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February 27, 1997

EA No. 96-412
EA No. 97-060
EA No. 97-061

Mr. Wilfred Connell, Vice President
Clinton Power Station
Illinois Power Company
Mail Code V-275
P. O. Box 678
Clinton, IL 61727

SUBJECT: NRC RADIATION PROTECTION AND CHEMISTRY INSPECTION REPORT NO. 50-461/96012(DRS)

Dear Mr. Connell:

On January 23, 1997, the NRC completed a radiation protection (RP) inspection at the Clinton facility. The enclosure to this letter presents the results of this inspection.

This inspection reviewed the circumstances surrounding several recent radiologically significant events which have occurred at the Clinton facility. It was determined that deficiencies similar to those identified during our review of the September 5, 1996, recirculation system pump seal failure event exist in your RP program. These deficiencies include procedural adherence and adequacy problems, and a lack of conservative decision-making. In addition, recent actions taken by your staff indicate that a general lack of sensitivity towards RP controls and alarms exists throughout all organizations at Clinton. These actions include, but are not limited to, workers not adhering to procedural requirements when encountering alarms at the gatehouse personal contamination monitor (PCM), a worker exiting a posted contamination area in full protective clothing to use a phone, worker(s) sleeping and smoking within the radiologically controlled area (RCA), two instances in which an individual (or individuals) secured the supply gas to a PCM, and subsequent to this inspection, the possible deliberate contamination of a worker. This lack of sensitivity has become so instilled in the work force that in the presence of an NRC inspector, a number of personnel attempted to circumvent PCM alarms at the RCA access point when exiting the plant at lunchtime.

The specific events we reviewed included the entry of three workers into the upper levels of the drywell while administrative controls prohibiting their entry were in effect, the significant spread of contamination resulting from workers disconnecting a sluicing hose from a pump outside of procedural controls and other less significant problems which involved the inadequate evaluation of the radiological hazards which could be present. As will be discussed below, each of these events have elements in them which are cause for concern. Of greatest concern though, is that these events occurred over a short period of time when relatively little work was occurring at the station.

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Specific to the drywell entry, a radiation safety work plan had been developed to ensure administrative controls were in place to prevent personnel entry into the upper drywell levels during fuel movements. Potentially fatal doses to workers can occur in the upper drywell levels should a mishap occur during fuel handling. Therefore, these administrative controls are among the most important radiological controls at the station and, as such, must be thoroughly understood and followed by all workers who are involved with work in this area. In this case, a change to these administrative controls had been made earlier in the day of the event but neither the drywell control point RP technician nor the shift outage manager were aware of the new requirements. Although verbal controls were in place preventing fuel movement while the workers were in the upper drywell. It was possible that fuel movement could have resumed prior to workers exiting the area. For the reasons noted above, the failure to follow the administrative controls preventing entry into the upper drywell levels is considered a significant problem.

During the waste sludge sluicing event, the failure to (1) consider previous occasions of hose blockage during pre-job planning, (2) to contact RP supervision prior to removing the hoses and (3) to revise the procedure to reflect the actual work conditions, resulted in the contamination of three workers. These, and other problems identified with this event, indicated weaknesses similar to those identified in the aforementioned, recirculation pump seal event.

During the outage, workers were aware of dose increases due to additional work scope, rework, and poor radiological work practices; however, these problems were not raised to plant supervision. Our inspection determined that this was due, in part, to worker acceptance that these problems were typical for an outage and that the problems would be addressed in the post outage critique. This perception led to the development of an inaccurate view of station radiological performance by your RP group and the inability to identify emerging problem trends prior to the manifestation of more significant problems. For example, multiple entries into the drywell to remove recently installed bioshield insulation were documented in the drywell logbook, but were not communicated to plant management until the problem was raised by the NRC during the inspection. Similar events associated with bioshield activities resulting in unnecessary dose were identified during this inspection.

We recognize that the events described above and in the enclosed report were documented in your Condition Reporting system and that critiques were held shortly after the events in an attempt to identify the circumstances surrounding them. Also, a number of immediate corrective actions were developed to prevent their recurrence. However, procedural adherence and conservative decision-making problems persist at the station. In addition, your staffs' actions described above show a continuing failure to recognize the importance of adhering to procedural and NRC requirements.

Based on the results from the inspection, several apparent violations of NRC requirements were identified and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600. Accordingly, no Notice of Violation is presently being issued for these inspection findings. In addition, the number and characterization of apparent violations described in the enclosed inspection report may change as a result of further NRC review.

An open pre-decisional enforcement conference to discuss these apparent violations has been scheduled for March 20, 1997 at 12:30 p.m. (CDT) in the Region III office in Lisle, Illinois. The decision to hold a pre-decisional enforcement conference does not mean that the NRC has determined that a violation has occurred or that enforcement action will be taken. The conference will be held to obtain information to enable the NRC to make an enforcement decision, including a common understanding of the facts and circumstances surrounding the violations, their root causes, your opportunities to identify the apparent violations sooner, your corrective actions, and the significance of the issues.

In addition, this is an opportunity for you to point out any errors in our inspection report and for you to provide any information concerning your perspectives on (1) the severity of the violations; (2) the application of the factors that the NRC considers when it determines the amount of a civil penalty that may be assessed in accordance with Section VI.B.2 of the Enforcement Policy; and 3) any other application of the Enforcement Policy to this case, including the exercise of discretion in accordance with Section VII.

You will be advised by separate correspondence of the results of our deliberations on this manner. No response regarding these apparent violations is required at this time.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and the enclosure will be placed in the NRC Public Document Room.

Sincerely,

Original Signed by James L. Caldwell

James L. Caldwell, Director
Division of Reactor Projects

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

Enclosure: Inspection Report No.
50-461/96012(DRS)

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