

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I  
SUSQUEHANNA

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b> The present industry operating experience program relies primarily on discussions during the initial screening of new industry experience reviews. However, once the event is determined to be applicable to PP&L, the issue is processed through the condition report system to provide a more detailed review and tracking of potential concerns.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> In general, significant facility self-assessment activities produced by Nuclear Assessment Services (NAS) are thorough, detailed, and critical. ISEG surveillances and investigations were also self critical and thorough. However, deficiencies documented in self-assessments in the past have not always resulted in action to correct the identified problems. SSES initiated a multi-focus Corrective Action Program (CAP) Improvement Plan to address the deficiencies identified by internal and external identified weaknesses in the present CAP.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The failure of most functional units to implement the requirements of the functional unit self-assessment program was identified, both by the NRC team and your Decision 2000 process, as a program deficiency and entered into the correction action program.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The plant operations review committee (PORC) and the Susquehanna review committee (SRC) demonstrated a critical, probing, and questioning attitude. Overall, implementation of the independent review organizations continue to challenge the effectiveness of the CAP. The management review team (MRT) was slow to respond to recent responsibility changes, however they effectively implemented most of the required tasks.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b> In general, PP&L appropriately identified problems and entered them into a corrective action mechanism. Formal investigations and assessments, such as scram investigations and independent safety engineering group (ISEG) assessments, were thorough and identified plant and human performance issues beyond the immediate causes of the scram.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> PP&L's proposed use of risk insights to assist in prioritizing attention on risk significant condition reports could develop into a useful tool to minimize plant risk.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/01/2000	1999012	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 5C <b>Ter:</b> 1C	<b>Executive Summary</b> PP&L made conservative and effective decisions in response to increasing primary containment leakage on Unit 2. (Section O4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>Executive Summary</b> PP&L delayed starting Unit 1 suppression pool cooling after the suppression pool water high temperature alarm had annunciated. Although this delay resulted in suppression pool water temperature exceeding the Technical Specification (TS) limit, temperature was restored within the allowed time. In addition, PP&L did not recognize that the suppression pool water temperature had exceeded the TS limit until after the water temperature had been restored. The NRC had previously identified a similar issue regarding delayed starting of suppression pool cooling in NRC Inspection Report 50-387, 388/99-06. (section O4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> PP&L's initial response to the "A" emergency diesel generator toxic gas event was appropriate and ensured personnel safety throughout the event. Areas for improvement in the emergency preparedness area were captured in the corrective action program. (section O4.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> PP&L successfully transferred the first dry shielded canister to the dry fuel storage pad, in accordance with design and license requirements. (Section O2.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/30/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Overall, the as-submitted written examination met the guidance of NUREG 1021. Eleven questions required replacement and several changes were also made to question stems to make the question easier to understand and to distractors to make them more plausible.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/30/1999	1999302	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> One instant SRO and one upgrade SRO applicant were administered an initial written retake licensing exam. Both applicants successfully passed the written retake examination.
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08/28/1999	1999007-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Safety Function Determination of RCIC Primary Containment Isolation Valve</b> On August 5, 1999, PP&L did not perform a Technical Specification required safety function determination for out of service primary containment isolation instruments because the requirement to perform a safety function determination for out of service primary containment isolation instruments was not contained in the procedure that controlled the Safety Function Determination Program. PP&L's failure to maintain adequate procedures for the control of the Safety Function Determination Program is a violation of Technical Specification Section 5.4, "Procedures." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is documented in PP&L's corrective action program as condition report 194180. (Section O3.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1B <b>Sec:</b> 5A <b>Ter:</b>	<b>Executive Summary - Section O5.1</b> Following the Unit 1 automatic reactor shutdown on July 1, 1999, operators unnecessarily delayed placing the second division of suppression pool cooling in service. The operators placed the second division of suppression pool cooling in service approximately 40 minutes after the SSES emergency operating procedures directed suppression pool cooling to be maximized. (Section O5.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> 1C <b>Ter:</b>	<b>Executive Summary - Section O5.1</b> PP&L's post trip event reviews following the Unit 1 automatic reactor shutdown on July 1, 1999, were weak in that the reviews did not identify the unnecessary delay in placing the second division of suppression pool cooling in service. (Section O5.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>Reportability Determinations</b> On July 1, 1999, PP&L did not notify the NRC within the required time period that the Unit 1 high pressure coolant injection system injected water into the reactor coolant system. On July 3, PP&L did not notify the NRC within the required time period that a main steam isolation valve had degraded to the extent that the valve's leakage rate exceeded the Technical Specification requirements. The failure to make these notifications within the required time period is a violation of 10 CFR 50.72. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is documented in PP&L's corrective action program as condition reports CR 187420 and CR 192457. (Section O4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
06/07/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> PP&L operators delayed entry into a technical specification limiting condition for operation to perform troubleshooting after a Unit 1 main turbine bypass valve did not meet surveillance test requirements. Whereas the delay to enter the technical specification limiting condition for operation was not consistent with operation's department procedures, no violation of technical specifications occurred since the corrective actions were completed within the required time. (Section O4.2)
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06/07/1999	1999005	Pri: OPS Sec:	Self	NEG	Pri: 2A Sec: Ter:	<b>EXECUTIVE SUMMARY</b>  During this inspection period a number of notable equipment problems occurred which challenged the plant staff and the availability of plant systems important to safety. Specifically, the equipment problems were related to the Unit 1 electro-hydraulic control system fast acting solenoid valves, the Unit 2 isophase bus duct, the "C" emergency diesel generator lube oil and air start systems, a containment atmosphere sample valve limit switch, and loose fastener hardware on the "B" emergency diesel generator. (Section O2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
06/07/1999	1999005-01	Pri: OPS Sec:	NRC	NCV	Pri: 2A Sec: Ter:	<b>SV 15774A PRIMARY CONTAINMENT ISOLATION VALVE POSITION INDICATION</b>  On May 28, 1999, operators did not satisfactorily implement an approved station procedure for containment atmosphere sample valve testing. The operators used an invalid control room indication to determine the position of valve SV 15774A when local valve position indication had failed. This Severity Level IV violation is being treated as a Non-Cited Violation. This violation is documented in PP&L's corrective action program as condition report 96931. (Section O4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1						
05/21/1999	1999301	Pri: OPS Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	<b>Executive Summary</b>  Overall, the as-submitted written examination met the guidance of NUREG 1021. Only two questions required more than minor revision; however, subsequent analysis by the licensee resulted in comments, concerning technical subject matter, for 8 questions (see Attachments 1 and 2).
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
05/21/1999	1999301	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>Executive Summary</b>  One performance problem exhibited by the applicants was identified concerning their knowledge of the function of the safety/relief valve (SRV) bellows and what affect its failure has concerning subsequent SRV function and operability.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
05/21/1999	1999301	Pri: OPS Sec:	Self	NEG	Pri: 1C Sec: Ter:	<b>Executive Summary</b>  Four instant SRO and one upgrade SRO applicants were administered initial licensing exams. Three applicants successfully passed all portions of the exam. Two applicants did not pass the written examination.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
05/21/1999	1999301	Pri: OPS Sec:	Licensee	POS	Pri: 1C Sec: Ter:	<b>Executive Summary</b>  The JPM set developed by the licensee met the guidance of NUREG 1021.
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04/26/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 4C <b>Ter:</b>	<b>Executive Summary</b> PP&L did not troubleshoot the unexpected slow pressurization of the residual heat removal system in a structured and methodical manner, which extended the time needed to identify the failed "1B" low pressure coolant injection valve. While troubleshooting was in progress, and unaware that the "1B" valve was failed, PP&L removed the "A" residual heat removal system from service for maintenance for 17 hours. During this 17 hour period, neither Unit 1 loop of residual heat removal was available for low pressure coolant injection. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> During the Unit 2 refueling outage, the control, execution, and performance of major activities were good. Management emphasized to the staff the importance of human performance, attention to detail, and personnel safety throughout the outage. (Section O1.1 and O1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b> PP&L identified and resolved a potential common cause failure of all RHR injection valves prior to any need for the system to function. The operator's initial identification of the "1B" residual heat removal system slow pressurization reflected a good questioning attitude. The system engineer appropriately focused station priorities to complete troubleshooting and identify a failed low pressure coolant injection valve. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004-03	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 1A <b>Ter:</b>	<b>Failure to Make a One Hour Notification for the Unit 1 Residual Heat Removal Injection Control Valve Failure</b> On February 27, 1999, PP&L did not notify the NRC, within one hour of identification, that the Unit 1 RHR loop B was in a condition that was outside of the design basis. The failure to make the notification within one hour is a violation of 10 CFR 50.72. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is documented in PP&L's corrective action program as part of condition report 90981. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1						
02/19/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> 5B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> The condition report process is focused on accomplishing initial reviews, reportability and operability determinations, cause assessments, and establishment of proposed corrective actions to correct the condition and prevent recurrence. However, process accountability is not readily apparent in the corrective action implementation portion of the process. Corrective action implementation dates do not correlate with the assigned significance level. Action due dates are controlled by the responsible manager who may change them during the course of implementation. The only procedural requirement regarding corrective action implementation is refueling outage related with the shortest lead time being approximately 7-10 months, and the longest lead time being approximately 31-37 months. The minimal administrative control over the corrective action implementation portion of the process contributes to a high process backlog. (Section E7.1)
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02/19/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> Annual assessments of the condition report process by NAS were thorough, critical, and well founded. NAS assessments conducted in 1997 and 1998 identified most of the concerns identified by the inspectors. (Section E7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/19/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>EXECUTIVE SUMMARY</b> The condition report (CR) process is a high volume, low threshold corrective action system that is acceptable to meet the requirements of 10 CR 50, Appendix B, Criterion XVI. Adverse conditions are promptly identified and the process appears to be widely accepted for use, and is used by a broad cross section of the plant staff. There are no significant delays in the initial assessment, investigation, and completion of initial operability and reportability determinations. Initial investigations and root cause assessments for issues of higher safety significance are thorough. Investigations and causal analyses for CRs of lesser safety significance are generally thorough, but there are some instances where extent of conditions and/or generic implications may not be sufficiently explored. (Section E7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/01/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 1A <b>Ter:</b> 3A	<b>Executive Summary</b> A Unit 2 feedwater heater leak was promptly identified, repaired, and returned to service. Management highlighted the importance of reactivity control manipulations prior to the plant's return to full power and maintained a 1% per hour increase in reactor power.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Examples were noted of human performance, work planning, or coordination issues which should have been addressed by a condition report (CR) but were not until prompting was provided by a licensee manager, auditor or NRC staff. Other examples were identified where CR generation was not timely.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The team identified that condition report due dates were sometimes revised without approval. About 12 condition report action (CRA) dates were changed per week. Maintenance stopped this practice in November 1999.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013-03	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Non-Conforming Material Extent of Condition</b> Industry events review program that existed in the late 1980s and early 1990s failed to remove non-conforming components. Those same components continue to challenge the plant. The failure of the Unit 2 "A" main transformer neutral bushing and the Unit 1 reactor core isolation cooling (RCIC) leak detection temperature switch resulted, in part, because of ineffective control of those non-conforming components. An NCV was issued on this failure to prevent the installation or inadvertent use of non-conforming materials, parts or components.
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01/01/2000	1999012	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5C <b>Sec:</b> 5A <b>Ter:</b> 2B	<b>Executive Summary</b> Two recent equipment failures related to the Unit 2 main transformer and Unit 1 reactor core isolation cooling temperature switch module were attributed to inadequate follow-up actions related to industry event information that had been previously reviewed by PP&L in the 1986 and 1990 time frames. (Section O8.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>Executive Summary</b> During the planned replacement of two emergency service water (ESW) pumps, PP&L's maintenance department exhibited excellent work performance and good management oversight. (Section M1.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 5B <b>Ter:</b> 5A	<b>Executive Summary</b> After PP&L management established an Event Review Team, PP&L successfully resolved the numerous problems that occurred following the 2 year preventive maintenance on the "A" emergency diesel generator. (Section M1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> During observations of five pre-planned work activities, the inspectors identified two examples of informal work control. Maintenance workers did not follow PP&L procedures and did not obtain the required approvals for changes to pre-approved work instructions. PP&L concluded that unapproved changes to work instructions did not meet management expectations. (section M4.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 4C <b>Ter:</b>	<b>Executive Summary</b> PP&L inappropriately used an informal process to determine that a core spray relay met specified surveillance test acceptance criteria. Although the core spray relay did not meet the specified surveillance acceptance criteria, PP&L concluded that the relay was functional based on their previous experience. After the core spray technical specification surveillance test results were approved, PP&L recognized that their actions were informal and inappropriate and performed an alternate test which verified that the core spray relay was functional. (section M4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary</b> On November 5, and on November 17, contract maintenance workers caused unexpected reactor protection system actuations (half-scrams). The inspectors concluded that PP&L's corrective actions for the November 5 event were narrowly focused and as a result, not effective at preventing a similar event on November 17. (section M4.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	MV	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  During this inspection period the inspectors concluded that station personnel were inconsistent in their use of PP&L's corrective action system. The types of inconsistencies observed included: failure to document equipment problems, narrowly focused corrective actions or evaluations, missed opportunities to correct problems, and slow problem evaluation. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>A Feedwater Penetration Exceeded Technical Specification Leakage Criteria</b>  PP&L did not promptly identify conditions which affected the ability of the Unit 1 and Unit 2 feedwater containment isolation valves to prevent leakage from September 1995 through March 25, 1999. On March 25, 1999, the leakage past both the inboard and outboard primary containment isolation valves for the Unit 2 "A" feedwater penetration exceeded the primary containment leak requirements, a significant condition adverse to quality. This level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the Enforcement Policy. This violation is entered in PP&L's corrective action program as condition report 204514. LER 99-002-00 is closed. (Section M4.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/02/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 4C <b>Ter:</b>	<b>Executive Summary</b>  The Certificate of Compliance requirements for heavy loads and for maximum handling height for the loaded transport cask and dry storage cask were adequately addressed based on appropriate procedures being in place, including procedures for qualification of crane operators, on the independently verified operable condition of the single-failure-proof crane, on the quality control measures on the independent spent fuel storage installation rigging, and on the documentation of the safe load path. (Section 12 )
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/02/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b>  The preparations for welding of the dry shielded canister welds, including training and qualification of the welders, were thorough. The quality of the welds were excellent including weld process parameter control, the visual appearance of each weld pass and the final as-welded surface as verified by dye penetrant testing. The capability to cut through the completed welds should a DSC need to be unloaded was demonstrated. The penetrant examination method for testing welds met the procedural requirements and industry standards. (Section 7 )
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NEG	<b>Pri:</b> 2A <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary - Section O2.1</b>  A number of equipment problems occurred which challenged the plant staff and the availability of important plant systems. Equipment problems caused two automatic plant shutdowns. A stem/disk separation on the Unit 1 "C" outboard main steam isolation valve caused one shutdown and a failure on the Unit 2 "A" main transformer caused the second. In addition, equipment problems caused two unplanned power reductions. A tube leak on the Unit 1 "3A" feedwater heater caused one power reduction and a motor failure on the Unit 1 "C" circulating water pump caused the second. (Section O2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/19/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 2A <b>Ter:</b>	<b>Executive Summary - Section S1</b> PP&L's physical security program testing and maintenance activities were conducted in a manner that protected public health and safety and met PP&L's commitments and NRC requirements. (Section S1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
06/07/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> Maintenance activities were well controlled and well performed during installation of a new battery for the "E" emergence diesel generator. Battery cell handling, physical and electrical installation, and post maintenance testing conformed to SSES procedures, industry practices, and regulatory requirements. (Section M1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
06/07/1999	1999005-02	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>"B" EMERGENCY DIESEL GENERATOR INOPERABLE DUE TO MISSING/LOOSE HARDWARE</b> PP&L technicians did not properly implement a maintenance procedure and properly fasten the generator inspection screens to the "B" emergency diesel generator. The improper fastening could have caused a failure of the emergency diesel generator. The failure to properly implement a maintenance procedure for safety related equipment is considered a violation of Technical Specification section 5.4. This Severity Level IV violation is being treated as a Non-Cited Violation. This violation is documented in PP&L's corrective action program as condition report 95536. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	Self	NEG	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b>	<b>Executive Summary</b> During a Unit 2 under vessel maintenance activity on a local power range monitor (LPRM), technicians momentarily unseated the seal between the LPRM and reactor vessel, spraying about two quarts of contaminated water on themselves. The additional total radiation exposure (both internal and external) to the individuals, as a result of the contamination, was non-consequential. PP&L initiated condition reports 92527 and 92528 to review this event. PP&L's initial response and proposed actions were appropriate. No violations of NRC requirements were identified. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3B <b>Ter:</b>	<b>Executive Summary</b> The inservice inspections had been performed acceptably and had included acceptable ASME program coverage, qualified personnel, approved procedures, proper implementation, appropriate examination documentation, and PP&L oversight. The inspections performed were thorough and of sufficient extent to determine the integrity of the components inspected. Indications of nonconforming conditions were identified, explored, evaluated, documented and dispositioned in accordance with established requirements. (Section M2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004-01	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2A <b>Sec:</b> 5C <b>Ter:</b>	<b>Main Steam Isolation Valve (MSIV) Seat Leakage</b> In a Licensee Event Report, PP&L identified that two main steam isolation valves did not meet a seat leakage specification. PP&L's corrective actions, including valve seat repair and re-test activities, were good. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is documented in PP&L's corrective action program as condition report 92338. LER 50-388/99-001 is closed. (Section O8.1)
<b>Dockets Discussed:</b> 05000388 Susquehanna 2						

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03/15/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> The observation of ultrasonic testing of the residual heat removal injection valves determined that the technique applied was effective in identifying significant stem cracking. The ultrasonic testing minimized personnel radiation exposure and resulted in the timely identification of an additional cracked valve stem. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/19/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 4B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> The inspectors concluded that the surveillance testing procedures reviewed satisfactorily met the testing requirements outlined in NRC Generic Letter 96-01. The inspectors also determined that the minor discrepancies noted in the procedures and drawings would not have affected the outcome of the testing. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/01/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 2A	<b>Executive Summary</b> During restoration of the "B" emergency diesel generator to service, following a 20 year overhaul, and removal of the maintenance spare "E" emergency diesel generator from service, the restoration of an operable emergency diesel generator was unexpectedly delayed due to work coordination issues and continued problems with the diesels' non-safety related control air system. Nonetheless, the restoration of an operable diesel was completed within the allowed time.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/01/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Executive Summary</b> Instrument and controls technicians identified that Technical Specification instruments had been contaminated with sodium hydroxide during planned surveillance tests. Initial corrective actions included a detailed operability determination and a thorough review to determine the extent of the sodium hydroxide contamination. Instruments were sampled, drained, flushed, and re-calibrated to restore equipment operability.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The team concluded that PP&L was not consistently meeting the industry guidance and procedure requirements for operability screenings and determinations. This resulted in a minor violation due to failure to follow the CR procedure requirements for not promptly submitting the CR for an operability screening.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Overall, the licensee's implementation regarding corrective actions for NCVs was acceptable. NCVs were entered into the corrective action program, as required. Corrective actions were properly implemented on closed CRs. However, in one instance, the licensee review of the main steam isolation valve (MSIV) leakage was weak regarding root cause analyses, extent of condition reviews, actions to prevent recurrence and timeliness.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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01/13/2000	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary</b> Although PP&L had identified decreasing margins on the high risk reactor water cleanup (RWCU) isolation valves, you extended the completion date of required internal inspections of those valves during the May 1999 forced outage at Unit 1 without reviewing the risk of extending those inspections.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b>	<b>Delayed Operability Determination for SLC Air Sparge</b> PP&L failed to perform a timely operability determination for the standby liquid control (SLC) system during air sparge. A non-cited violation (NCV) was issued for failure to timely inform the operating staff of a determination that concluded system inoperability.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/13/2000	1999013-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Inadequate Corrective Action Regarding Maintenance Rule Scope</b> PP&L did not identify the safety-related remote shutdown panel (RSP) transfer switch functions during their corrective action of a previous NRC violation, which identified that the bypass indication system was not in the maintenance rule scope. Failure to identify and include the safety-related functions of the RSP resulted in PP&L excluding the RSP from July 10, 1996 to January 10, 2000. An NCV was issued for inadequate corrective action.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b> The Independent Safety Engineering Group report results were indicative of thorough investigation and analysis of plant issues and personnel performance. The reports were objective and contained meaningful feedback to plant management. (Section E7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Three safety evaluations, performed for the Independent Spent Fuel Storage Installation, were reviewed and met the requirements of 10 CFR 50.59 and 10 CFR 72.48. The inspectors noted that, in one case, the basis for some assumptions and conclusions were not documented within the evaluation. (section E4.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The planning, fabrication, and documentation of the Susquehanna dry shielded canisters resulted in a quality product that met the design. Effective fabrication practices were in use and full-time Quality Assurance coverage by PP&L was in place at the manufacturing plant. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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10/16/1999	1999009-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>High Pressure Coolant Injection (HPCI) Vibration Limits</b>  Since May 1995, the HPCI surveillance test procedure contained incorrect vibration alert values for the Unit 1 and 2 HPCI pumps. When the correct values were used, the Unit 2 HPCI pump was in a degraded condition, due to high vibrations, for an extended period of time in 1998. The failure to use the correct alert vibration value is a Severity Level IV violation of Part 6 of ASME Oma-1988, "Inservice Testing of Pumps in Light-Water Reactor Power Plants," and is being treated as a Non-Cited Violation, consistent with Appendix C of the Enforcement Policy. This violation is entered in PP&L's corrective action program as condition report 199506. (Section E3.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  Although the majority of the operability assessments reviewed were acceptable, some operability assessments did not provide adequate justification to support operability conclusions. Most noteworthy was an error discovered in the technical basis of an operability assessment which resulted in two Emergency Service Water pumps subsequently being declared inoperable. (Section E1.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  PPL did not have an effective means to collect and evaluate open operability assessments and as a result did not routinely consider and evaluate the cumulative operability impact of all degraded conditions on a particular system. (Section E1.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  The design control process for permanent plant modifications was being properly implemented for the sample of modifications reviewed. The technical quality of changes was adequate and modification package content, including the 10CFR50.59 screening and safety reviews, was comprehensive. Post modification testing accomplished the verification of relevant design change attributes. (Section E1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  There were 13 open bypasses (temporary modifications) in use at Susquehanna. The open bypasses were properly designed and implemented. Increased oversight by PPL has significantly reduced the number of open bypasses in the last two years. (Section E1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  PPL did not perform 10CFR50.59 screening determinations or evaluations for seven waived "required" preventive maintenance items as required by a station maintenance procedure. This was a violation for failing to follow procedures and was considered a Non-Cited Violation of Technical Specification Section 5.4, "Procedures." (Section E2.4)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	WK	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> The engineering staff when fully engaged was providing adequate support for resolution of technical problems and was generally effective in supporting safe plant operations. However, communication and coordination weaknesses observed delayed resolution of some technical issues by engineering. (Section E2.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	WK	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> This inspection found no specific problems regarding the prioritization of engineering work backlogs. Nonetheless, the team was concerned about the effectiveness of PPL's efforts in managing the engineering work backlogs since due dates for other than priority 1 condition reports or corrective actions were routinely changed by the individuals assigned the task of resolving the issue, without management review and approval. (Section E2.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b>	<b>Failure to Follow Bypass and Preventive Maintenance Procedures</b> PPL failed to follow their administrative procedure governing the bypass program in that system configurations which were bypasses were not documented, evaluated, and controlled. This problem was in PPL corrective action program and was treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. (Section E1.2) PPL did not perform 10CFR50.59 screening determinations or evaluations for seven waived "required" preventive maintenance items as required by a station maintenance procedure. This was a violation for failing to follow procedures and was considered a Non-Cited Violation of Technical Specification Section 5.4, "Procedures." (Section E2.4)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Exceeding Technical Specification 3.7.2 LCO</b> Although engineering personnel generally responded in an effective manner to technical issues, several examples were noted where engineering support was not adequate. Specifically, engineering personnel were not successful in initially resolving issues relating to adverse ESW pump-to-pump interactions. Engineering performed an invalid operability assessment which resulted in two of the four ESW pumps being inoperable for in excess of the 7 day LCO time limit. This violation of Technical Specification Section 3.7.2.D, was considered a Severity Level IV violation and was treated as a Non-Cited Violation. A contributing cause was that engineering personnel had not adequately addressed the potential for adverse ESW pump-to-pump interactions during their review of NRC Bulletin 88-04. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010-03	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Inadequate Corrective Actions Secondary Containment Dampers</b> Engineering was not effective in resolving numerous Secondary Containment isolation damper stroke time surveillance test failures in a timely fashion, as eighteen surveillance test failures occurred within the last 2.5 years. These failures challenged station personnel to react to numerous Technical Specification Limiting Condition of Operation entries regarding secondary containment integrity. Failure to identify conditions adverse to quality constituted a violation of 10 CFR Part 50, Appendix B, Criterion XVI, corrective action. This Severity Level IV violation was treated as a Non-Cited Violation. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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09/02/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 4C	<b>Executive Summary</b> During the independent spent fuel storage installation (ISFSI) dry run, the PP&L ISFSI staff properly demonstrated the equipment, procedures, planning and training of the ISFSI work team members. When the preparations and dry run exercises identified issues or items for improvement, these were addressed by evaluation and appropriate action. Issues raised by the inspectors, including establishing a process for the acceptance of the dry run by management, were addressed by PP&L during the course of the inspection. The dry run demonstrated that the ISFSI staff along with the task equipment and procedures were adequately prepared to initiate the transfer of spent fuel from the spent fuel pool to the horizontal storage module pad area located on the plant site. (Section 2 )
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/02/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Based on the review of completed procedures and work packages, the detailed 10 CFR 72.212 evaluation documentation that compares the specifics of the Susquehanna independent spent fuel storage installation( ISFSI) project to that licensed by NRC, the extent of planning, and the overall effectiveness of the PP&L ISFSI project management, PP&L was found to be meeting the significant terms and conditions of the Certificate of Compliance, and 10 CFR Parts 50 and 72, as they related to the ISFSI, and was adequately prepared to use the ISFSI. (Section 1 )
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary - Section M1.1</b> A failed main transformer bushing resulted in the June 8, 1999, Unit 2 automatic reactor shutdown. The PP&L root cause analysis team concluded that PP&L had failed to take correct action on a vendor's 1990 recall notice which identified a manufacturing defect which eventually led to this failure. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary - Section E2.1</b> On July 1, 1999, the Unit 1 "C" outboard main steam isolation valve (MSIV) stem separated from the valve poppet, resulting in an automatic reactor shutdown. PP&L determined that the stop plate had not been properly installed in the valve poppet during valve maintenance performed in 1990. PP&L reviewed the maintenance history on all Unit 1 and Unit 2 MSIVs, inspected three additional Unit 1 MSIVs, and found no additional problems. The inspectors concluded that PP&L had performed a thorough root cause analysis and a comprehensive extent of condition review. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
06/07/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	Self	NEG	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b> Continued problems with the emergency diesel generator non-safety related control air system components have resulted in increased emergency diesel generator unavailability time, additional fast starts, and increased operator, maintenance and scheduling burden. (Section M1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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06/07/1999	1999005-03	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>SAFETY RELIEF VALVE ACOUSTIC MONITOR ENVIRONMENTAL QUALIFICATION AND INSTALLATION</b>  PP&L determined that all Unit 1 and Unit 2 safety relief valve acoustic monitors were not installed in an environmentally qualified configuration, as a result of a failure to apply RTV sealant during modification activities. PP&L failed to adequately translate vendor environmental qualification and design requirements into appropriate specifications and instructions. This is a severity level IV violation of 10 CFR 50 Appendix B, Criterion III, Design Control and is being treated as a Non-Cited Violation. This violation is documented in PP&L's corrective action program as condition report 97121. (Section E1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Executive Summary</b>  Although PP&L identified problems with roles and responsibilities during troubleshooting, they did not identify a change management issue. Specifically, the station staff was not fully aware that the system engineering interface with operations and maintenance during troubleshooting had been changed. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b>  The PP&L independent safety engineering group review of the slow pressurization of the residual heat removal system event was limited and missed opportunities to reveal additional insights related to the station staff response to the failed valve. (Section E2.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary</b>  Engineering personnel performed a comprehensive failure analysis and a thorough root cause determination of the Unit 1 and 2 low pressure coolant injection valve stem failures. Corrective actions, including the replacement of internal parts with an improved design and material, were acceptable. (Section E1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>Residual Heat Removal System Injection Control Valve Stem Failure - Old Design Issue</b>  Design control deficiencies in the mid-1980's led to the use of material in the stem of the low pressure coolant injection valves that was susceptible to stress corrosion cracking. These deficiencies constituted a violation of 10 CFR 50 Appendix B, Criterion III, "Design Control," In accordance with the NRC Enforcement Policy, Section VII.B.3, Violations Involving Old Design Issues, the NRC exercised enforcement discretion and did not cite this violation. (Section E1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
03/15/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	POS	<b>Pri:</b> 3A <b>Sec:</b> 4A <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b>  The planning and construction of the Susquehanna Independent Spent Fuel Storage Facility (ISFSF) were being accomplished well. Quality Assurance involvement has been evident throughout the ISFSF project. (Section E2.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

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Region I  
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/15/1999	1999003-01	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>CORE SPRAY QUARTERLY FLOW SURVEILLANCE DID NOT MEET ACCEPTANCE CRITERIA</b>  In a Licensee Event Report, PP&L identified that on two occasions, the Unit 2 core spray quarterly flow surveillance test did not meet the Technical Specification (TS) acceptance criteria due to a procedure error. PP&L's proposed and completed corrective actions, including procedure and programmatic actions, were good. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in PP&L's corrective action program as condition report 98-3070. LER 50-388/98-011 is closed. (Section O8.1)
<b>Dockets Discussed:</b> 05000388 Susquehanna 2						
03/15/1999	1999003-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<b>RESIDUAL HEAT REMOVAL SERVICE WATER (RHRWS) RADIATION MONITOR</b>  The residual heat removal service water (RHRWS) radiation monitors do not meet requirements of General Design Criteria 64. Specifically, the radiation monitors would not be functioning following a postulated design basis accident, since the monitors can not be manually started locally in the high post accident area radiation levels. In addition, the location of a backup grab sample would not provide a representative sample as delineated in Regulatory Guide 1.21. This is a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," which requires, in part, selection of suitable equipment that are essential to the safety related function of the system. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is documented in PP&L's corrective action program as condition report 91031. (Section E2.1)
<b>Dockets Discussed:</b> 05000388 Susquehanna 2						
02/19/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5C <b>Sec:</b> 5B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b>  Internal reviews of the condition report system by Operating Experience Services (OES) and external reviews by Nuclear Assurance Services (NAS), the Cooperative Management Audit Program, the Institute of Nuclear Power Operations, and the Susquehanna Review Committee are continuing to find incomplete or inadequate corrective action closure. A recent process change requiring OES to review completed actions to ensure that the actions satisfies the one prescribed, is reducing the amount of items identified. However, problems persist in this area. (Section E7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/19/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b>  The inspector concluded that PP&L's response to Generic Letter 96-01 adequately addressed the issues identified in the GL, and that there was an adequate basis for the positions taken in the response. (Section E1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/19/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4A <b>Ter:</b>	<b>EXECUTIVE SUMMARY</b>  The inspector determined that the procedures for control of modifications to the facility provided appropriate controls for ensuring that modifications were properly carried over into the technical specifications and surveillance tests. (Section E3.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/01/1999	1999001	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b>	<b>Executive Summary</b> Two Plant Operations Review Committee (PORC) meetings, related to a Unit 1 "C" reactor feedwater drain valve leak seal repair and a generic main generator synchronization issue, demonstrated that PORC conducted in-depth reviews of safety issues. The PORC recommendations for both meetings were sound and supported by a conservative decision making process.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Executive Summary</b> PP&L implemented overall effective surveys, monitoring, and control of radioactive materials and contamination. Health Physics technicians properly documented survey results. In general, radiological housekeeping conditions were acceptable. (Section R1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3B <b>Ter:</b>	<b>Executive Summary</b> Security and safeguards procedures and documentation were properly implemented. Event logs were properly maintained and effectively used to analyze, track, and resolve safeguards events. (Section S3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3C <b>Ter:</b>	<b>Executive Summary</b> Management support was adequate to ensure effective implementation of the security program, as evidenced by adequate staffing levels and the allocations of resources to support programmatic needs. (Section S6)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary</b> PP&L implemented effective applied radiological controls. The radiation work permit program was adequately implemented. Personnel occupational exposure was maintained within applicable regulatory limits and as low as reasonably achievable. Access controls to radiologically controlled areas were effective, and appropriate occupational exposure monitoring devices were provided and used. (Section R1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b>	<b>Executive Summary</b> Security and safeguards activities with respect to alarm station controls, communications, and protected area access control of personnel, packages and vehicles were effectively implemented. (Section S1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/01/2000	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> The security force members (SFMs) were provided effective training and adequately demonstrated that they had the requisite knowledge necessary to effectively implement their duties and responsibilities. (Sections S4 and S5)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> PP&L's program to transport low level radioactive waste and other radioactive materials was generally effective. (section R1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b> The assessment and corrective action programs, in the areas of radioactive waste and radioactive material transportation, were effective. The problem identification and corrective action program identified and adequately resolved Condition Reports. (section R7)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
11/20/1999	1999011	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Executive Summary</b> PP&L's solid radioactive waste management program continued to be effective, based on proper implementation of the program, the use of documented procedures and controls, satisfactory record keeping, and the acceptable condition of facilities and equipment. Also, the Process Control Program was detailed and provided a description of the waste types generated, waste stream sampling and analyses performed, and waste processing methods used. (section R1.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> PP&L effectively maintained and implemented the Radiological Environmental Monitoring Program (REMP) in accordance with regulatory requirements. The monitoring program was performed using the REMP procedures and the Offsite Dose Calculation Manual, the annual reports documented the results of the REMP, and the contractor laboratories continued to provide effective validation of analytical results. Overall, the environmental monitoring program was capable of ensuring independent verification and validation of the integrity of the effluent release program. (Section R1.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/16/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b> Overall, PP&L effectively maintained the meteorological instrumentation operable. Channel calibrations and channel checks were performed in accordance with the procedures and the Technical Requirements Manual. (Section R1.4)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/16/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  Performance of audits and assessments for the REMP activities were directly observed, timely feedback was provided and identified findings were appropriately categorized and entered into the corrective action process. The audits were thorough and of sufficient depth to assess the REMP activities. (Section R7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
10/12/1999	1999010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  The QA department was not effectively used to monitor, assess, and improve plant performance based on limited resources for audits and surveillances, lack of substantive performance based findings, and lack of trending findings. The on-site Quality Assurance organization did not appear to be fully integrated into significant work activities at the plant as observed by the inconsistency in QA coverage for the maintenance work performed on the D ESW pump motor. (Section E7.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/02/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Executive Summary</b>  The training program for personnel involved with the independent spent fuel storage installation (ISFSI) activities was implemented appropriately. The Certificate of Compliance requirement that training should include an overview, radiological safety issues, off normal event procedures, and licensing requirements was met. Criteria for determining which individuals required training were adequate. ISFSI operations personnel were given specialized training in the equipment and procedures. In numerous cases, hands-on simulation to demonstrate an ability to conduct the activities was conducted. The training of HP technicians for the radiological aspects of the ISFSI evolutions was performed in a thorough manner based on the detailed training materials used and on their involvement in the dry runs. (Section 11)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
09/02/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 3A <b>Ter:</b>	<b>Executive Summary</b>  PP&L's plans and preparations for controlling radiological activities for the independent spent fuel storage installation (ISFSI) were extensive and detailed. Specific radiation work permits, with appropriate radiological controls included, were available. Health physics technicians were observing the dry run activities, anticipating radiation conditions and providing countermeasures to the ISFSI work staff. The ISFSI operational procedures had been reviewed by radiation protection personnel and contained cautionary notes for specific radiological hazards. (Section 8)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
08/28/1999	1999007-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Self	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4C <b>Ter:</b>	<b>Packaging and Shipment of Radioactive Waste</b>  PP&L improperly packaged radioactive waste that was shipped to a low-level waste disposal facility. Upon identification, PP&L reviewed the circumstances of these shipments, entered the occurrences into their corrective action program as condition report 188042, and initiated corrective measures to prevent recurrence. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. (Section R8.1)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
07/19/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 3C <b>Ter:</b>	<b>Executive Summary - Section S2</b>  The SSES security force members adequately demonstrated that they had the required knowledge to effectively implement the duties and responsibilities associated with their position. (Section S2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>Executive Summary</b>  Access controls to radiologically controlled areas were effective, and appropriate occupational exposure monitoring devices were provided and used. Personnel occupational exposure was maintained within applicable regulatory limits and as low as reasonably achievable (ALARA). The ALARA efforts and results for 1998 were good, including the management of radiologically significant outage work. The annual and Unit 2 refueling and inspection outage collective dose goals for 1999 were aggressive and challenging. (Sections R1.1 and R1.3)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> 2B <b>Ter:</b>	<b>Executive Summary</b>  Radiological housekeeping conditions were noted to be good. In particular, the equipment and personnel work activity control and coordination for the Unit 2 refuel floor, suppression pool, and drywell were excellent. The number and type of personnel contaminations were tracked, trended, and evaluated for cause and corrective actions. (Section R1.2)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
04/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>Executive Summary</b>  PP&L's self-identification and corrective action processes in the area of radiation protection were effective. Nuclear Assessment Services surveillance reports, HP self-assessments, and the corrective action program continued to be effective in identifying, at a low threshold, deficiencies and improvement opportunities. Effective corrective actions were implemented for findings. (Section R7)
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						
02/01/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> 5A <b>Ter:</b> 3A	<b>Executive Summary</b>  The NRC identified that two accessible fire zones were not inspected by hourly firewatches since 1992. PP&L incorrectly treated the areas as inaccessible when in fact they were accessible. Once recognized, PP&L took immediate and effective corrective actions.
<b>Dockets Discussed:</b> 05000387 Susquehanna 1 05000388 Susquehanna 2						

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## 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.