

Clinton

3Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  May 23, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

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

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

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

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

Significance: SL-III Jan 24, 2003

Identified By: NRC

Item Type: VIO Violation

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

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

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated with the traditional enforcement process. The finding was determined to be of low safety significance because the operators had not acted in a solo capacity prior to having their license's amended. However, the regulatory significance was important because

the incorrect information was provided under sworn statement to the NRC and impacted a licensing decision for the two individuals. The issue was preliminarily determined to be an apparent violation of 10 CFR 50.9.

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

Barrier Integrity

Significance:  Feb 20, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

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

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

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

Emergency Preparedness

Occupational Radiation Safety

Significance:  Dec 12, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO CONDUCT ADEQUATE SURVEY OF AIRBORNE RADIOACTIVE MATERIALS

A finding of very low safety significance was identified through a self-revealing event, when a maintenance mechanic received an unexpected uptake of radioactive material during a valve maintenance procedure resulting in a 115 millirem committed effective dose equivalent (CEDE) dose. This self-revealing finding was caused by inadequate implementation of radiation protection procedures and improper work oversight by the radiation protection staff.

The finding is more than minor because it affects the occupational radiation safety cornerstone objective for exposure/contamination control and monitoring. Although an unexpected intake occurred, the radiological conditions associated with the work activity were not of a magnitude sufficient to produce a substantial potential for an exposure in excess of regulatory limits. Therefore, the finding was of very low safety significance (i.e., not an as-low-as-reasonably-achievable finding, not an overexposure or substantial potential for an overexposure, and did not compromise the ability to assess dose). A Non-Cited Violation of 10 CFR 20.1501(a)(1)(ii) was identified for failure to conduct surveys as necessary to assess the radiological conditions and to control exposure to airborne radioactive

material.

Inspection Report# : [2002009\(pdf\)](#)

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : December 01, 2003