

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region III
COOK

| Date | Source | Functional Area | ID | Type | Template Codes | Item Title Item Description |
|---|------------|------------------|-----|------|----------------|---|
| 01/13/2000 | 1999021 | Pri: OPS Sec: | NRC | NEG | Pri: 2B | Outage Risk Management Logic Error The inspectors identified an error in the Outage Risk Assessment and Management logic model associated with the electrical power supply to the spent fuel pool cooling system. It was possible to calculate an acceptable risk condition with no emergency diesel generators available to support spent fuel pool cooling. Also, the licensee identified a failure to perform an Outage Risk Assessment and Management evaluation of a scheduled work activity affecting offsite power availability. Because spent fuel pool cooling requirements were met during this period, these deficiencies did not result in a significant risk impact. The licensee had implemented adequate interim compensatory measures pending long term resolution of these identified deficiencies. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/13/2000 | 1999021 | Pri: OPS Sec: | NRC | POS | Pri: 1B | Operator Response to Partial Loss of Offsite Power Operators responded promptly and effectively to a partial loss of offsite power on Unit 1. Operators used their knowledge of the low heat load in the spent fuel pool, and did not start the Unit 2 spent fuel pool cooling pump until they verified that Unit 2 was not affected by the loss of power. Operators continually monitored spent fuel pool temperature during the short time that the spent fuel pool cooling system was not operating. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 12/28/1999 | 1999034 | Pri: OPS Sec: | NRC | POS | Pri: 1C | Weakness in Licensee's Operability Determination Program Addressed Weaknesses in the licensee's Operability Determination Program had been previously identified by the NRC, by licensee self-assessments, and through other licensee activities. The licensee identified root causes and contributing causes for those weaknesses, identified corrective actions, and at the time of this inspection had either completed or planned those corrective actions. The inspectors concluded that the licensee had identified causes which were reasonable with respect to the identified weaknesses, and had identified corrective actions which were appropriate to address the identified causes. This review closes CSC Item No. 14F. Based on review of recent operability determinations, corrective actions implemented at the time of the inspection resulted in improvements in timeliness and consistency of operability evaluations. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 12/28/1999 | 1999034-01 | Pri: OPS Sec: | NRC | NCV | Pri: 1C | BATTERY 1 AB CORROSION NOT PROMPTLY CORRECTED The licensee inappropriately interpreted the Technical Specifications when addressing an operability issue involving corrosion on the 250 Vdc battery. Technical Specification Surveillance Requirement 4.8.2.3.2.c.2 required verifying that cell-to-cell connections were "free of corrosion". Operations department personnel determined that the battery was operable, based on the minor amount of corrosion and their belief that the intention of TS was met. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 11/19/1999 | 1999020-02 | Pri: OPS Sec: | NRC | NCV | Pri: 1A | INADEQUATE GUIDANCE PROVIDED TO OPERATORS The licensee failed to provide appropriate guidance for load control of the reserve auxiliary transformer following an offsite power supply transformer tap setting change. A standing order was used to provide complex guidance on loading restrictions rather than a formal procedure. This was considered a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |

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|---|------------|--------------------------------|-----|------|--|---|
| 10/31/1999 | 1999020-01 | Pri: OPS Sec: | NRC | NCV | Pri: 1A Sec: Ter: | INAPPROPRIATE PARTIAL USE OF PROCEDURE The control room operators did not properly review partial use of the essential service water system normal operating procedure prior to switching the essential service water pumps. The failure to properly review partial use of the procedure resulted in the unintended chlorination of the Unit 2 ESW system. This was considered a non-cited violation of 10 CFR Part 50 Appendix B, Criterion V. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 10/08/1999 | 1999019 | Pri: OPS Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Procedures Not Revised After Modification Two spent fuel pool (SFP) cooling system abnormal operating procedures were not revised after modifications were made to plant equipment. The annunciator response procedure for low level in the SFP directed the operators to check a section of piping which had been previously removed, and the abnormal operating procedure for loss of spent fuel pool cooling referenced a temporary modification which had been removed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/08/1999 | 1999019 | Pri: OPS Sec: | NRC | POS | Pri: 5A Sec: Ter: | Quality of Review Committee Meetings Senior Management Review Team and Nuclear Safety Design Review Committee meetings observed during this report period were conducted in a detailed, probing, and appropriate manner. Differing view points of the committee members were considered and resolved prior to dispositioning the presented information. Both committees appeared to be effective in the performance of their oversight role. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | INADEQUATE CLEARANCE ON UNIT 2 REACTOR COOLANT SYSTEM Workers inadvertently drained several hundred gallons of primary coolant from the Unit 1 volume control tank while draining the Unit 1 and Unit 2 chemical and volume control system crosstie piping. Because the Unit 1 reactor core had already been off-loaded to the spent fuel pool, this event had no actual safety significance. |
| Dockets Discussed: 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: OPS Sec: | NRC | NEG | Pri: 5A Sec: Ter: | CORRECTIVE ACTION PROGRAM WEAKNESSES The licensee exhibited corrective action program implementation weaknesses, including examples of inaccurate description of issues on condition reports and inadequate completion of past due corrective actions. Case Specific Checklist item 2B, "Inadequate Corrective Actions for Previously Identified Conditions Adverse to Quality," remained open. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: OPS Sec: | NRC | POS | Pri: 2B Sec: Ter: | TECHNICAL SPECIFICATION SURVEILLANCE PROGRAM IMPROVEMENTS The licensee implemented several Technical Specification surveillance program initiatives to improve surveillance scheduling and review. Other planned improvements were in progress to provide a more effective method for ensuring compliance with Technical Specification requirements. Case Specific Checklist item 1 remained open. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 08/06/1999 | 1999016 | Pri: OPS Sec: | NRC | POS | Pri: 3B Sec: Ter: | Requalification Operating Examination Results With exception of the two SROs, two Shift Technical Advisors (non-licensed), and one RO, the three operating shift crews passed all portions of the requalification operating examination. The individual competency failures were appropriately remediated and reevaluated prior to resumption of licensed duties. Although the evaluators and the inspectors identified some minor weaknesses pertaining to procedure use and crew communications, the aggregate individual performance deficiencies did not adversely impact the crew's ability to implement necessary mitigating actions to safely control the plant during emergencies. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016 | Pri: OPS Sec: | NRC | POS | Pri: 3B Sec: Ter: | Operator Training Weaknesses Satisfactorily Corrected The licensee's training and operations departments have appropriately addressed past program weaknesses, and continues to address issues affecting training program quality. Although some minor performance weaknesses pertaining to procedure use, communications, and command and control were observed during this inspection, the overall operator performance was, in general, satisfactory. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016 | Pri: OPS Sec: | NRC | POS | Pri: 3B Sec: Ter: | Incorporating Lessons Learned The inspectors concluded that the licensee's current student feedback and curriculum development committee (CDC) processes appeared to be effective at incorporating feedback to revise the licensed operator requalification training (LORT) program. The strong representation by both training and operations personnel appeared to enhance the CDC's effectiveness. Overall, the inspectors concluded that licensee's training department self-assessment program was up to date and flexible enough to incorporate emerging training issues. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016 | Pri: OPS Sec: | NRC | POS | Pri: 3B Sec: Ter: | Adequate Remedial Training Program The inspectors concluded that the current remedial training program contained adequate measures to ensure individual and crew performance weaknesses were identified and assigned. Operator knowledge and performance deficiencies were, in general, properly remediated, and appropriate operator reevaluations were conducted prior to resumption of licensed duties. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016 | Pri: OPS Sec: | NRC | POS | Pri: 5C Sec: 3B Ter: | Restart Readiness Assessment The implementation of actions concerning the licensee's Restart Action Plan 005 to address NRC Case Specific Checklist Item 5.D was considered satisfactory. Furthermore, based on direct observation of crew performances on steam generator tube rupture and other simulator scenarios, and including the licensee's correction to the existing emergency operating procedure foldout page, the actions taken to improve communications and event diagnosis were considered adequate. The NRC Case Specific Checklist Item 5.D, "Applicant Abilities To Communicate And Diagnose Events During Dynamic Simulator Scenarios," is closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 08/06/1999 | 1999016-01 | Pri: OPS Sec: | NRC | NCV | Pri: 1C Sec: Ter: | EXAM MATERIAL LEFT OUT UNATTENDED SUBJECT TO COMPROMISE, A VIO OF 10 CFR 55.49 The licensee satisfactorily administered the annual requalification examinations according to program guidance and consistent with regulatory guidelines. Examination security throughout the examination period was satisfactory, with the exception of one isolated incident involving security and control of examination material. One simulator scenario was left unattended which compromised the integrity of the examination. The licensee identified and the corrected the problem by replacing the compromised scenario. The licensee is tracking this issue internally through its condition report process (CR P-99-18921), and the issue is being treated as a non-cited violation in accordance with Appendix C of the NRC enforcement policy. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016-02 | Pri: OPS Sec: | NRC | NCV | Pri: 1C Sec: Ter: | FAIL TO IMPLEMENT THE BIENNIAL MEDICAL EXAM WITHIN THE REQUIRED TIME LIMITS OF 10 CFR 55.21 The operator's current license conditions were in conformance with program guidance and regulatory requirements of 10 CFR 55.21 for biennial physical examinations. However, two past events and one current situation pertaining to the implementation of the required biennial medical examinations exceeded the required 24 months time limit. The failure to implement the biennial medical examinations within the required time limit was a violation of 10 CFR 55.21. The licensee is tracking this issue internally through its condition report process (CR P-99-15011), and the issue is being treated as a non-cited violation in accordance with Appendix C of the NRC enforcement policy. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016-03 | Pri: OPS Sec: | NRC | NCV | Pri: 1C Sec: Ter: | FAIL TO NOTIFY THE NRC WITHIN 30 DAYS OF LEARNING OF THE DIAGNOSES OF A MEDICAL CONDITION NO The licensee failed to identify and notify the NRC within 30 days of a licensed operator's changing medical condition. The failure to notify the NRC was a violation of 10 CFR 55.25; however, as the licensee took corrective actions per NRC Information Notice 94-14, Supplement 1, and subsequently identified and corrected the issue of the one missed individual, this issue is being treated as a non-cited violation in accordance with Appendix C of the NRC enforcement policy. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/06/1999 | 1999016-04 | Pri: OPS Sec: | NRC | NCV | Pri: 1A Sec: Ter: | INACTIVE LICENSED OPERATOR STANDING AN ACTIVE LICENSED CR ORGANIZATION SHIFT POSITION WAS The licensee, in general, maintained operator licenses active, in accordance with 10 CFR 55.53(e) and (f). However, the inspectors identified that the licensee's Assistant Shift Supervisor/Manager position in the control room shift organization was inappropriately given proficiency credit for maintaining an active SRO license. The failure to assure that all licensed operators standing watch in the control room organization to perform licensed duties have maintained an active license was a violation of 10 CFR 55.53(e). The licensee is tracking this issue internally through its condition report process (CR P-99-21039), and the issue is being treated as a non-cited violation in accordance with Appendix C of the NRC enforcement policy. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | The operating crews did not consider the potential implications of cross-train operation.. The inspectors identified that the licensee was operating some systems in a cross-train configuration. For example, the "A" Train residual heat removal pump was providing cooling to the reactor coolant system through the "B" Train residual heat removal heat exchanger. The operating crews did not consider the potential implications of cross-train operation. (Section O1.2) |
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| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Use of an extra reactor operator (RO) was not consistent with normal plant operations. The inspectors observed a crew in a simulator assessment and concluded that the use of an extra reactor operator (RO) was not consistent with normal plant operations. The licensee had already identified questions regarding the consistent use of the extra RO and was in the process of revising the use of the extra RO during simulator evaluations. (Section O5.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Three instances where CRs should have been written and CRs had not been initiated. The licensee's efforts to increase the use of the corrective action program through the initiation of more condition reports (CRs) had resulted in a lower threshold for initiating CRs. However, the inspectors identified three instances where CRs should have been written and CRs had not been initiated. (Section O7.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | NEG | Pri: 4B Sec: Ter: | Insufficient involvement of engineering personnel in a decision by operations personnel to proceed with the The inspectors identified that the licensee had removed the Unit 1 East Essential Service Water (ESW) pump from service even though the Unit 1 West ESW pump recently failed an In-Service Test. The inspectors concluded that operations staff lacked rigor in the assessment of the results of the test. Additionally, the inspectors noted insufficient involvement of engineering personnel in a decision by operations personnel to proceed with the planned removal from service of the Unit 1 East ESW pump. (Section O1.4) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | Recent actions by the licensee to restore the safety-related equipment to an operable status demonstrated an During this inspection period, the licensee restored all four (two per unit) diesel generators (D/Gs) to an operable status for Modes 5 and 6 (Cold Shutdown and Refueling). This marked the first time since January 11, 1999, that all four D/Gs were operable at the same time. In addition, the operability issues with boration control were addressed and corrected. The operability of the D/Gs and boration control resulted in the restoration of the plant's full capabilities in reactivity control, reactor coolant system inventory control, and AC power sources. The recent actions by the licensee to restore the safety-related equipment to an operable status demonstrated an appropriate safety focus. (Section O1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | The licensee's conduct of the Unit 2 drain down of the reactor coolant system (RCS) was methodical and thor The inspectors observed that in preparation for defueling, the licensee's conduct of the Unit 2 drain down of the reactor coolant system (RCS) was methodical and thorough. When the licensee identified a discrepancy between the indicated RCS water level and the calculated RCS water level, the drain down was stopped until the discrepancy could be resolved. (Section O1.3) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: OPS Sec: | NRC | POS | Pri: 1C Sec: Ter: | Operations management noted a declining trend in configuration control and attention to detail. Operations management noted a declining trend in configuration control and attention to detail. The inspectors concluded that the use of the functional area and programmatic assessment findings to identify the declining trend was effective. In addition, the inspectors concluded that management expectations about configuration control were presented to the plant staff in a timely manner, before an anticipated increase in plant workload. (Section 7.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 05/27/1999 | 1999010 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | During a routine tour of the control rooms, the inspectors determined that the control room operators were not fully cognizant of the status of the configuration of the source range nuclear instruments. The source range instrument alarms were treated inconsistently between the units and the licensed operators were not knowledgeable of the differences or of the reasons for the differences. (Section O1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | Several examples were identified by the inspectors where the licensee failed to consistently respond in a manner commensurate with the potential impact of the degraded condition on the current plant operational condition. The examples included degraded and inoperable Essential Service Water pump discharge strainers, and degraded 4 kV breakers and source range nuclear instruments. Licensee management personnel recognized the need to prioritize degraded material condition issues in order to focus on items important to reactor core safety in Mode 5, but did not always ensure the corrective actions were focused towards Mode 5 items first. (Section O1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | Overall, plant operations were performed using approved operating procedures and reflected good operating practices. The inspectors observed an operator conduct in-plant rounds and determined that the operator was knowledgeable of system status and operation, observed proper radiological controls, and appropriately communicated with the control room. (Section O1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | The inspectors identified that the licensee did not recognize that reactor coolant system temperature changes while in cold shutdown also resulted in reactivity changes. In response to this issue, the licensee identified that several previously performed plant activities had the potential to heat up the reactor coolant system and add positive reactivity, which was prohibited by Technical Specifications since all four emergency diesel generators were inoperable. The inspectors reviewed the licensee's evaluation of these occurrences and concluded that the significance of performing these activities was negligible since these activities resulted in no measurable reactivity changes. (Section O1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: OPS Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The licensee's procedural controls on the use of overtime were weak. Specifically, the plant operations policy procedure did not provide sufficient guidance on the use of time sheets by plant personnel; consequently, the licensee had difficulty assessing compliance with the plant overtime policy. One minor violation was identified for a licensed operator exceeding Technical Specification requirements on overtime. (Section O7.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | The operating crews demonstrated a conservative decision-making philosophy by stopping two surveillance test procedures following the identification of problems. (Section O1.1) |
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| 04/16/1999 | 1999004-01 | Pri: OPS Sec: | NRC | NCV | Pri: 5C Sec: Ter: | Inappropriate Condition Report Categorization Constituted a Missed Opportunity to Evaluate Significant Cond Case Specific Checklist Item 2A, "Failure to Promptly Identify and Evaluate Conditions Adverse to Quality." The inspectors concluded that the licensee inappropriately categorized two condition reports documenting maintenance and surveillance test procedure deficiencies as conditions adverse to quality rather than as significant conditions adverse to quality. A Non-Cited Violation was issued for the failure to determine the root cause of and implement corrective actions to preclude the repetition of significant conditions adverse to quality. The NRC's assessment of the licensee's effectiveness in addressing this case specific checklist item will continue as part of oversight of the licensee's restart effort. (Section O7.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: 2A Ter: | Operators failed to recognize indications of cavitation in the residual heat removal system until prompted by 1 Operators failed to recognize indications of cavitation in the residual heat removal system until prompted by the inspectors. The inspectors also noted that the residual heat removal system cavitation and vibration on both units appeared to be recurring, long-standing deficiencies. The licensee subsequently took prompt action to assess possible degradation of the system and formed a multi-disciplined project team to assess the operability of the system. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The inspectors concluded that several contractors working for the licensing department exceeded the workin The inspectors concluded that several contractors working for the licensing department exceeded the working hour limitations specified by Plant Manager's Instruction 4010, "Plant Operations Policy," Revision 12. No violations of regulatory requirements occurred since the contractors were performing nonsafety-related activities. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | Establishment of the core safety priorities list was a positive step taken by the licensee to focus attention on th Establishment of the core safety priorities list was a positive step taken by the licensee to focus attention on the issues that posed the greatest risk to core safety. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | Overall operator performance during this inspection report period was characterized by effective procedural Overall operator performance during this inspection report period was characterized by effective procedural compliance and conservative decision making. On two occasions operators stopped evolutions in progress until abnormal conditions could be resolved. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | POS | Pri: 1A Sec: Ter: | Control room operators alertly identified a slow level increase in the Unit 1 volume control tank and took app Control room operators alertly identified a slow level increase in the Unit 1 volume control tank and took appropriate action to identify and correct the source of the in-leakage. In addition, the inspectors concurred with the licensee's conclusion that the volume control tank in-leakage resulted from the failure to fully close the residual heat removal to letdown isolation valve following the previous operation. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |

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| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | POS | Pri: 1C Sec: Ter: | The Operations Department Leadership Plan established a framework for performance improvements, and if properly implemented, should result in the operations department being ready to support plant restart. The Operations Department Leadership Plan established a framework for performance improvements, and if properly implemented, should result in the operations department being ready to support plant restart. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: | NRC | POS | Pri: 1C Sec: Ter: | The Nuclear Safety and Design Review Committee (NSDRC) performed adequate oversight of the technical issues discussed. The inspectors also concurred with the licensee's conclusion that the NSDRC meetings were of mixed quality and not always effective. In addition, the inspectors concluded that the licensee's corrective actions following the NSDRC meeting 188 appeared to be effective in improving the quality of the subsequent NSDRC meeting. The Nuclear Safety and Design Review Committee (NSDRC) performed adequate oversight of the technical issues discussed. The inspectors also concurred with the licensee's conclusion that the NSDRC meetings were of mixed quality and not always effective. In addition, the inspectors concluded that the licensee's corrective actions following the NSDRC meeting 188 appeared to be effective in improving the quality of the subsequent NSDRC meeting. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001-02 | Pri: OPS Sec: | NRC | NCV | Pri: 1C Sec: Ter: | Equipment Tagging Procedure Not Appropriate to the Circumstances The inspectors identified that the licensee's clearance permit procedures did not address the tagging of all locations where out-of-service equipment could be operated. As allowed by the procedures, the operations department practice was to tag only the control room and local hand switches for safety-related equipment. The inspectors concluded that the licensee's tagging procedures and practices did not ensure worker safety during work on out-of-service equipment. One Non-Cited Violation was issued for the failure to have a procedure appropriate to the circumstances. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001-02 | Pri: OPS Sec: | NRC | NEG | Pri: 1A Sec: Ter: | One notable example of poor operator control and monitoring of plant equipment occurred. Specifically, a non-licensed operator failed to meet management expectations regarding operation of an emergency diesel generator starting air compressor. One notable example of poor operator control and monitoring of plant equipment occurred. Specifically, a non-licensed operator failed to meet management expectations regarding operation of an emergency diesel generator starting air compressor. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 03/02/1999 | 1999001 | Pri: OPS Sec: ENG | NRC | POS | Pri: 1A Sec: 4B Ter: | In response to weaknesses previously identified with the operability determination process by both licensee and NRC personnel, the licensee instituted a number of short and long-term corrective actions. The inspectors concluded that the licensee's corrective actions were timely and appeared to be effective in improving both the quality and the timeliness of operability determinations. In response to weaknesses previously identified with the operability determination process by both licensee and NRC personnel, the licensee instituted a number of short and long-term corrective actions. The inspectors concluded that the licensee's corrective actions were timely and appeared to be effective in improving both the quality and the timeliness of operability determinations. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/13/2000 | 1999021 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Molded Case Circuit Breaker Test Methodology Weakness The inspectors identified a weakness in the licensee's process for testing molded case circuit breakers. Specifically, the applicable test procedure did not require initial overcurrent test failures to be evaluated prior to performing a second test 20 minutes later. The inspectors did not identify any actual failures of the first test which would have affected the operability of specific in-service breakers. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/13/2000 | 1999021 | Pri: MAINT Sec: | NRC | POS | Pri: 2B Sec: Ter: | Safety Grade Fastener Control for Motor Operated Valves The licensee's actions to issue a stop work order and quarantine the motor-operated valve refurbishment trailer after they discovered that safety grade fastener may have been improperly stored was appropriate. The licensee's Performance Assurance department expanded the scope of the investigation and identified fastener storage problems with other onsite work groups. The widened investigation by the Performance Assurance department was appropriate and thorough. The failure to properly control safety grade fasteners did not affect the safety function of any equipment. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999026 | Pri: MAINT Sec: | NRC | POS | Pri: 2B Sec: 5C Ter: | Ice Condenser Testing and Contractor Control Overall, the licensee had implemented adequate corrective actions for previously identified issues related to surveillance testing of the ice condenser. Based on establishment of enhanced procedure controls and observations of contractor training, the inspectors concluded that adequate contractor controls existed to reduce the likelihood of ice basket damage. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 12/28/1999 | 1999034 | Pri: MAINT Sec: | NRC | POS | Pri: 2B Sec: Ter: | Preventive Maintenance Program Adequate to Support Restart The root cause analysis report for the Preventive Maintenance (PM) program identified a number of actions to be taken to improve the PM program. The corrective actions were expected to strengthen the program. The PM tasks were being scheduled and performed at the present time without major delays. This review closes CSC Item No. 14C. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 12/28/1999 | 1999034 | Pri: MAINT Sec: | NRC | POS | Pri: 5C Sec: 2B Ter: | Contractor Control Program Adequate to Support Restart Based on review of the Contractor Control Program administrative procedures, the inspectors determined that the procedures still lacked guidance to assure consistent training, qualification, and licensee oversight of contractor activities. As a result of the review of various licensee assessments and recent events involving implementation of the contractor control program at the site, continued management attention is warranted. The inspectors determined that the program was better defined and was more visible and, although additional development of program procedures and adequate metrics to measure contractor performance are needed, the weaknesses were adequately captured in the licensee's corrective action program, therefore, the program is considered adequate to support plant restart. This review closes CSC Item No. 14B. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 12/16/1999 | 1999021 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Contractor Maintenance Error in Switchyard On December 16, 1999, a maintenance error in the switchyard by the St. Joseph Division of American Electric Power resulted in the partial loss of off-site power to Unit 1. The St. Joseph Division personnel were non-nuclear trained American Electric Power employees who were responsible for performing maintenance in the switchyard. Although the St. Joseph Division personnel were not technically contractors, the problems associated with this event were similar to previous contractor control problems. A recent NRC inspection determined that the licensee made satisfactory improvements to the contractor control program. The licensee incorporated St. Joseph Division personnel into the contractor control program. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 11/19/1999 | 1999020 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Plant Winterization The licensee did not have an integrated process for controlling plant winterization. As an interim measure until a winterization program could be developed, the licensee appointed a project leader to ensure winterization activities would be completed. The interim measures appeared to adequately prepare the plant for winter. Not all of the required actions had been completed at the end of this inspection period. The winterization program development was scheduled to be completed by the end of 1999. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/19/1999 | 1999020 | Pri: MAINT Sec: | NRC | NEG | Pri: 3A Sec: Ter: | Stop Work Order for MOV Testing The licensee's Performance Assurance (PA) department identified a poor performance trend in motor-operated valve testing and issued a stop work order until the problems were corrected. This followed failure by maintenance personnel to install an open limit switch on a motor-operated valve. Engineering and maintenance department personnel failed to self-identify the poor performance trend and later issued a joint stop work order which provided an action plan to correct the trend. The PA department maintained appropriate oversight of the corrective actions until the stop work orders were lifted. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/08/1999 | 1999019-01 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | PROCEDURE INAPPROPRIATE TO THE CIRCUMSTANCES IN THAT IT DID NOT ENSURE THAT FUSES IN SAFET The licensee's procedures for controlling fuse configuration during breaker refurbishment were not adequate. The inspectors identified that the procedures did not specify that the fuse configuration be checked when returning a breaker to service. The failure to provide adequate guidance to ensure that breaker fuse configuration was properly controlled was a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V. |
| Dockets Discussed: 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | INADEQUATE EDG TROUBLESHOOTING Troubleshooting activities were performed on the Unit 2 C/D D/G governor without a formal troubleshooting plan, contrary to management expectations. Also, a vendor technical representative made an unauthorized adjustment to the engine governor during the troubleshooting. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: MAINT Sec: | NRC | NEG | Pri: 3A Sec: Ter: | WORKERS IMPROPERLY INSTALLED A STRAINER DRAIN VALVE ON THE UNIT 1 WEST ESSENTIAL SERVICE V Workers improperly installed a strainer drain valve on the Unit 1 West ESW pump. As a result, the pump failed to meet its in-service test criteria for differential pressure. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | The licensee had not provided sufficiently detailed guidance to ABB technicians regarding AEP expectations The licensee had not provided sufficiently detailed guidance to ABB technicians regarding AEP expectations in the areas of procedural compliance, test methods and practices, and standards for recording test results and other information. AEP relied too heavily on "skill of the craft". Consequently, the technicians were measuring and recording insulation resistance values incorrectly due to a procedural deficiency and lack of adequate guidance as to licensee expectations. (Section M1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 08/20/1999 | 1999025 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | The reduced control voltage prescribed in the procedures was not consistent with with the breaker manufact The reduced control voltage prescribed in the procedures for testing the tripping function of the breakers (180 Vdc) was arbitrarily the same as that used for closing and was not consistent with the breaker manufacturer's (ABB's) recommendation (140 Vdc). The licensee was not able to provide a sound engineering basis or satisfactory rationale for the deviation. (Section M3.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Documentation in work packages was weak and sometimes inconsistent with technicians' recollections. Due to lack of sufficient guidance on the rigorousness and level of detail expected, the documentation in work packages of as-found conditions (including lubricant), parts replaced and reasons for replacement, was weak and sometimes inconsistent with technicians' recollections. (Sections M3.3 and M5.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Inadequate Condition Reports. Terminology in breaker related condition reports was sometimes inconsistent with work documents and within the condition report itself. Condition reports did not always capture the root cause and/or extent of condition when required and did not always propose adequate corrective action and/or measures to prevent recurrence. (Section M7.4) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025-01 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | The procedures used for refurbishment of breakers were inappropriate. The procedures used for refurbishment of breakers were inappropriate. A significant example was that breaker timing tests at full/nominal control voltage were being performed first to determine as-found/prior breaker operability. This test sequence was inconsistent with current industry practice in which closing and tripping functional tests at reduced or minimum control voltage are the principal indicators of breaker operability. Performing three timing tests at full voltage first as prescribed by the procedures preconditioned the breakers and could mask a degraded condition in which a breaker may not have operated on demand at minimum control voltage under worst-case design-basis conditions. A non-cited violation was identified regarding inadequate breaker refurbishment procedures. (Sections M3.1 and M3.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025-02 | Pri: MAINT Sec: | NRC | NCV | Pri: 4A Sec: Ter: | Failure to translate the minimum expected control voltages into procedures. The licensee had not determined the minimum expected control voltages at the breaker control devices to verify component performance under worst case accident conditions. Consequently, the licensee failed to translate this design basis information into breaker refurbishment and maintenance procedures. Therefore it was indeterminate whether the voltages selected for the breaker testing would be valid to demonstrate previous (as-found) or current breaker operability under worst case conditions. A non-cited violation was identified regarding inadequate design control. (Section M3.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/20/1999 | 1999025 | Pri: MAINT Sec: ENG | NRC | POS | Pri: 2B Sec: Ter: | The basic general training and indoctrination received by ABB technicians was reasonably complete. The basic, general training and indoctrination received by ABB technicians at D. C. Cook, was reasonably complete and the approach of having them qualify on Cook procedures and general work practices was sound. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 07/16/1999 | 1999015 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | Minimal contractor control for the safety-related work being performed on the Unit 1 West Component Cooling Water (CCW) heat exchanger. The inspectors identified that there was minimal contractor control for the safety-related work being performed on the Unit 1 West Component Cooling Water (CCW) heat exchanger. The inspectors also determined that there was a programmatic deficiency in the licensee's understanding of quality assurance (QA) requirements. Most licensee personnel questioned incorrectly assumed that if a vendor had an approved QA program that the vendor was not required to follow the licensee's approved QA program. (Section M1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015 | Pri: MAINT Sec: | NRC | NEG | Pri: 5A Sec: Ter: | Plant maintenance personnel have not always been effective at identifying and correcting the root cause of an equipment failure, and repetitive failures of safety-related component have occurred. Plant maintenance personnel have not always been effective at identifying and correcting the root cause of an equipment failure, and repetitive failures of safety-related component have occurred. Within the maintenance organization, the quality of troubleshooting has varied. The licensee recognized this problem and issued guidance on how to perform troubleshooting activities. The troubleshooting guidance appeared to be effective; however, only a small number of troubleshooting activities have been performed since the troubleshooting guidance was issued. Also, the licensee had not yet developed clear expectations for when the use of the troubleshooting guidance was required. (Section M1.3) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/16/1999 | 1999015-01 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | FAILURE TO COMPLY WITH QA PROGRAM DESCRIPTION A non-cited violation was issued for the licensee's failure to have a department head review and approve the vendor's procedure for pulling tubes from the Unit 1 West CCW heat exchanger. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 07/16/1999 | 1999015-02 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | FAILURE TO FOLLOW PROCEDURE WHILE PULLING TUBES FROM U1 WEST CCW HEAT EXCHANGER A non-cited violation was issued for an inadequate procedure which was utilized to pull tubes from the Unit 1 West CCW heat exchanger, in that the procedure did not provide guidance for removing more than one tube. (Section M1.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 05/27/1999 | 1999010 | Pri: MAINT Sec: | NRC | NEG | Pri: 2A Sec: Ter: | The licensee's response to the degraded ESW strainers lacked a sense of urgency commensurate their importance to maintaining reactor core safety. Plant material condition continued to be identified including problems with the ESW pump discharge strainers. The licensee's response to the degraded ESW strainers lacked a sense of urgency commensurate with their importance to maintaining reactor core safety. Following NRC inspector observations on the need to re-evaluate the corrective actions on the ESW strainers, the licensee's corrective actions were appropriate. (Section M2.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: MAINT Sec: | NRC | POS | Pri: 3A Sec: Ter: | The inspectors concluded that the maintenance and surveillance activities observed were performed in accordance with procedures. The inspectors concluded that the maintenance and surveillance activities observed were performed in accordance with procedures. The current revision of the appropriate procedures were in use at the work sites, and appropriate radiological protection practices were noted. (Section M1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 05/27/1999 | 1999010-01 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | WEAK VENTILATION TEST PROCEDURE Surveillance procedure did not direct the operators to restore the Ventilation Exhaust Air Filter Train to a configuration included in the normal operating procedure or enter the appropriate TS limiting condition for operation action statement. The inspectors considered the failure of the surveillance procedure to return the system to an operable lineup to constitute an apparent violation of 10 CFR Part 50 Appendix B, Criterion V. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 05/27/1999 | 1999010-02 | Pri: MAINT Sec: ENG | NRC | NCV | Pri: 2A Sec: Ter: | NINE U-1 MAIN STEAM SAFETY VALVES HAD LIFT SETPOINTS ABOVE THE TS ALLOWED VALUES (Closed) Licensee Event Report 50-315/95002-00: Nine Unit 1 main steam safety valves had lift setpoints above the Technical Specification allowed values. In June 1995, with the unit at approximately 55 percent power, the licensee exercised the Unit 1 main steam safety valves (MSSVs). Nine MSSVs were found to be above the 3 percent lift setpoint tolerance allowed by Technical Specification (TS) 3.7.1.1. These valves were not reset to within 1 percent of the nominal lift setpoint until after the setpoints were questioned by the inspectors. This event was discussed in Inspection Report 50-315/95009. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 05/26/1999 | 1999013-01 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | FAILURE IMPLEMENT PROMPT CORRECTIVE ACTIONS FOR OVERDUE PREVENTATIVE MAINTENANCE TASKS As of May 26, 1999, the licensee failed to initiate prompt corrective actions for approximately 150 overdue PM tasks (identified in the Attachment), to determine if the operability of Unit 1 and Unit 2 safety related equipment was affected. The failure to initiate the prompt corrective actions for the overdue PMs on safety-related equipment is considered a Severity Level Violation of 10 CFR Part 50, Appendix B, Criterion XVI. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/24/1999 | 1998-035-01 | Pri: MAINT Sec: | Licensee | LER | Pri: Sec: Ter: | ICE CONDENSER LOWER INLET DOOR SHOCK ABSORBER On July 2, 1998, during an inspection of the condition of Ice Condenser Lower Inlet Door Shock Absorber equipment, damage was identified that potentially impacted the ability of the shock absorbing bumpers to perform their intended functions. Deficient shock absorbing bumpers could lead to damage of the lower inlet doors and excess debris in the Containment Recirculation Sump following a postulated accident. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 04/16/1999 | 1999004 | Pri: MAINT Sec: | NRC | NEG | Pri: 2B Sec: Ter: | The inspectors identified multiple examples of deficient maintenance procedures and job orders revealing a The inspectors identified multiple examples of deficient maintenance procedures and job orders revealing a potential programmatic weakness in this area. These maintenance procedures and job orders, which were used for performing safety-related maintenance activities, allowed workers to omit steps which they determined were not necessary without additional review and approval. (Section M3.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: MAINT Sec: | NRC | POS | Pri: 3A Sec: Ter: | The inspectors concluded that the observed work activities were performed in accordance with approved pro The inspectors concluded that the observed work activities were performed in accordance with approved procedures; the current revision of the procedures were in use at the work sites; and proper work safety and radiological protection practices were used. The inspectors also observed a good questioning attitude on the part of the workers when problems were identified during maintenance activities. In particular, the inspectors noted two examples where the workers and supervisors expanded their investigation scope to include related areas not directly affected by the identified problem. (Section M1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 04/16/1999 | 1999004 | Pri: MAINT Sec: | NRC | POS | Pri: 3A Sec: Ter: | The licensee's plan for repairing the Unit 2 chemical and volume control system cross-tie valves appeared to The licensee's plan for repairing the Unit 2 chemical and volume control system cross-tie valves appeared to include appropriate contingency actions for removing and replacing the valves if repairs were not possible. While the licensee experienced minor personnel errors and unforeseen material condition issues which delayed the completion of the maintenance activities, the valves were successfully repaired. (Section M2.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004-02 | Pri: MAINT Sec: | NRC | NCV | Pri: 2B Sec: Ter: | Failure of Surveillance Test Procedures to Contain Instructions Appropriate to the Circumstances Case Specific Checklist Item 1A, "Inadequate Instructions in Surveillance Tests." The inspectors concurred with the licensee's conclusion that three of the four surveillance test procedures, which were utilized to demonstrate operability of the safety-related centrifugal charging pumps, contained inadequate instructions to operate the pumps safely due to deficiencies in the procedure revision process. A Non-Cited Violation was issued for the failure to have procedures appropriate to the circumstances. The NRC's assessment of the licensee's effectiveness in addressing this case specific checklist item will continue as part of oversight of the licensee's restart effort. (Section M3.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: MAINT Sec: ENG | NRC | POS | Pri: 3A Sec: Ter: | The licensee appropriately expanded their piping cleanliness inspection when foreign material was identified The licensee appropriately expanded their piping cleanliness inspection when foreign material was identified in the chemical and volume control system cross-tie header. In addition, the licensee's engineering staff appropriately questioned the possibility of foreign material entering other safety systems from the refueling water storage tanks. (Section M2.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: MAINT Sec: | NRC | POS | Pri: 2A Sec: Ter: | The licensee conservatively declared all four emergency diesel generators inoperable due a question regardi The licensee conservatively declared all four emergency diesel generators inoperable due a question regarding the seismic qualification of the General Electric HFA safety- related relays installed in the emergency diesel generator circuits. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: MAINT Sec: | NRC | POS | Pri: 2B Sec: Ter: | Observed maintenance activities were performed in accordance with approved procedures. The inspectors i Observed maintenance activities were performed in accordance with approved procedures. The inspectors noted that the maintenance personnel performing the work activities were knowledgeable of their assigned tasks and utilized appropriate radiation protection work practices. In addition, the inspectors observed frequent management oversight of work in progress. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: MAINT Sec: | NRC | POS | Pri: 2B Sec: Ter: | The Maintenance Proficiency Evaluation training program appeared to be thorough and focused on improv The Maintenance Proficiency Evaluation training program appeared to be thorough and focused on improving the performance of both the maintenance workers and supervisors. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 03/02/1999 | 1999001-03 | Pri: MAINT Sec: | Licensee | NCV | Pri: 2B Sec: Ter: | Failure to Perform Technical Specification Surveillance Test for Pressurizer Power Operated Relief Valve Following the identification of a missed pressurizer power operated relief valve surveillance test, the licensee's review of scheduled and event-initiated surveillances identified that some required Mode 5 surveillances were not being performed. The licensee also identified several weaknesses in the tracking processes to ensure that Mode 5 surveillances were properly completed. The inspectors concluded that the licensee's efforts to identify missed surveillances were comprehensive and methodical. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 01/13/2000 | 1999021 | Pri: ENG Sec: | NRC | POS | Pri: 2B Sec: 4B Ter: | Emergency Diesel Generator High Pressure Fuel Oil Line Testing The licensee determined that the failures of several new emergency diesel generator high pressure fuel oil injection lines were due to manufacturing defects. Due to the difficulty in performing non-destructive testing of the lines, the licensee developed an alternate testing method to verify that any installed lines did not have any manufacturing defects which would lead to premature failure. The licensee conservatively declared three emergency diesel generators inoperable until susceptible lines could be verified operable using the alternate testing method. The licensee's efforts to resolve the high pressure fuel injection line leak issues were aggressive and thorough. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/13/2000 | 1999021-01 | Pri: ENG Sec: | NRC | NCV | Pri: 1C Sec: Ter: | INSERVICE TESTSING LOW ACTION LIMITS SET LOWER THAN MINIMUM OPERABILITY LIMIT The inspectors identified that the 2W Essential Service Water Pump In-Service Testing low action limit was set such that the pump could have degraded to a performance level below the required operability limit. Further, the In-Service Testing action limits established for the 1E and 2W Essential Service Water Pumps when both pumps were last required to be operable were inconsistent with the safety analysis. This constituted a failure to meet the requirements of 10 CFR Part 50, Appendix B, Criterion XI, and was identified as a non-cited violation. Also, the licensee did not consider the impact of instrument uncertainty when establishing In-Service Testing low action limits. This may have allowed pumps with operability limits more restrictive than the code allowable degradation to degrade to a level such that safety analysis requirements would not be met. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999026 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 6 - Resolution of Ice Condenser Issues For resolution of ice condenser issues, the scope of corrective actions documented in Restart Action Plan 6 was considered comprehensive. Fifty-eight corrective actions were specified in licensee's Restart Action Plan 6, which included revisions to procedures, enhanced training, component modifications, and improvements to the overall material condition in the ice condenser to address deficiencies in surveillance testing, material condition and the design basis for the ice condenser. Based on review of a sample of these corrective actions, Case Specific Checklist item 6 is closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999026 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 12 - Resolution of Containment Liner Pitting Comprehensive and thorough investigations of the containment liner pitting corrosion had been completed. Corrective actions for resolving the containment liner pitting included recoating of corroded areas and resealing of the containment liner floor interface and completion of an engineering evaluation to confirm liner integrity. The inspectors considered the corrective actions adequate to resolve this issue and Case Specific Checklist item 12 is closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/05/2000 | 1999026 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: 4A Ter: | Design Controls on Ice Condenser The inspectors concluded that the licensee had established appropriate corrective actions to address the causes for poor design controls associated with the ice condenser. Based on a review of modifications, vendor audit and observations of the Design Review Board, the inspectors concluded that adequate modification and design controls were implemented for ice condenser components. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | NEG | Pri: 5C Sec: Ter: | Case Specific Checklist Item 11 - Resolution of Hydrogen Mitigation System Operability and Materiel Condition CSC Item No. 11 remains open. The team identified that condition reports had been issued which raised concerns regarding the basis for resolution of the issue. The condition reports had been issued before the start of the inspection. The team concluded that the restart action plan addressing CSC Item No. 11 was incomplete and should have been revised to include relevant information. The team recommended that CSC Item No. 11 remain open until Restart Action Plan 11 is revised, corrective actions are implemented, and system performance is assured. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | NEG | Pri: 5C Sec: Ter: | Case Specific Checklist Item 14E - Electrical Protection Coordination Including Fuse/Breaker Control Program CSC Item No. 14E remains open. The team was concerned by the errors noted in two "preliminary" calculations and by the fragmented approach to the 4kV motor circuit protection scheme. Because these calculations were under review, the errors identified by the team could have also been identified by the licensee's review. Consequently, the team could draw no conclusions about the quality of activities associated with CSC Item No. 14E. The team recommended that this item remain open, subject to reinspection at a point in time when calculations and/or the design change are formally approved. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 1B Sec: Ter: | Confirmatory Action Letter Issue 3 - Thirty-Six Hour Cooldown With One Train of Cooling The team recommended that CAL Item No. 3 be closed. The team concurred with the licensee's position that a 36-hour cooldown using only one train of component cooling water was not a design requirement. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4A Sec: Ter: | Confirmatory Action Letter Issue 1 - Recirculation Sump Inventory CAL Item No. 1 is closed. The team found the material in the submittal supporting the Technical Specification change, the associated modification packages, and the corrective action report status to be satisfactory for closure of this issue, recognizing that physical accomplishment of the modifications remains to be accomplished as a startup constraint. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4A Sec: Ter: | Confirmatory Action Letter Issue 2 - Recirculation Sump Venting CAL Item No. 2 is closed. The team concluded that the specific recirculation sump ventilation holes that were the subject of the CAL Item No. 2 issue have been redrilled, and that the necessary foreign material exclusion screens have been installed within an adequate safety review framework. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4A Sec: Ter: | Confirmatory Action Letter Issue 5 - Compressed Air Overpressure CAL Item No. 5 is closed. The team concluded that the licensee had appropriately resolved the compressed air overpressure issue. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | Confirmatory Action Letter Issue 6 - RHR Suction Valve Interlock CAL Item No. 6 is closed based upon the licensee's completion of the corrective actions identified in CRs 99-04280 and 99-07144. The team reviewed the corrective action measures taken and found that they were in general agreement with C.1.2 and C.1.3 of D. C. Cook 0350 Guidelines for Restart Approval. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | Confirmatory Action Letter Issue 8 - RWST Mini-Flow Recirculation Lines CAL Item No. 8 is closed based on measured leakage past the CAL-specified six valves being less than the CAL-specified 10 gallons per minute rate. Verification of the actual total leakage rates, and a review of the associated operability determination will be required prior to Unit 2 startup. Review and approval of the new dose calculation is a post Unit 2 restart issue if the NRC staff determines the associated Generic Letter 91-18 operability determination was adequate to support startup. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | Case Specific Checklist Item 3D - Inadequate Consideration for System/Component Failure Modes CSC Item No. 3D is closed. The licensee's overall program for failure mode analysis was found to be adequate to support plant restart. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: 4A Ter: | Case Specific Checklist Item 3A - Inadequate Design Control Pertaining to Uncontrolled and/or Unintended CI CSC Item No. 3A remains open. The team was unable to conclude that there was reasonable assurance that CSC Item No. 3A was adequately resolved. Although significant changes in the design control program were noted through the extensive new procedures, the team recommended that this item not be closed. This was based on the following: very few engineering products generated under the new design control program were included in the scope of this inspection. Of the few engineering products reviewed by the team that were generated under the new design control program, one calculation did not consider a fundamental requirement of a modification, and a modification drawing was drawn with conflicting dimension lines resulting in another calculation incorrectly analyzing the modified piping configuration. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: 5C Ter: | Case Specific Checklist Item 3B - Failure to Update Final Safety Evaluation Report CSC Item No. 3B is closed. Based on the completed corrective actions and on actions committed to be completed before startup, the team concluded that CSC Item No. 3B had been adequately addressed by the licensee. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 2B - Inadequate Corrective Actions for Previously Identified Conditions Adverse to CSC Item No. 2B is closed. The team concluded that the D. C. Cook Corrective Action Program was capable of acceptably resolving identified conditions adverse to quality in a manner sufficient to support the plant's return to operation. This was based on validation of satisfactory completion of the corrective actions, determination that the most significant corrective actions were among those that were completed, formal requirement for Corrective Action Review Board follow-up review of the effectiveness of corrective actions for level 1 and 2 condition reports, a record of adjustments to the program in response to identified deficiency trends, a plan for workdown of corrective action backlog, and a review of sixty condition reports that did not identify any flaws that would have called into question the operability or functionality of a safety-related system. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 8 - Resolution of Hydrogen Recombiner Operability Issues CSC Item No. 8 is closed. The team reviewed 18 of 30 completed actions and found that corrective actions were generally in accordance with C.1.2 and C.1.3 of Enclosure 2 of the D. C. Cook 0350 Guidelines for Restart Approval. The team determined that CSC Item No. 8 had been properly addressed by the licensee. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 9 - Resolution of Distributed Ignition Technical Specification Issue CSC Item No. 9 is closed. The team reviewed documentation for four of the six corrective actions for Unit 2, including DCP-715, which among other things provided all new ignitor boxes. Actions that were not complete at the time of the inspection were scheduled for completion in December 1999. On the basis of the documentation reviewed and the scheduled completion of remaining activities, the team concluded that CSC Item No. 9 was adequately addressed by the licensee. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Case Specific Checklist Item 10 - Resolution of Containment Spray System Operability Issues CSC Item No. 10 is closed. The team reviewed closure documentation for five of the eight corrective actions, the most significant being completion of Configuration Control Determination 34040 which revised the normal position of the spray additive tank nitrogen supply valve. Corrective actions that were not complete at the time of the inspection were scheduled for completion and tracked. On the basis of the documentation reviewed and the scheduled completion of remaining activities, the team concluded that the licensee had adequately addressed CSC Item No. 10. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | High Priority Restart Issues Twenty-one high priority restart issues from the Restart Action Matrix were examined in detail to ensure that the licensee properly addressed the issues and completed corrective action, or had them scheduled and tracked for completion prior to plant restart. Fifteen of the twenty-one, discussed specifically in this report, were considered satisfactorily completed. The remaining six required additional engineering work to resolve the issues and consequently could not be closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Low Priority Restart Issues Seventy-four low priority issues from the Restart Action Matrix were examined to verify that the issues were entered in the corrective action system, that the issues were properly characterized and classified, that appropriate corrective actions had been specified, and that the corrective actions were scheduled and tracked. Sixty-six of these issues listed in the report are closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999029 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | Condition Report Review The team did identify cases where the licensee's staff had closed some low significance issues without finding effective and complete resolutions. While the team noted that there was some lack of consistency and thoroughness in resolving previously identified problems, no significant issues developed from the inspection of the random sample of sixty condition reports. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999032 | Pri: ENG Sec: | NRC | NEG | Pri: 5C Sec: Ter: | Case Specific Checklist Item 7 - Resolution of Nonsafety-Related Cables Going to Shunt Trip Coils The inspectors determined that licensing commitments related to CSC Item No. 7 appeared inconsistent and that electrical separation documents were not clear or concise and contained what appeared to be conflicting or insufficient information. Region III requested NRR's assistance in evaluating this concern to determine if the existing cable configuration is acceptable (TIA 99-031). This item remains open. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999032 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: 5C Ter: | Case Specific Checklist Item 3C - Failure to Consider Instrument Uncertainties, Setpoints, and/or Instrument B The inspectors concluded that licensee actions to address the concerns associated with failure to consider instrument uncertainties, setpoints and/or instrument bias appeared to be adequate. There was sufficient evidence of completed work combined with other open items linked to restart to close MC 0350 CSC Item No. 3C. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999032 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: 5C Ter: | Confirmatory Action Letter Issue 9 - Instrument Uncertainties The inspectors determined that licensee actions completed to address CAL Item No. 9 provided a reasonable level of confidence that the licensee understood the basic problems, defined the scope of action to be taken and completed sufficient actions to demonstrate adequate progress on this item. Several instrument uncertainty related issues required additional licensee actions including the review of approximately 1100 existing plant procedures and the completion of approximately 208 instrument uncertainty calculations prior to plant restart. These items are identified in the licensee's corrective action program for closure prior to restart. CAL Item No. 9 is considered closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/05/2000 | 1999032 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: Ter: | RWST Level Measurement Uncertainties The inspectors concluded that Condition Report 97-2312 adequately captured the problems associated with the failure to properly account for all RWST level measurement and uncertainties. The licensee implemented corrective actions and adequately resolved the technical issues associated with this problem. However, the inspectors identified some problems related to administration of the corrective action items which the licensee entered into the corrective action program. RAM Item No. R.2.3.22 is closed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/05/2000 | 1999029 | Pri: ENG Sec: OPS | NRC | POS | Pri: 4A Sec: 1C Ter: | Confirmatory Action Letter Issue 7 - Fibrous Material in Containment CAL Item No. 7 is closed based on the completed corrective actions and on actions committed to be completed before startup, the team determined that CAL Item No. 7 had been adequately addressed by the licensee and was closed by transfer of oversight of containment sump protection to Restart Action Plan 13B which addresses containment readiness. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/08/1999 | 1999019 | Pri: ENG Sec: | NRC | NEG | Pri: 3A Sec: Ter: | Temporary Modification Deficiencies The inspectors identified that the temporary modification (TM) process was not rigorously implemented for TM 12-96-07(refueling water cleanup system) as evidenced by several identified deficiencies. Signatures were not obtained to approve restoration and drawings were not revised. In addition, the safety analysis was not revised to evaluate the acceptability for extended partial restoration of the TM. No adverse safety consequences resulted from the identified deficiencies. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | MISC | Pri: 5A Sec: 5B Ter: 5C | The legacy backlogs were not completely reviewed to identify conditions adverse to quality, although the items were appropriately screened as to whether they were necessary for restart. The legacy backlogs were not completely reviewed to identify conditions adverse to quality, although the items were appropriately screened as to whether they were necessary for restart. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | MISC | Pri: 5C Sec: 5A Ter: 5B | procedures and process barriers were adequate to ensure that conditions adverse to quality would be effectively identified, documented, and evaluated. However, there were some instances where the procedural guidance was insufficient or required clarification to describe certain portions of the process. In general, the procedures and process barriers were adequate to ensure that conditions adverse to quality would be effectively identified, documented, and evaluated. However, there were some instances where the procedural guidance was insufficient or required clarification to describe certain portions of the process. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: Ter: | Performance Assurance Department audits and surveillances The Performance Assurance Department audits and surveillances were performed by qualified personnel. The results of the audits and surveillances were in-depth and identified a number of significant findings with respect to the corrective action program. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: 5C Ter: | Personnel adequately identifying issues. In general, plant personnel were aware of the corrective action program requirements, were adequately identifying conditions adverse to quality, and understood the low thresholds established for identifying problems. Most personnel interviewed were knowledgeable of the electronic corrective action process and able to demonstrate the use of the process. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | POS | Pri: 5B Sec: 5C Ter: | The root cause evaluations The root cause evaluations were consistent with the procedures and adequately considered such items as generic applicability, operating experience and prior station occurrences. Conclusions were found to be generally well-supported and, where developed, the corrective actions were appropriate. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: 5A Ter: 5B | performance indicators The licensee had established several performance indicators that were adequate to assess the effectiveness of the corrective action program. The event code process was too new for a complete assessment, but determined that appropriate mechanisms were in place for condition report event code trending activities and that Corrective Action Department was identifying potential adverse trends. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: | NRC | POS | Pri: 5C Sec: 5B Ter: 5A | The electronic corrective action program (eCAP) The electronic corrective action program (eCAP) was performing it's intended function. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/01/1999 | 1999024 | Pri: ENG Sec: OPS | NRC | POS | Pri: 5B Sec: Ter: | The operability determination process The operability determination process was effective and operability determinations and the supporting evaluations were acceptable. This was based on the performance of the temporary Shift Operability Review Team. Since the plant was in a shutdown condition and the requirements for equipment was significantly lessened, operability determinations consisted mainly of designating appropriate plant mode restrictions for each of the reviewed condition reports. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | ENGINEERING ACTION PLAN FOR UNIT 1 WEST ESSENTIAL SERVICE WATER PUMP The Engineering Action Plan to resolve the resolve the low differential pressure condition on the Unit 1 West Essential Service Water pump was comprehensive and thorough. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/25/1999 | 1999017-01 | Pri: ENG Sec: | NRC | VIO IV | Pri: 5C Sec: Ter: | FAILURE TO RESTORE COMPLIANCE FROM A PREVIOUS IDENTIFIED VIO INVOLVING INADEQUATE 10 CFR 50 The licensee's resolution of previously-identified regulatory non-compliances was weak. A cited violation was identified for failing to restore compliance from a previous non-cited violation. This non-cited violation, identified on March 9, 1999, involved failure to perform a safety evaluation following a change to a residual heat removal system surveillance procedure. In May 1999 the licensee again performed the procedure without having performed the safety evaluation. |
| Dockets Discussed: 05000316 D.C. Cook 2 | | | | | | |

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| 08/20/1999 | 1999025 | Pri: ENG Sec: | NRC | NEG | Pri: 4B Sec: Ter: | Many of the deficiencies observed in the breaker procedures were attributable to inadequate engineering inv Many of the deficiencies observed in the breaker procedures were attributable to inadequate engineering involvement and ineffective use of industry operating experience information. (Section M7.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-01 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: Ter: | DEFICIENT SAFETY INJECTION FLOW BALANCE PROCEDURE The failure to account for the effects of RWST level and reactor vessel level in safety injection pump flow test procedure 12 EHP 4030.STP.208SI was an example where the requirements of 10 CFR 50, Appendix B, Criterion V, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-02 | Pri: ENG Sec: | NRC | NCV | Pri: 5A Sec: Ter: | RHR SYSTEM WALKDOWN DEFICIENCIES The failure to identify a hydraulic transient on the Unit 2 RHR system was an example where the requirements of 10 CFR 50, Appendix B, Criterion XVI, were not met and was a violation. The RHR system had historically experienced hydraulic transient events when realigning the system from shutdown cooling to ECCS standby readiness. In addition, Procedure 01-OHP 4021.017.003, "Removing Residual Heat Removal Loop From Service," Revision 9, dated November 12, 1998, added precautionary steps intended to prevent hydraulic transients during realignment from shutdown cooling to ECCS standby readiness. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-03 | Pri: ENG Sec: | NRC | NCV | Pri: 5C Sec: 4C Ter: | RHR SYSTEM WALKDOWN DEFICIENCIES The failure to identify that several valves were not appropriately categorized in the inservice testing program was an example where the requirements of 10 CFR 50, Appendix B, Criterion XVI, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-04 | Pri: ENG Sec: | NRC | URI | Pri: 5B Sec: 4C Ter: | EDG FUEL OIL STORAGE TANK LICENSING BASIS Unresolved Item (50-315/99007-04(DRS); 50-316/99007-04(DRS)) pending NRC review of revised EDG fuel oil storage tank volume calculations and resolution of plant licensing basis questions. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-05 | Pri: ENG Sec: | NRC | URI | Pri: 4A Sec: Ter: | 600 VAC CABLE SIZING This is an Unresolved Item (50-315/99007-05(DRS);50-316/99007-05(DRS)) pending NRC review of information regarding cable insulation levels. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 08/16/1999 | 1999007-06 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: Ter: | MOTOR-OPERATED VALVE TESTING CONCERNS The failure to adequately consider the effects of elevated containment temperature and pressure on the differential pressure across the RHR system valves was an example where the requirements of 10 CFR 50, Appendix B, Criterion III, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-07 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: Ter: | HIGH LOADING CALCULATION CONCERNS The failure to fully consider the potential EDG loading sequence of various plant loads during EDG operation is an example where the requirements of 10 CFR 50, Appendix B, Criterion III, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-08 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: Ter: | HIGH ENERGY LINE BREAK PROCEDURE DEFICIENCIES The failure to have an adequate procedure regarding the installation of temporary HELB barriers is an example where the requirements of 10 CFR 50, Appendix B, Criterion V, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 08/16/1999 | 1999007-09 | Pri: ENG Sec: OPS | NRC | NCV | Pri: 4B Sec: Ter: | OPERABILITY EVALUATION DEFICIENCIES The failure to perform satisfactory operability evaluations for pipe support and pipe stress margins and fuse coordination and replacements were examples where the requirements of 10 CFR 50, Appendix B, Criterion XVI, were not met and was a violation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/30/1999 | 1999007 | Pri: ENG Sec: | NRC | MISC | Pri: 4C Sec: Ter: | Discovery Effort Still Ongoing There were several instances where the team identified issues in programmatic areas which were outside the ESRR review scope. In addition, the team determined that a number of problems had only been broadly identified by the ESRR reviews, and the corrective action process was being relied upon to identify specific deficiencies. As a result, the team concluded that although the ESRR reviews of the most safety-significant systems were complete, the total discovery effort was ongoing at the end of the inspection. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 07/30/1999 | 1999007 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | ESSR Process Effective Overall, the implementation of the ESRR process was considered effective. The scope of the review areas was broad and generally consistent with the purpose of the review effort to confirm the performance of system safety functions. Further, the breadth and depth of material reviewed was appropriate overall and resulted in the identification of substantive issues. Although some new issues were identified by the team which were within the scope of the ESRR effort, these issues represented isolated implementation weaknesses and not broad deficiencies in the ESRR process. |
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| 07/30/1999 | 1999007 | Pri: ENG Sec: | NRC | WK | Pri: 4C Sec: Ter: | Continued Attention Warranted in Operability Evaluation Area The team identified an example where the licensee did not exercise appropriate sensitivity to the potential impact on operability of fuse control deficiencies identified during the ESRR review of the 250 Vdc system. This was of particular concern since a problem regarding the sensitivity to operability of equipment required for Modes 5 and 6 was identified by the NRC following two electrical faults which occurred on April 19, and April 24, 1999. Two examples of operability evaluations which failed to adequately address structural deficiencies were also identified. Collectively, these examples indicated that continued management attention is warranted in the operability evaluation area. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The inspectors identified some weaknesses in the implementation of the assessment process, specifically related to documentation and process deficiencies. The inspectors did identify some weaknesses in the implementation of the assessment process, specifically related to documentation and process deficiencies. The documentation weaknesses were most apparent in engineering assessment reports which were not stand-alone documents and did not meet the expectations established by the System Readiness Review Board (Sections 07.3, 07.5, M7.1, E7.1, and E7.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Several process weaknesses were identified which could impact the effectiveness of the assessment efforts. Several process weaknesses were identified which could impact the effectiveness of the assessment efforts: the assessment procedures did not explicitly require a review to ensure past process performance problems were eliminated; the assessment methodology relied principally on interviews of departmental staff; the programmatic assessment procedure did not require review or approval of programmatic assessments by the System Readiness Review Board; the silo approach used for programmatic assessments appeared likely to produce inconsistencies; the Cross Functional Review Team was not fully effective in identification of programs in need of a detailed self assessment; and an informal word-of-mouth training process was used for personnel involved in programmatic area self-assessments. (Section 07.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Contractor Control and Material Condition program reviews were considered vague and lacking in detail. Contractor Control and Material Condition program reviews were considered vague and lacking in detail. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The Plant Fuse Control Program documentation was not sufficient to support the conclusion that adequate guidance existed. The Plant Fuse Control Program documentation was not sufficient to support the conclusion that adequate guidance existed. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | NEG | Pri: 4B Sec: Ter: | The preventive maintenance program had been ineffectively implemented. The preventive maintenance program had been ineffectively implemented resulting in inadequate equipment maintenance and a large backlog of overdue preventive maintenance tasks. The failure to initiate prompt corrective actions (condition reports or deferrals) for approximately 150 overdue preventative maintenance tasks, and to determine if the operability of Unit 1 and Unit 2 safety related equipment had been affected was considered a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion XVI. The licensee was taking appropriate corrective actions including the formation of a cross-discipline review team to address the causes of the overdue maintenance and the performance of operability determinations to assess the impact on affected safety related equipment (Section E7.2.3). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | The Systems Readiness Review Board members performed their charter functions and effectively challenged internal assessments and conclusions. The Systems Readiness Review Board members performed their charter functions and effectively challenged internal assessments and conclusions. The Systems Readiness Review Board process was an essential element in establishing quality expectations for the functional area assessment process (Section 07.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | The operations-related assessments were of good quality. The operations-related assessments were of good quality. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | The Electrical Load Control Program assessment identified substantive program issues. The Electrical Load Control Program assessment identified substantive program issues. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/11/1999 | 1999013 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: Ter: | Functional area assessments in the areas of operations, maintenance and engineering and the assessment of the Corrective Action Program were successful in identifying potential restart issues and engineering process deficiencies. Functional area assessments in the areas of operations, maintenance and engineering and the assessment of the Corrective Action Program were successful in identifying potential restart issues and engineering process deficiencies. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: ENG Sec: | NRC | POS | Pri: 4B Sec: Ter: | The inspectors observed that engineering personnel provided effective support to maintenance personnel in an effort to resolve the containment spray system problems in a timely manner. The inspectors observed that engineering personnel provided effective support to maintenance personnel in an effort to resolve the containment spray system problems in a timely manner. As appropriate, the problem scopes were expanded and/or re-assessed to ensure adequate technical resolutions were achieved. (Section E7.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 05/27/1999 | 1999010 | Pri: ENG Sec: | NRC | POS | Pri: 4B Sec: Ter: | Significant progress had been made by the licensee in the identification of technical issues related to the Co Significant progress had been made by the licensee in the identification of technical issues related to the Containment Spray System. At the end of the inspection report period, the system remained inoperable pending resolution of the identified issues. Case Specific Checklist item 10 remained open at the end of the inspection period. (Section E7.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | NEG | Pri: 5A Sec: Ter: | The inspector identified that setpoints listed in the Technical Specifications and in the Updated Final Safety A The inspector identified that setpoints listed in the Technical Specifications and in the Updated Final Safety Analysis Report were not referenced or used as guidance in developing design calculations. This was of concern because the setpoints could be less conservative. In addition, there was no technical basis or calculations for some of the setpoints (Section E1.2, E1.3 and E1.5). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | NEG | Pri: 5A Sec: Ter: | The assessment team system walkdowns were generally effective, however, the CS and the RHR teams had r The assessment team system walkdowns were generally effective, however, the containment spray and the residual heat removal teams had not taken motor nameplate information from the motor operated valves that were within the boundaries of their system. In addition, the reactor protection system team did not verify that balance-of-plant cables were not routed with redundant channels (Section E1.4 and E1.5). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | NEG | Pri: 5B Sec: Ter: | The licensee did not have administrative controls to prevent large loads from being connected to the batterie the licensee did not have administrative controls to prevent large loads from being connected to the batteries in modes five and six. Controls were put in place after the inspection (Section E1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: Ter: | The licensee's assessments were thorough and focused on design attributes. The licensee's assessments were thorough and focused on design attributes. The assessment teams identified significant design related issues (Sections E1.1, E1.2, E1.3 and E1.4). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: Ter: | The electrical safety bus and the 250VDC assessment teams identified a number of significant weaknesses wi The electrical safety bus and the 250VDC assessment teams identified a number of significant weaknesses with design calculations. The teams found that the emergency diesel generator loading calculations had not been updated since 1992 and the DC voltage drop calculations did not determine the available voltage to the end devices. (Sections E1.1 and E1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | POS | Pri: 5A Sec: Ter: | The operability of the station batteries was in question in modes one through four and as a consequence, this The operability of the station batteries was in question in modes one through four and as a consequence, this was correctly classified as a restart issue. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012 | Pri: ENG Sec: | NRC | POS | Pri: 5B Sec: Ter: | The licensee appropriately characterized open discrepancy reports and corrective actions items as restart or The licensee appropriately characterized open discrepancy reports and corrective actions items as restart or post restart (Sections E1.1, E1.2 and E1.3). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/21/1999 | 1999012-01 | Pri: ENG Sec: | NRC | URI | Pri: 4C Sec: Ter: | TRACEABILITY OF NONCONFORMING MCCBS The licensee was reviewing job orders to determine if all the MCCBs that were referenced in Commitment 2832 had adequate traceability or had been replaced. On June 1, 1999, a licensee representative stated that the review was not complete. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/05/1999 | 1999006 | Pri: ENG Sec: | NRC | NEG | Pri: 1C Sec: Ter: | As a result of observations during the inspection, though not directly related to the inspection's objectives, th As a result of observations during the inspection, though not directly related to the inspection's objectives, the team noted problems in the areas of management information systems, instrumentation calibration processes, preventive maintenance scheduling, surveillance procedures, and maintenance practices. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/05/1999 | 1999006 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | Implementation of the vertical slice components by the PA audit team resulted in a good examination of the f Although a few weaknesses were observed, implementation of the vertical slice components by the PA audit team resulted in a good examination of the four selected systems and identification of substantive issues. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/05/1999 | 1999006 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | The broad-scope horizontal component implemented by the PA audit team resulted in an effective assessme The broad-scope horizontal component implemented by the PA audit team resulted in an effective assessment of the ESRR implementation and making significant contributions to the effectiveness of the program. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 05/05/1999 | 1999006 | Pri: ENG Sec: | NRC | STR | Pri: 1C Sec: Ter: | The Performance Assurance (PA) department audit plan was well-designed. The Performance Assurance (PA) department audit plan was well-designed. The plan is sufficiently comprehensive that if properly implemented, should provide an accurate assessment of the Expanded System Readiness Review (ESRR) program's implementation. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/30/1999 | 1999011 | Pri: ENG Sec: | NRC | NEG | Pri: 4B Sec: Ter: | The operability basis for operability evaluations concerning the use of Anderol 732 to address circuit breaker The operability basis for operability evaluations concerning the use of Anderol 732 to address circuit breaker hardened grease concerns did not have a sound technical basis. (Section E2.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/30/1999 | 1999011 | Pri: ENG Sec: | NRC | NEG | Pri: 4B Sec: Ter: | A number of breakers were not appropriately prioritized for refurbishment. A number of breakers were not appropriately prioritized for refurbishment. (Section E2.3) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/30/1999 | 1999011 | Pri: ENG Sec: | NRC | POS | Pri: 1C Sec: Ter: | The planned long-term engineering-related corrective actions to address the motor control center failures we The planned long-term engineering-related corrective actions to address the motor control center failures were thorough and comprehensive. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/30/1999 | 1999011 | Pri: ENG Sec: | NRC | POS | Pri: 4B Sec: Ter: | There was reasonable assurance that the electrical distribution systems necessary for cold shutdown plant o There was reasonable assurance that the electrical distribution systems necessary for cold shutdown plant operation were capable of performing their function. (Section E2.2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | NEG | Pri: 3A Sec: Ter: | A change in the design fouling factor for the Unit 1 steam generator U-tubes had never been formally reviewe The inspectors identified that a change in the design fouling factor for the Unit 1 steam generator U-tubes had never been formally reviewed/ evaluated by the licensee nor incorporated into the updated final safety evaluation report |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | NEG | Pri: 3A Sec: Ter: | Several examples of operability determinations that contained poor quality engineering assessments The inspectors identified several examples of operability determinations that contained poor quality engineering assessments. These examples combined with the large backlog (in excess of 500 items) of operability questions which have not received timely engineering resolution, demonstrated poor engineering support for the operability determination process |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | POS | Pri: 3A Sec: Ter: | Scope of the planned review areas for the reactor coolant system was broad. The inspectors considered the scope of the planned review areas for the reactor coolant system to be broad and consistent with the purpose of the review effort to confirm the performance of system safety functions |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | POS | Pri: 3A Sec: Ter: | Control room instrumentation distribution system assessments were thorough and focused on design attribute The control room instrumentation distribution system assessments were thorough and focused on design attributes and the control room instrumentation distribution system review team identified a number of significant design related issues. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | POS | Pri: 4B Sec: Ter: | Breadth and depth of material reviewed for the reactor coolant system assessments was generally appropriate The breadth and depth of material reviewed for the reactor coolant system assessments was generally appropriate and the reactor coolant system review team was effective at identification of substantive design issues potentially impacting system safety functions. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | STR | Pri: 1C Sec: Ter: | The System indexed data base system represented a powerful resource tool. The system indexed data base system represented a powerful resource tool that enabled the expanded system readiness review teams to review an single integrated list of system deficiencies, work or modifications and as such, represented an essential element for effective system reviews |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | STR | Pri: 1C Sec: Ter: | The system readiness review board members followed a structured review process that offered a consistent The system readiness review board members followed a structured review process that offered a consistent approach for effectively reviewing the large amount of information contained in a typical expanded system readiness review system report. The auxiliary building ventilation systems expanded system readiness review report presentation demonstrated the team manager's thorough understanding of the system under review and of the relative significance of the system findings and assessments |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | STR | Pri: 3A Sec: Ter: | The licensee subsequently suspended the systems scheduled for system readiness review board review and The inspectors were concerned that performing significant additional licensing basis reviews (e.g. review of the historical design and licensing basis notebooks) following the system readiness review board approval process could change the system assessments and serve to "bypass" the system readiness review board review process step. The licensee subsequently suspended the systems scheduled for system readiness review board review and approval pending the receipt and review of the historical design and licensing basis notebooks by the expanded system readiness review teams. Inspectors considered this action to demonstrate a prompt effective management response to this concern |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | WK | Pri: 2B Sec: Ter: | The expanded system readiness review teams were being adversely affected by the ongoing problems. The expanded system readiness review teams were being adversely affected by the ongoing problems created by the disparity of system designators used in system indexed data base system and other plant data bases. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | WK | Pri: 3A Sec: Ter: | Failure to identify nonconservative assumptions for station blackout reactor coolant inventory. However, the failure of this team to identify nonconservative assumptions for station blackout reactor coolant inventory calculations demonstrated a lapse in the technical rigor for this assessment and indicated a need for more focus on the quality of the review effort |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | WK | Pri: 3A Sec: Ter: | Lack of receipt/review of historical design and licensing data (deliverable 2 notebooks) had a potential generi the lack of receipt/review of historical design and licensing data (deliverable 2 notebooks) had a potential generic impact on the quality of the ongoing expanded system readiness review team assessments |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009 | Pri: ENG Sec: | NRC | WK | Pri: 4B Sec: Ter: | Lack of control of indices of vendor analysis could adversely impact the expanded system readiness review te The inspectors were concerned that lack of control of indices of vendor analysis could adversely impact the expanded system readiness review team assessments which rely on the material in these index lists to identify the up-to-date source review materials |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/23/1999 | 1999009-01 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: 4A Ter: | FAILURE TO IMPLEMENT ADEQUATE DESIGN CONTROLS FOR THE UNIT 1 SG TUB PLUGGING AND SLEEVING The Unit 1 steam generator tube plugging and sleeving was not adequately controlled under a formal design control process such as that described by procedure 227400-STG-5400-3. The failure to implement adequate design controls for the Unit 1 steam generator tube plugging and sleeving activities that occurred during outages in March of 1997, September of 1995, April of 1994, August of 1992, November of 1990 and April of 1989 is a violation of 10 CFR 50, Appendix B, Criterion III. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |

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| 04/23/1999 | 1999009-03 | Pri: ENG Sec: | NRC | NCV | Pri: 4C Sec: Ter: | FAILURE TO FOLLOW THE OPERABILITY DETERMINATION PROCEDURAL REQUIREMENTS FOR THE UNIT 1 PRESSURIZER Failure to follow the operability determination procedural requirements on November 2, 1998 for the Unit 1 pressurizer instrument lines is a Violation of 10 CFR 50 Appendix B Criterion V. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |
| 04/23/1999 | 1999009-04 | Pri: ENG Sec: | NRC | NCV | Pri: 1C Sec: Ter: | FAILURE TO FOLLOW THE OPERABILITY DETERMINATION PROCEDURAL REQUIREMENTS FOR THE CONCERN The licensee identified that piping to the both Units emergency diesel air after-coolers was potentially susceptible to erosion and that no erosion inspections of this piping had been done. The licensee performed a screening for this condition on March 23, 1999, however this screening incorrectly identified that no safety related equipment was affected. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: ENG Sec: | NRC | MISC | Pri: 4B Sec: Ter: | During this inspection period, the licensee's staff continued with the discovery phase of the Expanded System During this inspection period, the licensee's staff continued with the discovery phase of the Expanded System Readiness Reviews (ESRRs). The ESRRs comprised a significant portion of the licensee's restart effort. In accordance with the NRC Inspection Manual Chapter 0350 Inspection Plan, the NRC established an inspection team to provide oversight of the ESRR process. The NRC oversight team will document their findings in a separate inspection report. (Section E1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004-04 | Pri: ENG Sec: | NRC | NCV | Pri: 4B Sec: Ter: | Failure to Perform a Safety Evaluation Case Specific Checklist Item 4A, "Failure to Perform Safety Evaluations or Safety Evaluation Screenings." A safety evaluation screening performed in support of a change to a surveillance procedure did not identify that the procedure change resulted in operation of the plant other than as described in the Updated Final Safety Analysis Report. Additionally, the licensee's use of 10 CFR Part 50.59 safety evaluation screenings appeared inconsistent. A Non-Cited Violation of 10 CFR Part 50.59 was identified for the failure to perform a safety evaluation for the procedure change. The NRC's assessment of the licensee's effectiveness in addressing this case specific checklist item will continue as part of oversight of the licensee's restart effort. |
| Dockets Discussed: 05000316 D.C. Cook 2 | | | | | | |
| 03/26/1999 | 1999003 | Pri: ENG Sec: | NRC | NEG | Pri: 4C Sec: Ter: | Preparation steps for the expanded system readiness review walkdowns did not require the teams to review Preparation steps for the expanded system readiness review walkdowns did not require the teams to review prior modifications. This was considered a potential weakness in the program because of previously identified programmatic deficiencies in the design control process. (Section E4.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/26/1999 | 1999003 | Pri: ENG Sec: | NRC | NEG | Pri: 5A Sec: 5C Ter: | Examples were identified where issues could not be consistently dispositioned due to erroneous or missing i Examples were identified where issues could not be consistently dispositioned due to erroneous or missing information in the electronic database, or because limited or incorrect problem descriptions were documented in condition reports. In particular, design requirements were not considered during one condition report disposition, that resulted in an inspector-prompted concern with improper instrument line slopes. Collectively, these issues could result in problems not being properly resolved or prioritized. (Section E3.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 03/26/1999 | 1999003 | Pri: ENG Sec: | NRC | POS | Pri: 4B Sec: Ter: | The licensee was effectively identifying system deficiencies through the expanded system readiness review process. The licensee was effectively identifying system deficiencies through the expanded system readiness review process. Programmatic and technical concerns that were identified included cable separation, electrical breaker refurbishment, and seismic mounting. The threshold for identification of problems was conservatively low, with 80 to 100 condition reports per day being initiated by the expanded system readiness review teams. (Section E3.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/26/1999 | 1999003 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | Overall, the system walkdowns appeared effective at identifying design and configuration deficiencies, as exemplified by the spray header blockage concern. Overall, the system walkdowns appeared effective at identifying design and configuration deficiencies, as exemplified by the spray header blockage concern. Most walkdown teams used comprehensive checklists to verify design parameters such as electrical separation, protective relay settings, transformer tap settings, and grounding. However, isolated weaknesses were identified with specific walkdowns which initially appeared to focus on materiel condition instead of design attributes. (Section E4.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/26/1999 | 1999003 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | Management maintained good oversight of the expanded system readiness review process and was appropriately addressing issues. Management maintained good oversight of the expanded system readiness review process and was appropriately addressing issues. The System Readiness Review Board provided technical rigor and consistency of approach for the expanded system readiness review team products, and identified generic issues of concern. In addition, after adjusting their participation in system walkdowns, the Performance Assurance group maintained an active and independent oversight role in the expanded system readiness review process. (Section E7.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The inspectors concluded that the Engineering Department Leadership Plan established a framework for performance improvements, and if properly implemented, should result in the engineering department being ready to support plant restart. The inspectors concluded that the Engineering Department Leadership Plan established a framework for performance improvements, and if properly implemented, should result in the engineering department being ready to support plant restart. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | NEG | Pri: 4C Sec: Ter: | The results of the diesel generator walkdown for the diesel generator were acceptable; however, the strategy for the walkdown was not documented and the walkdown did not include the control room. The results of the diesel generator walkdown for the diesel generator were acceptable; however, the strategy for the walkdown was not documented and the walkdown did not include the control room. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The inspectors concluded that weaknesses identified in the original system readiness review process had been corrected with one exception. The inspectors concluded that weaknesses identified in the original system readiness review process had been corrected with one exception. The licensee had not required the expanded system readiness review (ESRR) teams to consider the Individual Plant Examination (IPE) in selecting system attributes for review in the original version of the ESRR procedure. The licensee subsequently revised the ESRR procedure to include the use of the IPE. |
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| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The ESRR review scope was considered extensive and represented a substantial improvement over the original ESRR review. The expanded system readiness review (ESRR) scope was considered extensive and represented a substantial improvement over the original system readiness review (SRR) scope completed in early 1998. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The data base systems used by the licensee included a compiled data resource and an electronic data management system. The data base systems used by the licensee included a compiled data resource and an electronic data management system that provided an excellent and efficient method for the expanded system readiness review teams to implement the reviews of their systems. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The selection of experienced personnel to staff the ESRR teams, the focused approach on identification of issues and the licensee's decision not to project a restart date demonstrated the licensee's commitment to an effective effort. The selection of experienced personnel to staff the expanded system readiness review teams, the focused approach on identification of issues and the licensee's decision not to project a restart date demonstrated the licensee's commitment to an effective effort. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The ESRR training had been effectively implemented. The inspectors concluded that the expanded system readiness review (ESRR) training had been effectively implemented. The scope and depth of the ESRR training was adequate for the teams to perform their assigned responsibilities. However, the original scope of the ESRR training did not include training for all team members pertaining to 10 CFR 50.59, operability determinations and system design basis. This was subsequently corrected, but indicated a weakness in the scope of the original training. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The system readiness review board consisted of knowledgeable individuals. The board possessed a good focus on safety. The system readiness review board consisted of knowledgeable individuals. The board possessed a good focus on safety. In general, extensive management involvement was not needed to ensure consistent application of the expanded system readiness review process with one exception. Increased management oversight was needed in the development of the system assessment matrix. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 02/19/1999 | 1999002 | Pri: ENG Sec: | NRC | POS | Pri: 4C Sec: Ter: | The performance assurance department was actively engaged in oversight of the expanded system readiness review process. The performance assurance department was actively engaged in oversight of the expanded system readiness review (ESRR) process. The system readiness review oversight plan described oversight of the ESRR process and provided for prompt feedback. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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Region III

COOK

| Date | Source | Functional Area | ID | Type | Template Codes | Item Title Item Description |
|---|------------|-----------------------------------|----------|------|--|---|
| 02/19/1999 | 1999002-01 | Pri: ENG Sec: | Licensee | NCV | Pri: 4C Sec: Ter: | FAILURE TO ESTABLISH AN NSSS VENDOR RECONTACT PROGRAM A non-cited violation was identified concerning the failure of the licensee to establish a recontact program for the nuclear steam system supply vendors that supplied safety related plant equipment (Section E7.1.b.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | RADIOLOGICAL PLANNING Steam generator replacement project schedule acceleration contributed to some early planning problems which reduced the effectiveness of the ALARA program and resulted in increased dose expenditure (Section R1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | ALARA PLANNING ALARA plans were not consistently thorough, lessons learned information was not always used and documentation problems were identified with some ALARA packages. RP management agreed that individual worker doses needed to be more closely monitored and evaluated, and planned to more aggressively manage worker dose as the steam generator replacement project continued (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | RADIOLOGICAL PLANNING The radiation protection (RP) organization was adequately integrated in steam generator replacement project planning processes, and an effective interface with the principal contractor and subcontractor work force existed (Section R1.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | ALARA PLANNING The ALARA program for the steam generator replacement project was implemented adequately, as ALARA plans were developed consistent with procedure, and dose saving initiatives and engineering controls were established commensurate with the radiological hazards (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | SOURCE TERM REDUCTION Source term reduction strategies were planned and thus far implemented effectively for the steam generator replacement project, and adequate work control mechanisms were established to ensure dose savings initiatives were completed timely (Section R1.4). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | RAD PROTECTION ORGANIZATION The organizational scheme established for the steam generator replacement project and the mix of experienced contractor personnel contributed to the effectiveness of the RP program for the project (Section R6.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 2A Sec: Ter: | RADIOLOGICAL POSTINGS AND PRACTICES Radiological postings were adequately maintained and accurately reflected radiological conditions, and high and extreme high radiation areas were controlled consistent with requirements. Appropriate contamination control practices were observed at work sites and dose savings initiatives were as prescribed by ALARA plans. Isolated labeling and equipment control deficiencies noted by the inspector and brought to the licensee's attention were quickly rectified and did not reoccur (Section R4.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 3A Sec: Ter: | WORK CONTROL AND OVERSIGHT Radiation protection staff oversight and control of radiological work was generally effective thus far in the steam generator replacement project, although RP management recognized the need to heighten staff focus and awareness of radiological work activities (Section R1.3). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 3A Sec: Ter: | RAD WORKER PERFORMANCE Radiation worker performance was generally adequate and consistent thus far in the steam generator replacement project. Problems with loitering and dosimetry usage were being addressed by the RP staff (Section R4.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/14/2000 | 1999036 | Pri: PLTSUP Sec: | NRC | POS | Pri: 3B Sec: Ter: | QUALIFICATIONS AND TRAINING Qualification, selection and training of contract RP staff was consistent with industry standards and licensee procedures, and the size and experience of the supplemental RP staff was adequate to support the steam generator replacement project (Section R5.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 11/19/1999 | 1999020-04 | Pri: PLTSUP Sec: | NRC | NCV | Pri: 4B Sec: Ter: | UNIDENTIFIED VITAL AREA BARRIER BREACH CAUSED BY IMPLEMENTATION OF TEMPORARY MODIFICATION The inspectors identified a vital area barrier breach caused by the partial removal of ice loading Temporary Modification 12-98-28. The breach had existed for several months. The licensee took prompt compensatory measures upon notification by the NRC inspectors. One Non-Cited Violation of the Modified Amended Security Plan was identified. |
| Dockets Discussed: 05000315 D.C. Cook 1 | | | | | | |

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|---|------------|--|-----|------|--|---|
| 10/28/1999 | 1999030 | Pri: PLTSUP Sec: | NRC | POS | Pri: Sec: Ter: | Overall performance of Operations Staging Areas (OSA) management and staff was competent. Personnel w Overall performance of Operations Staging Areas (OSA) management and staff was competent. Personnel were focused on the emergency and their duties, and teamwork was evident. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030-01 | Pri: PLTSUP Sec: | NRC | IFI | Pri: 1C Sec: Ter: | EXERCISE WEAKNESS, THE FAILURE OF THE OSA STAFF TO EFFECTIVELY COMMUNICATE THE STATUS OF I An Exercise Weakness was identified concerning the failure of OSA staff to effectively communicate the status of inplant repair teams. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030-02 | Pri: PLTSUP Sec: | NRC | IFI | Pri: Sec: Ter: | THE UNTIMELY DISPATCH OF OSA TEAMS An Inspection followup item was identified in the OSA concerning the slow dispatch of some inplant repair teams. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030-04 | Pri: PLTSUP Sec: | NRC | IFI | Pri: 1C Sec: Ter: | EXERCISE WEAKNESS, THE FAILURE TO RELIEVE THE CRS SHIFT STAFF, IN A TIMELY FASHION, OF THE RE An Exercise Weakness was identified concerning untimely relief of the Control Room Simulator staff of the responsibility to transmit notification forms to the State of Michigan. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030 | Pri: PLTSUP Sec: PLTSUP | NRC | POS | Pri: Sec: Ter: | Overall licensee performance during the 1999 exercise was adequate. The exercise was considered a succe: Overall licensee performance during the 1999 exercise was adequate. The exercise was considered a successful demonstration of implementation of the emergency plan. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030 | Pri: PLTSUP Sec: PLTSUP | NRC | POS | Pri: Sec: Ter: | The Technical Support Center (TSC) staff's overall performance was effective. The TSC personnel demonstra The Technical Support Center (TSC) staff's overall performance was effective. The TSC personnel demonstrated effective communications and teamwork. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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|---|------------|--|-----|------|--|--|
| 10/28/1999 | 1999030 | Pri: PLTSUP Sec: PLTSUP | NRC | POS | Pri: Sec: Ter: | Performance of shift personnel in the Control Room Simulator was effective. The shift manager and unit supe |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 10/28/1999 | 1999030 | Pri: PLTSUP Sec: PLTSUP | NRC | POS | Pri: 1C Sec: Ter: | The participants and controllers initial facility critiques following termination of the exercise were self-critica The participants and controllers initial facility critiques following termination of the exercise were self-critical and detailed. An excellent consolidated critique meeting with participants provided a detailed discussion of strenghts, weaknesses, and concerns. The critiques included inputs from controllers and exercise participants. Overall licensee critiques findings were consistent with the NRC evaluation team's findings. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 09/24/1999 | 1999027-01 | Pri: PLTSUP Sec: | NRC | NCV | Pri: 5A Sec: Ter: | ACCESS CONTROL - PERSONNEL The inspector identified a non-cited violation in that, for a period of approximately eleven months, three metal detectors were not fully capable of detecting a weapon. The detectors failed because they were improperly calibrated when installed. An inadequate security testing procedure contributed to the deficient time period the detectors were ineffective. Adequate corrective measures were implemented in a timely manner. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 09/24/1999 | 1999027-02 | Pri: PLTSUP Sec: | NRC | NCV | Pri: Sec: Ter: | SECURITY BARRIERS The inspector identified a non-cited violation in that, for a period of approximately eleven months, three metal detectors were not fully capable of detecting a weapon. The detectors failed because they were improperly calibrated when installed. An inadequate security testing procedure contributed to the deficient time period the detectors were ineffective. Adequate corrective measures were implemented in a timely manner. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 09/24/1999 | 1999027-03 | Pri: PLTSUP Sec: | NRC | URI | Pri: Sec: Ter: | FITNESS FOR DUTY EVENT |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The 1998 Annual Radioactive Effluent Release Report was not submitted to the NRC within the timeframe requ The 1998 Annual Radioactive Effluent Release Report was not submitted to the NRC within the timeframe required by technical specifications, resulting in a violation of minor safety significance not subject to formal enforcement action. Inspector identified minor discrepancies in certain liquid effluent flow paths described in the Updated Final Safety Analysis Report (UFSAR) and ODCM and contractor audit recommendations for the development of a formal water management program were also being addressed by the licensee (Section R1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Problems were identified with the completeness of respirator issuance logs and with the timely removal of self contained breathing apparatus (SCBA) bottles from use for hydrostatic testing, both which the licensee acknowledged and planned to address. Also, licensee derived alpha emitter conversion factors and derived air concentration and annual limit of intake values used to assess internal dose were not recalculated when new scaling factors were determined (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Inconsistencies were identified with the labeling and tagging of containers housing radioactive materials. Inconsistencies were identified with the labeling and tagging of containers housing radioactive materials, and recent condition reports indicated that workers did not clearly understand the revised labeling program (Section R4.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The radiological respiratory protection program was effectively implemented. The radiological respiratory protection program was effectively implemented. Systems were in place to ensure workers were qualified to use respirators, and respiratory protection equipment was in good physical condition, inspected regularly by the licensee and properly maintained and stored. A program for quality testing of station breathing air was established and was properly executed, and sources of supplied breathing air met industry quality standards (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | Radiological control of access to high, extreme high and very high radiation areas (HRAs) was effective. Radiological control of access to high, extreme high and very high radiation areas (HRAs) was effective. Station procedures governing HRA access control and posting were developed consistent with technical specifications and regulatory requirements, included administrative mechanisms to ensure proper HRA key and area access control, and were appropriately and consistently implemented (Section R1.3). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | Radiological postings were well maintained and accurately reflected the area conditions. Radiological postings were well maintained and accurately reflected the area conditions. Radiological housekeeping in the Unit 2 containment building and the auxiliary building was generally good and had improved over the last several months (Section R4.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | STR | Pri: 1C Sec: Ter: | Gaseous and liquid effluents were adequately controlled, properly sampled, and quantified, and doses were c Gaseous and liquid effluents were adequately controlled, properly sampled, and quantified, and doses were determined consistent with the Offsite Dose Calculation Manual (ODCM). The total radioactivity released in liquid and gaseous effluents and associated doses remained well below regulatory limits. Annual Radioactive Effluent Release Reports for 1997 and 1998 included all required information, consistent with Regulatory Guide 1.21 (Section R1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | STR | Pri: 1C Sec: Ter: | The program for the use and for the radiological control of portable (HEPA) filtered ventilation systems and v The program for the use and for the radiological control of portable high efficiency particulate air (HEPA) filtered ventilation systems and vacuum cleaners and of tools and associated equipment was effective. A verification process implemented by the radiation protection (RP) staff ensured that portable HEPA units were maintained operable and in good physical condition and that the equipment's radiological condition did not preclude its safe use (Section R2.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 06/03/1999 | 1999014 | Pri: PLTSUP Sec: | NRC | STR | Pri: 1C Sec: Ter: | Recent efforts to audit and self-assess the chemistry and RP programs were effective. Recent efforts to audit and self-assess the chemistry and RP programs were effective. Programmatic and functional area restart readiness reviews included broad scope, self-critical assessments of the RP and chemistry programs' readiness. Other recent initiatives included thorough vendor and licensee audits of the radioactive effluents management program and ODCM implementation, both which identified several findings. Assessment and audit findings were entered into the licensee's corrective action process to track resolution and were being evaluated by RP/chemistry management and staff (Section R7.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 3A Sec: Ter: | Delay in the placement of plant equipment into an appropriate lay-up condition contributed to the degradatio Delay in the placement of plant equipment into an appropriate lay-up condition contributed to the degradation of some plant safety and nonsafety-related equipment. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 05/27/1999 | 1999010 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The licensee had recognized the need for an effective lay-up program and had taken action to place equipme The licensee had recognized the need for an effective lay-up program and had taken action to place equipment in lay-up and to develop planning for lay-up during future outages. (Section R2.1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999004 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The inspectors identified two minor problems with the implementation of the radiological protection program The inspectors identified two minor problems with the implementation of the radiological protection program outside the plant protected area. The inspectors found a radiation area sign on a publicly accessible beach just outside the perimeter fence. Additionally, the steam generator storage building, used for storing the removed Unit 2 steam generators, was cluttered with tools and work debris. No uncontrolled releases of radioactive material were identified. (Section R1) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999008 | Pri: PLTSUP Sec: | Licensee | NEG | Pri: 1C Sec: Ter: | The overall effectiveness of EP training was adequate. Two Non-Cited Violations were issued related to ann The overall effectiveness of EP training was adequate. Two Non-Cited Violations were issued related to annual retraining, training drills, and the semi-annual augmentation drill. These issues had been appropriately identified and tracked. Corrective actions were initiated and completed in a timely manner. (Section P5) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 04/16/1999 | 1999008 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The emergency implementing procedures reviewed were detailed. The Emergency Plan Administrative Tracking System (EPATS) was an adequate method to document, track, and close EP issues. The EPATS was in the process of being replaced by the Electronic Corrective Action Program. (Section P3) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999008 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | Management support and attention to the program appeared to be appropriate. Management involvement was indicated with the relocation to a new Emergency Operations Facility and upgrades in the Operations Staging Area. The increased managerial attention and specific objectives for areas of improvement for the EP program appeared to be an affective enhancement. (Section P6) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999008 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The licensee's 1998 and 1999 EP program audits provided good evaluations of the program. The audit satisfied the requirements of 10 Code of Federal Regulations 50.54(t). The performance assurance audits were of good scope and depth. (Section P7) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 04/16/1999 | 1999008 | Pri: PLTSUP Sec: | NRC | POS | Pri: 2A Sec: Ter: | Emergency response facilities were well maintained and in very good material condition, with the exception of the air conditioning units in the TSC. The issue was appropriately identified, tracked, and dispositioned. All emergency equipment demonstrated was verified operable. The prompt alert and notification system sirens were well maintained. Good identification and response was observed for the loss of offsite telephone communications in the EOF. (Section P2) |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | Deficiencies were identified with the level of detail in the licensee's PCP concerning 10 CFR 61.56 waste characteristics, and both the PCP and the Final Safety Analysis Report (FSAR) were not fully consistent with current onsite waste processing activities (Section R1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | NEG | Pri: 1C Sec: Ter: | The program for classifying waste streams and scaling difficult to measure radio-nuclides was implemented in accordance with station procedures and industry guidance. However, the procedure for the scaling factor program was not sufficiently developed to ensure consistent and appropriate implementation of the program (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | Direct licensee oversight of vendor resin dewatering activities and extensive supervisory involvement in radwaste processing ensured effective implementation of the radwaste management program. Wet solid wastes were processed in accordance with the Process Control Program (PCP) and implementing procedures, and dewatered waste streams were properly sampled and verified to ensure that regulatory limits for free standing liquid were met (Section R1.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The radwaste packaging and transportation program was effectively implemented. Shipments of radwaste were appropriately classified, vehicle and package surveys were performed as required, and manifests were completed in accordance with regulatory requirements (Section R1.2). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The training provided to licensee staff involved in the preparation and shipment of radioactive materials satisfied Department of Transportation requirements and imparted an adequate level of knowledge to ensure effective program implementation (Section R5.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/19/1999 | 1999005 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | The audit and self-assessment programs for the packaging and transportation of radioactive material for the 10 CFR 71 Quality Assurance program and for the processing of radwaste were effectively implemented. Audits and assessments were generally properly focused and were of sufficient scope and depth to assess program performance. Identified deficiencies were placed into the licensee's corrective action process for resolution (Section R7.1). |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 03/02/1999 | 1999001 | Pri: PLTSUP Sec: | NRC | POS | Pri: 1C Sec: Ter: | During normal resident inspection activities, routine observations were conducted in the area of security and safeguards, fire protection, and health physics activities. No discrepancies were noted. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |
| 01/13/2000 | 1999021 | Pri: OTHER Sec: | NRC | POS | Pri: 3A Sec: 2B Ter: | Immediate Corrective Action Implementation The licensee effectively implemented immediate corrective actions for performance problems. In addition, the use of the stop work orders demonstrated the licensee's willingness to stop work on critical path activities to ensure that problems are corrected prior to resuming work. |
| Dockets Discussed: 05000315 D.C. Cook 1 05000316 D.C. Cook 2 | | | | | | |

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| 12/28/1999 | 1999034-02 | Pri: OTHER Sec: | NRC | NCV | Pri: 5C Sec: Ter: | LEERS NOT SUBMITTED WITHIN 30 DAYS The inspectors determined that the reports to NRC were not submitted within 30 days as required by 10 CFR 50.73(a)(1). Instead, the issues were "binned" for submittal as part of a supplement for an LER that had already been issued |
| Dockets Discussed: | | | | | | |
| 05000315 D.C. Cook 1 | | | | | | |
| 05000316 D.C. Cook 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.