

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I  
LIMERICK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/20/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 5C <b>Ter:</b>	<b>Operations Procedure Quality</b> Plant management was responsive to an NRC inspector concern regarding deficiencies in the procedural guidance for a recirculation pump runback event.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
12/20/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Operations Procedure Quality</b> The operations staff responded well to a loss of a condensate pump and associated recirculation pump runback.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
12/20/1999	1999009-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Unit 1 RCIC system PCIV being inoperable for a period that exceeded the TS allowed outage time.</b> A primary containment isolation valve (PCIV) was made inoperable for a period that exceeded the Technical Specification allowed outage time on two separate occasions. Operators did not adequately review tagging clearances, which inadvertently defeated the automatic isolation capability of the PCIV. This Severity IV violation is being treated as a NCV consistent with Section VII.B.1.a of the enforcement policy. This violation is in the PECO corrective action program as PEP I0010301.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> 1A <b>Ter:</b>	<b>Operator Use of Procedures</b> The Operations staff generally implemented operating procedures well. Nonetheless, some procedure implementation and adherence issues occurred and were being addressed by plant management.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
10/28/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Unusual Event Declared at Limerick</b> PECO's staff appropriately classified and responded to the Unusual Event due to a bomb threat within the site boundary.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Licensed Operator Requalification Training Program Evaluation</b> The LORT program met regulatory requirements and effectively trained and evaluated licensed operators.
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09/27/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Tropical Storm Floyd</b> PECO's staff responded appropriately to the emergent challenges during Tropical Storm Floyd.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
09/27/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Unusual Event Declared at Limerick</b> On September 23, 1999, PECO's staff appropriately classified and responded to the Unusual Event due to the presence of toxic gases within the site boundary.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
09/27/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Main Control Room Deficiencies</b> Main control room equipment deficiencies were conservatively identified. There were no operability issues or conditions that would hinder the operator's ability to manage the plant during a transient.
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08/16/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Operator Challenges</b> The operations staff responded well to several challenges caused by extended high environmental temperatures and to an inadvertent single control rod automatically inserting into the core.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Miscellaneous Operations Issues</b> The inspectors determined that PECO identified that maintenance activities on the backup nitrogen supply to the automatic depressurization system rendered the ADS system inoperable because an on-shift operating crew had a good questioning attitude and engineering performed a thorough investigation
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 1A <b>Ter:</b>	<b>ADS Inoperable During Planned Maintenance</b> LER 1-99-004 reported two occurrences when the automatic depressurization system (ADS) was inoperable longer than the ADS technical specification allowed outage time during maintenance activities which isolated the backup nitrogen supply. This Severity IV violation is being treated as a Non-Cited Violation (NCV 50-352, 353/99-05-01), consistent with Appendix C of the NRC Enforcement Policy. This violation is in PECO's corrective action program as PEP I0009911.
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06/11/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 5C <b>Ter:</b> 1B	<b>Reactor Water Level Instrumentation- Momentary Level Spike - Unit 1</b> Prior to the Unit 1 automatic scram on June 11, 1999, PECO had not included a long standing instrumentation issue (momentary reactor water level spike indication following a turbine trip from high power) in PECO's program for operator work-arounds. PECO's corrective actions for this issue were adequate.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
06/11/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	Self	NEG	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b>	<b>Unplanned Reactor Shutdown - Unit 1</b> Operators responded appropriately to the June 11, 1999, automatic scram on Unit 1. The scram was caused by a personnel error during performance of a procedure for a routine turbine overspeed test. Two other personnel errors involving procedure use were noted during the event recovery and subsequent startup which resulted in missed technical specification surveillance activities.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
06/11/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Post-Scram Procedure (GP-18) Review - Unit 1</b> Although PECO's post-scram review of the June 11, 1999, automatic scram on Unit 1 was adequate, the review missed several documentation deficiencies regarding event details and unified control room log entries.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
06/14/1999	1999004-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3C <b>Sec:</b> 3B <b>Ter:</b>	<b>Late Performance of a Technical Specification required off-gas grab sample</b> LER 1-99-006 reported the late performance of an off-gas grab sample when the off-gas hydrogen analyzers were inoperable and the steam jet air ejectors and off-gas systems were in-service. The event occurred when an individual inappropriately signed-off an integrated startup procedure step indicating the hydrogen analyzers were in-service. This incorrect procedure notation led to the late performance of an off-gas grab sample and consequently the failure to comply with TS 3.3.7.12 and TS 3.11.2.5. This Severity IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the PECO's corrective action program as PEP I0009941.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
07/23/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Miscellaneous Operations Issues</b> An exam security problem was identified by PECO involving exam material previously copied by a PECO exam team member and later discovered in the same copy machine by another PECO exam team member.  The examiner determined based on the timeline developed by PECO, through interviews with those involved, and re-enactment of the event, that the event was minor and the exam was not compromised. Additionally, investigation of the event and subsequent corrective actions taken by the licensee were found to be acceptable. PECO PEP #I0009971 describes the problem and the corrective actions.
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07/23/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Operating Test Administration and Performance</b>  A performance deficiency was identified during the performance of a JPM when an applicant, while operating the refueling bridge under the direction of a fuel handling director (FHD), allowed the mast to make contact with the south fuel prep machine handrail. The mast was in the normal up position with no fuel grappled. Although the contact was minor and no damage resulted, the event indicated a lack of oversight on the part of the FHD and inattentiveness on the part of the applicant.  The licensee immediately addressed the issue and subsequently issued PEP #I0009971. Corrective actions were incomplete at the time of this report.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
07/23/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Examination Preparation and Quality</b>  The submitted written exam required revision on five of 65 questions due to either the question lacking stem focus or being unrelated to the required subject area. No revision was required on the operating exams. Facility personnel subsequently incorporated changes in the final exams.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
07/23/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Examination Preparation and Quality</b>  The facility used an examination preparation team of experienced instructors who assisted the NRC examiners in an excellent manner.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Unit 2 Refueling Outage</b>  Control room and refueling platform operators conducted shutdown and refueling activities well. Operators made effective use of procedures and peer-checking during the outage. PECO management's oversight of the outage provided effective support for station and contractor personnel and ensured that the outage was conducted safely.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 5B <b>Ter:</b>	<b>Automatic Shutdown From Full Power - Unit 1</b>  The control room staff's response to the complete loss of feedwater event and automatic reactor shutdown from full power was excellent. The operators successfully dealt with the several equipment failures that challenged them following the automatic reactor shutdown. PECO's review and interim corrective actions were adequate to support safe restart of Unit 1.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
04/12/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Removal of risk significant systems from service</b>  The operations staff did not perform a recommended risk assessment prior to removal of a train of the RERS from service to perform non-critical maintenance. As a result, the combined effect of the RERS train unavailability and a concurrent standby gas treatment problem was not evaluated for risk increase. In addition, the removal of RERS approximately 12 hours prior to the start of maintenance work resulted in unnecessary system unavailability.
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04/12/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Equipment operator identifies defective relay (gray-boot).</b> During a plant tour an equipment operator identified that a portion of the isolation logic for the shutdown cooling mode of the residual heat removal system was de-energized. PECO determined the event was caused by an open circuit at a Grayboot connector as a result of over crimping. PECO performed a thorough analysis including destructive examination of other Grayboot connectors to conclude that a generic issue involving the connectors did not exist.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Operations</b> Overall, the as-submitted examination material was acceptable with some exceptions. Five of 125 written exam questions required revision due to either being too easy or not evaluating at the appropriate level. Additionally, the operating test contained one JPM out of 20 which was also too easy and required replacement. Facility personnel subsequently incorporated changes in the final exams. Post-exam facility comments reflected needed technical corrections for five of the written exam questions, and also indicated a lack of thorough review on those questions by the facility during the examination preparation phase.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3B <b>Sec:</b> 1C <b>Ter:</b>	<b>Operations</b> Positive observations were noted on the simulator test in the area of communications and teamwork. However, three of nine applicants exhibited unsatisfactory individual knowledge of the reactor automatic depressurization system indicating a potential problem in the initial operator program.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Operations</b> The facility used an examination preparation team of experienced instructors who assisted the NRC examiners in an exceptional manner.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b>	<b>Reactor Man. Control Sys. Safety Eval. Review</b> PORC performed a thorough and probing review of the safety evaluation addressing a plant condition that potentially rendered all hydraulic control unit accumulators inoperable. The PORC resolved to submit a Technical Specification change request to clarify the TS requirements.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 1A <b>Ter:</b>	<b>Steam Jet Air Ejector Radiation Monitor Inoperable-Unit 1</b> The shift manager demonstrated an excellent questioning attitude during his review of the results of troubleshooting activities for a faulty steam jet air ejector radiation monitor. Operators declared the instrument inoperable which led to further engineer review that resulted in fully diagnosing the radiation monitor problem and appropriate repairs.
<b>Dockets Discussed:</b> 05000352 Limerick 1						

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03/01/1999	1999001-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b>	<b>Two RCIC PCIVs simultaneously inoperable from different causes - Unit 2</b>  Operations personnel left the RCIC steam line warmup bypass valve partially open in November 1998, causing the valve to be inoperable. The redundant containment isolation valve was also open and inoperable at the same time for short durations due to planned maintenance. This Severity IV violation, of TS 3.6.3, is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PEP I0009263. PECO's corrective actions adequately addressed this issue.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
01/25/2000	2-99-006-0	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Generator Lockout and SCRAM due to Failure of B Phase Main Transformer Surge Arrester</b>  On December 31, 1999 at 01:11 hours, Unit 2 reactor scrambled from 100% power on a main generator lockout/turbine trip when the generator protective relays detected a B-phase to ground fault. The fault was initiated when the 500kV surge arrester located next to the B-phase generator main step-up transformer failed. The fault was isolated from the system through the automatic operation of the 235 and 335 circuit breaker. Following the scram, it was discovered that one of the two external grading capacitors located on the B-phase pole of the 355 circuit breaker had also failed. No emergency core cooling systems (ECCS) were actuated. The cause of the failure of the surge arrester and capacitor are still under investigation. The surge arresters on all three (3) phases were replaced. The unit was returned to service on January 2, 2000.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
12/20/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b> 5A	<b>Unit 2 - Outboard MSIV Solenoid Failure</b>  PECO's engineering, maintenance, and operations staffs demonstrated careful planning and execution of work to replace, at power, a failed solenoid valve for a Unit 2 outboard MSIV.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NEG	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>Surveillance Testing Events</b>  Two inadvertent starts of emergency core cooling system pumps were caused by procedure deficiencies.
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08/16/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b> 3C	<b>General Comments on Maintenance Activities</b>  The quality of maintenance activities observed was appropriate. Maintenance technicians conducted thorough pre-job briefings and coordinated activities with operators prior to beginning work. Maintenance staff was appropriately trained and knowledgeable of assigned tasks. Procedures and work orders were used appropriately and supervisory oversight of field activities was noted.
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06/23/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 4B <b>Sec:</b> 3A <b>Ter:</b>	<b>High Pressure Coolant Injection Failure to Start</b> The Unit 1 high pressure coolant injection (HPCI) failure to start on June 23, 1999 was a maintenance preventable functional failure. PECO missed the opportunity to prevent the HPCI failure by not adequately reviewing prior industry experience, which recommended replacement of a component in the turbine's governor electro-hydraulic regulator following water intrusion into the HPCI oil system. Water intrusion had occurred during the extended HPCI operation on April 20, 1999. Additionally, a personnel error during the corrective maintenance extended the HPCI system outage time.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
07/12/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Review of Nuclear Maintenance Division Performance</b> The Nuclear Maintenance Department (NMD) management had recognized that performance had degraded in 1998 in the execution of refueling activities at Limerick and Peach Bottom. NMD management evaluated the performance deficiencies in aggregate and implemented appropriate corrective actions. The associated actions implemented prior to the recent Limerick refueling outage resulted in improved performance.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/10/1999	2-99-005-0	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>PCIV Isolation, ESF Actuation due to a failed fuse (cold solder joint failure)</b> Reports an actuation of the Unit 2 Primary Containment and Reactor Vessel Isolation Control System, an Engineered Safety Feature. A fuse failure resulted in the isolation of three primary containment isolation valves. The fuse failed due to a mechanical failure of a cold solder joint.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Oversight of Vendor NDE Activities</b> The non destructive examination vendor oversight plan was comprehensive and effective.
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05/24/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b> 3C	<b>Inservice Inspection (ISI) Program Review</b> The Limerick Generating Station Unit 2 inservice inspection program for the first 10 year interval was conducted as per the requirements of Sections V and XI of the American Society of Mechanical Engineers Boiler and Pressure Vessel Code. Acceptable procedures and calibrated equipment were used by qualified and certified personnel to conduct the various types of examinations. Inspection results were comprehensively documented.
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05/24/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b> 1C	<b>Core Shroud Ultrasonic Examination - Unit 2</b> The baseline ultrasonic testing (UT) inspection of the core shroud was performed in accordance with a core shroud inspection plan submitted in response to Generic Letter (GL) 94-03. The UT examination of the core shroud circumferential welds found several indications in circumferential welds. Analyses of the effect of indications indicated that operation until the next refueling outage (2R06) was acceptable.
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05/19/1999	1-99-003-0	<b>Pri:</b> MAINT <b>Sec:</b>	Self	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>RPC and PCRVICES actuations due to loss of feedwater flow transient caused by spuriously opening breaker.</b>  On April 20, 1999 at 1830 hours, LGS Unit 1 was operating at 100% power when a loss of feedwater was experienced. The Main Control Room received a condensate filter trouble, a reactor low level, and loss of feedwater alarms. All three reactor feed pumps tripped on low suction pressure causing a reactor scram when level decreased to +12.5 inches. The reactor protection system (RPS) actuation is reportable pursuant to 10CRF50.73(a)(2)(iv).  The low reactor water RPS actuation occurred due to a spurious tripping of a breaker that supplies position indication to the inlet valves of the deep bed condensate demineralizer system (DBCDS). Loss of inlet position indication to the DBCDS programmable logic controller created a signal for the deep bed outlet valves to close. The resultant rapid increase in differential pressure at the DBCDS bypass valves prevented their ability to be opened and maintain flow to the RFP and the reactor. This event is bounded by the previously analyzed loss of feedwater transient as described in the LGS updated final safety analysis report (UFSAR). The plant responded as designed to a loss of feedwater flow. The DBCDS breaker that spuriously tripped was replaced and the DBCDS breakers for the outlet valves were procedurally opened to prevent closure.  This event resulted in high pressure core injection, and reactor core isolation cooling injections into the reactor coolant system. Special report information required pursuant to TS 6.9.2. and TS limiting conditions for operation Action statements 3.5.1.f. and 3.7.3.b. is included in this report.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/18/1999	2-99-002-0	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	LER	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>Various ESF Actuations Due to Loss of Power to 2A RPS/UPS Distribution Panel Caused by a Loose Bus Con</b>  This LER reports automatic actuations of the Unit 2 Primary Containment and Reactor Vessel Isolation Control System and other Unit 2 and Common Plant Engineered Safety Features due to a loss of power to the Unit 2 "A" Reactor Protection System (RPS)/Uninterruptible Power Supply (UPS) power distribution panel. The loss of power was caused by a loose bus-bar connection on one the breakers providing power to the panel.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
04/12/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Plant housekeeping</b>  The inspector observed that the housekeeping and general area material condition had degraded, particularly in the vicinity of fire barrier upgrades. Corrective actions to resolve the deficiencies were appropriate.
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04/12/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Safeguards 1B1 battery replacement -Unit 1</b>  The 1B1D101 125vdc battery replacement activity was well planned and executed. Maintenance technicians were highly knowledgeable of all aspects of the battery activities.
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04/12/1999	1999002-01	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform a TS surveillance required locked-valve inspection.</b>  LER 1-99-002 reported a failure to perform a required Technical Specification locked-valve inspection. The required component had been inadvertently deleted from the surveillance procedure during a revision due to personnel error and an inadequate review. This Severity Level IV violation of Technical Specifications is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in PECO's corrective action program as PEP I0009525.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
03/01/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Troubleshooting &amp; repair of drywell chilled water valve HV-087-120B - Unit 1</b>  PECO's actions to perform an internal valve inspection to confirm operability of HV-087-120B, a primary containment isolation valve, demonstrated conservative decision making and a focus on early identification and resolution of equipment problems.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
12/10/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Bypass of the Reactor Water Cleanup (RWCU) Leak Detection System Isolation Logic</b>  Although, PECO's identification, overall investigation, and final corrective actions for the inappropriate use of jumpers to bypass the RWCU leak detection system logic were appropriate, PECO did not initially recognize the significance of this issue. Subsequent PECO analysis and corrective actions were appropriate.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
12/10/1999	1999008-01	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Failure to perform a safety analysis for a procedure revision that led to implementation of an activity involvin</b>  The failure to have a record of a written safety evaluation for a procedure revision involving an unreviewed safety question, which ultimately led to the inappropriate bypass of RWCU isolation logic on three occasions, was a violation of 10 CFR 50.59 requirements. This failure was determined to be severity level IV violation based on low risk and is being treated as a Non-Cited Violation consistent with Section VII.B.1 of the enforcement policy.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
12/10/1999	1999008-02	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Failure to restore the RWCU isolation logic within the allowed outage time when the RWCU isolation logic w</b>  The failure to restore the RWCU isolation logic within the allowed outage time when the RWCU isolation logic was required to be operable, was a violation of Technical Specification 3.3.2. This was a severity level IV violation based on low risk and is being treated as a Non-Cited Violation consistent with Section VII.B.1 of the enforcement policy.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
11/24/1999	1-99-014-0	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	LER	<b>Pri:</b> 3B <b>Sec:</b> 4B <b>Ter:</b>	<b>Fuel shipping cask lifted from rail care without refueling area secondary containment integrity established</b>
<b>Dockets Discussed:</b> 05000352 Limerick 1						

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09/27/1999	1999007-01	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Unavailability of safe shutdown equipment in the event of a fire</b>  LER 2-99-01 identified the unavailability of safe shutdown equipment in the event of a fire due to inadequate circuit breaker coordination. This condition was outside the design basis of the plant and a violation of the Operating License Condition 2.C.3. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV 50-352/99-07-01), consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as PEP I0009383.
<b>Dockets Discussed:</b> 05000352 Limerick 1						
07/12/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Equipment Malfunctions During Unit 1 Loss of Feedwater and Scram on 4/20/99</b>  The PECO evaluations of the causes for the equipment that malfunctions during the April 20, 1999 reactor scram were adequate. The equipment malfunctions were unrelated to each other.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
07/23/1999	2-99-004-0	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>13 Main Steam Relief Valves Failed to Meet 1% Setpoint Tolerance Due to Setpoint Drift</b>  Pressure setpoint drift of 13 Main Steam System Safety Relief Valves primarily caused by corrosion induced bonding within the SRVs. This resulted in a condition where a common cause resulted in more than two independent training becoming inoperable in a single safety system.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b> 4B	<b>Quality Assurance Inspection of Vendor Installed Darmatt KM1 Fire Barrier System</b>  The quality assurance inspectors were very knowledgeable about the Darmatt KM1 fire barrier system installation and inspection requirements. The quality assurance inspectors provided good quality assurance oversight of the vendor installed product.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b>	<b>Engineering Oversight of Vendor Supplied Cable Ampacity Derating Calculations</b>  PECO provided good oversight of engineering calculations performed by contractors. Safe shutdown cable ampacity calculations were well organized, and the methodology was consistent with established industry practices.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 3A <b>Ter:</b>	<b>Engineering Review and Closeout of Contractor Designed and Installed Darmatt KM1 Systems</b>  The Darmatt KM1 design, installation and engineering dispositions were thorough and complete and PECO provided good oversight of the vendors' activities.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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05/24/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 3A <b>Ter:</b>	<b>Engineering Oversight of Miscellaneous Contractor Design and Installed Datmatt KM1 Systems</b> PECO provided appropriate oversight of the vendors' activities involving, control room recorder replacements, reactor protection system instrument relocation during the main turbine retrofit and main steam relief valve replacement.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Engineering Oversight of Contractor Designed and Installed Sprinkler Modifications</b> PECO provided good oversight of contractor activities involving sprinkler modifications. The reviewed sprinkler modifications were well organized and the methodology was consistent with established industry practices. The calculations were appropriate to reflect the as-built system condition.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
04/12/1999	1999002-02	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Fire safe shutdown deficiencies</b> Overall PECO's identification of fire areas that contained unprotected emergency diesel generator control cables and the permanent resolution were very good. However, interim corrective actions and risk assessments were deficient as a result of the operability determination not addressing the appropriate safety function. The unprotected emergency diesel generator control cables represented a failure to maintain the provisions of the Facility Operating License. This failure is a Severity Level IV violation which is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy. This violation is in PECO's corrective action program enhancement process (PEP) evaluation I0008924.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 4B <b>Ter:</b>	<b>PCIV Operator Issue</b> The initial PECO evaluation of the mis-operation of the 2B core spray full flow test valve was narrowly focused. PECO evaluated the torque switch that failed, but did not initially consider other potential issues when a valve is operated in a manner to indicate closed, but is not fully closed. PECO engineers did not assess the effect on containment isolation or potential generic implications to other susceptible valves. Also, PECO did not identify that actions taken to address a similar event in 1993, were ineffective in that they relied on operator practices, which were not translated into procedures and had eroded over time. Appropriate analyses and corrective actions were implemented subsequent to discussion with the inspectors.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
09/01/1999	1-99-009-0	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	SGI	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Maintenance performed on an uncompensated safeguard system.</b> This Safeguard Event Report provides the 30-day written follow-up report regarding performance of maintenance that affected a safeguard system for which compensatory measures had not been employed.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Review of Holding Pond Water Release to the Local Waste Water Treatment Plant</b>  There was no impact to the public health and safety or to the environment due to a transfer, on September 18, 1999, of 6,500 gallons of holding pond water to the Pottstown Waste Water Treatment Plant prior to being sampled by PECO.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>External Exposure</b>  PECO has effectively controlled external dose to the station staff. Some contributing factors include low plant dose rates and short refueling outages. Plant radiological postings and high radiation area controls have been implemented effectively. Lowering of electronic dosimeter alarm thresholds has enhanced the ability to control individual exposures.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Internal Exposure</b>  Internal exposures for 1998 and 1999 have been minimal with all internal exposures well below reporting requirements. Emergency control room and fire brigade response Self-Contained Breathing Apparatus (SCBA) equipment was found in good working condition and control room operators were qualified in their use.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Implementation of the Radioactive Liquid and Gaseous Effluent Control Programs</b>  PECO maintained adequate radioactive liquid and gaseous effluent control programs. The Offsite Dose Calculation Manual (ODCM) contained sufficient specification and instruction to acceptably implement and maintain the radioactive liquid and gaseous effluent control programs.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Calibration of Effluent/Process/Area/Accident Radiation Monitoring Systems, Flow Rate Measurement Devices</b>  PECO maintained and implemented an adequate Radiation Monitoring System (RMS) calibration program. It was noted that PECO had improved the calibration methodology for the radioactive liquid effluent radiation monitors.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Air Cleaning Systems</b>  PECO maintained and implemented an effective routine surveillance test program for effluent air cleaning systems.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Quality Division RP Program Audit Reports</b>  The quality assurance (QA) oversight of the Radiation Protection (RP) program was effective. RP self-assessments were comprehensive in scope and provided an overall view of RP program strengths and weaknesses. The corrective action program provided for effective identification and resolution of RP issues.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
11/08/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Quality Assurance and Quality Control</b>  PECO's QA Surveillance Audit program for effluent control was effectively implemented. PECO's Quality Control (QC) program for radioactive liquid and gaseous effluent control to validate analytical results was effective.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
12/10/1999	1999008-04	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Failure to capture and store the monitored data from the south and north stacks RMS</b>  The failure of the RM-21 computer system to capture and to store the noble gas monitored data from the south and north stack radiation monitoring systems was a violation of Section 6.10.3.(d) of the Plant Technical Specifications. Section 6.10.3.(d) of the Technical Specification states "records of gaseous and liquid radioactive material released to the environs will be retained for the duration of the unit operating license." PECO promptly initiated corrective actions and there was no significant public dose or environmental impact. This violation was being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the enforcement policy. This is PEP 10010341 in PECO's corrective action system.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
09/27/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Communication problem between the emergency facilities.</b>  There was a communication problem between the emergency facilities when the Emergency Preparedness Display System (EPDS) displayed an erroneous reactor vessel water level. This lead some ERO staff to miscalculate the time to core uncover by greater than 30 minutes. Although, there were some key ERO personnel that were aware of the correct water level and made decisions accordingly, the information was not properly communicated nor noticed by all ERO staff in both the Technical Support Center and Emergency Operations Facility which caused confusion when core uncover occurred sooner than expected. The licensee also identified this issue and was investigating the problem to preclude its recurrence and ensure that other problems do not exist with the EPDS.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
09/27/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>ERO demonstrated that onsite emergency plans were adequate and that the licensee was capable of implem</b>  The NRC team determined that the overall performance of the emergency response organization (ERO) demonstrated, with reasonable assurance, that onsite emergency plans were adequate and that the licensee was capable of implementing them. Simulated events were accurately diagnosed, emergency declarations were timely and accurate, offsite agencies were notified in a timely manner and protective action recommendations were appropriate.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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09/27/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Critique process was well implemented</b>  The critique process was well implemented. Post-exercise facility debriefs were candid. At the formal critique, the licensee staff identified numerous issues, in addition to those identified by the NRC. The most significant issues identified were prioritized for prompt corrective action. Overall, the critique was balanced with positive and negative findings and was appropriately self-critical.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>EP Organization and Administration</b>  Consolidation of the PECO corporate office, Limerick, and Peach Bottom emergency preparedness programs did not adversely affect the emergency preparedness program.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Quality Assurance (QA) in EP Activities</b>  The inspector noted significant improvements in the PECO audit process since the previous Limerick emergency preparedness inspection. The 1998 audit report of the PECO emergency preparedness program met the requirements specified in 10 CFR 50.54(t).
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Y2K Initiatives</b>  PECO has completed upgrading its emergency response equipment and is Year 2000 (Y2K) compliant.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2A <b>Ter:</b>	<b>Status of EP Equipment, Instrumentation and Supplies</b>  Equipment inventories, communication tests, and siren tests were performed in accordance with PECO's Emergency Response Plan. Improvements were made in the maintenance of offsite sirens, meeting the requirements of PECO's Emergency Response Plan and the guidelines of the implementing procedures.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
08/16/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Staff Training and Qualification in EP</b>  PECO conducted emergency response training and drills as required. The inspector concluded that training for the Emergency Response Organization was effectively implemented. Shift operators successfully demonstrated the ability to properly classify emergency events using the new emergency action level scheme that was recently approved by the NRC. All required medical, radiation monitoring and fire drills were conducted in accordance with the Emergency Response Plan.
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<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Security and Safeguards Staff Training and Qualification</b> Security force personnel were being trained in accordance with the requirements of the Training and Qualification Plan, training documentation was properly maintained and accurate, and the training provided by the training staff was effective.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Security Organization and Administration</b> The level of management support was adequate to ensure effective implementation of the security program, and was evidenced by adequate staffing levels and the allocation of resources to support programmatic needs.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Conduct of Security and Safeguards Activities</b> PECO was conducting security and safeguards activities in a manner that protected public health and safety in the areas of access authorization, alarm stations, communications, and protected area access control of personnel and packages. This portion of the program, as implemented, met the commitments and NRC requirements.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Security and Safeguards Procedures and Documentation</b> Security and safeguards procedures and documentation were being properly implemented. Event logs were being properly maintained and effectively used to analyze, track, and resolve safeguards events.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Quality Assurance in Security and Safeguard Activities</b> The review of PECO's Security and Safeguards audit program indicated that the audits were comprehensive in scope and depth, that findings were reported to the appropriate level of management, and that the program was being properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weakness.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 1C <b>Ter:</b>	<b>Unit 2 Refuel Outage Radiological Controls</b> Radiological controls for Limerick Unit 2 fifth refuel outage were effectively planned and implemented and focused on jobs with elevated exposure estimates.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Security and Safeguards Staff Knowledge and Performance</b> The security force members adequately demonstrated that they had the requisite knowledge necessary to effectively implement the duties and responsibilities associated with their position.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
05/24/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Quality Assurance in Radiological Protection and Chemistry Activities</b> Self assessments and corrective action programs were effectively used. PECO identified, evaluated, and resolved radiological control issues as evidenced by the conduct of multiple self-assessments and audits to satisfy the radiation protection program review requirements.
<b>Dockets Discussed:</b> 05000353 Limerick 2						
04/12/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Fire system impairment</b> PECO did not evaluate the use of rubber matting on scaffolds in the vicinity of a fire suppression system in a combustion free zone nor initiate a fire system impairment resulting in a degraded and uncompensated fire barrier. PECO promptly rectified the deficiency when informed by the inspector.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
04/12/1999	1999002-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Compromise of safeguards information.</b> LER 1-99-001 reported that less than adequate administrative controls caused safeguards information to be inappropriately saved to a computer's hard-drive. The safeguards information was left unprotected on the stand alone computer in the security office area. This Severity Level IV violation of security requirements is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in PECO's corrective action program as PEP I0009463.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

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LIMERICK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Implementation of the Radiological Environmental Monitoring Program</b>  The licensee's contractors effectively performed sample collection activities according to the procedures and sample schedule, conducted the land use census, and maintained and calibrated the automatic sampling equipment. The licensee provided program oversight and met the reporting requirements in the ODCM. The radiological environmental monitoring program was effectively implemented in accordance with regulatory requirements.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Implementation of Meteorological Monitoring Program</b>  Communication and inter-departmental coordination enhanced the licensee's overall performance. Instrument and Controls together with Health Phphysics Support calibrated and maintained the meteorological monitoring instrumentation, and improved instrument reliability. The self-assessment identified areas for improvement. The licensee appropriately addressed and corrected each issue. The meteorological monitoring program was effectively maintained and implemented in accordance with regulatory requirements.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>QA of Analytical Measurements</b>  The environmental and quality assurance laboratories conducted the QA/QC programs in accordance with the appropriate procedures. The licensee provided effective program oversight by monitoring the progress and quality of both the environmental and the quality assurance laboratories. The quality assurance program was effectively maintained and implemented in accordance with regulatory requirements.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Control of Fire Protection Activities</b>  Effective administrative controls had been established for the hot-work that was accomplished in the skimmer surge tank pit. Proper storage of combustibles were in place. Good control of hot-work activities were evident.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Facility Tour</b>  The fire protection equipment conditions and housekeeping of the plant were good. The licensee maintained effective control of combustible materials. Roving fire watch personnel were knowledgeable of station procedures for reporting fires, roving fire watch duties, and responding to fires. Eight hour emergency light operation was good. Observed fire protection systems were capable of providing protection against fire and were consistent with the defense-in-depth principle.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Walkdown of Safe Shutdown Methodologies</b>  The pathways for safe shutdown activities performed by operators were generally illuminated in an acceptable manner, staged equipment needed by the operators was accounted for and adequately surveilled. Safe shutdown procedures were adequate to support safe shutdown activities of the plants.
<b>Dockets Discussed:</b> 05000352 Limerick 1 05000353 Limerick 2						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

LIMERICK

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Fire Brigade Training</b> Fire brigade members were current on all required training and annual physical examinations and the training program met NRC requirements.
<b>Dockets Discussed:</b>						
05000352 Limerick 1						
05000353 Limerick 2						
03/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Audits and Surveillances</b> The fire protection quality assurance audit appropriately reviewed fire protection program attributes and compliance with program requirements. The fire protection audit findings were appropriately addressed and timely corrective actions had been taken for identified deficiencies.
<b>Dockets Discussed:</b>						
05000352 Limerick 1						
05000353 Limerick 2						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

## 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
OTHR	Other
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.