UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
801 WARRENVILLE ROAD
LISLE, ILLINOIS 60532-4351

March 26, 1999

Mr. John P. McElwain
Chief Nuclear Officer
Clinton Power Station
Illinois Power Company
Mail Code V-275
P. O. Box 678
Clinton, IL 61727

SUBJECT: PLANT PERFORMANCE REVIEW - CLINTON

Dear Mr. McElwain:

On February 2, 1999, the NRC staff completed a Plant Performance Review (PPR) of Clinton Power Station. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. Plant Performance Reviews provide NRC management with a current summary of licensee performance and serve as inputs to the NRC's senior management meeting reviews. Plant Performance Reviews examine information since the last assessment of licensee performance to evaluate long-term trends, but emphasize the last 6 months to ensure that the assessments reflect current performance. The PPR for Clinton involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period April 6, 1997, to January 31, 1999. The NRC's most recent summary of licensee performance was provided in a letter of June 23, 1997, and was discussed in a public meeting with Illinois Power Company on July 2, 1997.

As discussed in the NRC's Administrative Letter 98-07 of October 2, 1998, the PPR provides an assessment of licensee performance during an interim period that the NRC has suspended its Systematic Assessment of Licensee Performance (SALP) program. The NRC suspended its SALP program to complete a review of its processes for assessing performance at nuclear power plants. At the end of the review period, the NRC will decide whether to resume the SALP program or terminate it in favor of an improved process.

Clinton Power Station remained shut down throughout this assessment period while work was being performed to address the restart items in the NRC Manual Chapter 0350 Restart Panel Case Specific Checklist and in your recovery plan, the Plan for Excellence. Steady progress has been made to address these items; however, a recurring theme for many of the closure packages for the restart items presented to the NRC for review was that comprehensive plans to address the items were developed but not all aspects of the plans had been sufficiently implemented to warrant closure of the items. Some items, most notably the development of a program to reduce main control room deficiencies, have been reviewed several times but were not ready to be closed. The result of this has been the deferral of the remaining items to the last three NRC team inspections scheduled prior to restart. It is likely that some follow up

inspection will be necessary after the three team inspections to ensure all restart items have been resolved.

The three areas of most concern with the performance at Clinton are operator performance, corrective action program implementation, and the resolution of engineering design issues. Corrective actions to address weaknesses in operator performance were not successful in preventing or reducing the number of operations department challenges, the most problematic of which involved Technical Specification implementation, the operator requalification program, and the implementation of emergency operating procedures. Multiple assessments of the corrective action program have been performed by your organization and the NRC with essentially the same conclusions: (1) management has not provided sufficient oversight; and (2) management is not adequately engaged in the corrective action process. In general, more effort has been focused on the more significant conditions adverse to quality and, as a result, the effective resolution of these items occurs more often than the effective resolution of lower level items. However, several significant conditions adverse to quality have recurred over the past 6 months. The main engineering design issues include the resolution of the degraded voltage problem, and the adequacy of the calculation and setpoint control processes.

Performance in plant operations remained consistent. While there has been some improvement in certain areas of plant operations, overall performance has been characterized by more repetitive issues than resolved issues. Operators have improved in recognizing new degraded conditions, shift turnovers have been significantly improved, and performance in the tagout program has been characterized by a reduction in the amount of significant errors. However, poor performance during the annual operating test indicated that crew members had failed to retain mastery of needed operator skills. In addition, recurring issues such as the failure to document compensatory actions for disabled annunciators, unfamiliarity with existing control room deficiencies, Technical Specification compliance problems, emergency operating procedures implementation problems during drills, and poor self-assessments indicate that much improvement is necessary in the operations area. In addition to normal core inspections, initiative inspections will be conducted to review operator readiness to startup and operate the plant, to continuously observe plant startup activities, and to review the routine conduct of operations following plant restart.

Performance in the maintenance area declined early in this assessment period from that described in the previous SALP report, but improved as the period progressed. Early in this period, both programmatic and human performance deficiencies existed in the maintenance functional area. For example, the molded case circuit breaker testing program was inadequate, troubleshooting activities were often conducted without properly adhering to procedures, and the scheduling and completion of surveillances was ineffective. In addition, the maintenance rule program was not adequately implemented. Improvement has been noted in all of these areas during the past several months. The adequacy of and adherence to procedures and the scheduling and completion of surveillance tasks has significantly improved. Also, the quality of condition report reviews has improved, a maintenance rule program has been established, 4,160 V circuit breaker issues have essentially been resolved, and a new molded case circuit breaker testing program has been implemented. However, the failure to update the status of the main control room deficiency log and tags as the deficiencies were resolved is indicative of

the need to improve support to the operations department. In addition to normal core inspections, the resident inspectors will perform initiative inspections to review maintenance planning and implementation as the work item backlog is reduced. In addition, an initiative inspection will be conducted to review the collective significance from a risk perspective of your maintenance item backlog.

Overall, engineering department performance has improved especially with regard to issue identification. Reviews and assessments of selected systems' design bases have identified multiple examples of engineering deficiencies. In particular, the system design and functional validation review and the fire protection re-validation project were comprehensive and effective in identifying programmatic issues. The content of current licensee event reports suggests a lowered threshold for identification of engineering design issues and an increased engineering staff understanding of the design basis. However, the NRC determined that a significant amount of work associated with corrective actions developed to address the deficiencies identified during the engineering assessments needed to be completed prior to plant restart. Several examples of inadequate engineering support to the operations department were also noted. In addition to normal core inspections, the resident inspectors will perform initiative inspections to review modification packages and the effectiveness of the corrective actions implemented to address programmatic deficiencies.

Radiation protection and chemistry department performance improved during the assessment period. Improvements in radiological planning and communications were observed during the replacement of emergency core cooling system strainers. In addition, the chemistry staff's adherence to sampling and quality control procedures was improved. However, personnel performance problems and program implementation issues continued to be observed, particularly early in the assessment period.

Emergency preparedness (EP) performance declined as numerous problems were identified in the program related to drills, exercises, and other program activities. Emergency facilities, equipment, and supplies were maintained in an adequate state of readiness but the material condition of these areas was in need of improvement. The EP performance during an actual loss of shutdown cooling event in February 1998 was mixed. Provisions for staffing the on-shift emergency organization and for augmenting it were flawed. Self-assessment of EP performance was inconsistent. During the November 1998 exercise, overall performance was adequate; however, significant performance concerns were identified regarding the operating crew and responders in the Technical Support Center, Operations Support Center, and Emergency Operations Facility. In addition to normal core inspections, initiative inspections will be performed to review EP exercise performance and other aspects of plant support performance.

The NRC Manual Chapter 0350 Oversight Panel for the Clinton station continues to hold frequent public meetings with licensee management to assess progress on corrective actions necessary for safe plant restart. During the extended shutdown, core resident inspections at the Clinton station are conducted as delineated in NRC Manual Chapter 2515 and regional initiative inspections are conducted under the direction of the Oversight Panel focusing on the Case Specific Checklist items required for restart.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Illinois Power Company. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that the NRC believes warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the Public Document Room as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the Clinton PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. The rationale or basis for each inspection outside the core inspection program is provided so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact Tom Kozak at 630-829-9866.

Sincerely,

/s/ G. E. Grant

Geoffrey E. Grant, Director
Division of Reactor Projects

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

Enclosures: 1. Plant Issues Matrix
2. Inspection Plan

See Attached Distribution

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Sincerely,

Marc L. Dapas, Deputy Director,
Division of Reactor Projects

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cc w/encls: G. Hunger, Station Manager
R. Phares, Manager, Nuclear Safety
and Performance Improvement
J. Sipek, Director - Licensing
M. Aguilar, Assistant Attorney General
G. Stramback, Regulatory Licensing
Services Project Manager
General Electric Company
Chairman, DeWitt County Board
State Liaison Officer
Chairman, Illinois Commerce Commission
M. Reidy, Clinton Police Chief
The Honorable Tom Edmunds
The Honorable Ken Schaub
R. Schumaker, DeWitt County
Board Chairman
R. Massey, DeWitt County Sheriff
M. Strain, DeWitt County Emergency
Preparedness Coordinator
The Honorable Thomas Brame
G. C. Riss, McLean County Board Chairman
S. Brienan, McLean County Sheriff
J. Wahls, Director, McLean County
Emergency Services and Disaster Agency
R. Scheffer, Piatt County Board Chairman
F. Sawlaw, Piatt County Sheriff
C. E. Morris, Emergency Services
Disaster Coordinator
R. Owen, Macon County Board Chairman
R. Walker, Macon County Sheriff
D. Sanner, Emergency Services Coordinator
INPO

Distribution:
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G. Tracy, OEDO w/encls
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Project Director, NRR w/encls
Project Mgr., NRR w/encls
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United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Region III
CLINTON

Date	Source	Functional Area	ID	Type	Template Codes	Item Description
02/16/1999	1999002	Pri: OPS Sec: 	NRC	NEG	Pri: 1B Sec: Ter:	The inspectors determined that operations personnel did not meet the guidance in NRC Emergency Preparedness and Radiation Protection Branch Position (EPPOS) No. 2, "Timeliness of Classification of Emergency Conditions," for declaration of the January 6, 1999, NOUE. Specifically, operations personnel declared the NOUE 26 minutes after the initiation of the LOOP even though the guidance in NRC EPPOS No. 2 specified that event declaration should occur within 15 minutes. Additionally, expectations for the timeliness in declaring emergency action levels in response to events were not specified in procedures for preparing and conducting emergency exercises
02/16/1999	1999002	Pri: OPS Sec: 	NRC	NEG	Pri: 1C Sec: Ter:	The inspectors determined that in most cases, the annunciator response procedures did not reference the Technical Specifications associated with the alarming condition
02/16/1999	1999002	Pri: OPS Sec: 	NRC	NEG	Pri: 5A Sec: Ter:	The inspectors determined that the licensee's critique of the LOOP event was not sufficiently critical to identify issues involving operator knowledge weaknesses, procedure discrepancies, timeliness of event declaration, and delays in the shift turnover process. Following discussions with the inspectors, the licensee initiated an event review team and conducted an effective assessment of the issues and concerns to identify issues involving operator knowledge weaknesses, procedure discrepancies, timeliness of event declaration, and delays in the shift turnover process.
02/16/1999	1999002	Pri: OPS Sec: 	NRC	NEG	Pri: 5B Sec: Ter:	The inspectors determined that the licensee's review of procedures to support closure of Case Specific Checklist (CSC) Restart Item II.3, "Review and Revise Abnormal Operations Sections of Operations Procedures," was ineffective in that the assessment did not determine that approximately 244 procedure changes associated with 113 operations procedures involved technical issues which needed to be addressed prior to restart or prior to the next time the procedure was used
02/16/1999	1999002	Pri: OPS Sec: 	NRC	POS	Pri: 1B Sec: Ter:	The inspectors determined that operations personnel responded appropriately to a loss of offsite power (LOOP) involving a Notice of Unusual Event (NOUE) declaration in that procedures were used in-hand, peer checks were frequently conducted, three-way communication techniques were good, and off-shift personnel were effectively utilized without becoming a distraction to the operating crew
02/16/1999	1999002	Pri: OPS Sec: 	NRC	WK	Pri: 3B Sec: Ter:	The inspectors identified operator knowledge weaknesses regarding the interlocks associated with the 4160V vital bus feeder breakers
02/16/1999	1999002-01	Pri: OPS Sec: 	NRC	NCV	Pri: 1C Sec: Ter:	The inspectors identified one Non-Cited Violation for the failure to translate design requirements into annunciator response procedures. Specifically, the design requirements for the operation of the 4160V 1A1 main and reserve feeder breakers following a trip of the emergency diesel generator was incorrectly translated into Procedure 5060:01, "Alarm Panel 5060 Annunciators - Row 1"
02/16/1999	1999002-02	Pri: OPS Sec: 	Licensee	NCV	Pri: 3A Sec: Ter:	The inspectors concluded that the licensee did not log EDG starts or formally track lightly-loaded run times for each EDG, which could result in the licensee failing to take necessary actions to ensure EDG reliability. One Non-Cited Violation was identified concerning this issue

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01/06/1999	1998020	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	The inspectors concluded that weaknesses in the implementation of the operability determination program still existed in that operations personnel had not conducted eight safety evaluations for long standing use-as-is nonconforming conditions. In addition, three maintenance activities associated with operability determinations had not been scheduled for completion prior to restart of the facility
01/06/1999	1998020	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 1C Sec: 3B Ter:	The inspectors concluded that interviewed operators were not aware of the overall status of deficient control room equipment and OWAs
01/06/1999	1998020-01	Pri: OPS Sec: Ter:	NRC	NCV	Pri: 5C Sec: Ter:	The inspectors identified one violation, for which enforcement discretion was exercised, concerning the failure of control room operators to enter nonconforming conditions into the licensee's corrective action program. Specifically, operations personnel documented four nonconforming conditions in the MCR journal but did not initiate a condition report. The issues involved an unanticipated loss of fill and vent on the residual heat removal system, a human performance error during maintenance on a station air compressor, a maintenance rule functional failure affecting the Division I switchgear heat removal unit, and three unplanned entries into a limiting condition for operation
01/06/1999	1998020-02	Pri: OPS Sec: Ter:	NRC	NCV	Pri: 1C Sec: Ter:	The inspectors identified one violation, for which enforcement discretion was exercised, that involved the failure of operations personnel to annotate a late entry in the MCR journal and the repeated failure to document the completion of shiftly compensatory actions
11/20/1998	1998027	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	Deficiencies in emergency operating procedure (EOP) implementation were identified. Specifically, operations personnel failed to start the hydrogen - oxygen monitors until 40 minutes after entering the EOP. In addition, operations personnel did not determine whether a valid entry condition into EOP-9, "Radioactivity Release Control," existed. Similar concerns were also identified during an emergency preparedness drill performed in October 1998.
11/17/1998	1998018	Pri: OPS Sec Ter:	NRC	NEG	Pri: 5C Sec: Ter:	The inspectors and the licensee identified multiple examples of ineffective corrective action program implementation for level 3 and 4 condition reports. Specific issues involved ineffective management oversight, poor apparent cause analysis, inadequate extent of condition determinations, and ineffective corrective actions for identified apparent causes.
11/17/1998	1998018	Pri: OPS Sec: Ter:	NRC	POS	Pri: 1B Sec: 5B Ter:	The licensee conducted effective post event assessments for a loss of Division I electrical power, sequential operation of the emergency reserve auxiliary transformer load tap changer, and movement of a radwaste liner. The assessments were timely and identified the causes associated with the events.
11/17/1998	1998018	Pri: OPS Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The new operations department shift turnover process, implemented in August 1998, was an improvement from the previous method used for turnovers in that personnel used clear communications, operators asked clarifying questions, and the full operations crew participated in the briefing.

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11/17/1998	1998018-01	Pri: OPS Sec: Ter:	NRC	NCV	Pri: 5B Sec: Ter:	The inspectors identified one violation, for which enforcement discretion was exercised, for the failure to conduct a hazards analysis as part of the safety evaluation for a temporary modification used to support Division I emergency core cooling system (ECCS) testing. Specifically, the safety evaluation did not address the possible effects of temporarily installed cables routed in the vicinity of safety-related equipment that was not being tested as part of the ECCS testing activities
11/17/1998	1998018-02	Pri: OPS Sec: Ter:	NRC	NCV	Pri: 1C Sec: Ter:	The inspectors identified one non-cited violation which involved the failure to adhere to procedures that limit staff working hours. One chemistry technician worked in excess of 24 hours in a 48-hour period, one instrumentation technician worked more than 72 hours in a 7-day period, and operations personnel failed to conduct a monthly review of overtime use for June 1998. Recent efforts to improve management oversight of the program have been successful in limiting staff working hours
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	The inspectors identified that the implementation and maintenance of the operator aid program did not meet management expectations in that: differences existed between two controlling procedures for operator aids, a lack of in-depth knowledge of the operator aid program by operations personnel contributed to inconsistent implementation of the program, and quarterly reviews of the operator aid log performed by operations personnel were not effective in identifying operator aids which had been in existence for extended periods.
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5A Sec: Ter:	The licensee and the inspectors identified that tracking of compensatory actions for out-of-service or disabled annunciators was inconsistent in that 12 compensatory actions were listed in the out-of-service annunciator log but were not included in the operations turnover checklist and 4 compensatory actions which had been cleared from the out-of-service annunciator log remained on the turnover sheet.
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5B Sec: Ter:	Between May 1 and September 1, 1998, at least 15 examples of poor implementation and use of the Technical Specifications were identified by the licensee and the inspectors. This is of concern because corrective actions implemented prior to May 1, 1998, have not been fully successful in improving implementation and use of the Technical Specifications
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5B Sec: Ter:	The inspectors noted mixed performance with regard to the awareness of plant conditions by operations personnel. On one occasion, operations personnel did not understand the reasons for an abnormal shutdown service water indication. However, on two occasions, operations personnel appropriately dispositioned deficiencies involving: the rod control and information system and, the high pressure core spray pump breaker.
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5C Sec: Ter:	The inspectors identified a failure to implement corrective actions to prevent a recurrence in the untimely performance of safety screenings and evaluations for disabled or out-of-service annunciators. As a result of the untimely performance, 13 of 27 out-of-service or disabled annunciators had not been evaluated to determine if the degraded conditions constituted defacto changes to the facility as described in the Updated Safety Analysis Report
10/01/1998	1998017	Pri: OPS Sec: Ter:	NRC	POS	Pri: 5A Sec: 5C Ter:	The inspectors noted that operations management appropriately recognized the need for additional awareness of and focus on equipment safety tagging problems by suspending operating crew activities in order to conduct a safety briefing in response to recent safety tagging events involving temporary lifting of tags.

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10/01/1998	1998017-01	Pri: OPS Sec:	NRC	VIO IV	Pri: 1C Sec: Ter:	The inspectors identified one violation which involved the failure of the area radiation monitor technician to announce annunciator alarms to the control room supervisor. The inspectors determined that this was a routine practice for certain alarms rather than a one-time occurrence. Corrective actions implemented by the licensee were sufficient to resolve the issue .
09/21/1998	1998301	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	The original retake examination material failed to meet all of the guidelines in NUREG-1021 for developing the job performance measures examination. Additional attention was necessary to correct errors concerning prescripted question content and difficulty level.
09/21/1998	1998301	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	The applicant appeared to be poorly prepared on Technical Specification knowledge items, and demonstrated unfamiliarity with plant equipment location and operation.
09/21/1998	1998301	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Operators on shift executed their duties in a professional manner and in accordance with station procedures and management expectations.
09/21/1998	1998301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Implementation of the licensed operator continuing training program invoiving scheduling and developing operating examinations according to program guidelines was characterized by a safety significant focus. Implementation of the licensed operator continuing training program involving the evaluation of operator performance in accordance with program guidelines was adequate. However, the practice of evaluating one or more training objectives in multiple settings reduced the comprehensive effectiveness of the operating test and placed the examinees in a double jeopardy situation.
09/21/1998	1998301	Pri: OPS Sec:	NRC	WK	Pri: 1C Sec: 3B Ter:	Licensed operator performance during the annual operating test had declined such that it was apparent that the crew members had failed to retain mastery of needed operator skills. The facility's evaluators recognized unsatisfactory crew and individual performances and implemented steps to document the performance and prevent the crew from assuming control room watch standing responsibilities until properly remediated.
08/18/1998	1998014	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	The operations department self-assessment program, between January and July 1998, did not have a stable program owner to oversee completion of self-assessments, weaknesses identified in operator radiation work practices were not addressed, and recommendations and weaknesses described in the radiation worker practice and quarterly assessment reports were not tracked or assigned a responsible owner.
08/18/1998	1998014	Pri: OPS Sec:	NRC	NEG	Pri: 3B Sec: 5B Ter:	Operations personnel implemented nonconservative compensatory measures for a potential fault condition affecting the Division I Nuclear System Protection System (NSPS) inverter. Specifically, operations personnel viewed declaring a faulted component administratively inoperable as an adequate compensatory measure even though leaving the faulted NSPS inverter energized could potentially introduce complications with the power supply .

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08/18/1998	1998014	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5A Sec: Ter:	Operations personnel did not recognize a potential reduction in ultimate heat sink inventory as a condition requiring an OD or mode restraint.
08/18/1998	1998014	Pri: OPS Sec: Ter:	NRC	NEG	Pri: 5C Sec: Ter:	The inspectors determined that the licensee's Generic Letter 91-18 program for operability determinations (ODs) was not effective in ensuring ODs were dispositioned in a timely manner. Specifically, 28 of 41 active ODs describing nonconforming conditions were older than 6 months. Actions taken in May 1998 to disposition the active ODs were not successful in that only one of five shift managers had completed the review of assigned ODs by August 1, 1998.
08/18/1998	1998014	Pri: OPS Sec: Ter:	NRC	POS	Pri: 5B Sec: 2A Ter:	The inspectors noted that operator performance improved with respect to questioning degraded or suspect indications, taking conservative immediate actions, and initiating the appropriate corrective action document. The performance improvement was due, in part, to implementation of the operations department event free performance initiative.
08/18/1998	1998014	Pri: OPS Sec: Ter:	NRC	POS	Pri: 5C Sec: Ter:	As a result of the corrective actions that were implemented to improve performance in the safety tagout program, including providing additional staffing, increasing management oversight, and improving training for operations and maintenance personnel, tagout events were reduced from 11 in 1997 to 3 as of August 1, 1998.
02/16/1999	1999002	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	The inspectors determined that training and oversight of new molded case circuit breaker test personnel did not ensure that expectations for using the smallest gage wire during testing were implemented
02/16/1999	1999002	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 5B Sec: Ter:	The inspectors determined that the licensee's assessment of corrective action effectiveness for CSC Restart Item V.1, "Develop Process to Review Deferrals of Preventive Maintenance Items," was not sufficiently critical to identify deficiencies associated with implementation of the deferral process for late preventive maintenance items. Consequently, CSC Restart Item V.1 will remain open pending a review of the licensee's root cause analysis and corrective actions associated with implementation of the PM deferral process
02/16/1999	1999002	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 5B Sec: Ter:	The inspectors determined that the licensee conducted a thorough evaluation and inspection of the Division IV nuclear system protection system battery after electrical maintenance personnel caused an accidental short circuit during maintenance on this battery
02/16/1999	1999002-03	Pri: MAINT Sec: Ter:	NRC	NCV	Pri: 2B Sec: Ter:	The inspectors identified one violation, for which enforcement discretion was exercised, concerning the failure to perform late preventive maintenance items tasks or process deferral requests prior to returning systems and components to an available status
02/16/1999	1999002-06	Pri: MAINT Sec: Ter:	NRC	NCV	Pri: 2B Sec: Ter:	Failure to perform required channel calibrations on the drywell and containment hydrogen and oxygen analyzers

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01/06/1999	1998020	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2B Sec: Ter:	Maintenance personnel conducted activities with the procedures present and in active use. Technicians were knowledgeable of the tasks and closely followed the procedure or maintenance work request
12/18/1998	1998005-01	Pri: MAINT Sec: Ter:	NRC	VIO IV	Pri: 2B Sec: Ter:	This was a violation for which enforcement discretion was exercised and involved not properly including SSCs in the scope of the MR. In the October 1997 QA audit, the independent assessment, and the subsequent re-scoping effort, the licensee identified SSCs and functions that required inclusion in the MR scope. In the recent QA audit, the audit team identified questionable scoping decisions for several SSC functions. From the investigation for the resulting CR 1-98-10-170, the licensee determined that an existing scoping document had been recently converted into a large database resulting in a number of errors. The licensee was in the process of re-evaluating and strengthening the information contained in the database to clarify the existing scoping. The inspectors evaluated the licensee's resolution of the scoping issues against the requirements of the MR and concluded that scoping concerns had been properly addressed. Closed in inspection report 050-461/1998028
12/18/1998	1998005-05	Pri: MAINT Sec: Ter:	NRC	VIO IV	Pri: 2B Sec: Ter:	This was a violation for which enforcement discretion was exercised and involved establishing inadequate performance criteria. Based on the sensitivity study performed for the availability criteria, and the use of the statistical approach as defined in the EPRI technical bulletins, the inspectors considered the licensee's performance criteria for both availability and reliability to be consistent with the assumptions in the updated PRA and therefore acceptable. Appropriate goals and corrective action plans were developed for SSCs assigned to category (a)(1) of the MR. CLOSED in inspection report 1998028
12/18/1998	1998005-06	Pri: MAINT Sec: Ter:	NRC	VIO IV	Pri: 2B Sec: Ter:	Based on the sensitivity study performed for the availability criteria, and the use of the statistical approach as defined in the EPRI technical bulletins, the inspectors considered the licensee's performance criteria for both availability and reliability to be consistent with the assumptions in the updated PRA and therefore acceptable. Appropriate goals and corrective action plans were developed for SSCs assigned to category (a)(1) of the MR. CLOSED in inspection report 1998028
12/18/1998	1998005-07	Pri: MAINT Sec: Ter:	NRC	NCV	Pri: 2B Sec: Ter:	This was a violation for which enforcement discretion was exercised and involved the failure to monitor goals for (a)(1) SSCs. Specifically, the licensee was not identifying MPFFs, not identifying and tracking unavailability, and not monitoring unavailability for SSCs which required monitoring and which were required to be available during shutdown. During this inspection, the inspectors verified that the licensee was tracking MPFFs and unavailability for SSCs needed for shutdown operations. The inspectors also evaluated the licensee's activities for tracking MPFFs and monitoring unavailability while shutdown for key safety functions as well as for other SSCs required during the shutdown mode of operations. Based on these evaluations, the inspectors determined that the licensee's monitoring activities were acceptable. This portion of the violation is closed. Due to recent issues identified in the QA audit concerning the inadequate implementation of the MR program, the other two issues will remain open pending further review by QA personnel and the NRC as to the effectiveness of the MR implementation and monitoring of availability and reliability.
12/18/1998	1998028	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	Training of personnel on the on-line risk procedures, however, needed to be completed prior to restart as part of NRC Manual Chapter 0350, Case Specific Checklist Item II.4.

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12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Although the risk ranking process continued to rely on a probabilistic risk analysis based predominantly on generic data, the risk ranking of structures, systems and components was acceptable.
12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	In general, the guidance for performing periodic evaluations met the requirements of the maintenance rule and the intent of the industry implementing guidance. The Cycle 6 assessment report provided good evaluations of system performance over the period by documenting changes to maintenance activities and changes to various maintenance rule program aspects.
12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Based on the sensitivity study performed for the availability criteria, and the use of the statistical approach as defined in the Electric Power Research Institute technical bulletins, the inspectors considered the licensee's performance criteria for both availability and reliability to be consistent with the assumptions in the updated probabilistic risk assessment and therefore acceptable.
12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Appropriate goals and corrective action plans were developed for systems classified as (a)(1) per the maintenance rule.
12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	In general, structures, systems and components were being properly classified under categories (a)(1) and (a)(2) of the MR. Performance criteria, goals, and corrective actions, both in progress and planned, for structures, systems and components in (a)(1) status appeared adequate. The structure, system and component functions for the systems reviewed were properly scoped under the MR. The inspectors reviewed condition reports, maintenance work requests, and the periodic assessment and did not identify any maintenance preventable functional failures not previously classified or unavailability time not properly tracked.
12/18/1998	1998028	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 5A Ter:	The 1998 quality assurance audit was thorough and probing. Based on individual issues, the auditors were able to identify significant underlying causes (lack of ownership and inadequate communications) for the ineffective implementation of the maintenance rule program. Although actions have been identified and were being implemented to correct the weaknesses, it was too soon to determine their effectiveness. The use of outside personnel in the audit provided independent insights into the maintenance rule program and added to the overall quality of the program assessments
12/18/1998	1998028	Pri: MAINT Sec: ENG	NRC	POS	Pri: 2B Sec: Ter:	The inspectors concluded the licensee had adequate on-line and outage risk assessment processes and had established acceptable thresholds for contingency planning.
12/18/1998	1998028	Pri: MAINT Sec: ENG	NRC	POS	Pri: 2B Sec: 5A Ter:	The inspectors concluded that the process for balancing the unavailability and reliability of structures, systems and components was acceptable, however, based on the Cycle 6 periodic assessment, the licensee concluded that implementation of this process was ineffective. In response to this self-identified concern, the licensee took action to ensure a proper balance existed between the reliability and availability for structures, systems and components.

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11/17/1998	1998018	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	The inspectors concluded that inadequate preparations for measuring the lifting torque on high pressure core spray inlet check valve resulted in the loss of as-found data during the measurement. The failure of the non-licensed operator to attend the pre-job briefing may have contributed to this event. No instructions were included in the work package as to what type of adapter was needed for the measurement and the workers did not note the problems with the adapter in the remarks section.
10/01/1998	1998017	Pri: MAINT Sec: Ter:	NRC	POS	Pri: 2B Sec: Ter:	The inspectors concluded that the licensee adhered to the revised molded case circuit breaker testing procedure. In addition, the newly instituted molded case circuit breaker enclosure testing and inspection program revealed a significant number of deficient conditions including incorrect fuses and degraded motor starter contactors.
08/18/1998	199801[illegible]	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	The Division II emergency core cooling system (ECCS) integrated surveillance testing preplanning for the test could have been more thorough. Some personnel assignments were initially made and/or changed at the briefing, communication links were not established ahead of time, the placement of test cables created a tripping hazard, mechanical stops were not used on open cabinets, and test switches were installed inside energized panels. Additionally, the prejob brief did not include lessons learned, industry experience, or contingencies
08/18/1998	1998014	Pri: MAINT Sec: Ter:	NRC	NEG	Pri: 2B Sec: Ter:	The inspectors noted that management expectations were not met during the review of selected condition reports (CRs) in that maintenance personnel did not determine and document the extent of the condition associated with some level three CRs.
08/18/1998	1998014	Pri: MAINT Sec: Ter:	NRC	WK	Pri: 2B Sec: 5C Ter:	The inspectors identified a weakness with the scheduling of Technical Specification Surveillance Requirements (SRs). 44 % of all monthly and quarterly surveillances were being performed in the 25 % grace period after the due date; 11 overdue SRs were omitted from a weekly surveillance test report; personnel were unaware of the safety-related preventive maintenance (PM) tasks that were required to meet a specific SR; and, the impact on SRs was not evaluated for a late safety-related PM task
02/16/1999	1999002	Pri: ENG Sec: Ter:	NRC	POS	Pri: 5B Sec: Ter:	The inspectors determined that the licensee had resolved the concerns associated with CSC Restart Item IV.7, "Resolve Emergency Diesel Generator Concerns"
02/16/1999	1999002-04	Pri: ENG Sec: Ter:	NRC	NCV	Pri: 4A Sec: Ter:	The inspectors identified one Non-Cited Violation pertaining to the licensee's identification that design basis requirements had not been adequately translated into maintenance procedures and instructions involving the replacement of the Division I and II shutdown service water pump oil coolers. The licensee's corrective actions to review the generic implications of the Division I shutdown service water pump bearing failure on other large safety-related motors was timely and conservative
02/16/1999	1999002-05	Pri: ENG Sec: Ter:	NRC	NCV	Pri: 5A Sec: Ter:	The inspectors identified one Non-Cited Violation for the failure to make a required 10 CFR 50.72(b)(2)(iii) report to the NRC within 4 hours of discovery that the shutdown service water system would not have performed its intended safety functions

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01/06/1999	1998020	Pri: ENG Sec:	NRC	POS	Pri: 5B Sec: Ter:	Quality assurance personnel conducted a thorough evaluation of the contractor control program
01/06/1999	1998020-03	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	The inspectors identified one violation, for which enforcement discretion was exercised, that involved the repeat failure to ensure design requirements for the MCR breathing air system were translated into plant procedures
01/06/1999	1998020-04	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	The failure to test the EDGs at 110 percent of rated load is a violation of TS SR 3.8.1.14.
12/18/1998	1998028	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	The system engineers were experienced and knowledgeable about their systems and understood their responsibilities with respect to the maintenance rule.
11/30/1998	1998026	Pri: ENG Sec:	NRC	NEG	Pri: 4A Sec: Ter:	The team concluded that the cable test documentation utilized by the licensee to support the qualification of Whittaker fire-rated safe shutdown cables did not adequately demonstrate that the fire-rated cables provided equivalent fire protection as that provided by a rated fire barrier. This issue will remain open pending NRC review prior to restart
11/30/1998	1998026	Pri: ENG Sec:	NRC	NEG	Pri: 4A Sec: Ter:	The team concluded that, due to obstructions, sprinkler systems installed in several risk significant fire areas may be incapable of suppressing a fire. This issue will remain open pending NRC review prior to restart
11/30/1998	1998026-01	Pri: ENG Sec:	NRC	VIO III	Pri: 5B Sec: 5C Ter:	A violation was identified regarding the licensee's failure to ensure that 54 MOVs would remain free of fire damage due to fire induced hot shorts in the valves' control circuitry . Enforcement discretion was exercised. The remaining corrective actions related to this violation will be reviewed by the NRC prior to restart
11/30/1998	1998026-02	Pri: ENG Sec:	NRC	VIO III	Pri: 4A Sec: Ter:	A violation with three (3) examples was identified regarding the failure to provide adequate electrical circuit isolation for several safe shutdown components. Enforcement discretion was exercised
11/17/1998	1998018	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	The inspectors determined that the local leak rate testing program was well controlled, that engineering personnel were knowledgeable of local leak rate testing requirements, and that adequate actions had been taken to implement Option B of Appendix J to 10 CFR Part 50.

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11/17/1998	1998018	Pri: ENG Sec:	NRC	POS	Pri: 5B Sec: Ter:	The inspectors determined that engineering personnel actively conducted critical self-assessments in an effort to identify departmental strengths, weaknesses, and opportunities for improvement. In addition, weaknesses and recommendations were adequately tracked to ensure resolution.
11/17/1998	1998018-03	Pri: ENG Sec:	NRC	NCV	Pri: 3B Sec: Ter:	One non-cited violation was identified due to the licensee's identification that engineering personnel had failed to fully understand the operational characteristics of the emergency reserve auxiliary transformer load tap changer prior to testing on October 22, 1998.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	The inspectors concluded that the SX system design and configuration controls were adequate. The SDFV assessment of the SX system was very comprehensive and thorough. The team concluded that actions taken as the result of the SDFV assessment would correct many operational problems and concerns with the SX system.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	The team concluded that the licensee's revised methodology for reviewing calculations in order to determine the technical adequacy of the CPS calculation program was satisfactory. However, insufficient activities were completed by the licensee at the conclusion of this inspection to support an adequate review by the NRC. As a result, the inspection of this issue could not be completed during the E&TS inspection.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	The team concluded that the licensee's Setpoint Program Action Plan methodology was sound. However, insufficient activities were completed by the licensee at the conclusion of this inspection to allow for an adequate review by the NRC. As a result, the inspection of this issue could not be completed during the E&TS inspection
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	The material condition of the walked down systems appeared to be good. The system engineers appeared to be knowledgeable of the systems.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	The team concluded that no major problems existed with the hardware change process or with the selected hardware changes reviewed that had not been previously identified by the licensee. The technical quality of the selected engineering work products was generally sound and the hardware changes reviewed were adequately implemented.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: Ter:	The engineering staff was effective in the identification of technical problems. The team concluded that the system design and functional verification program reviews conducted on the residual heat removal and shutdown service water systems identified significant issues and the quality of those reviews was considered excellent. These issues resulted in a significant amount of corrective action work.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: Ter:	Based on their system reviews, the team concluded that the System Health Report provided an accurate accounting of system status with regard to the numbers of CRs, MWRs, etc. No major discrepancies were identified with the System Health Report for the systems reviewed. The automatic depressurization system status could not be reviewed since the system was not addressed in the System Health Report.

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10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 5B Sec: Ter:	The licensee had an acceptable 10 CFR 50.59 program and that qualified personnel prepared and reviewed the 10 CFR 50.59 screenings and safety evaluations. The 10 CFR 50.59 screenings and safety evaluations reviewed were adequate with the exception of some minor errors. Although no specific issues were identified by the inspectors, the number of licensee identified condition reports (CRs) concerning safety screenings and evaluations revealed that problems still exist.
10/09/1998	1998019	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	In most instances, the corrective action process for the CRs selected for review was adequately implemented and resulted in acceptable corrective actions.
10/09/1998	1998019	Pri: ENG Sec:	NRC	WK	Pri: 1C Sec: Ter:	The team concluded that the system engineers were generally qualified and experienced. However, the team identified a weakness in that detailed training was not provided to the system engineers for their assigned systems. On October 10, 1998, the team was notified that system engineers would receive senior reactor operator system training for their assigned system(s).
10/09/1998	1998019	Pri: ENG Sec:	NRC	WK	Pri: 4A Sec: 4B Ter: 4C	The team concluded that the lack of a setpoint control program and a lack of trending of safety-related and maintenance rule-related instrument drift was a weakness. The team also concluded that lack of supporting calculations for important instrument setpoints was a weakness.
10/09/1998	1998019	Pri: ENG Sec:	NRC	WK	Pri: 4B Sec: Ter:	Present performance by the licensee on the SX system was excellent. However, the team noted that the licensee had not generated maintenance work requests (MWRs) or preventive maintenance tasks to assure replacement of limited life non-environmentally qualified equipment in the plant. The team considered this a weakness
10/09/1998	1998019-01	Pri: ENG Sec:	NRC	EEI	Pri: 4C Sec: Ter:	A violation for which enforcement discretion was exercised was identified involving the installation of a minor modification which caused the loss of suppression pool cooling.
10/09/1998	1998019-02	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: Ter:	An NCV was identified regarding the licensee's failure to take adequate and timely actions for excessive silt accumulations in the SX pump intake area.
10/09/1998	1998019-03	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Licensee failed to include the battery charger's minimum voltage requirement in the acceptance criteria for the degraded voltage transient calculation. A design change was issued to adjust the tap settings on the Division 1 and 2 battery charger transformers to assure that the minimum voltage requirement was met. The inspectors did not identify any discrepancies based on their review of appropriate calculations, design changes and corrective action work documents.
10/01/1998	1998017	Pri: ENG Sec:	NRC	NEG	Pri: 5C Sec: Ter:	The inspectors identified that ineffective corrective actions had been taken for selected level 3 condition reports. Specifically, four of ten randomly selected closed engineering department condition reports either lacked an appropriate apparent cause, did not identify the extent of the condition, or implemented corrective actions which did not address the apparent cause.

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10/01/1998	1998017-02	Pri: ENG Sec: Ter:	NRC	NCV	Pri: 4C Sec: Ter:	One non-cited violation was identified for the licensee's identification of the failure to submit changes in the quality assurance program which constituted reductions in commitments made to the NRC.
08/18/1998	1998014	Pri: ENG Sec: Ter:	NRC	NEG	Pri: 4B Sec: Ter:	Engineering personnel did not provide adequate support to operations personnel in that a CR addressing an already resolved issue was not closed in a timely manner
08/18/1998	1998014-01	Pri: ENG Sec: Ter:	NRC	NCV	Pri: 4A Sec: 5A Ter:	The inspectors identified that Technical Specification requirements were not met because the Division III EDG cannot automatically switch during surveillance testing from the test mode to the isochronous mode as required in response to an actual or simulated emergency core cooling system initiation signal. This item is of concern because the licensee did not recognize that the design of the EDG resulted in the inability to meet a Technical Specification requirement.
02/16/1999	1999002	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The inspectors determined that radiation protection personnel demonstrated conservative decision making by using a video camera and robot to minimize exposure to only 9 millirem during recovery of a radiography source
02/12/1999	1999005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The inspector noted improvements in the ALARA program. Increasing the resources for the ALARA program contributed to more timely and critical work planning reviews and to effective monitoring of department and station dose performance. The 1999 annual dose goals more accurately reflected the licensee's planned scope of work and were effectively monitored by the plant departments.
02/12/1999	1999005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	During routine contamination surveys and work coverage, RP technicians demonstrated acceptable techniques and clearly communicated radiological conditions to plant personnel. In addition, the licensee properly calibrated area radiation monitors at the frequency specified in plant procedures.
02/12/1999	1999005	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The licensee included an acceptable level of ALARA instructions in general employee and RP technician training, which included the use of mock-ups. The ALARA staff also participated in bench-marking to increase its awareness of successful industry practices.
02/12/1999	1999005-01	Pri: PLTSUP Sec: Ter:	Licensee	NCV	Pri: 3A Sec: Ter:	The licensee identified an inadvertent entry of two individuals into a posted high radiation area (HRA). The individuals were not on a radiation work permit which authorized the entry into the HRA, contrary to procedural requirements. This failure to follow procedure was considered a Non-Cited Violation. The inspector concluded that the licensee had performed an appropriate review of the incident and had implemented corrective actions, which were commensurate with the error.

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02/12/1999	1999005-02	Pri: PLTSUP Sec: Ter:	Licensee	VIO IV	Pri: 5C Sec: Ter:	The inspector concluded that the licensee had not adequately corrected a repetitive problem concerning the adequacy and thoroughness of radiological surveys. As a result of this ongoing problem, the licensee identified a failure of the RP staff to perform an adequate radiological survey incident to the changes in operation of the residual heat removal system. This inadequate survey was determined to be a violation of 10 CFR Part 20. Specifically, the RP staff failed to identify and post an HRA, which resulted from known operational changes within the facility.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	Overall performance of OSC management and staff was mixed, with examples of both good and poor individual performance. Overall command and control of the facility was insufficient. The OSC management did not maintain good awareness of deployed teams' progress or results. The OSC Director seldom stayed in the command area of the OSC where reports were being received so that these reports could promptly be assessed and an overall perspective of deployed teams' activities could be maintained.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	The OSC team briefings followed the same guidelines for high priority tasks as for lower priority tasks. There were no apparent management expectations for briefing and dispatching higher priority teams from the OSC more expeditiously than lower priority teams.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 1C Sec: Ter:	The EOF protective measures staff was unable to completely respond to the Emergency Manager's and simulated NRC responders' requests for several offsite dose projections in a timely manner.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 1C Sec: 2A Ter:	A backup power supply ceased powering the TSC Public Address (PA) system after 26 minutes of operation. The loss of the PA system meant that TSC managers' briefings were not audible in the OSC. An available megaphone was not utilized.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 2A Sec: Ter:	A modem on the computer assigned to the EOF protective measures staff actually failed and the staff was unaware that an available backup computer also had an installed modem.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	Overall performance in the Simulator Main Control Room (SMCR) was adequate. During the rapidly moving exercise scenario, control room shift personnel properly diagnosed reactor events at the Notification of Unusual Event, Alert, and Site Area Emergency classification levels. Notifications were promptly made to offsite officials.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The Technical Support Center (TSC) staff's performance was adequate. Plant event analysis, event classification, notifications, briefings, and communications with other facilities were competently performed by the staff.
11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	Self-critiques following termination of the exercise were critical and included inputs from controllers and exercise participants. In particular, the SMCR evaluators critically assessed operator performance.

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11/20/1998	1998027	Pri: PLTSUP Sec: Ter:	NRC	WK	Pri: 1C Sec: Ter:	Emergency Plan Implementing Procedure RA-02, "Protective Action Recommendations," identified the default minimum Protective Action Recommendation (PAR) upon the declaration of a General Emergency to be as follows: "Evacuate 0-2 mile radius and 2-5 miles downwind unless conditions make evacuation dangerous and advise the remainder of plume Emergency Planning Zone (EPZ) to go indoors (shelter) to monitor EAS (Emergency Alert System) broadcasts." However, Illinois Nuclear Accident Reporting System (NARS) message number 4, did not contain a recommendation to shelter persons in the remainder of the EPZ.
11/20/1998	1998027	Pri: PLTSUP Sec: OPS Ter:	NRC	NEG	Pri: 1C Sec: 3B Ter:	An operator error in the SMCR resulted in the isolation of the Reactor Core Isolation Cooling system, the only source of cooling water for the reactor at the time.
11/17/1998	1998018	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	Licensee controllers and evaluators in both the technical support center and the operations support center provided an accurate assessment of activities during the October 14, 1998, emergency drill. The licensee's observations and post drill critiques for the technical support center and operations support center were effective in recognizing strengths, weaknesses, and areas for continued improvement .
11/17/1998	1998018	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 5B Sec: Ter:	The licensee's assessment of the stuck fire shield in a shipping cask was effective in that the licensee, based on this assessment, determined that the event was caused by poor resolution of previously identified concerns and non-conservative decision making which resulted in a radwaste liner and fire shield becoming lodged in a shipping cask.
10/09/1998	1998025	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 1C Sec: 2A Ter:	Several emergency medical kits were present in an Operational Support Center (OSC) Emergency Response Organization (ERO) locker. The EP staff were unaware of their presence, and the condition of these kits was poor
10/09/1998	1998025	Pri: PLTSUP Sec: Ter:	NRC	NEG	Pri: 2A Sec: Ter:	The material condition of the Technical Support Center (TSC) was marginal, as identified in the two last inspections, with a conduit modification adding a considerable tripping hazard. The only change noted in the facility was a "catalog display stand" for the Emergency Plan and implementing Procedures. The Area Radiation/Process Radiation panel in the TSC was nonfunctional
10/09/1998	1998025	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 1C Sec: Ter:	The EP training program appeared effective. ERO personnel were qualified for their emergency response positions. The after-hours augmentation drill was successful. The drill critique documentation was good, including a summary, time line, backup data for individual response times, a list of problems identified, and recommended solutions.
10/09/1998	1998025	Pri: PLTSUP Sec: Ter:	NRC	POS	Pri: 5C Sec: Ter:	Corrective actions had been taken on a number of issues relative to the February 1998 Alert. Effective, acceptable corrective actions on these issues indicated that the EP program was on an improving trend. However, several other corrective actions, such as implementation of the new autodialer callout system, were yet to be completed.

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10/01/1998	1998017	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The inspectors noted a continued improvement in decontamination efforts in that radiation protection and facilities personnel successfully decontaminated the residual heat removal "A" heat exchanger room from 60 mrad smearable to less than 1,000 dpm/100 cm2.
10/01/1998	1998024	Pri: PLTSUP Sec:	NRC	NEG	Pri: 2A Sec: Ter:	In response to self-identified and NRC-identified deficiencies, the licensee had improved oversight of the post accident sampling system. Recent management focus on the system resulted in the completion of several maintenance activities. However, the system remained inoperable pending the completion of maintenance on the atmospheric sampling system.
10/01/1998	1998024	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The RP staff implemented effective planning for the vacuuming of the suppression pool and the removal and replacement of the ECCS strainers. For example, the planning documents contained recommendations contained in NRC generic communications and the lessons learned from industry performance. In addition, the RP staff provided good dose tracking and trending of the evolution.
10/01/1998	1998024	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	During the ECCS suction strainer modification, the inspector observed good teamwork and communications between the work groups. The RP staff effectively communicated radiological conditions to the divers and to the work groups and provided good control of the evolution.
10/01/1998	1998024	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The inspector observed chemistry technicians properly implementing sampling and analysis procedures. Chemistry technicians performed the activities with the procedures in-hand and demonstrated proper contamination control practices. The inspector also noted improvements in the content of chemistry procedures, which addressed previous inspection findings.
10/01/1998	1998024	Pri: PLTSUP Sec:	NRC	WK	Pri: 1C Sec: Ter:	The licensee's procedure for control of diving evolutions was generally consistent with NRC generic communications and industry lessons learned. However, the inspector observed weaknesses in the procedure concerning provisions for the use of remote monitoring and visual contact with the divers.
08/18/1998	1998014	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 5C Ter: 5B	The inspectors determined that emergency planning personnel had not verified the capability to staff emergency response organization positions following a failure of the autodialer pager system even though there had been four failures of the pager system since July 1997
08/18/1998	1998014	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	The licensee's self contained breathing apparatus inspection program was thorough in that inspections were performed at the proper frequency, all material condition and functionality issues were addressed, and appropriate actions were taken when test failures were identified .
08/18/1998	1998014	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	In preparation for the installation of a fire separation wall, the licensee removed a 2-inch suppression pool cleanup line which resulted in an estimated 28 person-rem dose savings for the modification. This demonstrated effective implementation of the As Low As Reasonably Achievable (ALARA) program

United States Nuclear Regulatory Commission

PLANT ISSUE MATRIX

By Primary Functional Area

Legend

Type Codes:

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

Template Codes:

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

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

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

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

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3/26/1999

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	7/1[illegible]98	Positive	IR 98011	Self-Revealed	Operations	1B	The inspectors concluded that operations personnel responded well to the loss of three of four offsite power sources during a storm. A Notice of Unusual Event was conservatively declared and safety system restoration was appropriately prioritized and accomplished in a reasonable timeframe.
	7/[illegible] 1998	Positive	IR 98011	NRC	Operations	1C	Operations personnel demonstrated improved command and control, appropriate prioritization of restoration activities, and good procedure adherence following a momentary loss of the emergency reserve auxiliary transformer (ERAT). The development of just-in-time training regarding electrical transients and plant response prior to an ERAT outage was considered a positive effort towards improving operator performance.
3	7/10/1998	ED	IR 98011	Licensee	Operations	5A	One violation for which enforcement discretion was exercised was identified concerning the failure of reactor operators to appropriately identify and resolve unusual trends in the shut down service water, reactor recirculation, and standby gas treatment systems during the performance of control room panel walkdowns.
4	7/10/1998	Negative	IR 98011	NRC	Operations	5A	The inspectors concluded that while reactor operators performed comprehensive control room panel walkdowns during shift turnover, oncoming senior reactor operators and shift managers performed cursory reviews of the control panels and did not examine all panels during shift turnovers. This may have contributed to performance problems involving identification of degraded or nonconforming conditions by control room personnel
5	7/10/1998	Negative	IR 98011	NRC	Operations	5A 3B	Eight days elapsed and inspector prompting was needed to initiate a condition report to document the repetitive failure of the outboard MSIVs to open during a monthly preventive maintenance task. Additionally, operations personnel did not recognize the failure of the MSIVs to open as a Technical Specification mode restraint until prompted by the inspectors.
6	7/10/1998	Positive	IR 98011	Licensee	Operations	5B	Operations personnel conservatively directed an inspection of the Divisions I and II emergency diesel generators (EDGs) following the discovery of fastener issues during the Division III EDG outage.

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Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
7	7/10/1998	ED	IR 98011	Licensee	Operations	5C	One violation for which enforcement discretion was exercised was identified for the failure to implement corrective actions in response to a long-standing, nonconforming condition involving excessive shut down service water flow to the residual heat removal heat exchanger bypass. Operations personnel did not challenge engineering personnel to seek a remedy for the condition (NCV 50-461/98011-01).
8	5/28/1998	Positive	IR 98008	NRC	Operations	1C	The inspectors concluded that operation's logs included sufficient detail to describe plant activities, compensatory measures for out-of-service annunciators were appropriate, and coordination and contingency plans referenced approved procedures.
9	5/28/1998	ED	IR 98008	NRC	Operations	5C	The inspectors identified a violation for not implementing corrective actions to preclude the failure to perform verifications on all primary containment manual isolation devices as required by Technical Specification's following a similar discovery affecting secondary containment manual isolation devices in June 1996.
10	5/15/1998	Negative	IR 98008	NRC	Operations	3B	The inspectors identified one example of a poor questioning attitude which involved the ability of operations personnel to recognize changing plant risk conditions during periods of degraded grid voltage.
11	5/5/1998	Misc	IR 98008	NRC	Operations	1C	The inspectors identified several items that had not been considered during the licensee's material condition review to declare Electrical Division II operable. The items were resolved, and the inspectors determined that Division II was operable for Mode 4.
12	4/14/1998	Positive	IR 98006	NRC	Operations	1C	Contingency plans for the Division II Inverter outage and the reserve auxiliary transformer excavation work were thorough in that they were communicated to affected personnel and considered the potential for several events.
13	4/14/1998	Positive	IR 98006	Self-Revealed	Operations	2A	The Division II Emergency Diesel Generator and Residual Heat Removal Systems B and C were returned to an operable status. These systems had been declared inoperable but available in August 1997 (Plant Summary).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
14	3/3/1998	NCV	IR 98003	NRC	Operations	1A	Control room operators intentionally deleted information from a control room computer screen in an attempt to maintain mental awareness. Although the line assistant shift supervisor (LASS) was aware of this practice, he failed to take action to address the situation. The actions of the LASS and the reactor operator (RO) were indicative of continued poor operator performance, a general disregard for main control room indications, and poor supervisory oversight (Section O1.1).
15	3/3/1998	NCV	IR 98003	NRC	Operations	1A 2A 2B	The inspectors identified that the corrective actions implemented failed to prevent another unmonitored increase in main control room (MCR) deficiencies and operator workarounds, even though both issues were the subject of a response to NRC Confirmatory Action Letter RIII-97-001 (Section O2.1)
16	3/3/1998	NCV	IR 98003	Licensee	Operations	1A 3B 2A	Operations and engineering personnel demonstrated poor knowledge of the breathing air system in that they believed the system had been abandoned in place and were unfamiliar with system operating parameters. Not using alternate compensatory methods to recharge the breathing air system bottles after identifying that the system was required to be maintained operable at all times demonstrated a nonconservative establishment of priorities for system restoration (Section O2.2).
17	3/3/1998	NCV	IR 98003	NRC	Operations	1A 5A	Actions were not implemented to operate the service water traveling screens during cold weather in order to prevent ice blockage and a potential loss of the ultimate heat sink. A delay in operating the traveling screens upon completion of a maintenance activity indicated poor oversight of restoring required plant systems to service by operations personnel. Implementation of procedural guidance to minimize ice blockage of the intake structure following the identification of the [illegible]e was delayed due to the poor prioritization of procedure revisions (Section O2.3).
18	3/3/1998	Positive	IR 98003	Licensee	Operations	1B	The shift supervisor limited access to the MCR by assigning an individual the responsibility to prevent entry by non-essential personnel. This action significantly reduced the number of distractions in the main control room. Operations personnel demonstrated good use of emergency, off normal, and system operating procedures in the MCR (Section P1.1).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
19	3/3/1998	Weakness	IR 98003	NRC	Operations	1B 1C	Minimum emergency plan staffing for on shift, 30 minute, and 60 minute response was not met. Seven radiation protection and maintenance personnel were added to the on shift emergency planning minimum staffing requirements due to concerns regarding the ability to meet the manning requirements (Section P1.1).
20	3/3/1998	Positive	IR 98003	NRC	Operations	1B 3A	During the Alert, the shift supervisor maintained an oversight role of activities in the control room and prompted actions when appropriate. The LASS controlled the activities of ROs and non-licensed operators. The shift supervisor used conservative decision making to activate the emergency response organization (ERO) in order to obtain additional resources to restore shutdown cooling (Section P1.1).
21	3/3/1998	Negative	IR 98003	NRC	Operations	1C	Implementing procedures for cold weather preparations were cumbersome in that they were not easily identified and provided vague criteria for initiating actions. Numerous discrepancies with cold weather requirements were identified amongst the various cold weather procedures (Section O2.4).
22	3/3/1998	Negative	IR 98003	NRC	Operations	1C	Even though the licensee was required to replace service air intake filters and secure ventilation systems due to icing on February 8, 1998, a requirement to verify the intake filters were free of obstructions during cold weather periods had not been added to system operating procedures or the area operator logs as of March 3, 1998 (Section O2.4).
23	3/3/1998	Weakness	IR 98003	NRC	Operations	1C	Several deficiencies were identified in the procedure change process which included the implementation of multiple one time procedure changes to address the same situation on 4 out of 51 procedures, the lack of periodic reviews to determine if changes needed to be incorporated into the procedures, untimely procedure changes due to poor prioritization of procedure revisions, and inadequate performance of independent technical reviews and impact assessments. Collectively, the deficiencies signified that the licensee's corrective actions to improve procedure quality in response to Confirmatory Action Letter III-96-013 have not been fully effective (Section O3.1).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
24	3/3/1998	URI	IR 98003	NRC	Operations	1C	Following an overload of the Division II Emergency Diesel Generator (EDG), the licensee identified that non-licensed operators had not been trained on the remote operation of the EDGs since late 1992 or early 1993. In addition, some non-licensed operators were unaware of the significance of indications provided on the local EDG panels. After discovery of the inadequate training, actions to ensure qualified personnel were available to perform local manual operation of the EDGs were not immediately taken (Section O5.1).
25	3/3/1998	NCV	IR 98003	NRC	Operations	1C 5C	Timely corrective actions were not implemented to prevent operations personnel from rendering both EDGs inoperable due to taking the maintenance switch for one EDG to the lockout position in preparation for surveillance testing while the other EDG was inoperable (Section O8.2).
26	3/3/1998	Negative	IR 98003	NRC	Operations	3A	Fire watch personnel failed to perform a tour of the Division II EDG room in order to evaluate the presence of transient combustible materials (Section F1.1).
27	3/3/1998	Positive	IR 98003	NRC	Operations	5A 3B	The licensee performed a critical assessment of ERO performance during the Alert. Deficiencies noted by the licensee included offsite notifications, activation of the technical support center (TSC), operation of the autodialer, control of field teams, communications between the TSC and the MCR, site wide announcements, use of ERO badges, and control of field samples (Section P1.1).
28	2/16/1998	Positive	IR 98004	NRC	Operations	1B	Operator response to a loss of shutdown cooling event on February 13, 1998, was generally good. One weakness identified was an emphasis on restoration of the division 2 nuclear system protection system (NSPS) bus as the sole success path for the restoration of shutdown cooling. (Section O1.1)
29	2/16/1998	NCV	IR 98004	NRC	Operations	1B	Licensee personnel failed to adequately assess the risk involved with tagging out the division 2 NSPS regulating transformer and, as a result, failed to develop contingency plans for the potential loss of the division 2 NSPS bus. (Section O7.1)

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES			DESCRIPTION
30	2/16/1998	NCV	IR 98004	NRC	Operations	1B	3B	3A	Some operators exhibited significant knowledge deficiencies regarding the configuration, operation, and availability of the division 2 NSPS bus and the associated supporting equipment following the loss of shutdown cooling event. This was the result of inadequate communication of the contingencies established should a loss of the NSPS bus recur. (Section O4.2)
31	2/16/1998	NCV	IR 98004	NRC	Operations	1B	3C		Procedures used to address the loss of shutdown cooling event failed to provide adequate instructions which unnecessarily challenged operators to respond to the event. (Section O3.1)
32	2/16/1998	NCV	IR 98004	NRC	Operations	3A	3B	5A	Operations personnel failed to take prompt actions to address a potential division 2 emergency diesel generator (EDG) overload event which occurred on February 11, 1998. In particular, the shift resource manager (SRM) and "B" control room operator (CRO) failed to conservatively reduce EDG loading during a surveillance test when indications of an overload condition were identified. (Section O1.2)
33	2/16/1998	Negative	IR 98004	NRC	Operations	3B			Some operators were not adequately knowledgeable regarding the operation of the division 2 NSPS bus static switch as well as the consequences of the loss of the NSPS bus on plant indications and logic inputs. (Section O4.1)
34	2/13/1998	Negative	IR 97025	NRC	Operations	1A			The inability to explain the status of the normally operating fuel building ventilation system was an example of poor awareness of plant conditions by operations personnel. (Section O1.1.b.8) Personnel Performance Deficiency
35	2/13/1998	Negative	IR 97025	NRC	Operations	1A			A 13-day delay in restoring SRMs to an operable status was an example of poor awareness of plant conditions and a lack of operations personnel involvement in restoring Technical Specification equipment to a fully operable status. The avoidable delay in restoration resulted in an unnecessary entry into plant Technical Specification 3.3.1.2, "Source Range Monitor Instrumentation." (Section O1.1.b.5) Other/NA
36	2/13/1998	Negative	IR 97025	NRC	Operations	1A			The failure to notice or provide a reason for the abnormal vent valve position indication associated with RHR Heat Exchanger A was an example of poor awareness of plant indications by operations personnel in the main control room. (Section O1.1.b.7) Personnel Performance Deficiency

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
37	2/13/1998	Negative	IR 97025	NRC	Operations	1A	Several deficiencies were identified involving the operations mode restraint tracking system, which included: condition reports and engineering evaluations which were not identified as mode restraints; condition reports and engineering evaluations which were classified as mode restraints but not tracked on a mode restraint list; ineffective implementation of corrective actions for previously identified mode restraint issues; and multiple departmental tracking systems for mode restraints. (Section O1.2) Inadequate Procedure/Instruction
38	2/13/1998	Positive	IR 97025	NRC	Operations	1A	An auxiliary operator was knowledgeable of systems and provided good responses to questions during a tour of the containment, fuel, control, and auxiliary buildings. (Section O1.4) Teamwork/Skill Level
39	2/13/1998	Negative	IR 97025	NRC	Operations	2B	Several discrepancies were noted during a walkdown of the alternate source of control room ventilation including: incorrect revisions of procedures, an uncontrolled vendor manual, and a lack of implementation of vendor recommended preventive maintenance items. (Section O2.1) Inadequate Oversight
40	2/13/1998	Negative	IR 97025	NRC	Operations	2B	Implementation of Technical Specifications for SRM channel functional testing was poor in that operations personnel were unable to initially explain the basis which allowed transfer of the reactor mode switch from shutdown to run. Additionally, operations personnel did not document the applicable Special Operation Technical Specification which allowed the deviation from the requirements of Technical Specification 3.3.1.2 prior to manipulating the reactor mode switch. (Section O1.1.b.5) Personnel Performance Deficiency
41	2/13/1998	Negative	IR 97025	NRC	Operations	3A	The failure to notice or provide a reason for the abnormally low cooling water inlet and outlet temperature indication associated with Residual Heat Removal (RHR) Heat Exchanger A following a transfer of shutdown cooling was an example of poor awareness of plant indications by operations personnel in the main control room. (Section O1.1.b.6) Personnel Performance Deficiency

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
42	2/13/1998	Negative	IR 97025	NRC	Operations	3B	The decision to continue work even though three out of four source range monitors (SRMs) were exhibiting unexpected responses indicated a poor awareness of conditions with the potential to impact Technical Specifications, and was an example of a poor questioning attitude and oversight of maintenance activities by operations personnel. (Section O1.1.b.4) Inadequate Oversight
43	2/13/1998	VIO/SL-IV	IR 97025	NRC	Operations	3B	One violation was identified due to the failure to implement required Technical Specification actions to restore either the Division I or II inverter to service. Specifically, operations personnel failed to recognize that declaring all 480VAC motors inoperable required an entry into Technical Specification 3.8.8, "Inverters-Shutdown." (Section 01.1.b.2) Personnel Performance Deficiency
44	2/13/1998	Weakness	IR 97025	NRC	Operations	3B	Fourteen examples of the failure of operations personnel to implement the Technical Specifications since January 1996 were identified by NRC inspectors and/or the licensee. The multiple failures represent a weakness in the ability to implement the requirements of the Technical Specifications and a poor awareness of plant conditions which impact Technical Specification requirements. (Section O1.1.b.3) Personnel Performance Deficiency
45	2/13/1998	Positive	IR 97025	NRC	Operations	3B	During the transfer of shutdown cooling from RHR Train B to RHR Train A, operations personnel appropriately referenced procedures, acknowledged annunciators, and performed the transfer without any significant complications. (Section O1.3) Teamwork/Skill Level
46	2/13/1998	VIO/SL-IV	IR 97025	NRC	Operations	3C	One violation was identified due to the failure to implement required Technical Specification actions to restore isolation capability to secondary containment penetrations between October 18 and December 16. Additionally, on-shift operations personnel were unfamiliar with how to implement licensing department guidance on acceptable administrative controls associated with Technical Specification 3.5.2.D.3. (Section O1.1.b.1) Personnel Performance Deficiency
47	2/5/1998	Positive	IR 97313	NRC	Operations	3B	Control room operators were observed monitoring control room instrumentation at acceptable time intervals. Their demeanor was business like and professional during observed periods. (Section O1.1)

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
48	2/5/1998	NCV	IR 97313	NRC	Operations	3B	Contrary to the requirements of 10 CFR 55.49, unauthorized people gained access to a copy of NUREG 1021, "Operator Licensing Examination Standards for Power Reactors," Interim Revision 8, January 1997, Form ES-301-2, Individual Walk-Through Test Outline, listing the proposed examination Job Performance Measures (JPMs) by title. This resulted in a breach of examination security. Additional examples of examination security problems were noted. (Section O5.1)
49	2/5/1998	Negative	IR 97313	NRC	Operations	3B	Individual communications practices of some of the applicants was poor and needed improvement. Applicants failed to comply with Emergency Operating Procedure (EOP) steps to initiate suppression pool cooling when required and used alternate injection systems when preferred injection systems were available. One applicant unnecessarily delayed execution of an EOP step resulting in unnecessary core uncoverage. (Section 05.5)
50	2/5/1998	Weakness	IR97313	NRC	Operations	3B	Examination developers failed to meet the guidelines of NUREG 1021 when developing the JPM examination outline. Validation of the JPM examination by facility personnel was weak. (Section O5.4.c)
51	2/5/1998	Negative	IR 97313	NRC	Operations	3B	Rigorous enforcement of motor operated valve test preparation switch use appeared to be lacking and needed improvement. (Section O5.4
52	2/5/1998	Positive	IR 97313	NRC	Operations	3B	Training department personnel developed a written examination that proved to be a good evaluation tool for determining applicant competence. However, the examination showed a lack of attention to detail. Applicants were well prepared to take the written examination. (Section 05.2)
53	2/5/1998	Misc	IR 97313	NRC	Operations	3B	Two SRO license applicants passed all portions of their respective examinations and were issued SRO licenses. Two SRO license applicants failed portions of the examination and were denied operator licenses. Three SRO and two RO license applicants passed all portions of their respective examinations but were not issued operating licenses. Licenses will be issued upon completion of 10 CFR 55 required reactivity manipulations and all Clinton Power Station training program requirements.
54	2/5/1998	Negative	IR 97313	NRC	Operations	3C 3B	CPS No. 3213.01, Fire Detection and Protection, Rev. 19, was inadequate in that it allowed emergency operation of the diesel fire pump with no jacket cooling water flow to cool the diesel. (Section O3.1)

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
55	1/23/1998	Negative	IR 98006	Self-Revealed	Operations	1C	A design deficiency, material condition issues, and the failure of an operator to appropriately communicate plant conditions to the control room resulted in a loss of service air and a subsequent manual reactor scram.
56	1/23/1998	Positive	IR 98006	NRC	Operations	5C	The operations department's root cause investigation for the reactor scram was thorough and identified several actions to improve equipment and operator performance. Although one of these actions was initially disapproved by the engineering work review board, operations personnel took the initiative to overturn the decision and to ensure that a long-standing operator work-around was appropriately resolved.
57	1/19/1998	LER	LER 97036	Licensee	Operations	2A	The licensee's engineering staff determined that without the motor shaft key which connects the motor to the fan hub of the Division II shutdown service water pump room cooler, the Division II shutdown service water pump room cooler could not be considered operable. The inoperability of the room cooler causes the associated Division II shutdown service water pump to be inoperable. It is likely that the motor shaft key was not installed during initial manufacturing. Other/NA
58	1/16/1998	LER	LER 97033	Licensee	Operations	1A	The shift supervisor recognized that the Containment Building Fuel Transfer Pool Ventilation Plenum Exhaust Radiation Monitors, which have been inoperable since October 18, 1997, impacted the status of some isolation dampers. These monitors isolate secondary containment and secondary containment bypass dampers on the detection of a high radiation condition. Administrative control was not in place to ensure isolation capability of these dampers. The cause of this event is due to a misinterpretation of technical Specifications, therefore the required actions for these monitors being inoperable were not taken. Inadequate Oversight

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES			DESCRIPTION
59	1/5/1998	Weakness	97SET	NRC	Operations	1A	1C	4C	The SET noted that several fire protection issues identified in 1995 had not been effectively addressed, including structural steel components with thermal shorts, inaccessible and inoperable fuel pool fire detectors, some fire barrier penetration seals not installed in the control room, and the potential for a single fire to cause loss of offsite power and loss of all diesel generators. The licensee had used an hourly fire watch in lieu of addressing identified problems. This action is counter to NRC guidance in GL 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," which discourages the use of compensatory measures instead of restoring equipment to full operability.
60	1/5/1998	Strength	97SET	NRC	Operations	1C	3B		Fire brigade knowledge and performance were a program strength.
61	1/5/1998	Negative	97SET	NRC	Operations	1C	4B		The SET noted that the current number of fire protection staff was consistent with the industry standard. However, in 1995, the fire protection staff was assigned additional duties. One engineer responsible for program implementation told the SET that only 20 percent of his time was available for fire protection activities. The SET also noted that during that period, there was a significant increase in the number of CRs related to fire protection and in the number of fire protection impairments. The SET concluded that the increased number of CRs and impairments occurred, in part, because the staff had insufficient time to devote to fire protection activities.
62	1/5/1998	Weakness	97SET	NRC	Operations	1C	4C		The SET noted that the licensee had extended surveillance for some fire protection systems beyond that previously approved by NRC or specified in NFCs. Monthly hose house inspections had been extended to an annual inspection. The SET noted mud dauber nests blocking the inside of fire hoses in each of two hose houses opened. Subsequently, the licensee identified a total of 11 fire hoses blocked by mud dauber nests. The last inspection had been performed in June 1997. The licensee committed to revert to monthly hose house inspections.

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63	1/5/1998	Negative	97SET	NRC	Operations	1C	4C		The SET noted, in general, that fire detection systems appeared to comply with the National Fire Code (NFC). However, the service water pump rooms were observed to have an elevated ceiling and the fire detection system did not appear to comply with the current NFC for such a ceiling. Also, the licensee's individual plant external event examination (IPEEE) stated that credit was taken in three fire areas (two cable spreading rooms and the Division III switchgear room) for automatic fire suppression allowing a reduction in core-damage frequency by a factor of 266. Although the licensee had evaluated and taken corrective actions for the sprinkler obstructions in the cable spreading rooms, the SET noted significant obstructions to sprinkler flow patterns in the Division III switchgear room.
64	1/5/1998	Weakness	97SET	NRC	Operations	1C	4C		The licensee was unable to give the SET the requested test data to demonstrate that three randomly selected fire barrier penetration seals were installed in a configuration validated by a fire test. The licensee did not classify the fire barrier penetration seals as inoperable.
65	1/5/1998	Positive	97SET	NRC	Operations	1C	4C		The SET noted that the licensee, during plant licensing, had been granted numerous deviations from NRC fire protection guidance. Many of the deviations were, in part, based on having fire detection and suppression in a fire area. The SET observed that the licensee's staff was closely monitoring the performance of associated fire protection systems to ensure that extending maintenance and surveillance frequencies beyond the NFC did not affect system performance.
66	1/5/1998	Weakness	97SET	NRC	Operations	5A	2A	1C	Problem identification was inconsistent and evaluation and corrective actions were generally ineffective. The SET concluded that the inability to identify, evaluate, and correct problems was a major impediment to improvement. Inconsistencies in problem identification resulted in failure to ensure that problems were effectively captured. Ineffective evaluation of identified problems contributed to failure to develop effective corrective actions. Failure to monitor and ensure implementation of CA plans contributed to recurring problems and an attitude of living with problems.

PLANT ISSUES MATRIX
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Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Operations" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
67	12/22/1997	Negative	IR 97022	NRC	Operations	1A	One example of nonconservative decision making was identified for not assessing the impact of shutdown risk due to reduced onsite electrical power availability. Specifically, the Division II Emergency Diesel Generator (EDG) was removed from service for maintenance while the Division I EDG was inoperable due to silting of the service water system (Section O1.1). Inadequate Oversight
68	12/22/1997	Negative	IR 97022	NRC	Operations	1A	One example of a violation of Technical Specification (TS) 3.0.2 was identified due to the failure to implement a TS Required Action. Specifically, between July 28 and October 26, 1997, an alternate method of decay heat removal was not verified within one hour and every 24 hours thereafter following the declaration of an inoperable train of residual heat removal. Consequently, component cooling water remained aligned to the "B" Reactor Water Cleanup Heat Exchanger even though the "A" Reactor Water Cleanup Heat Exchanger was being credited as the heat sink for the alternate decay heat removal source (Section O1.2). Inadequate Oversight
69	12/22/1997	Weakness	IR 97022	NRC	Operations	1A	One example of a violation of TS 3.0.2 was identified due to the failure to implement a TS Required Action. Specifically, actions were not pursued to restore the Division I and II electrical subsystems to an operable status immediately on two separate occasions. Corrective actions for the first occasion were narrow in focus in that they failed to prevent recurrence (Section O8.1). Other/NA
70	12/22/1997	Positive	IR 97022	NRC	Operations	2B	Improvements were made in sampling of the Diesel Fuel Oil System following the inspectors' identification that the fuel oil day tanks were inspected for water after recirculating the day tank to the fuel oil storage tank (Section O2.1). Inadequate Procedure/Instruction
71	12/22/1997	Negative	IR 97022	NRC	Operations	3B	Training provided to operations personnel did not include all systems which are available to reduce containment pressure. Additionally, the emergency operating procedures did not include all systems which may be beneficial in reducing containment pressure. These omissions contributed to operations personnel in the simulator main control room not taking emergency operating procedure actions to reduce containment pressure using available plant systems (Section P1.1). Other/NA

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
72	12/22/1997	Negative	IR 97022	NRC	Operations	3C	Operations personnel did not ensure that information needed to perform an operability determination for over-greasing of 480V motors was provided in a timely manner. This demonstrated a lack of plant ownership and leadership by the operations department and was indicative of a weakness in the operability determination program (Section M8.1). Inadequate Oversight
73	12/22/1997	Negative	IR 97022	NRC	Operations	4B	The inspectors identified that the low level alarm setpoint for both the Division I and III fuel oil day tanks were incorrectly stated in the corresponding annunciator response procedures (Section O2.1). Inadequate Procedure/Instruction
74	12/22/1997	Licensing	IR 97022	NRC	Operations	5A	NRC involvement was required for licensing personnel to recognize a 10 CFR Part 50.73 reportable condition involving the failure to verify an alternate method of decay heat removal, an operation or condition prohibited by the plant's Technical Specifications (Section O1.2). Other/NA
75	12/22/1997	Positive	IR 97022	Licensee	Operations	5A 2B	Quality assurance identified several weaknesses in the adequacy and implementation of the self assessment and maintenance rule programs. The audits represented an improvement in the quality assurance organization's ability to perform thorough and probing evaluations (Sections O7.1 and M7.1). Self-Critical
76	12/22/1997	Weakness	IR 97022	NRC	Operations	5C	Two weakness in the implementation of the corrective action program were identified. The weaknesses involved downgrading the significance of a condition report without supervisory review and operations, licensing, and corrective action review board personnel not being familiar with significance criteria associated with condition reports (Section O1.2). Inadequate Oversight

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
77	12/17/1997	LER	?R 97030	Licensee	Operations	1A	On October 26, 1997, the operations department discovered that component cooling water (CCW) was not aligned to the "A" reactor water cleanup (RWCU) non-regenerative heat exchanger (NRHX). Technical Specification Limiting Condition for Operation (LCO) 3.4.10 required verification of an available alternate method of decay heat removal for each inoperable RHR shutdown cooling subsystem. The RWCU system was being credited as one of the alternate methods of decay heat removal, and because of the unknown CCW system alignment to the "A" RWCU NRHX, the TS LCO action statement for verifying an alternate method of decay heat removal had not been met. Inadequate Procedure/Instruction
78	12/15/1997	LER	LER 97029	Licensee	Operations	3A	A scaffold was found partially supported by the Low Pressure Core Spray room area cooler, 1VY01S. The effect that this scaffold had on the room cooler could not be positively determined; therefore, the room cooler was determined to be inoperable due to seismic qualification concerns. Personnel Performance Deficiency
79	11/13/1997	LER	LER 97026	Licensee	Operations	5A	Plant engineers identified that the level of silt in the area of the shutdown service water system (SX) pump intake area exceeded the level required to ensure the operability of the Division I and II SX pumps. Other/NA
80	11/7/1997	Positive	IR 97023	NRC	Operations	3B	Licensee controls to revise the licensed operator requalification training program were satisfactory (Section O5.4).
81	11/7/1997	Positive	IR 97023	NRC	Operations	3B	Licensed operator requalification programs were implemented in accordance with 10 CFR Part 55 requirements (Sections O5.3 and O5.6).
82	11/7/1997	Strength	IR 97023	NRC	Operations	3B	All portions of the annual requalification examination were judged to be effective tools for determining operator weaknesses (Section O5.2).
83	11/7/1997	Negative	IR 97023	NRC	Operations	3B	The development of remediation plans lacked a comprehensive root cause analysis for individual performance (Section O5.5).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
84	10/29/1997	LER	LER 97024	Licensee	Operations	3C	On Labor Day weekend, August 30, 31, and September 1, 1997, Clinton Power Station suspended work that was ongoing to restore Westinghouse 4160 volt safety-related breakers to an operable status. Suspension of this work was later determined to be in conflict with the Technical Specification Action statements to immediately initiate action to restore operability of the affected electrical busses, sources, and/or components. Inadequate Oversight
85	10/6/1997	Weakness	IR 97019	Licensee	Operations	3B	The failure to activate a readily available alarm and eliminate unnecessary licensed operator trainee system reviews during a reactor vessel level drain down evolution was considered a significant weakness in operator performance. Personnel Performance Deficiency
86	10/6/1997	VIO/SL-IV	IR 97019/VIO	NRC	Operations	3C	One violation was identified due to a line assistant shift supervisor failing to properly direct and monitor the activities of the reactor operators such that a drain down of the reactor vessel was promptly identified and corrected. Reactor operators did not properly monitor and control reactor vessel level in a safe and competent manner. Personnel Performance Deficiency
87	10/6/1997	VIO/SL-IV	IR 97019/VIO	NRC	Operations	5A	One violation was identified due to the failure to provide complete and accurate information to the Commission. Specifically, the response to Notice of Violation 97009-01 stated that corrective actions in response to an inadvertent isolation of the reactor water cleanup system had been completed even though the actions were not scheduled for completion until February 15, 1998. Inadequate Oversight
88	10/6/1997	Weakness	IR 97019	NRC	Operations	5A	During a review of the tagout program, several weaknesses with the implementation of the corrective action program were noted including: root cause analyses which did not determine why previous corrective actions were ineffective, a lack of quality assurance involvement in deficient areas, a lack of communication between departments prior to extending corrective actions, and extending condition reports beyond 1 year without the approval of the corrective action review board. (Section 01.3) Inadequate Oversight
89	10/6/1997	VIO/SL-IV	IR 97019/VIO	NRC	Operations	5C	One example of a corrective action violation was identified for the failure to prevent the recurrence of eleven near miss tagging events. Inadequate Oversight

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
90	10/6/1997	Weakness	IR 97019	NRC	Operations	5C	The inability to track corrective actions involving responses to NRC violations was a weakness in the licensee's commitment tracking system. Inadequate Oversight
91	10/6/1997	VIO/SL-IV	IR 97019/VIO	NRC	Operations	5C	One example of a corrective action violation was identified due to the failure to revise procedures associated with the restoration from a Division I bus outage. The untimely corrective action resulted in a second inadvertent isolation of the reactor water cleanup system on August 22, 1997. Inadequate Procedure/Instruction
92	10/6/1997	Weakness	IR 97019	NRC	Operations	5C	One weakness was identified for the failure to implement corrective actions to ensure proficiency watches were properly credited for senior reactor operators. (Section 08.4) Inadequate Oversight
93	10/6/1997	VIO/SL-IV	IR 97019/VIO	NRC	Operations	5C 5A	One example of a corrective action violation was identified for the failure to preclude a third loss of service building security lighting. Two root cause analyses were of poor quality in that they did not determine why corrective actions were untimely, not implemented, or ineffective. The delay in initiation of root cause analyses and implementation of corrective actions until receipt of an NRC Notice of Violation was considered a poor corrective action program practice. (Section 08.5) Inadequate Procedure/Instruction

GENERAL DESCRIPTION OF PIM TABLE LABELS

#	A counter number used for NRC internal editing.
DATE	The date of the event or significant issue. For those items that have a clear date of occurrence use the actual date. If the actual date is not known, use the date the issue was identified. For issues that do not have an actual date or a date of identification, use the LER or inspection report date.
TYPE	The categorization of the issue - see the TYPE ITEM CODE table.
SOURCE	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
ID BY	Identification of who discovered the issue - see table.
SALP	SALP Functional Area Codes - Engineering, Maintenance, Operations, Plant Support and All/Multiple (i.e., more than one SALP area affected).
SMM CODES	Senior Manager Meeting Codes - see table.
DESCRIPTION	Details of the issue from the LER text or from the IR Executive Summaries.

TYPE ITEM CODE

DEV	Deviation from NRC Requirements
ED	Escalated Discretion - No Civil Penalty
EEI*	Escalated Enforcement Issue - Waiting Final NRC Action
LER	License Event Report to the NRC
Licensing	Licensing Issue from NRR
Misc	Miscellaneous (Emergency Preparedness Finding, etc.)
NCV	Non-Cited Violation
Negative	Individual Poor Licensee Performance
Positive	Individual Good Licensee Performance
Strength	Overall Strong Licensee Performance
URI**	Unresolved Inspection Item
VIO/SL-I	Notice of Violation - Severity Level I
VIO/SL-II	Notice of Violation - Severity Level II
VIO/SL-III	Notice of Violation - Severity Level III
VIO/SL-IV	Notice of Violation - Severity Level IV
Weakness	Overall Weak Licensee Performance

ID BY

Licensee	The licensed utility
NRC	The Nuclear Regulatory Commission
Self-Revealed	Identification by an event (e.g., equipment breakdown)
Other	Identification unknown

NOTES

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either
(1) respond to the apparent violation or
(2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

SENIOR MANAGEMENT MEETING CODES

1	Operational Performance: A - Normal B - During Transients C - Programs and Processes
2	Material Condition: A - Equipment Condition B - Programs and Processes
3	Human Performance: A - Work Performance B - Knowledge, Skills, and Abilities C - Work Environment
4	Engineering/Design: A - Design B - Engineering Support C - Programs and Processes
5	Problem Identification and Resolution: A - Identification B - Analysis C - Resolution

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Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Maintenance" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
1	7/10/1998	ED	IR 98011	Licensee	Maintenance	2B		One violation for which enforcement discretion was exercised was identified concerning the failure to ensure an adequate procedure was used during testing of the high pressure core spray discharge isolation valve. The inspectors concluded that some procedural adequacy and adherence problems continued to occur at the facility. (NCV 50-461/98011-05).
2	7/10/1998	ED	IR 98011	Licensee	Maintenance	2B		One violation for which enforcement discretion was exercised was identified for the failure of operations personnel to implement procedural requirements while performing troubleshooting activities on the logic for the outboard main steam isolation valves (MSIVs) and on main control room panel P-680.(NCV 50-461/98011-03).
3	7/10/1998	ED	IR 98011	Licensee	Maintenance	2B	1C	Two examples of a violation for which enforcement discretion was exercised were identified due to the failure to implement procedures to perform required testing on the meteorological monitoring tower and a process radiation monitor prior to returning the equipment to an operable condition. The failure to perform required surveillances prior to returning equipment to service is a repeat of previous, similar issues at the station. (NCV 50-461/98011-02).
4	7/10/1998	Negative	IR 98011	NRC	Maintenance	3B		The inspectors observed two poor electrical maintenance work practices during testing of 480 Vac molded case circuit breakers MCCBs which involved the use of excessive torque on fasteners and improper use of megger test equipment
5	7/10/1998	ED	IR 98011	Licensee	Maintenance	5C		One violation for which enforcement discretion was exercised was identified when the inspectors determined that corrective actions to address 4160 Vac circuit breaker testing problems were not applied to molded case circuit breakers (MCCBs). Specific MCCB test program deficiencies included: improper test cable size, not performing a low current instantaneous trip, excessive test current pulse length, excessive instantaneous test current, improper instantaneous trip times, preconditioning of breakers, not documenting valid test attempts, and not evaluating breaker coordination issues for failed breakers. In addition, the inspectors determined that the licensee did not effectively utilize industry information and experience even though it was involved in the development of standard industry guidance for testing of 480 Vac MCCBs . (NCV 50-461/98011-06).

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
6	5/28/1998	ED	IR 98008	NRC	Maintenance	1C 2B	The inspectors identified a violation for the failure to verify each secondary containment manual isolation device closed every 31 days as required by Technical Specifications between discovery on June 18, 1996, and initial performance of the implementing surveillance procedure on December 1, 1996.
7	5/28/1998	Weakness	IR 98008	NRC	Maintenance	5A	The inspectors determined that quality assurance inappropriately provided a positive review of maintenance department self-assessments in that: only five of eight scheduled audits were completed, condition reports were not generated, action items were assigned without due dates for completion, due dates for action items were allowed to be extended without approval by the respective manager, Task Performance Check Lists were not tracked or trended to provide performance indicators, and results from Task Performance Check Lists were not consistent with results from other performance monitoring systems.
8	5/10/1998	ED	IR 98010	Licensee	Maintenance	2B	One non-cited violation was identified concerning the failure to perform monthly meteorological tower operability verifications at the required frequency. In addition, the inspector identified some continuing problems concerning the licensee's attention to the backup meteorological tower. Specifically, a 6-month preventive maintenance surveillance was scheduled for January 22, 1998, but had not been performed.
9	5/7/1998	ED	IR 98008	NRC	Maintenance	3A	The inspectors concluded that procedures were not adequately adhered to when maintenance workers failed to return an Maintenance Work Request to planning personnel for revision following the change in scope of the Division I Emergency Diesel Generator Var meter calibration on two occasions. NCV-98008-03
10	5/1/1998	ED	IR 98008	NRC	Maintenance	2B	The inspectors concluded that an adequate procedure was not established and implemented for the installation of a clamp-on device on a safety-related motor power feed wire to monitor various parameters. NCV 50-461/98008-04
11	5/1/1998	ED	IR 98008	NRC	Maintenance	5C	The inspectors identified a violation for failing to implement corrective actions for licensee identified discrepancies in the air operated valve program. Maintenance department self-assessments were weak in that four of five completed assessments did not determine if program elements were effectively implemented. (NCV 50-461/98008-05)

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
12	4/14/1998	Negative	IR 98006	NRC	Maintenance	1C		Inadequate planning and work control resulted in two occasions where an available train of standby gas treatment was not maintained.
13	4/14/1998	Positive	IR 98006	NRC	Maintenance	2A		The visible condition of coatings inside the containment and drywell was considered good. The amount of coatings which were loose or flaking was negligible and did not present an appreciable source of debris which could clog the emergency core cooling system suction strainers.
14	4/14/1998	Positive	IR 98006	Licensee	Maintenance	2B		One example of good questioning attitude was identified when operations personnel stopped a surveillance to address the impact of a leaking equalizing valve on a flow instrument used during testing.
15	4/14/1998	Negative	IR 98006	NRC	Maintenance	5C		Past corrective actions to address degraded coatings were inadequate. As a result, degradation developed such that emergency core cooling system (ECCS) suction strainer clogging may have occurred under certain circumstances and ECCS operability was not assured.
16	3/3/1998	NCV	IR 98003	NRC	Maintenance	2B	3A	Provisions of the maintenance troubleshooting procedure were not implemented during testing of the Division II EDG kilowatt indication. Specifically, maintenance personnel did not have a procedure or test plan for performing specific tasks, the activities were not approved by operations personnel, tasks being performed were not documented as they occurred, the chronology of events did not specify all actions taken, electrical maintenance work practices were poor, and supervisory oversight was minimal (Section M1.2).
17	3/3/1998	Positive	IR 98003	NRC	Maintenance	3B		The briefing given prior to performing a special test procedure on the Division II EDG was improved from previous briefings and included information on communications, self checking, safety, and lessons learned from other utilities (Section M1.3).
18	2/16/1998	NCV	IR 98004	NRC	Maintenance	5C	2B	The licensee failed to correct deficiencies associated with the division 2 NSPS inverter despite repeated failures. (Section M1.1)
19	2/13/1998	Negative	IR 97025	NRC	Maintenance	2B		Maintenance personnel did not effectively plan work activities for the initial 480VAC motor inspections in that work began on the Shutdown Service Water (SSW) Pump Room A Supply Fan motor without having the appropriate parts on site, without having all parts approved through an accredited quality assurance program, and without having a method for greasing the motor bearings prior to installation. (Section M1.4) Inadequate Oversight

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
20	2/13/1998	Positive	IR 97025	NRC	Maintenance	3A	Maintenance personnel demonstrated good procedure usage during functional testing of the Division III 4.16 KV Bus under voltage relay in that they reviewed each step prior to performance, exhibited good independent verification techniques, were aware of the purpose of the surveillance test, and understood problems which could be encountered if the surveillance was not successfully completed. (Section M1.2) Teamwork/Skill Level
21	2/13/1998	NCV	IR 97025	NRC	Maintenance	3C	One example of a non-cited violation was identified for the failure to follow procedures involving the installation of an isolation transformer during testing of SRMs. Two examples of a poor questioning attitude were identified which involved the continuance of a maintenance activity even though there was an unexplained increase in test parameters and an unexplained increase in main control room SRM indications. (Section M1.5) Inadequate Oversight
22	2/13/1998	Positive	IR 97025	Licensee	Maintenance	5A	An audit conducted by quality assurance involving receipt inspections and shelf life determinations identified several weaknesses in the material management program and represented a continued improvement in the quality assurance organization's ability to perform thorough evaluations. (Section M7.1) Self-Critical
23	1/5/1998	Weakness	97SET	NRC	Maintenance	1C 2B 4A	The effect of heat exchanger fouling on equipment operability was difficult to determine due to the inadequate implementation of Generic Letter 89-13, "Service Water System Problems Affecting Safety Related Equipment" (page 16 of the SET report).
24	12/22/1997	Negative	IR 97022	NRC	Maintenance	1A	Work control procedures for outages did not provide guidance on evaluating risk associated with the daily implementation of the outage schedule. This item will be reviewed as part of the NRC 0350 Panel oversight of licensee improvement programs (Section O1.1). Inadequate Procedure/Instruction
25	12/22/1997	Weakness	IR 97022	NRC	Maintenance	2B	One violation was identified due to the failure to provide maintenance work instructions for repairing safety related hydramotors as required by procedures. Additionally, the use of a MWR with broad instructions instead of a procedure with specific hydramotor repair and overhaul guidance was considered a weakness (Section M1.4). Inadequate Procedure/Instruction

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
26	12/22/1997	VIO/SL-IV	IR 97022	NRC	Maintenance	2B		One violation was identified due to the failure to provide controlled copies of vendor manuals and instructions for measuring and test equipment. Operations personnel were not trained in the use of portable tachometers prior to using the tachometers in the field (Section M1.2). Inadequate Procedure/Instruction
27	12/22/1997	Negative	IR 97022	NRC	Maintenance	2B		Inconsistent guidance was provided in Procedure CPS 8170.06, "Maintenance Troubleshooting." Section 2.1.2 stated that the procedure may be used as guidance when troubleshooting under a job stepped maintenance work request (MWR) while Section 1.0 stated that the procedure should not replace or be used in addition to a job stepped MWR (Section M1.3). Inadequate Procedure/Instruction
28	12/22/1997	Positive	IR 97022	NRC	Maintenance	3A	2B	While problems were noted with the procedure for hydramotor work, it was considered a positive step that work was stopped on two occasions so that procedural instructions could be modified. Other/NA
29	12/22/1997	Weakness	IR 97022	NRC	Maintenance	5A		The licensee's corrective actions in response to a previously identified motor over greasing issue were narrowly focused and untimely in that multiple departments failed to recognize the potential generic implications of the over greasing issue until seven weeks after the initial concern was identified (Section M8.1). Other/NA
30	12/15/1997	Weakness	LER 97031	Licensee	Maintenance	2B		Logic circuit overlap testing did not adequately cover portions of the logic circuitry as required by the Technical Specification (TS) Surveillance Requirement (SR) 3.3.6.4.7 for the Suppression Pool Makeup System Instrumentation, and TS SR 3.3.6.1.6 for the Primary Containment and Drywell Isolation Instrumentation. Futher, overlap testing did not adequately cover a portion of the logic circuitry for the thermal overload bypass circuit of motor-operated valves (MOV) 1SM001A, 1SM001B, 1SM002A, and 1SM002B, supression pool dump valves, to verify that TS SR 3.6.2.4.4 was met. Other/NA
31	12/5/1997	LER	LER 97023	Licensee	Maintenance	2B		It was determined that all safety related motors that contain bearings requiring the periodic addition of grease may potentially fail. The possible premature failure of the motors is due to the use of an incorrect method for adding grease to safety-related motor bearings. Other/NA
32	10/11/1997	EEI	IR 97020/EA 97-467	NRC	Maintenance	1C		One apparent violation was identified for not controlling the use of consumable materials which resulted in the failure of multiple safety-related components. Inadequate Procedure/Instruction

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33	10/11/1997	EEI	IR 97020/EA 97-467	NRC	Maintenance	3C		One apparent violation was identified due to the failure to provide procedural guidance commensurate with the knowledge, skills, and abilities of personnel performing neon indicating light replacement activities. The assignment of inexperienced personnel to perform this work demonstrated poor oversight by maintenance management. Inadequate Procedure/Instruction
34	10/11/1997	Negative	IR 97020	NRC	Maintenance	5A		The root cause evaluation for neon indicating light failures was an improvement over past root cause analyses. However, the root cause analysis only addressed the specific equipment failure and did not address ineffective management oversight, the poor quality of engineering evaluations, and the lack of control of consumable materials. Self-Critical
35	10/6/1997	VIO/SL-IV	IR 97019/VIO	Self-Revealed	Maintenance	2B	3B	One violation was identified for the failure to provide guidance which was commensurate with the knowledge, skills, and abilities of electrical maintenance individuals performing the lubrication of the Division III Shutdown Service Water Pump. This was the third example in 4 months where technicians were unable to competently perform "tool box skills." (Section M1.3) Inadequate Procedure/Instruction

GENERAL DESCRIPTION OF PIM TABLE LABELS

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DATE	The date of the event or significant issue. For those items that have a clear date of occurrence use the actual date. If the actual date is not known, use the date the issue was identified. For issues that do not have an actual date or a date of identification, use the LER or inspection report date.
TYPE	The categorization of the issue - see the TYPE ITEM CODE table.
SOURCE	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
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SMM CODES	Senior Manager Meeting Codes - see table.
DESCRIPTION	Details of the issue from the LER text or from the IR Executive Summaries.

TYPE ITEM CODE

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EEI*	Escalated Enforcement Issue - Waiting Final NRC Action
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Misc	Miscellaneous (Emergency Preparedness Finding, etc.)
NCV	Non-Cited Violation
Negative	Individual Poor Licensee Performance
Positive	Individual Good Licensee Performance
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URI**	Unresolved Inspection Item
VIO/SL-I	Notice of Violation - Severity Level I
VIO/SL-II	Notice of Violation - Severity Level II
VIO/SL-III	Notice of Violation - Severity Level III
VIO/SL-IV	Notice of Violation - Severity Level IV
Weakness	Overall Weak Licensee Performance

ID BY

Licensee	The licensed utility
NRC	The Nuclear Regulatory Commission
Self-Revealed	Identification by an event (e.g., equipment breakdown)
Other	Identification unknown

NOTES

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SENIOR MANAGEMENT MEETING CODES

1	Operational Performance: A - Normal B - During Transients C - Programs and Processes
2	Material Condition: A - Equipment Condition B - Programs and Processes
3	Human Performance: A - Work Performance B - Knowledge, Skills, and Abilities C - Work Environment
4	Engineering/Design: A - Design B - Engineering Support C - Programs and Processes
5	Problem Identification and Resolution: A - Identification B - Analysis C - Resolution

PLANT ISSUES MATRIX
Clinton

3/26/1999

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Engineering" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	7/10/1998	Negative	IR 98011	NRC	Engineering	4B	The adequacy of information provided in engineering and operability evaluations was mixed. Engineering personnel provided an adequate basis for continued operation of the residual heat removal B and C water leg pump. However, engineering personnel did not initially provide an adequate basis for the automatic transfer of the Division III electrical safety bus or adequate assurance that a piece of copper tube was not located in the lube oil system of the Division I Emergency Diesel Generator.
2	7/10/1998	Negative	IR 98011	Licensee	Engineering	5A 4B	One example of a degraded condition affecting the calibration of control room indications was identified by engineering personnel but not brought to the attention of operations personnel. Consequently, an evaluation of the generic implications of uncalibrated instrumentation on continued plant operations was not initiated until prompted by NRC inspectors.
3	5/10/1998	Positive	IR 98010	Licensee	Engineering	1C 4B	The system engineer performed good trending of system operability for the primary meteorological tower. The calibrations and surveillances for the primary meteorological tower were properly performed.
4	3/27/1998	VIO/SL-IV	IR 98007	NRC	Engineering	4B	One violation was identified concerning an inadequate 10 CFR 50.59 analysis which had been performed to address discrepancies between the plant configuration and the description of the plant in the Updated Safety Analysis Report. Specifically, the inspector identified that the safety analysis, which was performed by the licensee to address the absence of radiation monitors in the residual heat removal rooms A and B, did not address the leak detection function that was attributed to the monitors by the Updated Safety Analysis Report
5	3/19/1998	NCV	IR 98006	Licensee	Engineering	4A	Engineering personnel inappropriately determined that the dry film thicknesses (DFT) for containment coatings applied in November 1997 were acceptable without performing an adequate evaluation of coatings with less than the minimum allowed DFT
6	3/3/1998	Negative	IR 98003	NRC	Engineering	3A 3B 5A	The shift supervisor's review of condition report 1-97-12-221 involving inadequate testing of RTDs and the diesel ventilation system was poor and lacked intrusiveness in that it was not properly classified, it did not consider possible generic implications on other plant equipment, and it did not ensure that an appropriate tracking mechanism was in place to prevent an EDG from being returned to an operable status prior to resolving the issue (Section E1.2).

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Engineering" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
7	3/3/1998	NCV	IR 98003, LER-97002	NRC	Engineering	4A	Design basis information involving ambient outside air temperature was not translated into specifications which effected the service life of EDG components, and resulted in the Division III EDG being inoperable when outside air temperatures exceeded 91 F (Section E1.1).
8	3/3/1998	NCV	IR 98003	NRC	Engineering	4A	An adequate 10 CFR Part 50.59 safety evaluation was not performed to ensure that changes in the testing methodology for the diesel ventilation system did not constitute an unreviewed safety question. Specifically, changes were made to delete test requirements from procedures even though the USAR clearly specified the testing to be performed (Section E1.2).
9	3/3/1998	NCV	IR 98003	Licensee	Engineering	4A	Design basis information regarding the proper electrical isolation between Class IE and non-Class IE components was not translated into a modification package for replacing the Division I and II EDG annunciator power supplies. This resulted in improper electrical isolation between non-Class IE and Class IE EDG circuitry for approximately six years and created an unreviewed safety question which may have prevented the Division I and II EDGs from operating when outside air temperatures exceeded 91 F (Section E1.1).
10	3/3/1998	Negative	IR 98003	NRC	Engineering	4A 3B	Engineering personnel did not recognize the significance of extreme outside air temperatures on EDG operability. After prompting by the NRC inspectors, an appropriate engineering evaluation was performed (Section E1.1).
11	3/3/1998	NCV	IR 98003	NRC	Engineering	4A 4C	No testing of resistance temperature devices (RTDs) within the diesel ventilation system was performed to demonstrate that the RTDs would perform satisfactorily in service even though the Updated Safety Analysis Report (USAR) clearly delineated the requirement (Section E1.2).
12	1/28/1998	NCV	IR 98006	Licensee	Engineering	5B	Engineering, operations, and work control personnel failed to appropriately implement the requirements of Technical Specification 5.5.7, "Ventilation Filter Testing Program." As a result, testing of the HEPA filter and the charcoal adsorber bed for the standby gas treatment system was not performed following painting in a ventilation zone which directly communicated with the standby gas treatment system.

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Engineering" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
13	1/16/1998	LER	LER 97034	Licensee	Engineering	4A	During degraded voltage conditions, the Divisions 1 and 2 emergency diesel generator (EDG) room vent fans could cause offsite power supply breakers to trip on undervoltage during transient electrical bus loading conditions associated with a Loss of Coolant Accident block start. Improper cable resistance values and brake horsepower ratings were used in the original design of the Divisions 1 and 2 EDG vent fans. Engineering/Design Deficiency
14	1/16/1998	LER	LER 97035	Licensee	Engineering	4A	The Divisions 1 and 2 safety-related battery chargers had not been analyzed in the degraded voltage calculations. Further, the battery chargers may not be capable of supplying full rated voltage and current flow at the degraded voltage trip setpoint with the present battery charger transformer tap setting at 480 volts. Engineering/Design Deficiency
15	1/2/1998	LER	LER 97032	Licensee	Engineering	4A	Plant Operations determined that protions of the High Pressure Core Spray (HPCS) pump suction piping, Reactor Core Isolation Cooling (RCIC) pump suction piping, and RCIC tank level instrumentation standpipe, located outside of a missile protected building, were not designed to withstand missiles generated by a design basis tornado. Engineering/Design Deficiency
16	12/23/1997	Weakness	LER 97028	Licensee	Engineering	4A	The environmental qualification of the power shield trip units associated with all thirty-three inservice ABB 480-volt K-Line safety-related circuit breakers were not sufficient to withstand the expected dose rates following a worst case loss of cooling accident. Other/NA
17	12/22/1997	Positive	IR 97022	NRC	Engineering	5A	Although trending of equipment deficiencies was not actively performed in the past, the engineering department was taking action to identify adverse trends in equipment performance (Section E1.1). Other/NA
18	12/4/1997	LER	LER 97027	Licensee	Engineering	4B	On August 31, 1990, maintenance completed installation of the first portion of a modification to add interlocks to the residual heat removal (RHR) system. In October, 1997, further review determined that the addition of a relay to two of the RHR loops increased the probability for an equipment malfunction which would affect the ability of the plant to use the suppression pool cooling mode of operation. Therefore, addition of this relay resulted in an unreviewed safety question. The cause of this event was a misinterpretation of 10 CFR 50.59. Engineering/Design Deficiency

PLANT ISSUES MATRIX
Clinton

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
19	10/28/1997	LER	LER 97025	Licensee	Engineering	4A	A hot short could potentially cause motor operated valves (MOVs) required for safe shutdown of the plant from the remote shutdown panel to spuriously operate, bypassing the MOV control circuitry protective features. When the MOV control circuit protective features are bypassed, the potential exists for the valve to be damaged to the extent that the valve could not be operated. Engineering/Design Deficiency
20	10/6/1997	Weakness	IR 97019	NRC	Engineering	4A	Three discrepancies with the Updated Safety Analysis Report were identified involving alarm set points, omission of sensitivity studies, and the detection capability of radiation monitors. (Section E8.1) Other/NA
21	10/6/1997	NCV	IR 97019	Self-Revealed	Engineering	4B	A non-cited violation was identified for the failure to maintain required technical specification indications for leakage detection systems. Engineering/Design Deficiency

GENERAL DESCRIPTION OF PIM TABLE LABELS

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PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
1	6/25/1998	Negative	IR 98013	NRC	Plant Support	1C	Numerous documentation errors were identified in whole body contamination monitor calibration records and the documentation of instrument maintenance histories warranted improvement.
2	6/25/1998	Positive	IR 98013	NRC	Plant Support	1C	Air sampling activities for the containment and drywell containment coatings work were properly performed and representative of work activities. Observations of work confirmed that workers were using good radiation work practices and that radiation protection technician coverage was appropriate.
3	6/25/1998	Negative	IR 98013	NRC	Plant Support	1C	The inspector noted that station procedures did not instruct personnel when to perform air sampling and did not contain a formal process for tracking the assignment of la[illegible] air samplers and associated sample analysis results. These areas were being addressed by the licensee
4	6/25/1998	Positive	IR 98013	NRC	Plant Support	1C	Whole body contamination monitoring and counting instrumentation was properly calibrated and maintained. Radiation protection oversight of this equipment, including instrument technician performance, was considered good.
5	5/10/1998	Positive	IR 98010	NRC	Plant Support	1C	The radiation protection staff properly implemented the external dosimetry quality control program. The licensee maintained National Voluntary Laboratory Accreditation Program accreditation in accordance with 10 CFR Part 20. In addition, periodic thermoluminescent dosimeter quality control tests were performed as required, and the results were evaluated for long term biases or trends.
6	5/10/1998	Negative	IR 98010	NRC	Plant Support	1C	The inspector identified problems in the documentation of quality control test results and corrective actions performed during routine thermoluminescent dosimeter processing.
7	5/10/1998	Negative	IR 98010	NRC	Plant Support	1C	The radiation protection (RP) staff continued to initiate improvement actions to address radiation worker practices and RP program weaknesses and to perform self assessments to monitor performance. Although some reduction in radiation worker problems was noted, the inspector observed that radiation worker practices and RP technician performance continued to be a challenge. The inspector also noted that planned RP improvement actions were not always met with a high level of plant-wide commitment.

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
8	5/10/1998	Positive	IR 98010	NRC	Plant Support	1C 5A	Quality assurance assessments of the licensee's radiological environmental monitoring program, including the performance of the vendor laboratory, were thorough. In particular, the audit of the vendor laboratory identified notable weaknesses in the vendor's implementation of its quality control program. The inspector observed that the radiation protection organization was aware of the issues and was taking actions to address audit findings and recommendations.
9	5/10/1998	Positive	IR 98010	NRC	Plant Support	1C 5A	Environmental sample results did not indicate any discernable effects from plant operations and/or radioactive releases. The 1996 and 1997 annual reports were well written, and the licensee had replaced some sampling instrumentation to improve operability of the air samplers.
10	5/10/1998	VIO/SL-IV	IR 98010	Licensee	Plant Support	1C 5C	A violation was identified concerning the failure to post a radiation area in the control rod drive filter area within the turbine building. Although the licensee identified this violation, the radiation protection (RP) staff missed two prior opportunities to identify and correct this violation. On two independent radiological surveys, RP technicians measured and documented radiation levels in the area which would have required a radiation area posting but did not recognize that the area was not properly posted.
11	5/10/1998	Negative	IR 98010	NRC	Plant Support	1C 5C	The licensee continued to maintain administrative external dose levels to ensure that personnel doses were maintained ALARA. With the exception of one individual's total effective dose equivalent (TEDE), personnel doses for 1996 and 1997 were below the administrative dose levels. Although the radiation protection staff investigated the incident and implemented corrective actions, the inspector noted that the licensee's actions were not timely. In addition, the inspector noted some errors in the licensee's quarterly comparisons of doses measured via thermoluminescent dosimeters and electronic dosimeters.
12	5/10/1998	NCV	IR 98010	Licensee	Plant Support	3A 5A 5C	Two non-cited violations were identified concerning the deliberate falsification of a radiological survey record by a radiation protection technician. The licensee performed a thorough investigation of the incident and implemented immediate corrective actions.

PLANT ISSUES MATRIX
Clinton

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES		DESCRIPTION
13	5/10/1998	Negative	IR 98010	NRC	Plant Support	3B		The inspector identified some problems concerning technician knowledge level and techniques. In addition, performance problems concerning well water compositors were not fully evaluated by the radiation protection staff to ensure that a representative sample was obtained.
14	5/8/1998	Positive	IR 98009	NRC	Plant Support	1B		A timely and comprehensive critique of the Emergency Response Organization performance was held following the loss of shutdown cooling event.
15	5/8/1998	VIO/SL-IV	IR 98009	NRC	Plant Support	1B		In one case, on-shift staffing was inadequate during the 2/13/98 event, because only one of two mechanical maintenance workers on site was appropriately trained. This was a violation.
16	5/8/1998	Positive	IR 98009	NRC	Plant Support	1B		The Shift Supervisor's decision to classify an Alert in response to a loss of shutdown cooling event on February 13, 1998 was conservative and defensible.
17	5/8/1998	Negative	IR 98009	NRC	Plant Support	1B		Initial notifications of the Alert on 2/13/98 were made in a timely manner but contained some inaccurate meteorological information.
18	5/8/1998	Negative	IR 98009	NRC	Plant Support	1B		Control of in-plant operators was not well-coordinated between the main control room (MCR) and the Technical Support Center (TSC) during the 2/13/98 Alert.
19	5/8/1998	VIO/SL-IV	IR 98009	Self-Revealed	Plant Support	1B	1C	The Emergency Response Data System was not initiated within the required timeframe of one hour after the Alert on 2/13/98 was declared. This was a violation.
20	5/8/1998	Negative	IR 98009	NRC	Plant Support	1B	5C	Involvement of the Shift Technical Advisor in making initial notifications during the 2/13/98 event detracted from his primary duties. This was a repeat of events that occurred during the 9/5/96 recirculation pump seal failure event.
21	5/8/1998	Positive	IR 98009	NRC	Plant Support	1C		An excellent decision was made to continue the Emergency Operations Facility (EOF) training drill during the actual power loss to the EOF. Participants coped well with the effects of the power outage. Some emergency ceiling lighting allowed participants to gather and position other lighting equipment. Dose projection could not be performed in the EOF due to backup failures. All emergency exit lighting failed almost immediately. Emergency power supplies failed quickly, well before expected failure times.

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
22	5/8/1998	Positive	IR 98009	NRC	Plant Support	1C	Overall, the Emergency Preparedness program has been generally maintained in an adequate state of operational readiness. Emergency response facilities, equipment, and supplies have generally been adequately maintained, with some exceptions.
23	5/8/1998	VIO/SL-IV	IR 98009	NRC	Plant Support	1C	The call-in system and lack of Emergency Response Organization badges delayed Technical Support Center activation beyond goal timeframes during the 2/13/98 Alert. This was a violation. A good decision was made to control facility access, but security had to call the main control room for access approval for some personnel--a potential distraction at a critical time.
24	5/8/1998	Negative	IR 98009	NRC	Plant Support	1C 2B	The material condition of t[illegible]hnical Supp[illegible] Center (TSC) was marginal, as was noted in the la[illegible] inspection. The failure of the TSC backup dose assessment laptop computer to function indicated that its test frequency was not adequate.
25	5/8/1998	Positive	IR 98009	NRC	Plant Support	5A	The licensee's 1997 and 1998 Emergency Preparedness audits were adequate and satisfied the requirements of 10 CFR 50.54(t). The audits were of adequate scope and depth, but were weak in the area of equipment maintenance, particularly considering identified equipment operability problems.
26	4/14/1998	Positive	IR 98006	NRC	Plant Support	1C	The fire brigade responded promptly during the performance of a fire drill
27	4/7/1998	Negative	IR 98006	Licensee	Plant Support	3A	Numerous emergency response personnel failed to respond several pager tests. Specifically, only 1 of 6 pager tests had 100 percent response from emergency response personnel.
28	3/27/1998	Negative	IR 98007	NRC	Plant Support	1C	The inspector found radiological hazards in the radiologically controlled area to be properly controlled and posted. However, access to certain safety related equipment, including the emergency core cooling system pump rooms, was encumbered by radioactively contaminated areas.
29	3/27/1998	NCV	IR 98007	Licensee	Plant Support	1C	One Non-Cited Violation was identified for the failure to adequately implement Radiological Protection procedures concerning the basis for waiving an employment termination whole body count

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "10/1/1997" , Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
30	3/27/1998	Negative	IR 98007	NRC	Plant Support	1C	The licensee performed a thorough assessment of a February 4, 1998, incident involving a malfunction of a high range calibrator and the staff's decision to use the instrument after the malfunction was identified. Although no unexpected personnel doses were received, the staff's decision to permit a third measurement with the malfunctioning high level source was a non-conservative decision, which was addressed by RP management
31	3/27/1998	Negative	IR 98007	NRC	Plant Support	1C 2B	The licensee performed calibrations of area and process radiation monitoring system monitors in accordance with procedures, which were consistent with regulatory guidance. However, the inspector identified that about 20 percent of the calibrations and functional tests were performed in the "grace period" (i.e., between 1.00 and 1.25 times the stated performance frequency). The inspector also identified a problem with certain calibration procedures which had not been properly identified and resolved by the staff.
32	3/27/1998	Negative	IR 98007	NRC	Plant Support	5A 5C	The material condition of radiation monitors was generally acceptable, with a few exceptions. Corrective actions were in progress to resolve shaft seal problems with the liquid process radiation monitors and to resolve operability problems with the standby gas treatment system and the heating, ventilation, and air conditioning system high range radiation monitors. Although radiation monitor indications were generally consistent, the inspector identified problems concerning the RP staff's routine review of radiation monitor performance, which included the identification and resolution of anomalous monitor responses
33	3/27/1998	Positive	IR 98007	Licensee	Plant Support	5B	The licensee performed a comprehensive review of the design basis of the area and process radiation monitoring system and the monitoring console. The inspector noted that the current system configuration did not conflict with the design basis. Although the RP area was not equipped with monitor readout capability, plans were developed to replace the radiation monitor console in the control room and to install monitor readout capabilities in the RP area and in the technical support center

PLANT ISSUES MATRIX
Clinton

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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
34	3/27/1998	NCV	IR 98007	Licensee	Plant Support	5C	One Non-Cited violation was identified concerning the failure to implement an adequate procedure to determine the proper trip setpoints for the main steam line radiation monitors. Although the licensee identified and corrected the deficiency in 1997, the RP staff had noted the problem in 1990 but did not completely assess and resolve the issue.
35	2/13/1998	Positive	IR 97025	NRC	Plant Support	2A	No deficiencies were noted during a lighting tour of the protected area. (Section S2.1) Other/NA
36	2/13/1998	Negative	IR 97025	NRC	Plant Support	3A	One example of an individual incorrectly processing through a PCM-1B was identified. (Section R4.1) Personnel Performance Deficiency
37	2/2/1998	Negative	IR 98002	NRC	Plant Support	2B	The licensee properly packaged and classified radioactive material and waste shipments in accordance with regulatory requirements. However, the inspectors identified that procedures lacked guidance in determining the level of fixed contamination on material packaged and shipped under the surface contaminated object classification. The shipping documentation and low level waste manifests contained the information required by 49 CFR Part 172 and Appendix F of 10 CFR Part 20 (Section R1.4). Inadequate Procedure/Instruction
38	2/2/1998	NCV	IR 98002	NRC	Plant Support	2B	The licensee maintained effective oversight of the respiratory protection program and implemented numerous program improvements. Required surveillances and maintenance were completed as required, and the equipment was in good working order. Personnel using the equipment were properly trained, medically qualified, clean-shaven, and properly fit-tested. However, one non-cited violation was identified concerning the failure of plant security force members and supervisors to maintain their required respiratory protection qualifications (Section R1.1). Involved Management
39	2/2/1998	Negative	IR 98002	NRC	Plant Support	2B	Radioactive material and waste shipping procedures were consistent with regulatory requirements. However, the inspectors identified some problems and inconsistencies within and between procedures indicating the need for additional review of procedures (Section R3.1). Inadequate Procedure/Instruction
40	2/2/1998	Positive	IR 98002	Licensee	Plant Support	3B	The RP staff properly determined the activity of radioactive waste shipments via scaling factors. The inspectors noted good evaluation of radionuclide data but identified one error in the interpretation of the vendor's radioanalytical results (Section R1.3). Teamwork/Skill Level

PLANT ISSUES MATRIX
Clinton

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41	2/2/1998	Positive	IR 98002	NRC	Plant Support	3B	Respiratory protection evaluations were sound and were consistent with NRC guidance. The RP staff properly evaluated radiological conditions to determine whether the use of respiratory protection would maintain the total effective dose equivalent as-low-as-is-reasonably-achievable (ALARA) (Section R1.2). Teamwork/Skill Level
42	2/2/1998	Positive	IR 98002	Licensee	Plant Support	3C	The licensee had identified problems concerning the control of work hours and overtime for RP personnel, which will be reviewed as part of the NRC 0350 Panel (Section R4.1). Other/NA
43	2/2/1998	Positive	IR 98002	Licensee	Plant Support	5A	Audits of the radioactive waste management and shipping programs were of good depth. The audit team maintained a balance of performance-based and compliance-based observations and identified issues, which were being resolved by the RP staff (Section R7.1). Self-Critical
44	2/2/1998	Weakness	IR 98002	NRC	Plant Support	5A	The licensee had difficulty maintaining operability of the area and process radiation monitoring (AR/PR) equipment. Although the staff recognized the problem in October of 1997, late and/or missed surveillances had resulted in equipment operability problems with these monitors during 1997. With respect to the AR/PR remote monitoring console the inspectors concluded that (1) there was a lack of clear, reliable indication of AR/PR readings in the main control room; (2) frequent nuisance alarms were distracting operators from their ass_ned duties and the monitoring of plant conditions; and (3) previous modification plans were unsuccessful because of various technical and licensing problems and uncertainties. Although plant management had recently placed a high priority on the AR/PR system, the licensee's final plans to resolve these problems remained uncertain (Section R2.1). Inadequate Oversight
45	1/2/1998	Positive	IR 97024	NRC	Plant Support	1C	The security organization was knowledgeable of security requirements and implemented the physical security program in an effective manner. Security management showed appropriate attention to detail and program ownership, which contributed to effective implementation of security requirements and reduction of security errors. Effective maintenance support activities contributed to the reliable performance of security equipment. (Section S6.1 and 2) Other/NA

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "Plant Support" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
46	1/2/1998	Negative	IR 97024	Licensee	Plant Support	3A	A licensee-identified violation occurred when an in-processing employee improperly characterized a fitness for duty allegation as an anonymous allegation when it should have been characterized as a credible allegation. The actions of the employee were attributed to poor judgement when he was advised of the allegation. The significance of the failure was reduced because a fitness for duty test was administered. (Section S1.1) Personnel Performance Deficiency
47	1/2/1998	Negative	IR 97024	NRC	Plant Support	3B	The inspector identified a safety/security vulnerability regarding the untimely closing of an active vehicle barrier gate. The barrier was normally left in the open position after vehicle traffic passed through the barrier. Barrier effectiveness was reduced when the barrier was left in the open position. (Section S.2.1) Personnel Performance Deficiency
48	12/22/1997	Positive	IR 97022	NRC	Plant Support	1B	The shift supervisor's efforts to provide additional supervisory oversight during the exercise were prudent in that he recognized degrading command and control of activities in the simulator control room and inserted himself in the decision making processes (Section P1.1). Other/NA
49	12/22/1997	Weakness	IR 97022	NRC	Plant Support	1B 3B	Performance in the technical support center during the off hours exercise was poor in that personnel did not recognize when minimum manning requirements were met, did not ensure priorities for restoration of plant equipment were communicated, did not ensure field teams were accounted for, did not update status boards with information regarding field teams and degraded equipment, did not adequately reference emergency operating procedures, and transmitted inaccurate information concerning system availability due to the use of informal communications (Section P1.1). Personnel Performance Deficiency
50	12/22/1997	Weakness	IR 97022	NRC	Plant Support	1B 3B	A number of problems were identified with operator performance during the off hours emergency exercise. Simulator main control room personnel failed to recognize a loss of all DC control power, did not attempt to restore the reactor core isolation cooling system, did not initiate the standby gas treatment system as required by the emergency operating procedures, did not effectively communicate priorities, and did not perform periodic site wide announcements (Section P1.1). Personnel Performance Deficiency

PLANT ISSUES MATRIX
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#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES	DESCRIPTION
51	12/22/1997	Negative	IR 97022	NRC	Plant Support	1C	During the drill, the shift supervisor/command authority did not consult with security personnel to determine if an alternate response location should be established for personnel in the emergency response organization. This was considered significant in that the effectiveness of the emergency response organization could have been significantly compromised during an actual security threat event (Section P1.1). Personnel Performance Deficiency
52	12/22/1997	Weakness	IR 97022	NRC	Plant Support	5A	Licensee drill observers did not critically assess performance during the off hours exercise in that several problems were either not recognized or were inappropriately classified as positive attributes by evaluators (Section P1.1). Personnel Performance Deficiency
53	10/6/1997	Weakness	IR 97019	NRC	Plant Support	5C 5A	Several weaknesses with the implementation of the corrective action program were noted including: the completion of root cause analyses which did not determine why previous corrective actions were ineffective, poor integration of quality assurance (QA) findings, a lack of QA involvement during the closure of condition reports initiated by QA inspectors, and poor trending of deficient conditions. (Section R8.1) Inadequate Oversight

GENERAL DESCRIPTION OF PIM TABLE LABELS

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TYPE	The categorization of the issue - see the TYPE ITEM CODE table.
SOURCE	The document that contains the issue information: IR for NRC Inspection Report or LER for Licensee Event Report.
ID BY	Identification of who discovered the issue - see table.
SALP	SALP Functional Area Codes - Engineering, Maintenance, Operations, Plant Support and All/Multiple (i.e., more than one SALP area affected).
SMM CODES	Senior Manager Meeting Codes - see table.
DESCRIPTION	Details of the issue from the LER text or from the IR Executive Summaries.

TYPE ITEM CODE

DEV	Deviation from NRC Requirements
ED	Escalated Discretion - No Civil Penalty
EEI*	Escalated Enforcement Issue - Waiting Final NRC Action
LER	License Event Report to the NRC
Licensing	Licensing Issue from NRR
Misc	Miscellaneous (Emergency Preparedness Finding, etc.)
NCV	Non-Cited Violation
Negative	Individual Poor Licensee Performance
Positive	Individual Good Licensee Performance
Strength	Overall Strong Licensee Performance
URI**	Unresolved Inspection Item
VIO/SL-I	Notice of Violation - Severity Level I
VIO/SL-II	Notice of Violation - Severity Level II
VIO/SL-III	Notice of Violation - Severity Level III
VIO/SL-IV	Notice of Violation - Severity Level IV
Weakness	Overall Weak Licensee Performance

ID BY

Licensee	The licensed utility
NRC	The Nuclear Regulatory Commission
Self-Revealed	Identification by an event (e.g., equipment breakdown)
Other	Identification unknown

NOTES

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

SENIOR MANAGEMENT MEETING CODES

1	Operational Performance: A - Normal B - During Transients C - Programs and Processes
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4	Engineering/Design: A - Design B - Engineering Support C - Programs and Processes
5	Problem Identification and Resolution: A - Identification B - Analysis C - Resolution

PLANT ISSUES MATRIX
Clinton

Search Sorted by Date (Descending) and SMM Codes (Ascending): Search Column = "SALP" ; SALP Area = "All/Multiple" ; Beginning Date = "10/1/1997" ; Ending Date = "8/18/1998"

#	DATE	TYPE	SOURCE	ID BY	SALP	SMM CODES			DESCRIPTION
1	1/5/1998	Weakness	97SET	NRC	All/Multiple	1C	3B	4C	Management did not ensure that the infrastructure was suitable to support major changes. The SET concluded that management did not recognize that the infrastructure at CPS was insufficient to support major changes. As a result, management made organizational, programmatic, and resource decisions in the context of reengineering without appropriately considering the longer term and integrated effects of the decisions. Management did not ensure that there were appropriately qualified staff, integrated programs and processes, and appropriate resources to support implementation of the reengineering and downsizing effort.
2	1/5/1998	Weakness	97SET	NRC	All/Multiple	2B	1A	3C	CPS programs, processes, and procedures did not consistently provide defense in depth to assure plant activities were conducted in a safe manner. The SET concluded that programs, processes, and procedures failed to integrate activities across departments, incorporate industry information, and clearly delineate ownership and accountability. Program implementation was not effective in ,attaining the intended objectives. Processes and procedures were overly cumbersome and by failing to provide appropriate guidance unnecessarily challenged workers performing an activity. Programs and processes did not provide effective monitoring and feedback.
3	1/5/1998	Weakness	97SET	NRC	All/Multiple	5A	3A	3C	Management generally did not establish and implement effective performance standards. The SET concluded that the failure of IP and CPS management to establish and implement effective performance standards was a root cause of the significant decline in safety performance. Management failed to establish and communicate appropriate, clearly defined expectations and priorities, and failed to monitor their implementation for the desired performance. Management decisions that were inconsistent with stated expectations contributed to declining performance. In addition, management did not give the staff sufficient feedback and failed to establish accountability.
4	10/11/1997	EEI	IR 97020/EA 97-467	NRC	All/Multiple	1A			One apparent violation was identified for the failure to implement corrective actions for multiple failures of safety related components. Maintenance, operations, and management did not recognize the significance of multiple safety-related component failures. The failure to take prompt and effective corrective actions demonstrated a lack of ownership in the facility, a poor questioning attitude, and a willingness to accept substandard workmanship. Conservative Decision

PLANT ISSUES MATRIX
Clinton

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5	10/11/1997	Weakness	IR 97020	NRC	All/Multiple	5C	Management demonstrated poor oversight of the corrective action program in that the initiation of efforts to determine the causes for inadequate control of consumable materials were delayed until August 1997, even though deficiencies were noted in February and June 1997. Inadequate Oversight
6	10/6/1997	Positive	IR 97019	Licensee	All/Multiple	3C	The plant manager declared a site wide stand down on September 11, 1997, due to an increase in personnel errors. Involved Management

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INSPECTION / ACTIVITY PLAN

IP - Inspection Procedure
TI - Temporary Instruction
Core - Minimum NRC Inspection Program (mandatory all plants)
Regional Initiative - Discretionary Inspections

INSPECTION / ACTIVITY	TITLE / PROGRAM AREA	NUMBER OF NRC INSPECTORS/ INDIVIDUALS	PLANNED DATES	TYPE OF INSPECTION/ ACTIVITY- COMMENTS
IP93802	Operational Readiness	5	March 29 - Apr 3, 1999	Regional Initiative①
IP81700	Security (SEC2)	1	March 1 - 5, 1999	Core
IP82301 IP82302	Special Emergency Preparedness Exercise	4	March 9 - 12, 1999	Regional Initiative②
84750	Radiation Protection / Chemistry	1	June 28 - July 2, 1999	Core
IP73753	Inservice Inspection	1	June/July 1999	Core
IP82701	Emergency Preparedness Program Maintenance	1	July 19 - 23, 1999	Regional Initiative①
IP81700	Security (SEC1)	1	July 19 - 23, 1999	Core
IP81110	Security OSRE	1	November 15 - 19, 1999	Special
IP71707	Control Room Oversight	7	During Restart	Regional Initiative
IP71001	Licensed Operator Requal	2	October 4 - 8, 1999	Core

Notes:
① Followup on previous concerns and determination of operational readiness for unit restart.
② Followup on previously identified concerns.