

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/18/2000	1999-007-00	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Operating License Thermal Power Limits Exceeded During Previous Cycle Coastdown</b>
<b>Dockets Discussed:</b> 05000440 Perry 1						
01/05/2000	1999014	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Operator appeared to be inattentive to duties</b>  The inspectors identified one instance where the At-the-Controls operator appeared to be inattentive to duty. The licensee promptly initiated an investigation and determined that the operator was tired but was fit for duty. As a conservative action, the operator was reassigned to the operations foreman position. The licensee's review of this issue was thorough and lessons learned were effectively promulgated to plant personnel
<b>Dockets Discussed:</b> 05000440 Perry 1 05000441 PERRY 2						
01/05/2000	1999014-02	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 5C <b>Ter:</b> 3B	<b>Inadequate tagout for electrical maintenance work.</b>  The licensee identified that inattention-to-detail during the preparation and review of a tagout led to the use of an inadequate tagout for an electrical relay that was to be replaced. Through the investigation, the licensee determined that there had been several other tagout issues in the past year and initiated a collective significance review of these issues. This was a non-cited violation.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b> 3A	<b>Operator errors detract from typically good conduct of operations</b>  Two minor operator errors, the failure to update an operator aid on two occasions, and an ineffective turnover of a reactor core isolation cooling system operability concern detracted from the thoroughness with which operators typically performed their duties.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 5C <b>Sec:</b> 1A <b>Ter:</b> 3A	<b>Failure to promptly initiate a condition report.</b>  Although plant operators took immediate actions in response to a minor error which occurred during control rod movements, they did not meet plant management's expectation to initiate a condition report for the error. This issue was eventually entered into the corrective action program by a system engineer. Once the issue was brought to plant management's attention, thorough actions were taken to address the error and the failure to promptly enter the issue into the corrective action program.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Conduct of Operations was good</b>  The inspectors concluded that the overall conduct of operations continued to be professional, with an appropriate focus on safety.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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10/07/1999	1999010	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 1A <b>Ter:</b>	<b>Inadequate test procedure for EDG fuel oil transfer pump</b>  The inspectors identified that an inadequate procedure was used to perform emergency diesel generator (EDG) fuel oil transfer pump testing. The procedure rendered the EDG inoperable during the test, however, there was no information in the surveillance test procedure to alert the shift supervisor that equipment operability was affected.
<b>Dockets Discussed:</b> 05000440 Perry 1						
10/07/1999	1999010-01	<b>Pri:</b> OPS <b>Sec:</b> ENG	NRC	NCV	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b>	<b>Improper storage of ladders within the suppression pool swell region of containment</b>  The inspectors concluded that ladders were improperly stored within the suppression pool swell region of the containment which had the potential to impact safety-related equipment in the area. The ladders were too long and there was an extra ladder at one location. This was a Non-Cited Violation.
<b>Dockets Discussed:</b> 05000440 Perry 1						
08/25/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Conduct of Operations was good</b>  The conduct of operations was professional. The inspectors observed appropriate use of procedures and consistent three-part communications. Panel walkdowns were generally completed thoroughly and consistently.
<b>Dockets Discussed:</b> 05000440 Perry 1						
08/25/1999	1999009-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>Communication breakdown resulted in the control room not receiving a severe thunderstorm warning</b>  The inspectors concluded that a communication breakdown resulted in control room operators not receiving notification of a severe thunderstorm warning for the county. As a result, the necessary compensatory measures were not taken. This issue was appropriately addressed in the licensee's corrective action program, subsequent severe weather notifications were promptly received, and compensatory actions were taken as required. One Non-Cited Violation for the failure to follow the instructions in an off normal instruction was identified. (NCV 50-440/99009-01(DRP))
<b>Dockets Discussed:</b> 05000440 Perry 1						
08/25/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Operations personnel did not ensure that test equipment was removed following test.</b>  Operations personnel did not ensure that test equipment installation and removal was properly controlled during a surveillance test. Specifically, operators failed to remove a meter from an electrical panel following completion of a high pressure core spray system pump and valve operability test. There was no impact on system operability as a result of this event.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/08/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Inattention-to-detail during tagout restoration</b>  Inattention-to-detail by a non-licensed operator during restoration of a clearance resulted in an error. The operator unintentionally energized the motor control center for a normally de-energized motor-operated valve. This error did not result in a re-positioning of the valve and was considered to be of minor significance.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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07/08/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 5A Ter:	<b>Conduct of operations was good</b>  The inspectors concluded that the overall conduct of operations continued to be professional, with a continuing focus on safety. Operators demonstrated good attention to panels during hourly walkdowns and promptly identified two problems.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 5C Ter:	<b>The overall conduct of operations continued to be professional with an appropriate focus on safety.</b>  The inspectors concluded that the overall conduct of operations continued to be professional with an appropriate focus on safety. Lessons learned were applied from the previous refueling outage in the areas of procedure adherence, safety tagging, and work control. In general, the licensee effectively managed a complex refueling outage with only minor problems noted.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: OPS Sec:	NRC	POS	Pri: 2A Sec: 5A Ter: 5C	<b>The licensee was effective in inspecting, identifying, and correcting fuel failures</b>  The inspectors concluded that the licensee was effective in inspecting, identifying, and correcting fuel failures which occurred during the operating cycle. Although the licensee could not guarantee the removal of all foreign material from the reactor vessel, steps were taken to minimize the potential for future fuel damage.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003-01	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: Ter:	<b>Failure to Follow Procedure - Two Examples</b>  A Non-Cited Violation was identified through two examples of operations department personnel failing to follow procedures as written. The inspectors were specifically concerned that, in these cases, operations personnel exercised some latitude with the procedures that was not applicable.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: OPS Sec: MAINT	NRC	MISC	Pri: 1A Sec: 3C Ter:	<b>Overtime generally effectively controlled during outage</b>  The plant Technical Specifications limit individual work hours to 72 hours in any 7-day period unless very unusual circumstances arise requiring deviation from the limit. Most plant employees worked approximately 72 hours each week during the refueling outage. Numerous deviations were processed during the outage to approve work in excess of 72 hours a week. Some of the deviations did not document specific reasons for the deviations nor did they provide any limit to the number of hours worked in a week. Plant management indicated that these deviations were for work on critical path activities which were considered to be very unusual circumstances.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/12/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: Ter:	<b>Operators responded to all simulated events with one minor exception.</b>  Operators assigned to validate the licensed operator dynamic simulator test accurately diagnosed and responded to all simulated events with one minor exception. A high system and plant knowledge level was evident during the operator review of the written and JPM follow up questions.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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04/12/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: Ter:	<b>All nine applicants successfully passed all portions of the examinations they were administered.</b>  Operator initial license examinations were administered to nine applicants during the week of March 15, 1999. One reactor operator (RO) applicant failed the August 1997, examination and only took a written re-take examination. All other applicants took the operating and written examinations. All nine applicants successfully passed all portions of the examinations they were administered.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/12/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 3B Sec: Ter:	<b>Applicants were well prepared</b>  The applicants appeared to be well prepared for the licensed operator examination as evidenced by their performance on all portions of the examination. Only a few minor training and individual performance weaknesses were noted by the examination team. Facility training personnel properly staged all portions of the examination, and examination security was well controlled. The written examination was discriminatory and was a good evaluation tool for determining applicant knowledge level.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 3C Ter:	<b>The operators were well-prepared for refueling outage 7.</b>  The inspectors concluded that the operators were well-prepared for refueling outage 7. Operators performed well and the minor equipment challenges which were encountered were effectively handled during the shutdown for the outage. Plant management's expectation for three-way communications between operators was not consistently implemented during the shutdown; however, this did not result in any operator errors.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002-01	Pri: OPS Sec:	Licensee	NCV	Pri: 3B Sec: Ter:	<b>Operator Isolated Hydraulic Control Unit Without Proper Controls</b>  One Non-Cited Violation was identified when a supervising operator failed to obtain the required approval from a unit supervisor prior to hydraulically isolating a hydraulic control unit which rendered the associated control rod inoperable. The licensee effectively dispositioned this item in the corrective actions program.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002	Pri: OPS Sec: MAINT	Licensee	POS	Pri: 2A Sec: 3B Ter:	<b>Operators on shift responded effectively when an Residual Heat Removal pump failed to start</b>  Operators on shift responded effectively when an Residual Heat Removal pump failed to start for shutdown cooling. Maintenance personnel provided good support and promptly repaired a failed optical isolator.
<b>Dockets Discussed:</b> 05000440 Perry 1						
03/05/1999	1999005	Pri: OPS Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	<b>Managed restoration process for equipment unavailability not consistently implemented</b>  While operators generally understood the guidance associated with counting unavailability times while using managed restoration, tighter controls were necessary to avoid misuse of the process and to ensure continuous availability of a dedicated operator.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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02/26/1999	1999001	Pri: OPS Sec:	Licensee	NEG	Pri: 3B Sec: Ter:	<b>Inattention to detail by a licensed operator led to using the wrong section of an Operating Instruction</b>  Inattention to detail by a licensed operator led to using the wrong section of an Operating Instruction for a system restoration activity. The operator identified his error and appropriately notified operations management of the occurrence. Plant management provided training to operations personnel emphasizing the importance of self-checking and attention to detail during work activities
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999001	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	<b>The licensee effectively replaced two circuit cards in the redundant reactivity control system</b>  The inspectors concluded that the licensee effectively replaced two circuit cards in the redundant reactivity control system, which was categorized as a medium risk maintenance activity, through the use of good briefings, effective command and control, and clear communications between operations and maintenance personnel
<b>Dockets Discussed:</b> 05000440 Perry 1						
01/05/2000	1999014	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: 2B Ter: 1A	<b>Maintenance and Surveillance Activity Performance Effective</b>  Maintenance and surveillance activities observed were adequately planned and executed in the field without an adverse impact on plant operations. Pre-job briefings were thorough and activities were properly coordinated between departments and performed according to approved procedures.
<b>Dockets Discussed:</b> 05000440 Perry 1						
12/22/1999	1999-006-00	Pri: MAINT Sec:	Licensee	LER	Pri: Sec: Ter:	<b>Disengaged Locking Spring on Relay Renders One Train of Standby Liquid Control System Inoperable</b>
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	Pri: MAINT Sec: OPS	NRC	NEG	Pri: 1A Sec: 3A Ter:	<b>Inattention to detail during tagout activities</b>  The inspectors concluded that several inadequacies observed in the implementation of administrative requirements associated with tagouts and work orders were principally due to a lack of attention-to-detail on the part of clearance preparers/reviewers and the work group performing the maintenance activities. These inadequacies were promptly and appropriately addressed in the licensee's corrective action program.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	Pri: MAINT Sec: OPS	NRC	POS	Pri: 2B Sec: 1A Ter:	<b>Online maintenance and allowed outage time effectively managed for EDG</b>  The licensee's first use of the recently approved extended emergency diesel generator outage time was effectively implemented. Protected trains and risk status were clearly posted and communicated to plant staff to increase staff awareness and sensitivity to plant risk.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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08/25/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 3A Ter:	<b>Maintenance and surveillance testing activities were properly controlled</b> Maintenance and surveillance activities were generally properly controlled and performed per approved procedures. There was good coordination between the control room and other work groups for these activities.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/08/1999	1999008	Pri: MAINT Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>An inadequate review prior to changing the surveillance test schedule resulted nearly missing the test</b> While the licensee generally scheduled surveillance tests to be performed by their due date, an inadequate review prior to changing the surveillance test schedule resulted in a high pressure core spray pump and valve surveillance test being scheduled past its due date and the allowed 25% extension specified in Technical Specifications (TS). The unit supervisor on shift identified the discrepancy on the last day before the TS interval was exceeded and the test was performed satisfactorily.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/08/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>Maintenance and surveillance activities were properly controlled</b> Maintenance and surveillance activities were properly controlled and performed per approved procedures. There was good coordination between the control room and other work groups for these activities. There was good preplanning for routine control rod exercise testing to address contingencies that could occur during the testing.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: MAINT Sec:	Self	NEG	Pri: 1C Sec: 2A Ter: 5C	<b>Three EDGs inoperable simultaneously</b> A series of two surveillance failures concurrent with a scheduled maintenance activity led to a condition where the emergency diesel generators (EDGs) for Divisions 1, 2, and 3 were inoperable at the same time during the refueling outage. The inspectors determined that the licensee met all Technical Specification requirements associated with the scheduling of these activities and that, due to the Division 1 EDG being available, there was no increase in plant risk as a result of these activities.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: 3C Ter:	<b>The outage-related maintenance and surveillance activities were well coordinated</b> The inspectors concluded that outage-related maintenance and surveillance activities were well coordinated and performed properly, with few exceptions. Management oversight of activities was good.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 3A Sec: 1C Ter:	<b>Test Equipment Left in a Safety-Related Relay</b> A maintenance technician left test equipment in a relay following a calibration activity as a result of inattention to detail. This was identified when the Division 2 EDG Loss of Offsite Power Test failed and resulted in a Non-Cited Violation.
<b>Dockets Discussed:</b> 05000440 Perry 1						

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04/16/1999	1999006	Pri: MAINT Sec: ENG	NRC	POS	Pri: 1C Sec: 4B Ter:	<b>Inservice inspection activities were effectively implemented</b>  Inservice inspection activities were effectively implemented and in accordance with the licensee program and ASME requirements. The inservice inspection program reflected a strong commitment to safety through the examinations of welds susceptible to intergranular stress corrosion cracking using procedures and personnel qualified by Performance Demonstration Initiative.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999006	Pri: MAINT Sec: ENG	NRC	POS	Pri: 1C Sec: 5B Ter: 5C	<b>A strong inservice inspection program with active oversight of contract personnel</b>  A strong inservice inspection program with active oversight of contract personnel was demonstrated by the licensee's independent evaluation of contractor-identified nondestructive examination indications and the pro-active reevaluation of feedwater nozzle flaws.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002	Pri: MAINT Sec:	Licensee	POS	Pri: 2A Sec: 3B Ter:	<b>Operators responded well to unexpected results during maintenance on APRMs.</b>  During maintenance on APRM power supplies, there were two instances of unexpected results. The on-shift licensed operators held thorough pre-job briefings, properly monitored the activities, and responded promptly to unexpected indications.
<b>Dockets Discussed:</b> 05000440 Perry 1						
03/05/1999	1999005	Pri: MAINT Sec:	NRC	NEG	Pri: 1C Sec: Ter:	<b>The practice of revising unavailability criteria on a recurrent basis had potential to mask degrading equipment</b>  The licensee practice of revising unavailability criteria on a recurrent basis had the potential to mask degrading equipment performance. Similarly, the practice of revising reliability criteria as the number of functional failures approached limits also had the potential to mask degrading equipment performance.
<b>Dockets Discussed:</b> 05000440 Perry 1						
03/05/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: Ter:	<b>The practice of managed restoration appeared to have an acceptable risk-informed justification</b>  The practice of managed restoration, i.e., the discounting of maintenance rule unavailability when simple, defined operator actions can make an inoperable system available for accident mitigation within specified time periods, appeared to have an acceptable risk-informed justification. The acceptability of "managed restoration" as a practice is a policy matter that will be reviewed by the Office of Nuclear Reactor Regulation (NRR).
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999001-02	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	<b>Plant personnel failed to adhere in all cases to plant procedures governing the storage of items near safety-r</b>  Plant personnel failed to adhere in all cases to plant procedures governing the storage of items near safety-related equipment. One Non-Cited Violation was identified concerning this issue
<b>Dockets Discussed:</b> 05000440 Perry 1						

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02/26/1999	1999001-03	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Missed hydrogen igniters surveillance</b>  The procedure for conducting surveillance testing of hydrogen igniters was revised to ensure that increased frequency testing would be performed in the future when necessary. The failure to perform the increased frequency testing between March 15 and October 1, 1998, was a violation of TS SR 3.6.3.2.2. This non-repetitive, licensee-identified and corrected violation is being treated as an NCV, consistent with Section VII.B.1 of the NRC Enforcement Policy. (NCV 50-440/99001-03(DRP))
<b>Dockets Discussed:</b> 05000440 Perry 1						
01/05/2000	1999014	<b>Pri:</b> ENG <b>Sec:</b> OPS	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 1C <b>Ter:</b> 5C	<b>Initial Operability Determination for Emergency Diesel Generator not thorough</b>  The licensee did not thoroughly evaluate the effects of repetitive emergency diesel generator turbo charger bolt failures in the initial operability determination. For example, the seismic qualification of the EDG, the effect of additional vibrations due to the loose/broken bolts, and the possibility for a common mode failure cause were not initially evaluated.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/15/1999	1999011	<b>Pri:</b> ENG <b>Sec:</b> OPS	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 3A <b>Ter:</b>	<b>Engineering support for plant operations was good</b>  Engineering department personnel provided good support for maintenance activities, surveillance tests, and operability questions during the inspection period.
<b>Dockets Discussed:</b> 05000440 Perry 1						
09/27/1999	1999-003-0	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	LER	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Operating Limit Exceeded for Relief Valve Leakage Outside of Containment</b>  On 2/18/99, Perry Nuclear Power Plant reported that leakage outside of containment exceeded the operating limit criteria required to maintain post-accident dose limits within the criteria specified in 10 CFR 50 Appendix A and 10 CFR 100. The leakage was measured at approximately 135 gph. The leakage source was determined to be a relief valve on a connecting line between the RHR heat exchangers to the RCIC system. As an immediate corrective action, the valve was gagged. NUREG-1465 methodology, "Accident Source Terms for Light Water Nuclear Power Plants," which had not been fully approved as part of the plant's licensing basis until 3/26/99 was used initially for verifying compliance with 10 CFR 50 & 10 CFR 100. Upon recognition that NUREG-1465 was inappropriate to use at the time of the event, a sensitivity study utilizing Reg.Guide 1.3, "Assumptions Used for Evaluating the Potential Radiological Consequences of a Loss of Coolant Accident for Boiling Water Reactors," was conducted. The study concluded that the limits in 10 CFR 50 Appendix A & 10 CFR 100 would have been exceeded during a LOCA. Therefore, based on the potential to exceed the dose limits, this constitutes a condition that was outside the design basis of the plant, which is reportable in accordance with 10 CFR 50.73(a)(2)(ii).
<b>Dockets Discussed:</b> 05000440 Perry 1						
08/25/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<b>One figure in the Updated Safety Analysis Report (USAR) was not updated</b>  One figure in the Updated Safety Analysis Report (USAR) was not updated when the reactor core isolation cooling system was modified in 1987. When this was identified by the inspectors, a condition report was initiated to investigate this discrepancy and correct the USAR. The inspectors concluded that the modification and safety evaluation were properly completed at the time and that other USAR sections containing information associated with this modification had been appropriately updated.
<b>Dockets Discussed:</b> 05000440 Perry 1						



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07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> 3A <b>Ter:</b>	<b>Engineering procedures and documentation</b> The inspectors identified two examples where the document authors were not attentive to assuring that the documents contained the appropriate details. A CR did not discuss the relevance of removing the control complex chillers' high temperature sensor trip on the chillers' safety function and no bases were provided in the ECCS strainer debris calculation for the engineering judgement used.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Modification Support and Closeout Support Effective</b> The inspectors concluded that effective engineering staff support was provided during the modification closeout process.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 1C <b>Ter:</b> 3B	<b>10 CFR 50.59 applicability checks and safety evaluations thorough</b> The inspectors concluded that the 10 CFR Part 50.59 applicability checks and safety evaluations were thorough and appropriate for the plant changes reviewed. In addition, 10 CFR Part 50.59 procedures and training were consistent with commitments made to the NRC.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b>	<b>Engineering Staff Knowledge Good</b> The inspectors concluded that the system and design engineering staff interviewed were qualified and knowledgeable about their systems and system design issues.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b>	<b>System Engineering Program Effective</b> The inspectors concluded that, in general, the system engineers were providing good plant technical support and were knowledgeable about Maintenance Rule requirements. The inspectors also concluded that plant housekeeping and material condition of safety-related equipment observed was good; there were a few areas where a lack of attention-to-detail was noted. A procedural weakness for monitoring safety significant hangers was identified by the inspectors.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 5A <b>Ter:</b>	<b>Engineering Quality Assurance Audits and Surveillances met requirements</b> The inspectors concluded that the audit process met 10 CFR Part 50, Appendix B, requirements. The QA audits were identifying problems and the licensee was taking appropriate corrective actions.
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/30/1999	1999013	Pri: ENG Sec:	NRC	STR	Pri: 4C Sec: 3A Ter: 1A	<b>Modification Packages Good and Modification Process Effective</b>  Although instances where a lack of attention-to-detail were identified, in general, the modification packages reviewed by the inspectors were of good technical quality, well planned, and comprehensive. Modification safety evaluations and screenings were reasonable and clearly described the proposed design change. The inspectors concluded that design configuration controls were properly maintained throughout the modification process and were effective.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec:	NRC	STR	Pri: 4C Sec: 4B Ter:	<b>Operating Experience Program Effective</b>  The inspectors concluded that the operating experience program was effectively implemented.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec:	NRC	STR	Pri: 5A Sec: 5B Ter:	<b>Corrective Action Trending Effective</b>  The inspectors concluded that appropriate mechanisms were in place for self- assessments and quality assurance trending activities and that a number of plant and organizational problems were being identified. The licensee's trending program and effectiveness reviews contributed to identifying repetitive problems and inspectors concluded that QA investigations were accurate and thorough.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec:	NRC	STR	Pri: 5C Sec: 5A Ter:	<b>Corrective Action Program Effective</b>  The inspectors concluded that the majority of plant problems were identified, assessed, and had appropriate corrective actions assigned. Establishment of the CIG, recent efforts to prioritize the "CR database" backlog, and the trending and binning of reports demonstrated that effective methods were being applied by the licensee to improve the CR action item program.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec:	NRC	WK	Pri: 5C Sec: Ter:	<b>Management of "ACTON" data base in Corrective Action Program not effective</b>  The inspectors concluded that the ACTON database was not under effective management review and control. Therefore, there appeared to be a lack of an integrated, well managed program with management overview for all past and present plant action items contained in this database. The inspectors concluded that continued effort would be required by the licensee to address and resolve this issue.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013-01	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	<b>Temporary modifications generally effectively controlled; procedural violation identified.</b>  The inspectors concluded that temporary modifications (TMs) were being controlled in an acceptable manner. Existing TMs were appropriately installed and tested. However, a NCV was identified involving the failure of Document Control Department personnel to follow written procedures in posting a TM on control room, TSC, and EOF facility drawings and controlling a safety evaluation.
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/30/1999	1999013-03	Pri: ENG Sec:	NRC	VIO	Pri: 4B Sec: Ter:	<b>Failure to correctly derive ECCS pump TS surveillance requirements from the USAR.</b>  The inspectors concluded that the failure to correctly derive ECCS pump TS surveillance requirements from the USAR was a violation of 10 CFR Part 50.36. The violation was cited and a response required as a result of the failure to submit the required TS amendment in a timely manner.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec: OPS	NRC	STR	Pri: 4B Sec: 1C Ter:	<b>Engineering support to operations good</b>  Overall, Engineering's support of the facilities and equipment, and its involvement with and contributions to the plant's day-to-day operations, were satisfactory.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013	Pri: ENG Sec: OPS	NRC	STR	Pri: 5A Sec: 4C Ter:	<b>Review Committee Activities Effective</b>  The inspectors concluded the review committees effectively performed their duties of maintaining periodic review of activities, safety issues and evaluations. The inspectors concluded inter-departmental communications were effective in promoting active staff participation. The inspectors also concluded that the establishment of the Continuous Improvement Group (CIG) demonstrated a rigorous attempt by the licensee to improve the plant CAP.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013-02	Pri: ENG Sec: OPS	NRC	NCV	Pri: 4B Sec: 4A Ter: 5C	<b>Not applying engineering calculation results to a TS surveillance in a timely manner.</b>  In most cases, the methods used in performing and revising design calculations for recent design changes were correct and appropriate. Documentation of the calculation purpose, assumptions, and design inputs had improved from previous inspections. However, the inspectors identified one NCV where a calculation had not been revised in a timely manner which resulted in a TS surveillance not being conducted utilizing conservative criteria.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/30/1999	1999013-04	Pri: ENG Sec: OPS	NRC	NCV	Pri: 4B Sec: 1C Ter:	<b>Operability determination process effective; however, unapproved dose calculation method results in NCV</b>  The licensee's operability determination process was effective. Operability determinations and the supporting evaluations were acceptable. However, a NCV was identified due to the licensee's use of an unapproved accident dose calculation method, which resulted in not meeting the requirements of 10 CFR Part 50.72 and Part 50.73 for leakage outside containment.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/08/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5A Ter: 5B	<b>Good engineering support</b>  The inspectors concluded that engineering department personnel provided good support to plant operations by promptly dispositioning emergent equipment issues. Operability evaluations were generally well documented and engineering personnel demonstrated good understanding of plant systems.
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/17/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	<b>The engineering department personnel provided timely and effective technical support</b>  The inspectors concluded that engineering department personnel provided timely and effective technical support to other departments for a variety of activities during the refueling outage.
<b>Dockets Discussed:</b> 05000440 Perry 1						
05/17/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 2A Ter: 5B	<b>The licensee utilized effective methods to maintain fuel accountability</b>  The licensee utilized effective methods to maintain fuel accountability and verify the proper placement of fuel bundles in the core prior to reactor vessel reassembly.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999006	Pri: ENG Sec:	NRC	POS	Pri: 3B Sec: 4B Ter:	<b>Preparation for the weld overlay of the feedwater nozzle to safe-end weld was well done</b>  Preparation for the weld overlay of the N4C reactor vessel feedwater nozzle to safe-end weld was well done through the use of a weld mock-up with identical nozzle and biological shield configurations.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 4A Ter: 4B	<b>Good use of industry experience</b>  Through good use of industry operating experience, the licensee identified that the design of the control complex building was not sufficient to protect the interior walls in the case that a design basis tornado touched down onsite. Although final plans to address this issue were adequate to support continued plant operations, the inspectors determined that the licensee's initial operability evaluation did not adequately address all issues associated with this condition.
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999001	Pri: ENG Sec:	Licensee	NEG	Pri: 4A Sec: Ter:	<b>The Unit 2, Division 3 battery was declared inoperable due to exceeding service life</b>  The Unit 2, Division 3 battery was declared inoperable after the licensee identified that its age was greater than its rated lifetime and that increased frequency testing was required by Technical Specifications. The battery was subsequently successfully tested.
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	<b>There was an appropriate amount of management involvement in the corrective action program</b>  The inspectors concluded that there was generally an appropriate amount of management involvement in the corrective action program
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/09/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b>	<b>Process and effluent radiation monitoring instrumentation effectively maintained.</b>  The licensee effectively maintained the material condition of process and effluent radiation monitors. The proper calibration and effective tracking of instrument operability ensured that liquid and gaseous process effluent radiation monitors accurately measured radioactivity in station effluents.
<b>Dockets Discussed:</b> 05000440 Perry 1						
12/09/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 2B <b>Ter:</b> 4C	<b>Engineered safety features ventilation filtration testing completed as required.</b>  The licensee tested ESF ventilation filtration systems as required. Test results indicated that system performance was within specifications.
<b>Dockets Discussed:</b> 05000440 Perry 1						
12/09/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> 2A <b>Ter:</b> 2B	<b>Implementation of the Radioactive Effluents Program effective.</b>  The 1998 Annual Environmental and Effluent Release Report demonstrated that radioactive effluents were maintained below regulatory limits and that there was no significant environmental impact from plant operation. As a result of the licensee's water management program, the licensee had no liquid radioactive waste releases in 1998. Also, the offsite dose calculations were properly performed.
<b>Dockets Discussed:</b> 05000440 Perry 1						
12/09/1999	1999017	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b> 5B	<b>Quality Assurance audits comprehensive.</b>  Quality assurance audits were comprehensive, performance-based, and identified deficiencies and areas needing improvement. Condition reports documented audit findings. The corrective action program effectively implemented improvements.
<b>Dockets Discussed:</b> 05000440 Perry 1						
11/04/1999	1999016-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Medical Review Officer Made an Error in Evaluating a FFD Laboratory Test Result Report</b>  A Non-cited violation was identified for the Medical Review Officer's failure to accurately interpret a fitness-for-duty positive test result laboratory report.
<b>Dockets Discussed:</b> 05000440 Perry 1						
08/25/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2A <b>Ter:</b>	<b>Emergency facilities were well maintained</b>  During evaluation of a routine emergency preparedness training drill on July 21, 1999, the inspectors concluded that emergency response facilities were maintained available for emergency operations, that there was good performance by the participants in the drill, and that the post-drill critiques were self-critical.
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Licensee personnel performed proper classifications during two actual activations</b>  Licensee personnel performed proper classifications and timely notifications during two actual activations of the emergency plan.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The Condition Report system was an effective method to track and close EPU issues</b>  The Condition Report system was an effective method to track and close Emergency Planning Unit issues. Procedures were clear and easy to use.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The Emergency Planning Unit training program appeared effective.</b>  The Emergency Planning Unit training program appeared effective. All personnel reviewed were qualified for their emergency response positions. Interviewed emergency response organization personnel successfully demonstrated very good knowledge of their emergency roles and procedures.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Continued management support for the emergency preparedness program evident.</b>  Continued management support for the emergency preparedness program was indicated during discussions with site and Emergency Planning Unit (EPU) staff. The new EPU staff and management were professional and proactive.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2A <b>Ter:</b>	<b>Emergency response facilities, equipment, and supplies were well maintained</b>  Emergency response facilities, equipment, and supplies were well maintained and in a very good state of operational readiness. Demonstration of emergency response equipment verified that the equipment was operable and ready for use.
<b>Dockets Discussed:</b> 05000440 Perry 1						
07/16/1999	1999012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>The licensee's 1998 and 1999 QA audits of the EP program were of good scope and depth</b>  The licensee's 1998 and 1999 Quality Assurance Section audits of the emergency preparedness program were of good scope and depth and satisfied the requirements of 10 Code of Federal Regulations 50.54(t).
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/20/1999	01012-99012	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	VIO II	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>Discrimination Against RP Supervisor</b> Radiation Protection Manger counseled an RP supervisor prior to his testimony at a hearing for a different discrimination case.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> <b>Ter:</b>	<b>The RP staff provided strong oversight of outage dose performance</b> The radiation protection program staff provided strong oversight of outage dose performance. The staff prepared graphical representations, which were displayed throughout the licensee's facility. In addition, the staff performed critical reviews of work in progress.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The inspectors observed effective communications and radiation protection (RP) program oversight</b> The inspectors observed effective communications and radiation protection (RP) program oversight in removing the jet pump mixers. Radiological conditions and instructions were properly communicated to the work crew. In addition, the work crew and the RP staff properly implemented the radiation work permit and ALARA [as-low-as-is-reasonably-achievable] review and performed necessary evaluations when unexpected radiological conditions were identified.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The licensee effectively implemented the internal dosimetry program.</b> The licensee effectively implemented the internal dosimetry program. The radiation protection program staff performed and maintained an evaluation which concluded that formal internal monitoring was not required. Specifically, radiation workers were effectively monitored for internal deposition of radioactive material via the passive monitoring program, with the portal contamination monitor alarm setpoints set to indicate intakes of 1 to 2 percent of an Annual Limit on Intake.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The radiation protection program staff provided strong oversight of outage activities</b> The radiation protection program staff provided strong oversight of outage activities at radiologically controlled area access points. Technicians properly communicated radiological information to workers and monitored workers' performance. Radiological areas were properly posted and controlled in accordance with NRC requirements.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2A <b>Ter:</b>	<b>Respiratory protection equipment was in good material condition</b> The licensee's respiratory protection maintenance and storage program ensured the integrity of respiratory protection equipment. The RP staff performed the required inspections and inventory of respiratory protection equipment, which was in good material condition. The inspectors also concluded that personnel issued respirators were qualified in accordance with the licensee's procedures and that training provided personnel with the necessary level of information.
<b>Dockets Discussed:</b> 05000440 Perry 1						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/16/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3C <b>Ter:</b> 3B	<b>Radiation protection personnel screening and training was thorough</b>  Radiation protection personnel screening and training was thorough and ensured that only qualified and trained personnel supplemented the radiation protection (RP) program staff. The licensee conducted comprehensive training and evaluations of the contract RP staff, which prepared workers for assigned outage tasks. Staff qualification matrices were properly maintained to ensure that personnel were qualified for their assignments.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/16/1999	1999007-01	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Failure to perform an adequate radiological survey to support the transfer of radioactive tank contents</b>  The licensee identified that the transfer of the contents of a radioactive tank resulted in HRAs within the Radwaste Building, which subsequently were not properly posted, in violation of 10 CFR 20.1501. The inspectors concluded that the licensee had performed a thorough review of the incident and had planned to implement corrective actions through the corrective action program which were commensurate with the error. One Severity Level IV Non-Cited Violation was identified.
<b>Dockets Discussed:</b> 05000440 Perry 1						
04/06/1999	1999002-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Handling of Individual Fuel Rods not According to Procedure</b>  One Non-Cited Violation was identified concerning the failure to handle individual fuel rods in the spent fuel pool in accordance with the procedure in use for this evolution. (NCV 50-440/99002-02(DRP))
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The RP staff effectively considered radiological hazards in preparing controls for the 1999 refueling outage</b>  The RP staff effectively considered radiological hazards in preparing controls and instructions for the 1999 refueling outage. For example, the ALARA Reviews and RWPs contained appropriate radiological hold points, anticipated radiological conditions, and provisions for engineering controls, which were routinely incorporated directly into the work orders. Extensive system flushes and training via work site mock-ups, which included the use of the Unit 2 facility, were also planned to reduce radiation dose.
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The licensee provided thorough planning and strong oversight of diving work</b>  The licensee provided thorough radiological planning and strong oversight of diving work associated with the inclined fuel transfer system. The work instructions and radiological planning documents contained appropriate radiological controls and lessons learned from previous diving evolutions. The inspector observed good communications between the RP staff and the diving crew and effective control of the evolution.
<b>Dockets Discussed:</b> 05000440 Perry 1						
02/26/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>The licensee's radiation worker training program was well implemented.</b>  The licensee's radiation worker training program was well implemented. Training lesson plans provided an appropriate level of radiation safety instruction, which was consistent with NRC requirements. In addition, the licensee conducted training exercises which effectively challenged trainees to demonstrate radiological practices and to identify work area problems.
<b>Dockets Discussed:</b> 05000440 Perry 1						



United States Nuclear Regulatory Commission  
PLANT ISSUE MATRIX

By Primary Functional Area

Region III  
PERRY

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/26/1999	1999004	Pri: PLTSUP	NRC	POS	Pri: 1C	The quality assurance and RP staffs performed comprehensive reviews of the RP program.
Dockets Discussed: 05000440 Perry 1		Sec:			Sec: 5B	The quality assurance and RP staffs performed comprehensive reviews of the RP program. The assessments were well planned and of appropriate scope. In addition, the RP staff also performed thorough evaluations of RP performance indicators. The inspector concluded that these assessments and evaluations were effectively used to identify and to correct performance issues.
					Ter:	

United States Nuclear Regulatory Commission  
**PLANT ISSUE MATRIX**  
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.