tensioners	
Training Request 2010-02-0013A	Chemistry CRC – The use of Fixatives	Revision 0
Training Request	Chemistry CRC – The use of Gel Fixatives	Revision 0

WORK ORDERS AND DRAWINGS		
<u>Number</u>	<u>Description or Title</u>	<u>Revision</u>
2010-02-0012A		

CONDITION REPORTS GENERATED DURING INSPECTION	
<u>Number</u>	<u>Description or Title</u>
AR 1223508	Computation Error in IR 919673
AR 1217584	Closure of IR 670088 Action 04 not Clearly Documented
AR 1223723	NRC PI&R: WO 988866-99 Has Two NDE Exams for Same Item
AR 1223512	NRC Identified Issue With WO Documentation
AR 1221646	NRC PI&R: Root Cause 972235 Does Not Have EFR As Required
AR 1221661	NRC PI&R: Root Cause 979700 Does Not Have EFR As Required
AR 1223806	NRC PI&R EFRs Not Identified As Required
AR 1224527	NRC PI&R: As-Found LRT For Each MSIV Not Performed In C1R12
AR 1223723	NRC PI&R: Inaccuracies in Reproduced Document
AR 1223508	1AP9EH227X1 NRC PI&R Issue – Computation Error in IR 919673
AR 1226340	Maximum Steady State Voltage for TS 3.8.1 Nonconservative
AR 1224313	TS 3.8.1 Design Basis/Licensing Basis Inconsistency
AR 1225436	Inaccurate Information Provided to NRC in License Amendment
AR 1224057	(NRC Identified) Issue Identified with PMRQ

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access Management System
AR	Action Request
ASME	American Society of Mechanical Engineers
CA	Corrective Action
CAP	Corrective Action Program
CAPR	Corrective Action to Prevent Recurrence
CDBI	Component Design Basis Inspection
CPS	Clinton Power Station
CFR	Code of Federal Regulations
DC	Direct Current
DG	Diesel Generator
DRP	Division of Reactor Projects
EACE	Equipment Apparent Cause Evaluation
ECP	Employee Concerns Program
EDG	Emergency Diesel Generator
EFR	Effectiveness Review
FASA	Focused Area Self Assessment
FSAR	Final Safety Analysis Report
IEMA	Illinois Emergency Management Agency
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IR	Inspection Report
ISI	Inservice Inspection
kV	Kilovolt
LCO	Limiting Condition for Operation
LLRT	Local Leak Rate Testing
LOOP	Loss of Offsite Power
MRC	Management Review Committee
MSIV	Main Steam Isolation Valve
MSL	Main Steam Line
N/A	Not Applicable
NCV	Non-Cited Violation
NDE	Nondestructive Examination
NOS	Nuclear Oversight
NRC	U.S. Nuclear Regulatory Commission
OE	Operating Experience
PARS	Publicly Available Records System
PI&R	Problem Identification and Resolution
PMRQ	Preventative Maintenance Request
RAT	Reserve Auxiliary Transformer
RCR	Root Cause Report
RFP	Reactor Feed Pump
RHR	Residual Heat Removal
RR	Reactor Recirculation
SCWE	Safety-Conscious Work Environment
SDP	Significance Determination Process
SOC	Station Oversight Committee
TS	Technical Specification
UV	Undervoltage

Vdc
WO

Volts Direct Current
Work Order

If you contest the subject or severity of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with a copy to the Regional Administrator, U.S. Nuclear Regulatory Commission - Region III, 2443 Warrenville Road, Suite 210, Lisle, IL 60532-4352; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the Resident Inspector Office at the Clinton Power Station. In addition, if you disagree with the cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Clinton Power Station.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Mark A. Ring, Chief
Branch 1
Division of Reactor Projects

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

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Letter to M. Pacilio from M. Ring dated July 8, 2011

SUBJECT: CLINTON POWER STATION NRC PROBLEM IDENTIFICATION AND
RESOLUTION INSPECTION REPORT 05000461/2011008

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