

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II

VOGTLE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/27/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Refueling outage performance</b> Operations performance during Unit 2 startup following refueling outage 2R7 was thorough and activities were well controlled. In particular, during high risk evolutions, such as reactor coolant system reduced inventory, activities were conducted with direct management oversight and with heightened emphasis on risk.
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
11/27/1999	1999008-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3C <b>Sec:</b> 1A <b>Ter:</b>	<b>Air intrusion of Safety Injection pumps due to inadequate procedures</b> Inadequate procedural guidance for Safety Injection (SI) system fill and vent was a violation of Technical Specification 5.4.1. (Licensee Event Report 50-425/99-002)
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
09/04/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Licensed Operator Requalification Program evaluation</b> The licensed operator requalification examinations were challenging and operators' performance matched testing objectives. Post-examination discussions comprehensively assessed individual and crew performance. The content of the annual operating tests, written and operating test sample plan development, security program, feedback program, and the remediation program were considered satisfactory.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
09/04/1999	1999006-01	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>Inadequate test of high energy line break circuits leads to operation outside of Technical Specifications TS)</b> The licensee failed to test the High Energy Line Break (HELB) actuation instrumentation as required by TS since initial plant startup in 1987 until the TS was relocated to the Technical Requirements Manual in 1997. The cause of the violation was an inadequate test procedure. (Licensee Event Report 50-424/99-02)
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
06/19/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 2A <b>Ter:</b>	<b>Conservative decision making</b> Management demonstrated conservative decision making to replace the generator stator cooling water strainer. Management resolve in addressing repetitive strainer plugging issues was evident by the decision to initiate an Event Review Team to study the problem.
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
06/19/1999	1999004-01	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 3A <b>Ter:</b>	<b>Technical Specification overtime limits exceeded</b> Overtime requirements specified in Technical Specification 5.2.2 was not met. In nine cases, the overtime requirement was exceeded without either prior approval or documentation for the basis of the deviation.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						

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05/01/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	STR	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Plant Review Board (PRB) activities</b>  PRB meetings continued to be thorough and self-critical. Safety Audit and Engineering Review (SAER) group audits were comprehensive and findings were well developed and effectively communicated to management. An increase in monitoring and oversight by SAER was observed during critical outage related activities in the control room. Management continued to emphasize the initiation of Condition Reports with low thresholds and corrective action plans were normally thorough.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
05/01/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b> PLTSUP	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Operations performance and material conditions and housekeeping</b>  Overall material condition and housekeeping for both units were acceptable. Particularly noteworthy was the as-left condition of the Unit 1 containment following the refueling outage. Only a small amount of debris was identified by the NRC during a containment walkdown; this was indicative of continued positive management emphasis in this area.  Operator performance during startup was satisfactory with management involvement and oversight.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
03/20/1999	1999002-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to follow verification procedure results in feedwater valve closure and manual reactor trip</b>  Two non-licensed plant operators erroneously removed control power fuses to the Unit 2 main feedwater isolation valve instead of the intended Unit 1 valve during an equipment clearance activity. The root cause of the error was poor self-checking and verification by the plant equipment operators.
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
01/08/2000	1999009-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Control Room Emergency Filtration system inoperable</b>  The failure to ensure that the Control Room Emergency Filtration System remained operable during control room door maintenance was a violation of Technical Specification 3.7.10.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
06/19/1999	1999004-02	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Inadequate procedures for conducting maintenance on safety-related circuit breakers</b>  The non-cited violation was for inadequate procedures for conducting maintenance on safety-related circuit breakers. Procedures were not appropriate to the circumstances, in that, they failed to contain adequate controls for ensuring that required seismic restraints were properly secured. As a result, numerous 480 volt safety-related circuit breakers were not returned to proper seismic configurations after maintenance.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
05/01/1999	1999003-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Containment sump operation outside of Technical Specification requirements</b>  Technical Specification (TS) 3.4.15 requires containment sump level monitors to be operable in Modes 1, 2, 3, and 4. An inoperable water level monitor represented operation in a condition prohibited by the TS. (Licensee Event Report 50-424/99-01)
<b>Dockets Discussed:</b> 05000424 Vogtle 1						

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03/20/1999	1999002-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Licensed power limit exceeded due to improper maintenance activities - multiple examples</b>  Maintenance personnel conducted on-line calibration of Unit 2 feedwater heater instruments and caused the heaters to isolate. As a result feedwater temperature decreased causing reactor power to increase to about 103.85 percent power. Contributing to the problem was operators lack of understanding and response to the problem.  Another example where reactor power exceeded 100 percent was when maintenance personnel non-conservatively calibrated the feedwater flow computer input signal to the reactor power calculation. Reactor power was slightly above 100 percent power for several days. (Licensee Event Rreport 50-425/98-10)
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
02/13/1999	1998010-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Maintenance personnel failed to follow reactor trip response time surveillance procedure</b>  Instrument and Control personnel failed to follow procedure for reactor trip response time surveillance test. This was a violation of The reactor trip response time for overpower delta temperature and overtemperature delta temperature was not performed correctly during the previous 18 months. The cause was due to a plant modification wire mis-landing that occurred in 1991. (Licensee Event Report 50-424/98-07)
<b>Dockets Discussed:</b> 05000424 Vogtle 1						
03/20/1999	1999002-03	<b>Pri:</b> ENG <b>Sec:</b> OPS	Licensee	NCV	<b>Pri:</b> 3B <b>Sec:</b> 3A <b>Ter:</b>	<b>Sequencer inoperability leads to operation outside of Technical Specifications</b>  The cause of the event was the inability of licensee personnel to interpret the cause of control room alarms and their impact on sequencer operability. As a result of insufficient knowledge, the system engineer provided incorrect information which operations personnel used to determine the sequencer was operable. (Licensee Event Report 50-425/98-09)
<b>Dockets Discussed:</b> 05000425 Vogtle 2						
09/04/1999	1999006	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	STR	<b>Pri:</b> 3A <b>Sec:</b> 4C <b>Ter:</b> 1C	<b>Physical Security controls and administration</b>  The temporary removal of a section of the Protected Area (PA) fence and vehicle barrier system was well planned and coordinated. Conservative security compensatory measures were implemented during the period that the PA fence and vehicle barrier system was degraded.  Security activities associated with temporary removal of Protected Area fencing and vehicle barrier system was well planned and coordinated. Conservative security compensatory measures were implemented. (Inspection Report (IR) 99-04, 6/19/99)  The licensee controlled access in accordance with the Physical Security Plan commitments (IR 99-05, 8/16/99)  Both the active and passive barriers of the Vehicle Barrier System were in place and operational as required by the Physical Security Plan and licensee procedures. (IR 98-12, 10/09/98)
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						
02/13/1999	1998010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Maintaining the Emergency Preparedness program</b>  The Emergency Preparedness program was being maintained in a state of operational readiness. Personnel with dose assessment responsibility demonstrated the ability to perform dose assessments and analysis of dose protection information for upgrading of emergency calssifications.
<b>Dockets Discussed:</b> 05000424 Vogtle 1 05000425 Vogtle 2						

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02/08/1999	1999001-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	VIO IV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Failure to have response officers positioned to interpose themselves between intruders and vital equipment</b>  On numerous occasions from March 1997 to October 1998, select response force officers were posted in locations that would not permit them to interpose themselves between intruder(s) and the vital area nearest to the point of penetration. This was a violation of Chapter 9 of the Physical Security Plan, Rev. 37, dated December 1998.
<b>Dockets Discussed:</b>						
05000424 Vogtle 1						
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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.