UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

August 17, 2011

Mr. Michael J. Pacilio
Senior Vice President, Exelon Generation Company, LLC
President and Chief Nuclear Officer (CNO), Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: ERRATA TO CLINTON POWER STATION, UNIT 1, NRC PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000461/2011008

Dear Mr. Pacilio:

On July 8, 2011, the U.S. Nuclear Regulatory Commission (NRC) issued Problem Identification and Resolution Inspection Report 05000461/2011008 (ML11189A129). In the Inspection Report, the alphanumeric identifier for the cross-cutting aspect for non-cited violation (NCV) 05000461/2011008-02 was incorrect. Please replace pages 2 and 11 of Inspection Report 05000461/2011008 with the enclosed corrected pages.

We apologize for any inconvenience to you and your staff.

Sincerely,

/RA/

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

Docket Nos. 50-461
License Nos. NPF-62

Enclosure: Errata to Inspection Report 05000461/2011008

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

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

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

Cornerstone: Initiating Events

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

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

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

Cross-Cutting Aspects

This finding has a cross-cutting aspect in the area of Human Performance, Resources because the licensee did not ensure complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components. (IMC 0310 H.2(c))

Enforcement

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

Contrary to the above requirements, on November 23, 2009, during resolution of AR 00988866, "RR B Motor Change out Spreader Beam NDE INSP Report Missing," the licensee approved a decision to recreate from recollection of memory the missing NDE report and, therefore, failed to maintain a sufficient quality record providing evidence of the NDE. Failure to maintain a sufficient record that provides evidence of the NDE affecting quality of the safety-related spreader beam was a violation of 10 CFR 50, Appendix B, Criterion XVII. Because this violation was of very low safety significance and was entered into the CAP, this violation is being treated as an NCV consistent with Section VI.A.1 of the NRC Enforcement Policy.
(NCV 05000461/2011008-02 Failure to Maintain Quality Record as Evidence of Activity Affecting Quality of Safety-Related Equipment). The licensee entered this issue into the CAP as AR 1223723.

(1) Effectiveness of Corrective Actions

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

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Letter to M. Pacilio from M. Ring dated August 17, 2011

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