

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II
ST LUCIE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/14/2000	2000003	Pri: OPS Sec: OTHER	NRC	NEG	Pri: 5C Sec: 5A Ter: 5B	Corrective Action Program Two significant deficiencies and other observations indicated that the Corrective Action Program has not yet fully matured. The deficiencies involved the lack of an effective trending process and the failure of the process to reduce human errors (Section O7.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/14/2000	2000003	Pri: OPS Sec: OTHER	NRC	POS	Pri: 5A Sec: 5C Ter: 5B	Licensee self-assessment Licensee self-assessment and other oversight activities were generally thorough and have resulted in identification of the significant problems in implementation of the corrective action program (Section O7.2).
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01/14/2000	2000003	Pri: OPS Sec: OTHER	NRC	POS	Pri: 5C Sec: 5A Ter: 3C	Corrective action backlog The corrective action backlog received strong management attention and was decreasing. No significant backlogged issues were noted (Section O7.3).
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01/14/2000	2000003	Pri: OPS Sec: OTHER	NRC	POS	Pri: 5C Sec: 5A Ter: 5B	Corrective action program The corrective action program was effective in identifying problems and evaluating significant equipment issues. The process was strongly supported at all levels as a viable tool for addressing problems and management had a clear vision of an effective process (Section O7.1).
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01/14/2000	2000003-01	Pri: OPS Sec: OTHER	Licensee	NCV	Pri: 5A Sec: 5B Ter: 5C	Untimely Correction of EOP Program Implementation Deficiencies Trending methods were not effective in identifying recurring problems with implementation of the program requirements for revising emergency operating procedures. Adverse conditions were identified and documented during the period since 1998. However, several of the corrective actions were in effective or not implemented in a timely manner resulting in recurring problems. A Non-Cited Violation was identified for untimely corrective actions (Section O7.4).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/01/2000	1999008	Pri: OPS Sec:	NRC	NEG	Pri: 3B Sec: Ter:	Requalification training One instance of poor Job Performance Measure administration and one instance of poor exam security practices were observed (Section O5.1).
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01/01/2000	1999008	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: Ter:	Requalification training The conduct of the annual requalification examination met regulatory requirements. Remedial training packages were satisfactory and re-evaluation testing appropriately addressed identified operator deficiencies. The inspector concluded that these portions of the licensee's operator requalification training program met the requirements of 10 CFR 55.59 (Section O5.1).
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01/01/2000	1999008-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1C Sec: 3C Ter: 3A	Inadequate Program Implementation For Emergency Operating Procedures Significant problems were identified with maintenance of the Emergency Operating Procedures. Licensee reviews concluded that Operations supervision was not sufficiently involved in the Emergency Operating Procedure revision process and personnel did not follow administrative requirements. The licensee and NRC inspectors identified instances where Emergency Operating Procedure revisions were issued that contained errors. A Non-Cited Violation was identified for inadequate implementation of the program requirements for revising Emergency Operating Procedures. The licensee concluded that the Emergency Operating Procedures could adequately mitigate accidents, and has initiated comprehensive measures to identify and correct all Emergency Operating Procedure discrepancies. These efforts include an Emergency Operating Procedure recovery action plan which will reprocess Emergency Operating Procedure revisions in accordance with governing procedures, establish proper documentation, and reverify the adequacy of the Emergency Operating Procedures (Section O3.1).
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11/13/1999	1999007	Pri: OPS Sec:	NRC	MISC	Pri: 1B Sec: 2A Ter:	Operators completed post trip and reactor trip recovery actions Following an automatic reactor trip of Unit 1, operators completed the standard post trip and reactor trip recovery actions per the emergency operating procedures. All safety equipment operated as expected. The root cause was determined to be a defective diaphragm in the turbine trip block (Section O1.5).
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11/13/1999	1999007	Pri: OPS Sec:	Self	NEG	Pri: 1B Sec: 3A Ter: 3C	Operators manually tripped Unit 1 The operators manually tripped Unit 1 in accordance with procedures when the 1A Steam Generator level dropped below the Steam Generator Low Level Pre-trip Alarm setpoint. The low level was caused by a steam flow/feed flow mismatch when operators became distracted during the conduct of a routine shift turnover. Operations supervision had allowed crew turnover to begin even though plant parameters were not stabilized following a recent increase in power to above the point of adding heat (Section O1.6).
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11/13/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter:	Unit 1 startups Both Unit 1 startups were well controlled and managed. Control room operators were consistently alert for any indications of abnormal equipment performance and attentive to all annunciator alarms. Communications, peer checking, and control room command were excellent (Section O1.4).
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11/13/1999	1999007-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: 3A Ter:	Violation of Equipment Clearance Order Boundary An inadvertent draindown of the refueling water tank to the reactor vessel and refueling cavity occurred during the refueling outage. A valve stroke test established a flowpath which resulted in a violation of an equipment clearance supporting valve maintenance. A non-cited violation was identified. The event investigation conducted by the licensee was thorough in identifying the root causes and developed appropriate corrective actions to prevent recurrence (Section O1.2).
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11/13/1999	1999007-02	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 3A Ter: 3C	Failure To Maintain Minimum Required SDCS Flow During Draindown to Midloop Operations conducted the reactor coolant system draindown in a controlled manner according to applicable procedures, with one significant exception. Operations management had decided to implement a temporary change for establishing midloop conditions which restricted allowable shutdown cooling system flowrates too tightly. During the draindown, operators were unable to maintain shutdown cooling flow within the band required by the temporary change. A non-cited violation was identified (Section O1.3).
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11/13/1999	1999007	Pri: OPS Sec: ENG	NRC	POS	Pri: 4B Sec: 2A Ter: 2B	The Unit 2 high pressure safety injection system condition and configuration The Unit 2 high pressure safety injection system operability and configuration were appropriate to support plant operations. The system engineer was knowledgeable of system status and properly monitoring the system under the maintenance rule program. Material condition and housekeeping of the high pressure safety injection system were acceptable (Section O2.3).
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10/02/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 5B Ter: 2B	Significant Operating Evolutions Operations performed well during several significant operating evolutions. Operators conducted these evolutions following procedures in a methodical and well controlled manner. Conservative decision making and close control of plant conditions was demonstrated. Good communications, command and control and peer checking were consistently used by Operations personnel. Complications that occurred during the evolutions were handled properly. Operations management oversight and supervisory command of the evolutions was evident at all times.
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10/02/1999	1999006	Pri: OPS Sec: ENG	NRC	POS	Pri: 1A Sec: 5B Ter: 2B	Unit 1 Refueling Activities Refueling activities observed were performed well and in accordance with procedural requirements. Minor grid/rod damage to a new fuel assembly occurred during movement from the new fuel storage rack to the spent fuel pool that necessitated offsite repairs. A thorough root cause analysis of the event was performed and appropriate corrective actions were implemented. Reactor core reload verification activities accurately confirmed the intended fuel load for Cycle 16.
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08/21/1999	1999005-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: 3A Ter:	Procedural adherence issues A non-cited violation was identified for several procedural adherence errors associated with reactor protection system logic matrix testing, one of which caused two pairs of trip circuit breakers to be open at the same time. However, since both pairs of breakers were supplied by the same motor generator all control element assemblies remained energized. The operating crew supervision overseeing the test failed to adequately control and resolve difficulties encountered while performing the test. (Section O1.2)
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08/21/1999	1999005	Pri: OPS Sec: ENG	NRC	POS	Pri: 2B Sec: 4B Ter: 3B	New fuel receipt, inspection, and transfer activities New fuel receipt, inspection, and transfer activities were conducted in accordance with procedural requirements. Required records and logs were maintained during all fuel inspections and transfers. Operators performing the activities were knowledgeable and the level of supervision provided for these efforts was appropriate. (Section O1.3)
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08/21/1999	1999005	Pri: OPS Sec: OTHER	NRC	POS	Pri: 5B Sec: Ter:	Licensee evaluations of Unit 2 shutdown cooling system issues Licensee evaluations, root cause analysis, Quality Assurance audit, and self-assessment efforts to address the Unit 2 shutdown cooling system event last outage were comprehensive, thorough, and self-critical. The resulting corrective actions appropriately targeted identified causes, complemented each other well, and appeared to be effective. (Section O7.1)
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08/21/1999	1999005-02	Pri: OPS Sec: ENG	NRC	NCV	Pri: 5C Sec: 3A Ter: 5A	Inadvertent heat-up during mid-loop conditions Nonconservative decision-making, schedule pressures, insufficient questioning attitude, and inadequate implementation of the corrective action process contributed to the inadvertent heat-up of the reactor coolant system during Unit 2 Cycle 11 mid-loop operation. A non-cited violation was identified for inadequate identification and correction of degraded shutdown cooling system performance. (Section O7.1)
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07/10/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: 3A Ter: 3B	Operations decision making during startup Operations decision making was not conservative as evidenced by proceeding with a main turbine test during reactor startup and maintaining the Unit 2 reactor in a suspended startup condition (i.e., shutdown and regulating groups withdrawn) for an extended period. (Section O1.4)
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07/10/1999	1999004	Pri: OPS Sec:	NRC	NEG	Pri: 1B Sec: 3A Ter: 3B	Inadequate supervisory actions involving restoration of MSIV The Assistant Nuclear Plant Supervisor failed to demonstrate sufficient caution and attention to detail in supervising main steam isolation valve restoration and recovery activities. Both the Event Response Team and root cause analysis failed to recognize and/or adequately address certain aspects of the event. (Section O1.3)
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07/10/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3C Ter: 3A	Crew briefings for Unit 2 restart Crew briefings conducted by Operations supervision included appropriate guidance and clarified management expectations for Unit 2 restart. Operators successfully performed the reactor startup in a cautious manner, closely following procedures and input from Reactor Engineering. Supervisory oversight was effective throughout the evolution. (Section O1.5)
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07/10/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter: 2A	Operator actions in response to two control element assembly drop events Operator actions in response to two control element assembly drop events were conservative and consistent with established off-normal and emergency operating procedures. Plant systems functioned as designed, with only a few minor equipment problems. (Section O1.2)
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07/10/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	Post-trip review for manual trip The post-trip review for the control element assembly related manual trip was complete and thorough. The Facility Review Group decision to approve startup was based on a reasonable assurance that the causes of the event were sufficiently understood and appropriate corrective actions were taken. (Section O1.2)
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07/10/1999	1999004-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1B Sec: 3A Ter: 3B	Failure To Properly Release The 2B MSIV Clearance Order Improper release of an equipment clearance order for the Unit 2 main steam isolation valves by Operations caused the 2B main steam isolation valve to unexpectedly open resulting in an inadvertent cooldown of the reactor coolant system and actuation of the reactor protection system. This failure to follow procedure was identified as a non-cited violation. (Section O1.3)
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07/10/1999	1999004-02	Pri: OPS Sec:	NRC	NCV	Pri: 1B Sec: 3A Ter:	Failure To Follow MSIV Restoration Procedure Operator efforts to reclose the 2B main steam isolation valve, following the cooldown event, using the normal restoration procedure were hindered when a procedural step was inadvertently missed. This failure to follow procedure was identified as a non-cited violation. (Section O1.3)
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07/10/1999	1999004-03	Pri: OPS Sec:	Licensee	NCV	Pri: 1B Sec: 3A Ter: 3B	Failure to Follow Turbine Trip Procedure A non-cited violation was identified for the failure to follow procedures and reset the fifteen percent main feedwater bypass valves following a post-maintenance test turbine related trip which resulted in a steam generator overfeed condition and inadvertent reactor coolant system cooldown. (Section O1.4).
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05/29/1999	1999003	Pri: OPS Sec:	NRC	NEG	Pri: 3A Sec: 5A Ter: 5B	Questioning attitude of control room operators Two examples were identified in which control room operators did not apply a questioning attitude or properly pursue resolution of important equipment operability issues (Section O1.1).
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05/29/1999	1999003	Pri: OPS Sec: OTHER	NRC	POS	Pri: 3C Sec: 5C Ter:	Site management actions to improve the utilization of the corrective action program Senior site management initiated actions to improve the utilization of the corrective action program. These actions addressed recent findings that some work groups were not using Condition Reports to address problems (Section O7.1).
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04/17/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3A Ter: 3C	Execution of Unit 2 shutdown due to emergent issue Operations personnel and plant equipment performed well during the Unit 2 shutdown required by Technical Specification 3.0.3 and during the subsequent power ascension. Management decisions were conservative and clearly communicated to the operating crews. Crew turnover and briefings were accomplished in a professional and informative manner. Strong control room supervision was observed. (Section O1.2)
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04/17/1999	1999002-01	Pri: OPS Sec: ENG	NRC	NCV	Pri: 3A Sec: 4A Ter: 4B	Safety Evaluation not performed for valve position changes A Non-Cited Violation was identified for failing to perform written safety evaluations to determine if changes to the positions of containment isolation valves described in the Updated Final Safety Analysis Report involved unreviewed safety questions. (Section O3.1)
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03/19/1999	1999009	Pri: OPS Sec: OTHER	NRC	WK	Pri: 3B Sec: 1C Ter: 5C	Licensee's training program self assessment The licensee's training program assessment identified a number of implementation weaknesses in the Systems Approach to Training (SAT) for the operator licensing training program. The licensee's initial corrective actions may have been too narrowly focussed and did not address all of the underlying weaknesses in the implementation of the SAT process. These weaknesses along with additional NRC identified examples, directly contributed to the poor pass rate on the December 1998 initial operator licensing examination.
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03/06/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 5C Sec: 5B Ter: 5A	Corrective action process improvements The licensee established several actions to improve the corrective action process. Previous problems with the Plant Manager's Action Item program have been corrected. Detailed reviews by the licensee continue to identify minor problems with proposed corrective actions. The licensee initiated corrective actions to address the identified issues (Section O8.1).
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03/06/1999	1999001-01	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 3A Ter: 5C	Inadequate Corrective Actions Improper communications between Operations, Engineering, and Chemistry and a lack of attention to detail resulted in incomplete corrective actions associated with a containment isolation valve. Although a CR was initiated to address the condition adverse to quality, corrective actions were not fully implemented. A non-cited violation was identified (Section O2.4).
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03/06/1999	1999001	Pri: OPS Sec: ENG	NRC	NEG	Pri: 3A Sec: 3B Ter: 1A	Human performance errors and procedural deficiencies Several human performance errors and procedural deficiencies were identified following a routine emergency diesel generator (EDG) surveillance test. During the test, the 1A EDG was unintentionally overloaded when a control room indication failed to operate properly. Operator decision making was not conservative. Operators and Engineering personnel lacked knowledge of EDG load ratings. Engineering and Operations conducted a thorough investigation of the event. Detailed inspections were completed to verify EDG operability. The human performance and procedural deficiencies were effectively corrected as evidenced during subsequent EDG tests (Section M1.3) .
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03/06/1999	1999001	Pri: OPS Sec: ENG	NRC	POS	Pri: 2B Sec: 3A Ter: 2A	Condition of shield building ventilation system Shield building ventilation system operability and configuration were appropriate to support plant operations. The system component engineer was knowledgeable of system operation and status. Material condition and housekeeping of the system were acceptable (Section O2.3).
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03/06/1999	1999001-02	Pri: OPS Sec: MAINT	NRC	NCV	Pri: 3A Sec: 2A Ter: 2B	Scaffolding Construction Discrepancies In general, scaffolds observed by the inspector were well constructed and properly restrained to prevent damage to safety-related electrical equipment from planned work or a seismic event. However, the inspector did identify a non-cited violation involving several instances of improperly constructed scaffolds over safety-related electrical equipment. Procedural requirements were not met (Section M1.5).
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11/13/1999	1999007-03	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 2B Ter: 5C	Inadequate Corrective Action To Prevent Working Outside Authorized Work Order Scope During reactor protection system channel A troubleshooting activities, an Instrumentation and Control supervisor decided to take additional voltage readings of channel B which were not authorized by the existing work order. This action resulted in the inadvertent actuation of three separate channel B reactor protection system trip signals. Other examples of failures to limit work activities to within the authorized work scope had occurred previously. A non-cited violation was issued for inadequate corrective actions to prevent recurrence (Section M4.2).
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10/02/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	Emergency Diesel Generator 1B Preventive Maintenance Overall, contractor and licensee personnel were proficient during refueling outage maintenance on the 1B emergency diesel generator. Procedures were present at the work location and provided sufficient detail and guidance for the assigned work.
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10/02/1999	1999006-01	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 3A Ter: 4C	Failure of Contractors to Follow Emergency Diesel Generator Maintenance Procedures A non-cited violation was identified when contractor personnel failed to follow maintenance procedures during leakage testing of the engine power assembly valves. (Section M1.2).
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10/02/1999	1999006	Pri: MAINT Sec: ENG	NRC	POS	Pri: 2B Sec: 4C Ter:	Inservice Inspection Inservice Inspection activities were being performed in accordance with requirements with strong licensee direction and oversight of contract personnel. Overall, the licensee's inservice inspection program was considered to be a strength. (Section M1.5).
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10/02/1999	1999006-03	Pri: MAINT Sec: ENG	NRC	NCV	Pri: 4C Sec: 3B Ter: 3A	Failure of Contractors To Follow Procedures Associated With Freeze Seal Activities Contractor personnel were knowledgeable with their freeze seal equipment and its operation, but were not familiar with licensee procedures or maintenance practices. Consequently, they did not adhere to several procedural requirements. A non-cited violation was identified. (Section M1.3).
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08/21/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: 4B Ter:	Evaluation of control room air conditioning system failures Recent failures associated with the control room air conditioning system were appropriately evaluated with respect to the Maintenance Rule. The licensee's monitoring and tracking through the use of system performance windows has led to increased reliability of several systems that are important to safety. (Section E2.1 and E2.2)
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08/21/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter: 3B	Conduct of maintenance and surveillance activities Observed maintenance and surveillance activities were performed consistent with established work control processes. Risk assessments were performed prior to emergency diesel generator and start-up transformer maintenance outages to ensure there were no significant increase in risk. Also, unavailability time during these critical maintenance activities was managed appropriately. (Section M1.1)
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08/21/1999	1999005-03	Pri: MAINT Sec: ENG	Licensee	NCV	Pri: 2B Sec: 4C Ter:	Inadequate procedures for functional testing of SI system A non-cited violation was identified for the failure to maintain adequate procedures for conducting engineering safeguards actuation functional testing. Due to the longstanding procedure errors, both safety injection actuation systems have been blocked simultaneously for short periods during monthly surveillance testing, which is a condition prohibited by Technical Specifications. (Section M8.1)
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07/10/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	Conduct of surveillance activities Surveillance activities were appropriately planned, performed and coordinated with the control room. The Emergency Diesel Generator 1A surveillance and the Unit 1 Moderator Temperature Coefficient test were well briefed and executed. (Sections M1.1, M1.2, and M1.3)
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07/10/1999	1999004-04	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 3A Ter:	Failure to Control Work Scope Per Administrative Procedure Control of work activities during control element drive mechanism control system repairs was not accomplished in accordance with the scope change requirements of the licensee's administrative procedure. A non-cited violation was identified. (Section M4.2)
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05/29/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3B Ter: 4B	Overall resolution of Intake Cooling Water pump shaft corrosion problems The licensee's overall resolution of Intake Cooling Water pump shaft corrosion problems was effective. While initial efforts to investigate the pump shaft failure were not aggressive, once the shaft corrosion was identified, the licensee's actions were reasonable and prudent. Mechanical maintenance activities were conducted according to written work instructions by skilled personnel. Maintenance supervision provided active oversight and direction of the work. Engineering support of the work activities, resolution of emergent problems, and root cause investigation was effective. (Section M1.2).
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05/29/1999	1999003-01	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 3C Ter:	Inadequate Foreign Material Accountability Controls For The Spent Fuel Pool Areas Foreign material exclusion controls in the spent fuel pool areas were effective for routine day-to-day entries. However, long term accountability and control of items left in the areas were not adequate. A non-cited violation was identified regarding inadequate procedural guidance for these aspects of foreign material exclusion controls (Section M2.1)
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05/29/1999	1999003	Pri: MAINT Sec: OPS	NRC	POS	Pri: 3A Sec: 2B Ter: 5A	Conduct of Auxiliary Feedwater system relay test Operations and Instrumentation and Controls personnel properly performed an Auxiliary Feedwater Actuation System relay test using effective pre-job briefings, three part communications, and peer checking. Attention to detail by the involved technicians resulted in a test procedure error being identified and corrected (Section M4.1).
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04/17/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 2B Ter: 3B	Application of lessons learned Application of lessons learned and effective teamwork during the planning, preparation, and implementation of work, resulted in successful repairs of emergency core cooling system header leaks while minimizing the out of service time of important safety systems. (Section M1.2)
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04/17/1999	1999002-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 2B Ter: 5A	Missed Steam Generator U-Tube Inspection A Non-Cited Violation was identified for failure to complete the required steam generator tube inspections during the Unit 2 Cycle 11 refueling outage. This condition was identified and reported by the licensee in Licensee Event Report (LER) 50-389/ 98-008-00. (Some tubes not inspected due to software encoding errors related to use of remote positioning device) (Section M8.1)
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04/17/1999	1999002	Pri: MAINT Sec: ENG	NRC	POS	Pri: 3A Sec: 2B Ter: 4B	Surveillance testing of sodium hydroxide tank vacuum breaker check valves Surveillance testing of the Unit 1 sodium hydroxide tank vacuum breaker check valves was conducted in a methodical, step-by-step manner. The test engineer immediately notified the control room and wrote a three-day condition report when one of the check valves failed to open. Compensatory measures to restore operability were prompt and effective. Engineering dispositions of the applicable condition reports were thorough and comprehensive. (Section M1.3)
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03/06/1999	1999001	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter:	Contingency preparations for failure of the emergency cooling canal discharge valves Contingency preparations for mitigating a potential failure of the emergency cooling canal discharge valves during routine surveillance testing were not fully implemented. Transfer of responsibility for installation of ultimate heat sink stop logs from Maintenance Services to the Mechanical Maintenance department had not been well executed (Section M1.2).
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03/06/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 5A Sec: 3A Ter: 3B	Troubleshooting efforts for a failed containment isolation valve Troubleshooting efforts for a failed containment isolation valve were successful once Instrumentation and Control supervision became involved, helping the crew focus on problem identification. Clearances were observed to provide the necessary safety boundary for completion of the work. Replacement and post maintenance testing of the valve were successfully completed by skillful and knowledgeable maintenance personnel (Section M1.4).
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03/06/1999	1999001	Pri: MAINT Sec: ENG	NRC	POS	Pri: 4B Sec: 5A Ter: 5C	Quarterly system health review meeting The quarterly system health review meeting between management, engineering, and maintenance relative to equipment status and the status of corrective actions for equipment problems was effective (Section M1.6).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
03/06/1999	1999001	Pri: MAINT Sec: OPS	NRC	POS	Pri: 2B Sec: 3A Ter: 3B	Maintenance and surveillance activities Observed maintenance and surveillance activities were performed in a quality manner and documentation was appropriate. Procedures were in place and were being conscientiously followed by knowledgeable and qualified maintenance personnel. Interface between maintenance and operations personnel was good (Sections M1.1 and M1.6).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 4C Ter:	Response to Generic Letter 98-02 The licensee's assessment in response to Generic Letter 98-02, Loss of Reactor Coolant Inventory and Associated Potential for Loss of Emergency Mitigation Functions While in a Shutdown Condition, identified potential draindown paths where flow could be redirected from the shutdown cooling system. Engineers performed a thorough assessment to identify all vulnerabilities and analyze the potential impact on the ability of the shutdown cooling system and the emergency core cooling system to perform their design functions. Corrective actions have been implemented which provide adequate administrative controls, procedures, and training to preclude inadvertent manipulation of valves associated with the potential draindown paths (Section E8.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/02/1999	1999006	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 4C Ter:	Amendment 12 to the St. Lucie, Unit 2, Updated Final Safety Analysis Report Amendment 12 to the St. Lucie, Unit 2, Updated Final Safety Analysis met the requirements of 10 CFR 50.71 and 10 CFR 50.59, including the timeliness requirements for submission of this amendment to the NRC (Section E4.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
10/02/1999	1999006	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5B Ter: 5C	Fuel Sipping and Ultrasonic Testing Operations Extensive fuel sipping, inspection, and testing efforts were completed to identify the source of minor Unit 1 fuel leakage. Responsible licensee and contractor personnel were knowledgeable and performed their activities in accordance with applicable procedures. Close coordination was evident among the refueling team, Reactor Engineering, and the fuel sipping team. All effected fuel assemblies were either discharged or repaired. The root cause analysis was thorough, detailed and comprehensive. Long-term actions were proposed to improve future fuel performance. (Section E1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
10/02/1999	1999006-02	Pri: ENG Sec:	Licensee	NCV	Pri: 1C Sec: 3A Ter:	Failure to Repair Steam Generator Tube that Exceeded TS Plugging Limits Failure to Repair Steam Generator Tube that Exceeded TS Plugging Limits
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
08/21/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 4B	Reactivity Management Event summaries Reactivity Management Event summaries provided specific insights of recent events from a reactor engineering perspective and were a useful tool in succinctly communicating the scope and impact of reactivity management events to management. (Section E1.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 4B Ter:	Containment radiation monitoring systems Containment radiation monitoring systems were determined to meet original design and were sufficient to meet the intent of Regulatory Guide 1.45. (Section E8.2)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 4A Ter: 5B	Year 2000 readiness The Year 2000 inspection was completed in accordance with Temporary Instruction 2515/141. Overall, the Year 2000 project was 100 percent complete for Category 1 and 2 items and contingency planning, and 85 percent complete for Category 3 items. (Section E8.4)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 5B Ter: 5C	Initial root cause evaluations and corrective actions for control element assembly events Initial root cause evaluations and corrective actions for the control element assembly events were sufficient to support restart of Unit 2, and the final root cause determination and associated corrective actions were appropriate. The cause of the dropping of assembly No. 40 was two separate ground faults that created a phase to phase to ground fault. The cause of the dropping of the assemblies in subgroup No. 21 was misalignment of the power switch compartment during troubleshooting activities. (Section E2.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 5B Sec: 3C Ter: 4B	Event Response Team (ERT) and root cause analysis activities Event Response Team (ERT) and root cause analysis activities for the two control element assembly drop events and other issues associated with the control element drive mechanism control system were conducted in a thorough and comprehensive manner. Management involvement and oversight was evident throughout. A detailed self-assessment of ERT performance was very self-critical and identified many significant lessons learned. (Sections E1.1 and E2.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004-05	Pri: ENG Sec:	NRC	EEI	Pri: 4A Sec: 4C Ter:	Apparent violation for failure to establish environmental qualification An apparent violation was identified regarding the failure to establish environmental qualification, in accordance with 10 CFR 50.49, for electrical equipment located in the Unit 1 steam trestle area. (Section E8.3)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
05/29/1999	1999003	Pri: ENG Sec:	Licensee	NOED	Pri: 4A Sec: 5B Ter: 5C	Errors in the analysis of a main steam line break in containment The licensee identified several errors in the analysis of a main steam line break in containment. A re-analysis, using more appropriate assumptions, indicated that Unit 1 containment pressure could exceed the value specified in the Updated Final Safety Analysis Report and Technical Specification bases. The licensee completed an evaluation which concluded that the Unit 1 containment was operable and continued operability was justified per the guidance of Generic Letter 91-18. The licensee's immediate corrective actions were comprehensive and additional actions are planned (Section E8.2).
Dockets Discussed: 05000389 Saint Lucie 2						
05/29/1999	1999003	Pri: ENG Sec: MAINT	NRC	NEG	Pri: 4C Sec: 4B Ter: 5C	Implementing action of Technical Specification 6.8.4.a(i) Program requirements for implementing Technical Specification 6.8.4.a(i) regarding preventive maintenance and visual inspection of potential highly radioactive primary coolant leaks outside containment were not well defined. Other existing plant processes were adequately minimizing leakage. Engineering conducted a thorough review of the issue and developed corrective actions for providing additional controls to ensure leakage limits were maintained within the safety analysis assumptions (Section E3.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/17/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 3A Sec: 4C Ter: 5A	Root Cause Team for the 2B Qualified Safety Parameter Display System The Root Cause Team assembled to coordinate troubleshooting and repair activities for the 2B Qualified Safety Parameter Display System used good teamwork to systematically determine the root cause of the equipment failure. Communications were effective between team members. (Section E2.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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03/06/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 4C Ter: 5C	Accuracy of Unit 1 feedwater flow indications Engineering support and written evaluations to address questions involving the accuracy of Unit 1 feedwater flow indications were comprehensive and technically sound. Management decisions throughout the investigation were conservative. Facility Review Group involvement was evident (Section E1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/01/2000	1999008	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 3A Ter:	Unit 1 vital areas Unit 1 vital areas were devitalized per procedure at the beginning of the outage. Although allowed by the Physical Security Plan and security procedures, it was not necessary to devitalize all of the areas. Management was not involved in the decision. (Section S2.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/01/2000	1999008-02	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 4A Ter: 4B	Appendix R Cable Separation Problems Inside Containment These issues involve the failure to provide adequate spatial separation between redundant Appendix R train cables or provide for radiant energy shields (Section F8.4).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/01/2000	1999008-03	Pri: PLTSUP Sec:	NRC	URI	Pri: 1C Sec: 4A Ter: 4B	PORV Cabling May Not be Protected from Hot-Shorts Inside Containment (Section F8.8) The inspectors questioned how the power operated relief valve (PORV) was protected from spurious opening due to fire induced hot shorts. The licensee could not locate the referenced "analysis" nor any correspondence from the NRC granting an exemption. The licensee requested to time to locate such documents. Therefore, this issue is identified as an Unresolved Item. (Section F8.8)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
01/01/2000	1999008-04	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 4A Ter: 4B	Incorrect Cable Tray Fire Stop Assemblies The failure to install qualified 3-hour rated cable tray fire stops is a violation of the licensee's approved fire protection program as described in the UFSAR. (Section F8.12)
Dockets Discussed: 05000389 Saint Lucie 2						
01/01/2000	1999008-05	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 3A Ter:	Failure to Obtain Negative Drug Test Result Prior to Granting an Individual Unescorted Access (Section S1.2) Due to an administrative error, two individuals were granted access to the protected areas for about 1 day before the results of drug testing were received. One individual accessed the protected area. (Section S1.2)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: Ter:	Emergency preparedness program and response capabilities The licensee's emergency preparedness program and response capabilities were maintained in a state of operational readiness. Additionally, changes to the Emergency Preparedness program met commitments, NRC requirements, and did not affect the licensee's overall state of preparedness. Minor procedure and equipment issues were identified (Section P1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: 2B Ter:	1998 Annual Effluent Release Report and Annual Radiological Environmental Monitoring Report The 1998 Annual Effluent Release Report and Annual Radiological Environmental Monitoring Report were submitted in accordance with Technical Specifications and documented results demonstrated gaseous and liquid effluent processing and subsequent releases met established regulatory limits and did not significantly impact the surrounding environs (Section R3.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: 3A Ter:	Radiological environmental monitoring program for sampling airborne and surface water radionuclides The radiological environmental monitoring program for sampling airborne and surface water radionuclides, and for monitoring direct radiation was implemented in accordance with the Offsite Dose Calculation Manual specifications (Section R2.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: 3A Ter: 2B	Radiological controls and monitoring for low-level radioactive waste processing/storage areas Radiological controls and monitoring for low-level radioactive waste processing/storage areas and effluent processing activities were implemented effectively and maintained in accordance with Updated Final Safety Analysis Report, Technical Specification, and 10 CFR Part 20 requirements. Occupational worker doses were within administrative and regulatory limits. The onsite storage and disposal of solid radioactive waste was managed effectively (Section R1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: 5A Ter:	Counting-room Quality Control activities Counting-room Quality Control activities were implemented appropriately and verified the accuracy of radionuclide analytical measurement instrumentation (Section R7.2).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Knowledge of procedures and proficiency for a liquid effluent release Licensee staff demonstrated appropriate knowledge of procedures and proficiency in completing a waste monitor tank liquid effluent release. Overall, the liquid effluent release was implemented effectively. For 1999, effluent radionuclide concentrations and resultant projected offsite doses to members of the public were within regulatory limits and design objectives (Section R1.2).
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/13/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5B Ter: 5C	Licensee actions for radiation protection condition report issues Licensee actions for radiation protection condition report issues associated with radioactive waste and effluent processing and releases, chemistry, and transportation were appropriate and completed in a timely manner (Section R7.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
10/02/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	Conduct of Unit 1 Refueling Outage Radiological Protection Controls Radiological controls were maintained and implemented in accordance with the Updated Final Safety Analysis Report, Technical Specifications, license conditions, and 10 CFR Part 20 requirements. Occupational worker doses were within administrative and regulatory limits (Section R1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
10/02/1999	1999006	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	As Low As Reasonably Achievable (ALARA) Program Implementation As Low As Reasonably Achievable program activities and initiatives for the Unit 1 refueling outage were conducted in accordance with approved procedures and were effective in reducing dose expenditures. The 1999 year-to-date dose expenditures met the reduced cumulative year-to-date exposure budget targets for the site and Unit 1 refueling outage activities (Section R1.2).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
08/21/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Health Physics response to a contamination event Health Physics response to a contamination event was in accordance with licensee procedure and exhibited appropriate radiological control practices. (Section R4.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Occupational worker doses for calendar year 1998 and year-to-date 1999 Occupational worker doses were within regulatory limits for CY98 and YTD99. ALARA program implementation was conducted in accordance with approved procedures, and YTD99 cumulative exposure results met established goals. (Section R1.2)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Radioactive effluent releases Radioactive effluent releases and resultant doses were maintained within Technical Specifications, 10 CFR Part 20, Offsite Dose Calculation Manual limits, and the design objectives of Appendix I to 10 CFR Part 50. (Section R3.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/10/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 2B	Overall radiological controls Radiological controls were maintained and implemented in accordance with the Updated Final Safety Analysis Report, Technical Specifications, and 10 CFR Part 20 requirements. Disposal of high level radwaste from the Unit 1 spent fuel pool was particularly well controlled. (Sections R1.1 and
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
07/10/1999	1999004	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5A Ter: 5C	Audit program activities for the radiation protection and effluent program areas Audit program activities were implemented effectively for the radiation protection and effluent program areas. In general, follow up actions for issues identified in Condition Reports associated with radiation protection or effluent program activities were appropriate and completed in a timely manner. (Section R7.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
05/29/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter: 3B	Security officers served as roving Fire Protection Program watches Security officers completing Fire Protection Program requirements for roving fire watches as part of their dedicated patrols were knowledgeable of their fire watch responsibilities. The fire watch tours were routinely being accomplished more frequently than specified by regulatory requirements (Section S1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/17/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3A Ter:	Annual emergency preparedness exercise scenario The annual emergency preparedness exercise scenario was well crafted and challenged the emergency response organization. Communications and coordination between the emergency response facilities were effective. Licensee declarations of progressively higher emergency action level classifications were consistent with implementing procedures and the simulated deterioration of plant conditions. (Section P1.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/17/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 3B Ter: 3A	Routine radiological surveys Routine radiological surveys were completed by knowledgeable technicians using efficient and conservative methods. (Section R4.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/16/1999	1999010	Pri: PLTSUP Sec:	NRC	MISC	Pri: 1C Sec: Ter:	Changes to the Physical Security Plan Changes to the Physical Security Plan submitted by the licensee were generally satisfactory. The inspectors identified that the licensee failed to submit a revision to the Physical Security Plan when the response station was no longer utilized (Section S3.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/16/1999	1999010	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Security officer continuous communication Two examples were identified in which officers, for a brief period of time, did not maintain the capability for continuous communication with an individual in the Central or Secondary Alarm Station (Section S1.3).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/16/1999	1999010	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Low number of Condition Reports generated by Security Security generated a lower number of Condition Reports than actual problems that had been identified and corrected (Section S7.4).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/16/1999	1999010-02	Pri: PLTSUP Sec:	NRC	NCV	Pri: 1C Sec: 3A Ter:	Failure to Detect Test Explosive Device One Non-Cited Violation of regulatory requirements was identified when the inspectors bypassed one of the explosive detectors with a test source due to configuration of the metal and explosive detectors (Section S.2.2).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
04/16/1999	1999010-03	Pri: PLTSUP Sec:	NRC	NCV	Pri: 3A Sec: 1C Ter:	Security Shift Specialist Duties Interfere with Ability to Direct in Emergencies One Non-Cited Violation was identified in that, in some instances, duties of the Security Shift Specialist were not being performed as required in the Physical Security Plan (Section S6.2).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
03/06/1999	1999001	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: 2A Ter:	Poor radiological practice A poor radiological practice resulting in decreased effectiveness of labels, contamination controls, and As Low As Reasonably Achievable program implementation was identified associated with the Unit 1 drumming facility locked-high radiation area. (Section R1.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
03/06/1999	1999001	Pri: PLTSUP Sec:	NRC	NEG	Pri: 2B Sec: 3A Ter:	Counting room gamma-spectroscopy Quality Control activities Counting room gamma-spectroscopy Quality Control activities and inter-laboratory analyses were implemented appropriately and no negative trends were identified. The addition of standard deviation to the observed value of a quality control spiked sample in order to meet acceptance criteria was identified as a poor practice (Section R7.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/06/1999	1999001	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 2A Ter:	Low-level radioactive waste storage areas The licensee continued to consolidate low-level radioactive waste storage areas and reduce quantities of solid radioactive waste stored onsite. Excluding the Unit 1 drumming facility, selected radiological control area locations were uncluttered. Area postings, container labels, and radiological controls were maintained in accordance with regulatory requirements (Section R1.1).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
03/06/1999	1999001	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 2B Ter:	Radiation Monitor System (RMS) detector and electronic calibrations Radiation Monitor System (RMS) detector and electronic calibrations were conducted at required frequencies and met established acceptance criteria. The Unit 2 emergency core cooling system particulate sample line installation contained 90 degree bends immediately preceding the sample filter housing. This configuration is not recommended and could adversely affect sample accuracy. In general, RMS equipment and sample lines were installed in accordance with the Updated Final Safety Analysis Report, configuration control diagrams, and acceptable industry practices (Section R1.2).
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						
03/06/1999	1999001-03	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: 3A Ter:	HP Technician Exceeded TS Overtime Limits The licensee identified that a Health Physics technician exceeded Technical Specification overtime limits by working 29 hours in a 48 hour period. A non-cited violation was issued (Section R6.1)
Dockets Discussed: 05000335 Saint Lucie 1 05000389 Saint Lucie 2						

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By Primary Functional Area

Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
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.