

March 15, 2002

Mr. John L. Skolds, President  
and Chief Nuclear Officer  
Exelon Nuclear  
Exelon Generation Company, LLC  
4300 Winfield Road  
Warrenville, IL 60555

SUBJECT: CLINTON POWER STATION  
NRC INSPECTION REPORT NO. 50-461/02-03 (DRP)

Dear Mr. Skolds:

On February 15, 2002, the NRC completed a team inspection at the Clinton Power Station. The enclosed report documents the inspection findings which were discussed on February 15, 2002 with Mr. J. M. Heffley and other members of your staff.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

On the basis of the sample selected for review, the team concluded that, in general, problems were properly identified, evaluated, and corrected and that corrective action program implementation had improved in the last year. The improvement was attributed to active involvement of the corrective action program coordinators and the management review committee. The team concluded that continued involvement of these groups was critical to further program improvement. There was one Green finding identified during this inspection involving inadequate corrective actions for a repetitive problem with a standby liquid control pump motor breaker. The finding was determined to be a violation of NRC requirements. However, because of the very low safety significance and because the finding has been entered into your corrective action program, the NRC is treating this issue as a Non-Cited Violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this Non-Cited Violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Clinton facility.

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Sincerely,

*/RA/Christine A. Lipa*

Christine A. Lipa, Chief  
Branch 4  
Division of Reactor Projects

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

Enclosures: Inspection Report No. 50-461/02-03(DRP)

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Nuclear Services  
J. Cotton, Senior Vice President -  
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report No: 50-461/02-03(DRP)

Licensee: AmerGen Energy Company, LLC

Facility: Clinton Power Station

Location: Route 54 West  
Clinton, IL 61727

Dates: January 28 - February 15, 2002

Inspectors: L. L. Collins, Lead Inspector  
P. L. Loudon, Senior Resident Inspector  
H. A. Walker, Reactor Engineer

Approved by: Christine A. Lipa, Chief  
Branch 4  
Division of Reactor Projects

## SUMMARY OF FINDINGS

IR 05000461-02-03, on 01/28 - 02/15/2002, AmerGen Energy Company LLC, Clinton Power Station; identification and resolution of problems. One finding was identified in the area of effectiveness of corrective action.

The inspection was conducted by two region-based inspectors and one senior resident inspector. This inspection identified one green finding, which was a Non-Cited Violation. The significance of issues is indicated by their color (green, white, yellow, red) and was determined by the Significance Determination Process. Findings for which the SDP does not apply are indicated by "No Color" or by the severity level of the applicable violation. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at: <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

### **Identification and Resolution of Problems**

Improvements were noted in most areas of the corrective action program that were reviewed. While one example of inadequate corrective action was identified, the licensee generally identified, evaluated, prioritized and implemented corrective actions for identified issues in an effective manner. Improvements in these areas were primarily due to active involvement in the program by program coordinators and the management review committee. The trending program and the interface between the corrective action and maintenance work order programs were two areas that could be further improved. Continued involvement by the program coordinators and the management review committee is critical to further program improvement.

### **Cornerstone: Mitigating Systems**

Green. A Non-Cited Violation (NCV) of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for inadequate corrective action taken to prevent recurrence of a Standby Liquid Control "A" System (SLC) pump motor breaker failure was identified.

This finding was determined to be of very low safety significance due to the low initiating event frequency for Anticipated Transient Without Scram, the availability of the "B" SLC pump, and the high likelihood of successful operator recovery actions.

## Report Details

### **4. OTHER ACTIVITIES (OA)**

#### 4OA2 Problem Identification and Resolution

##### .1 Effectiveness of Problem Identification

###### a. Inspection Scope

The inspectors reviewed inspection reports issued over the last year, selected plant modifications and maintenance work orders for one high risk system (125 VDC system), various condition reports (CR) and corrective action documents, industry operating experience documents, audits, and self-assessments, in order to determine if problems were being identified at the proper threshold and entered into the corrective action process. The documents listed in Attachment 1 were used during the review.

###### b. Issues and Findings

In general, the licensee effectively identified plant problems and entered them into the corrective action program by initiating CRs. The threshold for initiating a CR was appropriate. Nuclear Oversight assessments and department self-assessments appeared to be effective problem identification processes. The use of trending to identify deficiencies improved over the last year. However, additional opportunities to use trending as an identification tool exist. Several observations are discussed in the following paragraphs.

##### CR Initiation

The inspectors assessed the threshold the licensee used to initiate a CR. In general, the inspectors found the threshold to be very low for identified deficiencies both for plant equipment and programmatic issues. The inspectors noted that the CR generation rate had increased slightly from the previous year and that the licensee implemented additions to the process to include CR generation for program and procedure enhancements and improvements. The inspectors also noted that while a few CRs were generated during the year as a result of inspector prompting, the overall number of those instances had decreased significantly compared to the previous year.

##### Trending

The inspectors reviewed the effectiveness of the licensee's trending program which was used to identify problems. During the previous Problem Identification and Resolution inspection, the inspectors found that the trending program was not fully effective in identifying declining performance trends. The trending program had been fully revised since that inspection. The current program required that trend codes be assigned to CRs at initiation and after a root or apparent cause evaluation, if one was performed. Periodic assessment of the trend codes by each department was performed to identify potential trends which would then receive a common-cause analysis and further

corrective action, as needed. After reviewing the coding process and several common cause analyses, the inspectors concluded that trending had improved as an identification tool, but remained an area that could be strengthened. In particular, the equipment trend coding to identify equipment problems and site wide trending across departments were two weaker areas of the trending program.

### Nuclear Oversight Assessments and Department Self-Assessments

The inspectors reviewed the four quarterly Nuclear Oversight Continuous Assessment Reports for 2001 and a sample of self-assessment reports performed by various plant departments. The reports indicated a thorough review of plant activities. Deficiencies were documented on CRs and entered into the corrective action program and enhancements were tracked via the action tracking system. In particular, the inspectors found that the most recent corrective action program self-assessment conducted in October 2001 was thorough and critical. Condition reports were generated to correct problems and improve weaknesses in implementation. Overall NRC conclusions regarding problem identification, prioritization and evaluation, and effectiveness of corrective actions during this current inspection were consistent with the self-assessment and Nuclear Oversight conclusions.

## .2 Prioritization and Evaluation of Issues

### a. Inspection Scope

The inspectors conducted an independent assessment of the prioritization and evaluation of a selected sample of CRs. The assessment included a review of the category assigned, operability and reportability determinations, extent of condition evaluations, cause investigations, and the appropriateness of the assigned corrective actions. The documents listed in Attachment 1 were used during the review.

The inspectors attended daily staff and management meetings to observe the assignment of condition report categories for current issues and the review of root cause analyses and corrective actions.

### a. Issues and Findings

Quality of root cause evaluations and apparent cause evaluations had improved since the previous Problem Identification and Resolution Inspection. The inspectors attributed the improvements in these evaluations, and in the corrective action program implementation in general, to active involvement in the process from the department corrective action program coordinators (CAPCOs) and from managers at the Management Review Committee (MRC). Daily meetings were conducted to review CRs, cause analyses, and proposed corrective actions. During these meetings, the inspectors observed these review groups actively coaching plant staff who were presenting information to ensure a thorough cause evaluation and specific corrective actions. Although improvements were noted in this area, the inspectors had several observations which included the role of the CAPCO and MRC, untimely completion of corrective action for one CR, and the closure of corrective actions to maintenance work orders.

### Role of CAPCO and MRC

The inspectors noted that some cause evaluations and proposed corrective actions presented to the CAPCO and MRC review groups lacked the necessary specificity to ensure effective implementation of corrective actions. However, both the CAPCO and MRC provided sufficient feedback to ensure that the evaluations and proposed corrective actions were appropriately revised. Based on these observations, the inspectors concluded that continued active participation of these groups was critical to further improvements in the overall corrective action program implementation.

### Untimely Completion of Corrective Actions for One CR

The inspectors conducted a detailed review of the more significant CRs generated during the previous year. The classification for those CRs were "2A" as designated through the licensee's review of the issue. The inspectors noted that 20 CRs had been classified at the 2A level during 2001. Of these, 19 were assessed to be properly prioritized for corrective action timeliness. One CR (2-01-02-165) was determined to not have been dispositioned in the most timely manner possible, consistent with the significance level.

The details of CR 2-01-02-165 concerned the ineffectiveness of corrective actions taken to address repetitive radiological protection posting and control issues surrounding radioactive waste transfers. The root cause identified 13 corrective actions, one of which was identified as a corrective action to prevent recurrence (CAPR). The original completion date for the corrective actions were in the June to July 2001 time period. The corrective action item identified as a CAPR was completed on schedule; however, one of the other corrective actions involving additional revisions to the radioactive waste transfer procedure was not completed until January 2002. Furthermore, an initial Corrective Action Review for Effectiveness (CARE) could not be adequately conducted at the originally specified time due to the remaining open corrective action.

Although no additional radioactive waste transfer performance deficiencies had occurred during the corrective action implementation time period, the inspectors questioned the priority placed on completing all the corrective actions. The inspectors' comments were based on the fact that only 20 CRs at the 2A level had been generated throughout the entire organization for the year 2001 and the subject CR was the only one at that significance classification within the Radiation Protection (RP) organization. In addition, the root cause of this CR was ineffective corrective actions taken to previous similar occurrences. The inspectors concluded that more focus from the RP organization on implementation and closure of corrective actions would have resulted in more timely dispositioning of the issue. The licensee generated a CR on the untimely resolution of this issue (93313).

### Closure of Corrective Actions to Maintenance Work Orders

The inspectors noted that the current corrective action program allowed the closure of most corrective actions requiring equipment repair to maintenance work orders, unless the action was defined as a corrective action to prevent recurrence. This practice had been previously stopped because of problems with closing corrective actions to



maintenance work orders which were inappropriately extended or canceled. In fact, the previous Problem Identification and Resolution Inspection documented a finding in which this had occurred. During this current inspection, the inspectors reviewed CR 2-01-07-278, which was written on incorrectly procured material for the fuel pool cooling pumps bearing housings. The CR noted that the incorrect material was also currently installed in the pump bearing housings. The CR was closed to two maintenance work orders (MWOs). The MWOs had been written for work on the pumps because of pump performance problems and did not specify use of the correct bearing housings. In addition, the removal of the unacceptable material from stores to prevent issue and use was not addressed in either the CR or the MWO as a corrective action.

During subsequent follow-up by the inspectors, licensee personnel indicated that, although not specified in the referenced MWOs, the unacceptable bearing housings were removed from the pumps and acceptable housings were installed using the referenced MWOs. In addition, licensee personnel stated that the unacceptable housings were removed from stores and were not available for installation and use. CR 95175 was written on this issue. In this example, the necessary corrective action in the CR was not properly translated to the MWO. However, the proper corrective action was ultimately completed.

### .3 Effectiveness of Corrective Action

#### a. Inspection Scope

The inspectors reviewed selected condition reports and associated corrective actions to evaluate the effectiveness of corrective actions. Additionally, the inspectors evaluated the current status of corrective actions to improve previously identified weaknesses including the plant labeling program, use of surveillance test and preventive maintenance program grace periods, the trending program, and the corrective action effectiveness review process. The inspectors also reviewed the licensee's corrective actions for two Non-Cited Violations (NCVs) documented by NRC inspections in the past year. The documents listed in Attachment 1 were used during the review.

#### b. Issues and Findings

The inspectors identified one Green finding for inadequate corrective actions and had several observations in this area. In general, the inspectors found that the licensee effectively corrected plant problems. The inspectors' review of longstanding plant issues identified during the previous Problem Identification and Resolution inspection determined that recent corrective actions for these issues have been effective. In addition, effectiveness reviews had improved, mainly due to added structure and format required by the new corrective action program. The finding and observations are discussed in the following paragraphs.

#### Inspection Finding - Inadequate Corrective Actions for SLC Breaker Problem

Green. A Non-Cited Violation of 10 CFR Part 50 Appendix B, Criterion XVI, "Corrective Action," was identified for ineffective corrective actions taken to prevent the recurrence of a Standby Liquid Control (SLC) "A" system pump motor breaker failure. On

January 4, 2001, during a quarterly surveillance test for the SLC system "A" and "B" pumps, the "A" pump failed to start when an operator depressed the start button at the local panel. A CR was written (2-01-01-012) and the apparent cause evaluation concluded that the event was a hardware failure with no apparent cause identified. However, the evaluation continued with a potential explanation of the failure to be intermittent binding of the starter contactor. This intermittent binding created a higher than normal start current which in turn caused an instantaneous over-current trip of the breaker. The licensee also sent the breaker to a vendor laboratory for failure analysis.

The failure was characterized as a maintenance rule functional failure and was inserted into the maintenance rule failure evaluation process. Part of this process was to conduct a followup review of past failures and provide a cause determination assessment.

The licensee received a breaker analysis report from the vendor laboratory in September 2001. The report concluded that the breaker functioned normally with no identified deficiencies. The inspectors found no evidence that this information was added to the CR documented assessment of the January 2001 breaker failure.

In October 2001, a cause determination for the January SLC breaker trip was conducted in accordance with the maintenance rule program procedure. The engineer who conducted this review was not involved in the apparent cause evaluation which reviewed the January 2001 breaker failure. The maintenance rule cause determination concluded that the January 2001 failure of the SLC "A" pump motor breaker was due to inadequate breaker sizing (amperage) not intermittent binding of the contactors. The cause determination was provided to a System Engineering Supervisor and the Maintenance Rule Coordinator for review. Each of these individuals concurred on the assessment; however, a CR was not generated nor did the conclusion of the cause determination prompt a re-review of the original apparent cause evaluation for the January 2001 event.

Subsequently, the SLC "A" pump breaker was tested on its normal periodicity in November 2001. During this test the "A" motor breaker tripped similar to the occurrence in January 2001. The prompt investigation into this occurrence concluded that the breaker was inappropriately sized for the in-rush current experienced during pump starts, and the breaker was replaced.

The performance deficiency associated with this finding was an inadequate programmatic tie between the corrective action program and the Maintenance Rule cause determination process which resulted in inadequate corrective actions. This deficiency led to the identification of an incorrect apparent cause evaluation which was not entered into the corrective action program to either prompt a re-review of the original condition and conclusions; or to initiate another CR which could alter the maintenance activities planned in future system outage windows. The finding was greater than minor because if left uncorrected, the same conditions could become a more significant safety concern. The issue was also assessed to have had a credible impact on the operability, availability, and reliability of a safety related mitigation system. Therefore, the inspectors assessed the issue using the At-Power Significance Determination Process (SDP). Using the Anticipated Transient Without SCRAM (ATWS) worksheet, the inspectors concluded that the issue was of very low safety significance (Green), mainly

due to the low initiating event frequency, the availability of the unaffected SLC “B” pump, and the high likelihood of operator recovery actions.

Criterion XVI, of 10 CFR Part 50 Appendix B, requires, in part, that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. Contrary to this, the licensee failed to correct a condition adverse to quality regarding the SLC system. This is a violation of 10 CFR Part 50 Appendix B, Criterion XVI. However, because of the very low safety significance and because the issue is in the licensee’s corrective action program, it is being treated as a Non-Cited Violation, consistent with Section VI.A.1 of the NRC Enforcement Policy (**NCV 50-461/02-02-01**). This violation is tracked in licensee’s corrective action program as CRs 94602 and 94122.

#### Corrective Actions for Several Longstanding Plant Issues

The inspectors reviewed corrective actions for several longstanding plant issues that had not been effectively corrected as of the previous Problem Identification and Resolution inspection. These issues included the surveillance testing and preventive maintenance programs, plant labeling, and trending. Observations on the trending program are included in section 4OA2.1. Other observations are discussed below.

The inspectors reviewed the status of PM tasks and noted that the tasks were current with no items past the specified grace period dates. Considerable improvement had been made in this area since January of 2001 when the backlog of new PM tasks, which had not been scheduled, planned or performed, was more than 2300. Recent PM status reports indicated that no PM tasks were currently past the grace period due date allowed by procedures. Licensee personnel stated that all PM tasks had been scheduled and, although the planning of some PM tasks had not been completed, task planning would be completed prior to the scheduled completion date so the tasks could be performed as scheduled. The improvement in PM performance indicated that corrective actions taken in this area had been adequate and were being properly implemented. The inspectors noted similar improvements and additional management controls over the surveillance testing program.

The inspectors reviewed licensee’s corrective actions regarding labeling problems which were documented on CR 2-01-01-125 and three additional CRs. In addition, changes made to address this issue in revision 1 of CPS procedure 1033.00, “Plant Labeling Program” were reviewed and appeared to provide adequate control. Actions taken to address the labeling problem were considered adequate.

#### .4 Assessment of Safety-Conscious Work Environment

##### a. Inspection Scope

The inspectors conducted interviews with plant staff to assess whether there were impediments to the establishment of a safety conscious work environment. During these interviews, the inspectors used Appendix 1 to Inspection Procedure 71152,

“Suggested Questions for Use in Discussions with Licensee Individuals Concerning PI&R Issues,” as a guide to gather information and develop insights. The inspectors also discussed the implementation of the Employee Concerns Program (ECP) with the plant’s ECP Coordinator.

b. Issues and Findings

The inspectors did not find any reluctance by the station employees to raise safety issues. The inspectors concluded the employees felt a safety responsibility to raise issues, were familiar with the various processes to raise issues, and felt that management was supportive in identifying and correcting safety problems.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. J. M. Heffley and other members of licensee management in an exit meeting on February 15, 2002. Licensee management acknowledged the findings presented and indicated that no proprietary information was provided to the inspectors.

PARTIAL LIST OF PERSONS CONTACTED

Licensee

K. Baker, Design Engineering Manager  
T. Bostwick, Regulatory Assurance  
C. Dieckmann, Shift Operations Superintendent  
R. Frantz, Regulatory Assurance Representative  
J. Heffley, Site Vice President  
W. Iliff, Director - Regulatory Assurance Director  
J. Madden, Nuclear Oversight Manager  
M. Pacilio, Plant Manager  
J. Randich, Work Management Director  
J. Sears, Radiation Protection Director  
R. Svaleson, Operations Director  
F. Tsakeres, Training Manager  
J. Williams, Site Engineering Director

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

50-461-02-03-01      Inadequate Corrective Actions for Repetitive Failure of SLC Pump Motor Breaker

Closed

50-461-02-03-01      Inadequate Corrective Actions for Repetitive Failure of SLC Pump Motor Breaker

## LIST OF ACRONYMS

ATWS	Anticipated Transient Without Scram
CAPCO	Corrective Action Program Coordinator
CAPR	Corrective Action to Prevent Recurrence
CARE	Corrective Action Review for Effectiveness
CR	Condition Report
MRC	Management Review Committee
MWO	Maintenance Work Order
NCV	Non-Cited Violation
RP	Radiation Protection
SLC	Standby Liquid Control

## ATTACHMENT 1

### LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection, including documents prepared by others for the licensee. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire documents, but, rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. In addition, inclusion of a document on this list does not imply NRC acceptance of the document, unless specifically stated in the body of the inspection report.

#### PROCEDURES

1033.00	Plant Labeling Program	Revision 1
7200.33	Conduct of Transfer Evolutions	Revisions 3 and 4
RS-AA-115	Operating Experience (OPEX)	Revision 2
LS-AA-125-1004	Effectiveness Review Manual	Revision 0
NO-AA-200 -001	Nuclear Oversight Continuous Assessment Procedure	Revision 2
LS-AA-125	Corrective Action Program (CAP) Procedure	Revision 1
LS-AA-125-1002	Common Cause Analysis Manual	Revision 0
LS-AA-125-1001	Root Cause Analysis Manual	Revision 0
LS-AA-125-1005	Coding and Trending Manual	Revision 0
EI-AA-101	Employee Concerns Program	Revision 2
LS-CL-126	Self-Assessment	Revision 0

#### CAREs

2-01-02-138 64488	Failure to Perform Required ITS Surveillance Within 1.25 Frequency
1-98-03-459	RC&IS System Should Be Classified as A(1) Under the Maintenance Rule
2-00-05-004	Issuance of a Protective Action Recommendation at a Site Area Emergency Vice a General Emergency
1-99-11-140	Violation of CPS 1817 - Low Chlorine Concentration in Potable Water Storage Tank
3-98-04-353	Safety Evaluation Program (50.59) Implementation Is Not Effective
1-97-12-220	Actual RWCU Trip Thermal Cycle Different than Design Basis Thermal Cycle
2-00-08-062	Inadvertent Rod Motion During RC&IS Troubleshooting
1-99-11-012	Reclassification of CM System to Maintenance rule A(1) Status Due to Excessive Functional Failures
Q-00-01-008	Departure From Industry Standards and Numerous Process Deficiencies Associated With Temporary Modifications
1-97-11-047	Status of DC System Maintenance Rule Classification

## OTHER CONDITION REPORTS (CRs) REVIEWED

2-00-01-076	Failure to Recognize Risk During Outage DC System Maintenance Activities
2-00-06-058	Interrupted Daisy Chain Neutral while De-Terming HFA Relays for VC-A outage
2-00-11-034	Division 2 Battery Charger Float Voltage Regulation Out of Specification
2-00-11-096	Maintenance Rule Failure of 1DC08E (Division 4 Battery Charger) Due to Float/Equalize Switch
2-00-11-147	Diesel generator B generator bearing vibration
2-01-01-007	Division 2 diesel generator 12 cylinder bearing Vibration levels took a step change
2-01-01-012	1C41-C001A SLC Pump A Tripped During Surveillance Testing
2-01-01-035	Apparent declining trend in overall execution and performance of the preventive maintenance program
2-01-01-049	Area for Improvement (OP.5-1)
2-01-01-076	Div 2 DG exceeded established vibration limits during 24 hour surveillance run during shutdown
2-01-01-100	Adverse trend in the sites ability to properly track, schedule and document the performance of STS
2-01-01-125	Vulnerability for Configuration Control Errors when Component Identification Deficiencies are found
2-01-01-165	Affected Areas Not Posted For RadWaste Transfer
2-01-01-180	Design change did not account for stray current path Potential
2-01-01-191	SX piping was not replaced as scheduled to prevent a violation of minimum wall thickness
2-01-01-228	Untimely and ineffective corrective action on valve 1E51-F095 identified during NRC inspection
2-01-02-053	Missing orifices in main turbine control stop
2-01-02-093	Ineffective evaluation and corrective action causing Repetitive deficiencies in determination of DG oil level
2-01-02-113	Valve 1E51-F045 stroked outside of acceptance band
2-01-02-138	Failure to Perform Required ITS Surveillance Within 1.25 Frequency
2-01-02-253	Failure of clearance holders to perform proper clearance section (sign on/off)
2-01-03-156	CP-20 MOD Component Labels for "E" and "F" Cells Do not match Equipment Description fields in the CP System Lineups 3104.01V003 and V004 and are Inconsistent with cells "A" - "C"
2-01-03-247	New Failure Trend Identified in Love Electronic Controllers
2-01-04-140	Documentation of NRC Battery Concerns/Observations Noted During Equipment Walkdown
2-01-05-272	Performance of Battery Preventive Maintenance
2-01-05-338	Plant Label Team Daily Goal not met
2-01-05-404-0	Inadequate Clearance - Electrical shop recognized HFA could cause unexpected system response due to unidentified daisy chained neutrals
2-01-06-002	Critical component failure of remote shutdown system Control switch
2-01-06-111	The fuel pool cooling pump "B" adverse trend in differential pressure



2-01-06-180	The fuel pool cooling and cleanup system health report was made yellow due to low flow from the "A" pump 1FC02PA
2-01-07-043	Common Cause Analysis (CCA) – Potential Adverse Trend on Overdue/Late PMs and PMs Exceeding Their Critical Date
2-01-07-093	Repetitive Malfunctions of BOP 1E and 1F Battery Chargers
2-01-07-278	Incorrectly procured 1FC02PA & B Thrust and coupling End bearing housings
2-01-08-018	Div 3 DG KVAR oscillations during 9080.02 Surveillance run
71973	Inconsistent Flow Data from Surveillance Testing
73775	On 7/27/01 9080.01 for Division 2 Diesel generator was approved with bad acceptance data
75704	Unanticipated Increased Vibration Levels on the "A" Reactor Recirculation Pump Motor
79222	Slow start of the Division 1 Emergency Diesel Generator
79339	Unexpected EDG Speed Droop Response
79346	Starter Pickup Voltage Found Outside Acceptable Limits
82946	SLC pump A failed to start during performance of 9015.01
83328	DC MCC 1E Battery Charger Amps Oscillating
83976	DC MCC 1F Charger Loud Banging Noise
87223	ERAT Trip and Deluge
94887	CA Identified Training Needs but No Action Taken
89224	There seemed to be no effective method in place to identify Technical Specification surveillance failures
93313	Untimely Root Cause Corrective Action Completion
94122	Failure to Initiate CR w/CDE Contradiction of Previous ACE
94602	Flawed Failure Analysis on SLC "A" Starter

**NON-CITED VIOLATIONS (NCVs)**

461/2001-01 – Thinning of the shut-down service water piping  
461/2001-02 – Failure to correct leakage of the RCIC turbine steam by-pass valve (1E51-F095)

**NUCLEAR OVERSIGHT ASSESSMENT REPORTS**

NOA - C - 01 - 01Q	Nuclear Oversight Continuous Assessment Report January – March 2001
NOA - C - 01 - 02Q	Nuclear Oversight Continuous Assessment Report April – June 2001
NOA - C - 01 - 03Q	Nuclear Oversight Continuous Assessment Report July – September 2001
NOA - C - 01 - 04Q	Nuclear Oversight Continuous Assessment Report October – December 2001

## **COMMON CAUSE ANALYSES**

80522 Potential Adverse Trend in Operations Schedule Accuracy  
64583 Cause for Numerous Systems Being in (a)(1) due to Repetitive Maintenance Rule Functional Failures  
2-01-04-081 Potential Adverse Trend - 13 Unplanned LCOs Entered in March  
87589 Shutdown and Startup Delays due to Control Rod Motion in C1F36

## **MAINTENANCE WORK ORDERS**

2871 Fuel pool cooling "A" pump inboard bearing degrading and leaking  
4619 Monitoring indicates beginning of fuel pool cooling pump 1B bearing wear. Oil analyst and vibration monitoring do not indicate imminent failure or in-operability  
327118 Fuel pool cooling pump 1FC82PB inboard bearing showing signs of early degradation  
C990517016 Vibration problems on the fuel pool cooling 1FC02PA pump

## **MISCELLANEOUS DOCUMENTS**

Site Engineering Policy Statement #5  
Clinton CAP Program Effectiveness Performance Indicators for Jan. 2001 through Jan. 2002  
Exelon Power Labs Report on Instantaneous Trip Testing of ITE/Gould HE3B100 Circuit Breaker  
Maintenance Rule Cause Determination for CR 2-01-01-12  
Engineering Evaluation Associated with CR 2-01-05-272  
Critical Surveillance Monitoring Data (miscellaneous for 2001)  
Nuclear Safety Review Board Meeting Minutes, March 29 and 30 2001  
Nuclear Safety Review Board Meeting Minutes, December 13 and 14, 2001