

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
FARLEY

| Date  | Source     | Functional Area                      | ID       | Type | Template Codes                                     | Item Title<br>Item Description   |
|---|------------|--------------------------------------|----------|------|--|--|
| 01/22/2000  | 1999010    | <b>Pri:</b> OPS<br><b>Sec:</b> ENG   | NRC      | POS  | <b>Pri:</b> 1A<br><b>Sec:</b> 1C<br><b>Ter:</b> 4B | <b>General Plant Operations</b><br>Planned Unit 1 power reductions to repair secondary plant equipment were well planned and executed. Unit 2 restart from the refueling outage and power ascension activities were effectively controlled. Licensee actions for Y2K rollover were in accordance with established procedures and were well planned and controlled.   |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |          |      |  |  |
| 12/12/1999  | 1999010-01 | <b>Pri:</b> OPS<br><b>Sec:</b>       | NRC      | NCV  | <b>Pri:</b> 1A<br><b>Sec:</b> 1C<br><b>Ter:</b>    | <b>Mode Change Made with Required 600 Volt Lead Center Room Cooler Inoperable</b><br>A Non-Cited Violation was documented for a licensee-identified error to ensure all required equipment was operable when changing modes during power ascension. The Unit 2E load center room cooler was not operable as required when the licensee entered Mode 4 and Mode 3 due to communication errors and deficiencies in the licensee mode restraint tracking process. |
| <b>Dockets Discussed:</b><br>05000364 Farley 2                      |            |                                      |          |      |  |  |
| 10/30/1999  | 1999007-01 | <b>Pri:</b> OPS<br><b>Sec:</b>       | NRC      | NCV  | <b>Pri:</b> 3A<br><b>Sec:</b> 1C<br><b>Ter:</b>    | <b>Technical Specification violation for control room ventilation</b><br>The licensee violated Technical Specifications 3.3.3.1 by not starting the Control Room Emergency Ventilation system within one hour after making Radiation Monitors RE 35A&B inoperable. Personnel error during initial construction and drawing validation resulted in an incorrect drawing that contributed to the problem.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |          |      |  |  |
| 06/26/1999  | 1999004    | <b>Pri:</b> OPS<br><b>Sec:</b>       | NRC      | POS  | <b>Pri:</b> 1B<br><b>Sec:</b> 3A<br><b>Ter:</b>    | <b>Operator Performance</b><br>Operator performance was excellent as noted during normal plant operations and in response to reactor trips on Unit 1 and on Unit 2. This strong performance included startup activities on both units, and response to a steam generator level transient on Unit 2   |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |          |      |  |  |
| 06/26/1999  | 1999004    | <b>Pri:</b> OPS<br><b>Sec:</b> MAINT | Licensee | NEG  | <b>Pri:</b> 3A<br><b>Sec:</b> 1B<br><b>Ter:</b> 2A | <b>Switching lube oil coolers results in reactor trip</b><br>Operator performance when switching lube oil coolers and during the load reduction, combined with procedural and training weaknesses, resulted in the Unit 1 automatic reactor trip   |
| <b>Dockets Discussed:</b><br>05000348 Farley 1                      |            |                                      |          |      |  |  |
| 04/14/1999  | 1999003    | <b>Pri:</b> OPS<br><b>Sec:</b> MAINT | NRC      | POS  | <b>Pri:</b> 3A<br><b>Sec:</b> 1B<br><b>Ter:</b>    | <b>High Voltage Switch Yard (HVSY) Evolutions</b><br>The licensee took conservative and appropriate actions during the observed evolution of placing the capacitor bank in service in the high voltage switch yard.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |          |      |  |  |

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| 03/29/1999  | 1999003    | <b>Pri:</b> OPS<br><b>Sec:</b>     | NRC      | NEG  | <b>Pri:</b> 1C<br><b>Sec:</b> 1B<br><b>Ter:</b>    | <b>Penetration Room Filtration (PRF) Operability Determination</b><br>The inspector concluded that the safety evaluation of manual operator action to maintain PRF system operability was not thorough in that the normal Shift Foreman Operating (SFO) duties may have prevented the SFO from fulfilling this function.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                    |          |      |  |   |
| 02/20/1999  | 1999001    | <b>Pri:</b> OPS<br><b>Sec:</b>     | NRC      | NEG  | <b>Pri:</b> 1A<br><b>Sec:</b> 1C<br><b>Ter:</b>    | <b>Implementation of Out of Service Monitor</b><br>The inspectors noted that the Shift Supervisor did not always include all out-of-service risk-significant equipment when updating the EOOS monitor to obtain a new RAW value. These omissions resulted in the EOOS monitor underestimating the increase in relative risk. Improvement in Operations department personnel implementation of the risk-based equipment out of service monitor was warranted.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                    |          |      |  |   |
| 02/20/1999  | 1999001    | <b>Pri:</b> OPS<br><b>Sec:</b>     | NRC      | STR  | <b>Pri:</b> 1B<br><b>Sec:</b> 2A<br><b>Ter:</b> 3A | <b>Response to Instrument Air Problems</b><br>The inspectors observed that control room operators responded promptly to decreasing Instrument Air pressure on Unit 1 and high Instrument Air pressure on Unit 2.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                    |          |      |  |   |
| 02/20/1999  | 1999001    | <b>Pri:</b> OPS<br><b>Sec:</b> ENG | Licensee | POS  | <b>Pri:</b> 1B<br><b>Sec:</b> 4B<br><b>Ter:</b> 5B | <b>Response to Increased Dose Equalivent Iodine</b><br>The licensee appropriately responded to the Unit 1 increased Dose Equalivent Iodine and Chemistry and Engineering support personnel provided accurate and timely analysis and recommendations.   |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                    |          |      |  |   |
| 12/11/1999  | 1999008-01 | <b>Pri:</b> MAINT<br><b>Sec:</b>   | Self     | NCV  | <b>Pri:</b> 1A<br><b>Sec:</b> 1C<br><b>Ter:</b> 3A | <b>Inadequate Lower Internals Lift Procedures and Failure to Follow ACP-15.0</b><br>An inadequate maintenance procedure and a failure to follow an administrative control procedure during the Unit 2 reactor vessel lower internals lift was a non-cited violation. The root cause efforts were thorough and well conducted, and appeared effective based on performance during subsequent lifts. (Section M1.2)   |
| <b>Dockets Discussed:</b><br>05000364 Farley 2                      |            |                                    |          |      |  |   |
| 09/18/1999  | 1999006-02 | <b>Pri:</b> MAINT<br><b>Sec:</b>   | NRC      | NCV  | <b>Pri:</b> 3A<br><b>Sec:</b> 2B<br><b>Ter:</b>    | <b>Inadequate Implementation of Corrective Actions Resulting in Additional Scaffold Errors</b><br>Corrective actions for previous scaffolding issues did not prevent recurrence of inadequately secured scaffolding or to ensure inadequately secured scaffolding was evaluated. This issue was dispositioned as NCV 50-348, 364/99-06-02 because of the extent to which senior site management became immediately and aggressively involved in assuring effective corrective actions and the lack of actual safety significance. |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                    |          |      |  |   |

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|---|------------|--------------------------------------|-----|------|--|---|
| 08/07/1999  | 1999005    | <b>Pri:</b> MAINT<br><b>Sec:</b> OPS | NRC | NEG  | <b>Pri:</b> 3A<br><b>Sec:</b> 2B<br><b>Ter:</b> 2A | <b>Work Control during EDG Maintenance</b><br>Work control issues during 1C diesel generator maintenance substantially contributed to unnecessary D/G unavailability.   |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |     |      |  |   |
| 06/26/1999  | 1999004    | <b>Pri:</b> MAINT<br><b>Sec:</b> ENG | NRC | NEG  | <b>Pri:</b> 1C<br><b>Sec:</b> 4B<br><b>Ter:</b>    | <b>Maintenance Rule Program</b><br>The inspectors concluded the documentation maintained by the licensee for the Maintenance Rule program was weak and that implementation of attributes in the process were inconsistent.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |     |      |  |   |
| 05/15/1999  | 1999003    | <b>Pri:</b> MAINT<br><b>Sec:</b>     | NRC | POS  | <b>Pri:</b> 2B<br><b>Sec:</b> 3C<br><b>Ter:</b>    | <b>Equipment Outage Scheduling</b><br>The implementation of 12 week rolling schedules for on-line maintenance has resulted in timely completion of most work items. As a result, the maintenance backlog has been trending downward.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |     |      |  |   |
| 02/20/1999  | 1999001-01 | <b>Pri:</b> MAINT<br><b>Sec:</b>     | NRC | NCV  | <b>Pri:</b> 2B<br><b>Sec:</b> 3A<br><b>Ter:</b> 5C | <b>Inadequate Corrective Actions Results in Additional Scaffolding Errors</b><br>The corrective actions for previously identified scaffolding construction deficiencies did not address the adequacy of the procedural guidance or the training of licensee personnel responsible for erection and inspection of scaffolding.   |
| <b>Dockets Discussed:</b><br>05000364 Farley 2                      |            |                                      |     |      |  |   |
| 02/20/1999  | 1999001    | <b>Pri:</b> MAINT<br><b>Sec:</b> OPS | NRC | POS  | <b>Pri:</b> 2B<br><b>Sec:</b> 3C<br><b>Ter:</b> 1A | <b>Implementation of 13-week Rolling Maintenance Schedule</b><br>The licensee implemented a new 13-week rolling maintenance schedule designed to better utilize maintenance resources. There were positive initial results from the first few weeks of implementation.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |     |      |  |   |
| 09/18/1999  | 1999006-01 | <b>Pri:</b> ENG<br><b>Sec:</b>       | NRC | NCV  | <b>Pri:</b> 4A<br><b>Sec:</b> 4C<br><b>Ter:</b> 5A | <b>Incorrect 10 CFR 50.59 Screening</b><br>An incorrect 10 CFR 50.59 screening allowed a change to the plant as described in the FSAR without a written safety evaluation. The licensee promptly restored compliance and issued OR 1-99-589 to develop additional corrective actions. This issue was dispositioned as NCV 50-348, 364/99-06-01<br><br>The NRC identified two additional examples of inadequate 10 CFR 50.59 screening evaluations for procedure revisions. One evaluation failed to take into account reactor operating modes while propping open water tight doors to install temporary ventilation. The second example allowed a procedure change that removed the guidance to secure the control room utility exhaust fan. This allowed the main control room to be operated at a negative pressure contrary to design. These issues were identified as additional examples of NCV 50-348, 364/99-06-01 (IR 99-07) |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                      |     |      |  |   |

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|---|------------|-----------------------------------|----------|--------|--|---|
| 06/26/1999  | 1999004    | <b>Pri:</b> ENG<br><b>Sec:</b>    | Licensee | NEG    | <b>Pri:</b> 4A<br><b>Sec:</b> 1C<br><b>Ter:</b> 2A | <b>Piping Support Mod Causes Loss of Condenser Vacuum and Reactor Trip</b><br>A steam dump piping failure, due to a piping support modification, caused a loss of main condenser vacuum and subsequent manual reactor trip.   |
| <b>Dockets Discussed:</b><br>05000364 Farley 2                      |            |                                   |          |        |  |   |
| 08/07/1999  | 1999005    | <b>Pri:</b> PLTSUP<br><b>Sec:</b> | NRC      | POS    | <b>Pri:</b> 3A<br><b>Sec:</b> 2B<br><b>Ter:</b>    | <b>Contamination Drill Response</b><br>Proper radiological control practices were demonstrated during a Contamination Drill and the drill effectively evaluated the ability of personnel to respond.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                   |          |        |  |   |
| 06/26/1999  | 1999004-01 | <b>Pri:</b> PLTSUP<br><b>Sec:</b> | NRC      | NCV    | <b>Pri:</b> 1C<br><b>Sec:</b><br><b>Ter:</b>       | <b>Inadequate Procedures to Verify Manual Hose Station Pressure Restricting Valve Flow and Pressure Requirer</b><br>The licensee's fire protection surveillance test program for the manual hose and standpipe system did not meet all fire protection requirements as described in the UFSAR. The licensee had not provided adequate surveillance procedures to verify functional performance of the pressure restriction valves in the manual hose and standpipe system.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                   |          |        |  |   |
| 03/10/1999  | 1999009    | <b>Pri:</b> PLTSUP<br><b>Sec:</b> | NRC      | POS    | <b>Pri:</b> 2A<br><b>Sec:</b> 2B<br><b>Ter:</b>    | <b>Security Equipment</b><br>The licensee's access control equipment, perimeter intrusion detection system, and closed circuit television camera assessment met the requirements outlined in the Physical Security Plan.  |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 2 |            |                                   |          |        |  |   |
| 03/10/1999  | 1999009-02 | <b>Pri:</b> PLTSUP<br><b>Sec:</b> | NRC      | VIO IV | <b>Pri:</b> 1C<br><b>Sec:</b> 3A<br><b>Ter:</b> 3C | <b>Failure to Intercept and Engage Mock Adversary Force</b><br>Apparent Violation, EEI 50-348, 364/99-09-01, was identified in March 1999, due to the existing design basis threat response strategy. Response objectives of the Security Plan were not met in that security force members failed to intercept and engage a mock adversary force to protect against radiological sabotage. The Apparent Violation was later identified as a violation of 10 CFR 73.55 and the Physical Security Plan, based upon the licensee's initial corrective action to restore compliance (i.e., to implement compensatory measures, on March 11, 1999, was not implemented in a reasonable amount of time. It was 24 hours after the violation was identified before compensatory measures were in place.) |
| <b>Dockets Discussed:</b><br>05000348 Farley 1<br>05000364 Farley 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.