United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/16/1999	1999012	**Pri:** OPS **Sec:**	NRC	MISC	**Pri:** 1A **Sec:** **Ter:**	**CONCLUSIONS ON OPERATOR KNOWLEDGE AND PERFORMANCE** The inspectors concluded that the corrective actions initiated to address the weaknesses observed in the operational events were reasonable. **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**MOVEMENT OF IRRADIATED FUEL ASSEMBLIES IN THE FUEL STORAGE BUILDING.** Licensee personnel conducted a thorough root cause evaluation regarding the failure to perform the daily surveillance, DWO-1, "Daily/Weekly Surveillance Data Sheet," of plant parameters, as required by Technical Specifications, on November 23, 1999. Also, corrective actions were considered reasonable. **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012-02	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 1A **Sec:** 3A **Ter:**	**TS REQUIREMENT NOT MET FOR ENSURING THAT THE SECONDARYY TEMP WERE LESS** Operations personnel failed to ensure that the secondary and primary coolant system temperatures met Technical Specification requirements prior to starting the first primary coolant pump on December 4, 1999. The evolution was characterized by weaknesses in the conduct of operating crew turnovers, the unclear designation of individuals' roles and responsibilities, and a lack of plant parameter validation prior to performing an evolution. No adverse safety consequences resulted from the failure. This licensee identified issue was a Non-Cited Technical Specification Violation. **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012-03	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 1A **Sec:** **Ter:**	**TS REQUIREMENT NOT MET FOR THE SURVEILLANCE OF FUEL OIL STORAGE TANK LEVEL** A lack of rigor regarding responsibilities by the Control Room Supervisor and the Nuclear Control Operator contributed to a missed surveillance of daily plant parameters. No adverse safety consequences resulted from the failure to perform the daily surveillance, DWO-1, "Daily/Weekly Surveillance Data Sheet," as required by Technical Specifications, on November 23, 1999. The missed surveillance was identified by licensee personnel and resulted in a Non-Cited Violation. **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012-01	**Pri:** OPS **Sec:** ENG	Licensee	NCV	**Pri:** 1A **Sec:** **Ter:**	**TS REQUIREMENT NOT MET FOR THE OPERATION OF CHARCOAL FILTER DURING IRRADIATED FUEL MOVES** On November 6, 1999, the licensee failed to ensure that the ventilation system was aligned as required by Technical Specifications while moving fuel in the spent fuel pool. A lack of internal and external communications amongst the operating crew and a lack of attention to detail by the operating crew while completing routine checklists were contributing factors. No adverse safety consequences resulted from the failure. This licensee identified issue was a Non-Cited Technical Specification Violation. **Dockets Discussed:** 05000255 Palisades
11/03/1999	1999011	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Weak Procedural Guidance for Venting the Primary Coolant System** Weak procedural guidance for venting the primary coolant system to atmospheric pressure following plant cool down unnecessarily challenged the operators and radiation protection personnel. Also, control room operators demonstrated non-conservative decision making by not obtaining additional guidance when the procedure, as written, did not vent the primary coolant system to atmospheric pressure as expected. **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
11/03/1999	1999011	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Positive Safety Focus During Fall 1999 Refueling Outage** Outage planning personnel and site management consistently demonstrated a positive focus on safety during the outage. Also, a heightened awareness of plant conditions was effectively communicated to all work groups when the primary coolant system was in reduced inventory, a condition of high potential risk based on the licensees shutdown risk assessment.
Dockets Discussed: 05000255 Palisades						
11/03/1999	1999011	**Pri:** OPS **Sec:** MAINT	Licensee	NEG	**Pri:** 1A **Sec:** 3C **Ter:**	**Tagging Problems** Some tagging order problems demonstrated a lack of rigor and poor attention to detail during tagging order development. Consequently, some tagging orders were not effectively aligned with procedure requirements or were scheduled to be issued when the appropriate plant conditions did not exist. This unnecessarily challenged work control center personnel and plant operators.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** OPS **Sec:**	NRC	MV	**Pri:** 1A **Sec:** **Ter:**	**PROCEDURE ADHERENCE ERROR** A lack of rigor regarding attention to detail and ineffective Senior Reactor Operator oversight during a routine activity to vent a safety injection tank on September 14, 1999, contributed to a procedure adherence error which was considered minor.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**OPERATIONAL STATUS OF FACILITIES AND EQUIPMENT - LEAK FROM SAFETY INJECTION TANK T-82B MOTC** Operations personnel lacked a rigorous questioning attitude regarding the impact on other plant equipment from the leak from Safety Injection Tank T-82B Motor Operated Isolation Valve.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**CONDUCT OF OPERATIONS, AND OPERATIONAL STATUS OF FACILITIES AND EQUIPMENT** O.1.1 Conduct of operations was characterized by a professional environment in the control room. Power was reduced slightly to eliminate spurious Thermal Margin Low Pressure and Variable High Power pre-trip alarms which demonstrated a positive focus on safety. O.2.1 Control room operators demonstrated effective monitoring of equipment parameters by identifying and accurately diagnosing an increase in the leak rate from a Safety Injection Tank T-82B Motor Operated Isolation Valve.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**FAILURE OF CHARGING PUMP TO START ON DEMAND.** The operators' response to the failure of Charging Pump P-55C to start as designed, on August 18, 1999, was timely and in accordance with plant procedures. System restoration, following repairs, was completed without incident.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
08/11/1999	1999009	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 1C **Ter:**	**UPDATE OF EMERGENCY CLASSIFICATION PROCEDURE IN CONTROL ROOM.** The inspectors identified that the controlled copy of an emergency plan implementing procedure in the control room was not the current revision. Upon discovery, the licensee took immediate actions to update the control room procedure and initiate development of an improved process for informing on-shift operations staff of procedure revisions.
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The operator's actions to roll Emergency Diesel Generator 1-2 after water was identified in cylinder 1R during** The operator's actions to roll Emergency Diesel Generator 1-2 after water was identified in cylinder 1R during surveillance testing were ill-informed. The actions were taken prior to obtaining a recommendation from engineering personnel which was not typical of past performance. Also, the documented guidance in the operating procedures was not clear which contributed to the operators taking actions that would not have been recommended by engineering. (Section O3.1)
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Auxiliary operators effectively monitored Emergency Diesel Generator 1-2 parameters which resulted in the t** Auxiliary operators effectively monitored Emergency Diesel Generator 1-2 parameters which resulted in the timely identification of abnormal lube oil pressure. As a result, the Emergency Diesel Generator was manually tripped before lube oil pressure dropped below the acceptable limit. This precluded a challenge to the low lube oil pressure automatic trip. (Section M1.2)
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Operations personnel appropriately used risk assessment information during the performance of emergent m** Operations personnel appropriately used risk assessment information during the performance of emergent maintenance activities which demonstrated a positive focus on safety. (Section M1.2)
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1A **Sec:** **Ter:**	**Observations of control room activities were consistent with past performance.** Observations of control room activities were consistent with past performance. Specifically, a professional atmosphere was maintained in the control room which was free of unnecessary activities and control room operators were knowledgeable of ongoing maintenance activities. (Section O1.1)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
06/14/1999	1999301	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** 3B **Ter:**	**OPERATOR LICENSING EXAM RESULTS.** Generic weaknesses exhibited by the applicants on the operating examinations included: problems in verifying system response during normal and abnormal evolutions, failures to follow appropriate operating procedures, and failures to accurately determine the minimum protective action requirements for an emergency implementation plan. In addition, nineteen questions on the written examinations were answered incorrectly by more than one half of the applicants. The high failure rate implied that the training program had not adequately prepared the applicants for the examination nor to perform licensed duties at the facility. The root cause evaluation indicated that the applicants had not been adequately prepared for higher cognitive level questions on the examination, and that weaknesses existed in the examination validation and management oversight processes. These weaknesses contributed to difficulties with test item development and resolution. The staff stated they intended to perform a root cause analysis and subsequently propose a corrective action plan to eliminate the high failure rate on the operating test.
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**In general, the plant was operated in a conservative manner throughout the inspection period.** In general, the plant was operated in a conservative manner throughout the inspection period. The licensees decision to place the plant in a cold shutdown condition to repair the Primary Coolant Pump P-50A seal package was pro-active and conservative. Actions were taken to repair the degraded seal before any Technical Specification limits were challenged. Effective controls were implemented during high risk evolutions related to Primary Coolant System reduced inventory operations which demonstrated a positive focus on safety. (Section O1.1)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Operator training provided during the outage regarding shutdown cooling and reduced inventory operations** Operator training provided during the outage regarding shutdown cooling and reduced inventory operations was effective and timely. (Section O5)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** OPS **Sec:**	NRC	STR	**Pri:** 1B **Sec:** 1C **Ter:**	**Operator performance was satisfactory and generally characterized by strict procedure adherence.** Operator performance was satisfactory and generally characterized by strict procedure adherence. During the transition to reduced inventory, the Nuclear Control Room Operator's positive questioning attitude regarding primary coolant system level instrumentation response and their rigorous monitoring of plant parameters demonstrated deliberate and conservative plant operation. (Section O4)
Dockets Discussed: 05000255 Palisades						
04/09/1999	1999003	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The licensee's cold weather preparations were adequate to preclude any significant problems due to cold we** The licensee's cold weather preparations were adequate to preclude any significant problems due to cold weather, even though some of the actions had not been completed as required by the licensee's procedures. Specifically, voltage and current checks for several trace heating systems had not been completed to ensure that they were operable. Also, operators did not consistently perform additional daily checks when outside air temperature was less than 20 F. The affected equipment did not provide an active safety function which precluded the potential for any adverse safety consequences. However, weaknesses in the licensee's cold weather preparations were previously identified and therefore, corrective actions that have been implemented were apparently not thorough. (Section O3.1)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
04/09/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Control room operator's contingency actions were appropriately planned and thorough in order to protect sa** Control room operator's contingency actions were appropriately planned and thorough in order to protect safety-related equipment, as needed, if problems with the instrument inverter breaker transfer emerged. This demonstrated a pro-active initiative with a positive focus on safety. (Section M3.1) **Dockets Discussed:** 05000255 Palisades
04/09/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Control of overtime for operations personnel during 1998 was consistent with regulatory requirements and lic** Control of overtime for operations personnel during 1998 was consistent with regulatory requirements and licensee administrative procedures. Effective scheduling of operations personnel contributed to overtime guideline adherence with one isolated exception. (Section O6.1) **Dockets Discussed:** 05000255 Palisades
04/09/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**An audit performed by the Nuclear Performance Assessment Department was effective, in that, it identified th** An audit performed by the Nuclear Performance Assessment Department was effective, in that, it identified the failure to perform a required channel check on auxiliary feedwater system flow indicators. The licensee's root cause evaluation and corrective actions were thorough. (Section O7.1) **Dockets Discussed:** 05000255 Palisades
02/28/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**In general, the conduct of operations continued to be professional and unnecessary distractions in the contr** In general, the conduct of operations continued to be professional and unnecessary distractions in the control room were minimized. Control room operators were aware of ongoing plant activities and plant equipment that was out of service. When questioned, operators were knowledgeable of the reasons that annunciators were in an alarm condition. No significant emergent equipment problems challenged plant operations during this inspection period. (Section O1.1) **Dockets Discussed:** 05000255 Palisades
02/28/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**Overall, crew performance during the observed dynamic simulator requalification examination was satisfact** Overall, crew performance during the observed dynamic simulator requalification examination was satisfactory. Crew teamwork, crew communications, event diagnosis, and implementation of emergency operating procedures were effective. Command and control by the Control Room Supervisor diminished at times but was adequate overall. The inspector's overall evaluation of crew performance was consistent with the licensee evaluators. Also, the inspectors agreed with the licensee evaluator's grading of the competencies with a couple of noted exceptions. The noted exceptions resulted in a higher grade than was warranted for the associated competency but would not have changed the overall evaluation. (Section O5) **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012	**Pri:** MAINT **Sec:**	NRC	MISC	**Pri:** 5A **Sec:** 5C **Ter:**	**INADVERTENT BREACH OF THE PRIMARY COOLANT SYSTEM.** Interim corrective actions were considered reasonable and the Incident Response Team's evaluation was thorough for the inadvertent loss of primary coolant while in a reduced inventory condition. Initiating a multi-discipline root cause evaluation to evaluate circumstances related to the event was considered appropriate. **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/16/1999	1999012-04	**Pri:** MAINT **Sec:**	Self	NCV	**Pri:** 2B **Sec:** **Ter:**	**INADEQUATE TAGGING ORDER WHICH RESULTED IN THE INADVERTENT BREACH OF THE PCS WHILE IN REDI** The inadvertent loss of 6 gallons of primary coolant system inventory on November 10, 1999, due to an inadequate tagging order, did not result in significant adverse safety consequences. However, the potential significance of the incident was increased, in that, the incident occurred when the primary coolant system was in a reduced inventory condition. This self-revealing incident resulted in a Non-Cited Violation.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** MAINT **Sec:** OPS	NRC	POS	**Pri:** 1A **Sec:** 2B **Ter:**	**HIGH PRESSURE SAFETY INJECTION SYSTEM TESTING.** The operating crew quickly recognized and terminated the inadvertent transfer of borated water to the primary coolant system, which minimized the potential adverse consequences of this event.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** MAINT **Sec:** OPS	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**CLASS 1 PRIMARY COOLANT SYSTEM LEAKAGE TEST.** Auxiliary operators performed the primary coolant system leakage test in a thorough and comprehensive manner. This resulted in the identification of several issues, some of which required the repair of active system leaks.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012-05	**Pri:** MAINT **Sec:** ENG	Self	NCV	**Pri:** 2B **Sec:** 4C **Ter:**	**INADEQUATE TEST PROCEDURE WHICH RESULTED IN THE INADVERTENT TRANSFER OF SOLUTION TO THE F** No significant adverse consequences resulted from the inadvertent transfer of approximately 6,000 gallons of water from the refueling water storage tank to the primary coolant system on November 2, 1999. The licensee's root cause evaluation was considered thorough and the corrective actions to prevent recurrence were reasonable. This self-revealing event resulted in a Non-Cited Violation. The root cause for an incident in which borated water was inadvertently transferred from the safety injection refueling water tank to the primary coolant system was an error in the surveillance procedure that was developed by engineering personnel. Also, the procedure deficiency demonstrated a lack of rigor regarding procedure development and technical review by both engineering and operations personnel.
Dockets Discussed: 05000255 Palisades						
11/09/1999	1999015-01	**Pri:** MAINT **Sec:**	NRC	NCV	**Pri:** 4C **Sec:** **Ter:**	**ISI NDT-UT-32 7& NDT-8T-33 PROCEDURES DID NOT MEET TS 6.5.REQUIREMENTS** In general, the inspectors concluded that the ISI program was implemented in accordance with NRC and ASME Code requirements. However, the inspectors noted that the ISI program did not always control the use of alternatives to required Code nondestructive examination methods. While it appeared that the technical aspects of the ISI program were satisfactory, a violation of regulatory requirements was identified. Ultrasonic examination procedures (and associated examinations) did not meet the 1989 ASME Code as required by plant technical specifications. A noncited violation was issued.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
11/09/1999	1999015	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 2A **Sec:** 5C **Ter:**	**MATERIAL CONDITION OF SAFETY RELATED SYSTEMS** The inspectors considered the material condition of safety-related systems near the 607 foot elevation of containment, spent fuel pool room heat exchangers and east/west safeguards room generally good. The inspectors noted several corroded components, and verified the licensee had previously identified and appropriately documented the issues. However, the lack of timely corrective actions in completing the evaluations required by NRC commitments on components affected by boric acid indicated a need for continued effort to improve the boric acid program and IFI 50-255/99009-01 will remain open.
Dockets Discussed: 05000255 Palisades						
11/09/1999	1999015	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**STEAM GENERATOR INSERVICE INSPECTION (ISI)** The steam generator eddy current examination scope, methods and repairs met or exceeded the technical specification requirements. Personnel acquiring eddy current data used state-of-the-art industry qualified techniques, were knowledgeable and performed eddy current examinations in accordance with the approved procedures.
Dockets Discussed: 05000255 Palisades						
11/09/1999	1999015	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:** 3B	**VOLUMETRIC EXAMINATIONS OF CODE CLASS 1 AND 2 WELDS and NONDESTRUCTIVE EXAMINATION PERSO** M.1.2 & M.5.1 The licensee's inservice inspection personnel performing ultrasonic examination of Code Class 1 and 2 pipe welds and component supports used state-of-the-art industry qualified techniques, were well prepared, well trained and conducted a thorough examination in accordance with the approved procedures. The use of the industry sponsored Performance Demonstration Initiative requirements for ultrasonic examinations demonstrate a commitment to a quality inservice inspection program. M.5.1 Ultrasonic and eddy current examination personnel had extensive experience and training above the minimum required by Code.
Dockets Discussed: 05000255 Palisades						
11/09/1999	1999015	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 5A **Sec:** **Ter:**	**INSERVICE INSPECTION PROGRAM AUDITS.** The inspectors considered that the ISI program audits conducted by the Nuclear Performance Assessment Department were noticeably improved for the conduct of performance based audits. Specifically, audits of ISI activities included numerous direct observations of Code field activities with qualified personnel.
Dockets Discussed: 05000255 Palisades						
11/03/1999	1999011-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 1A **Sec:** **Ter:**	**Failure to Perform Technical Specification Surveillance in 1995 (Found in 1999)** The licensee failed to perform Technical Specification 4.17.5, Item 12, within the required 18 month interval plus allowable extension. This involved calibration of safety injection and refueling water tank level indication. The licensee successfully performed the calibration 34 days late and revised procedures to prevent recurrence.
Dockets Discussed: 05000255 Palisades						
11/03/1999	1999011	**Pri:** MAINT **Sec:** ENG	Self	POS	**Pri:** 1A **Sec:** 4B **Ter:**	**Departmental Coordination Following Failure of Inverter** Maintenance and engineering personnel provided prompt support to and effectively coordinated with operations personnel following an unexpected failure of Inverter ED-08. Risk reviews of the outage schedule that were conducted by Probabilistic Safety Assessment personnel demonstrated a positive focus on safety.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
09/21/1999	1999010	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**MAINTENANCE AND SURVEILLANCE TESTING OBSERVATIONS** There were overall job performance and documentation weaknesses during the maintenance outage on Spent Fuel Cooling Pump P-51B. Workers incorrectly installed the new seal resulting in re-work and there was a valve lineup error during restoration resulting in a leak. In addition, some licensee identified conditions adverse to quality were not documented until prompted by the inspectors.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2A **Sec:** 2B **Ter:**	**MAINTENANCE AND SURVEILLANCE TESTING OBSERVATIONS** The inspectors noted frequent supervisory oversight of maintenance activities and competent general work practices.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 2A **Sec:** 4B **Ter:**	**FAILURE OF CHARGING PUMP TO START ON DEMAND AS DESIGNED.** Prompt support by maintenance and system engineering personnel during emetgent maintenance on Charging Pump P-55C contributed to repairs being completed in a timely manner. Operations, maintenanc, and engineering personnel coordinated effectively during the planning and execution of the emergent repairs and subsequent system restoration. System engineering personnel provided prompt support following failure of Charging Pump P-55C to start because of an emergent problem with the associated breaker's charging spring motor.
Dockets Discussed: 05000255 Palisades						
08/11/1999	1999009	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**CONDUCT OF MAINTENANCE** During performance of the High Pressure Safety Injection System surveillance, procedures were adhered to, self-checking practices were used, and control room responsibilities were clearly defined.
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**An operations representative did not attend the post-job critique which was considered a potential detriment t** An operations representative did not attend the post-job critique which was considered a potential detriment to the effectiveness of the critique process. (Section M1.2)
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 3A **Sec:** **Ter:**	**The three hydrogen ignitions which occurred on June 9, 1999, during grinding operations of Multiassembly S** The three hydrogen ignitions which occurred on June 9, 1999, during grinding operations of Multiassembly Sealed Basket Number 15 were of minor industrial safety significance. However, plant personnel did not communicate the issues to on-shift operations personnel or plant management until the next morning. Consequently, several opportunities were missed to preclude recurrence of the incident in a timely manner. Upon notification, plant management initiated timely and comprehensive corrective actions. (Section O1.2)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
06/30/1999	1999008	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Emergent maintenance was completed in a skillful manner on Emergency Diesel Generator 1-2 as evidenced** Emergent maintenance was completed in a skillful manner on Emergency Diesel Generator 1-2 as evidenced by the lack of rework. Thorough support was provided by maintenance planning personnel and maintenance supervisors. Required maintenance rule evaluations were documented in condition reports and considered appropriate. The post-job critique was self-critical and effective. (Section M1.2
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** MAINT **Sec:**	NRC	STR	**Pri:** 3A **Sec:** **Ter:**	**Maintenance and surveillance activities observed were performed with the procedures and work packages at** Maintenance and surveillance activities observed were performed with the procedures and work packages at the job site and actively being used. System engineers and maintenance supervisors were frequently observed at the job location providing technical support to maintenance technicians. (Section M1.1)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**Past repairs for Primary Coolant Pump oil leaks have not been effective.** Past repairs for Primary Coolant Pump oil leaks have not been effective. The May 1999 maintenance outage was required to repair an oil leak on Primary Coolant Pump P-50D which was subsequently determined to be a maintenance preventable functional failure. (Section M3.1)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Maintenance rule evaluations were conducted as required for maintenance activities during the May outage** Maintenance rule evaluations were conducted as required for maintenance activities during the May outage and were considered adequate. Also, the requirements of 10 CFR 50.65 for a periodic evaluation were met. (Section M3.1)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** MAINT **Sec:**	NRC	STR	**Pri:** 2B **Sec:** **Ter:**	**Maintenance activities were effectively controlled during the outage.** Maintenance activities were effectively controlled during the outage. (Section M1.2)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** MAINT **Sec:**	NRC	WK	**Pri:** 2B **Sec:** **Ter:**	**Failure of a Main Steam Isolation Valve to fully close was a maintenance preventable functional failure that** Failure of a Main Steam Isolation Valve to fully close was a maintenance preventable functional failure that resulted in the maintenance rule screening criteria to be exceeded. (Section M3.1)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
04/09/1999	1999003	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**Lack of a permanent maintenance procedure to accomplish the 8-hour Technical Specification action statem** Lack of a permanent maintenance procedure to accomplish the 8-hour Technical Specification action statement to bypass the safety injection refueling water tank level switch was a plant shutdown vulnerability. (Section M3.1)
Dockets Discussed: 05000255 Palisades						
04/09/1999	1999003	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The observed maintenance activities were conducted appropriately. Specifically, supervisory oversight of m** The observed maintenance activities were conducted appropriately. Specifically, supervisory oversight of maintenance activities was evident; maintenance activities were completed in accordance with station procedures; and maintenance personnel were knowledgeable of the associated activities and followed good general work practices. Also, the risk associated with planned and emergent work was consistently evaluated and noted in the "Operators Risk Report." (Section M1.1)
Dockets Discussed: 05000255 Palisades						
04/09/1999	1999003	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The breaker transfer associated with the instrument inverter modification project that required entry into an 8** The breaker transfer associated with the instrument inverter modification project that required entry into an 8-hour limiting condition for operation was effectively planned and executed. The modification team effectively coordinated with operations.
Dockets Discussed: 05000255 Palisades						
02/28/1999	1999001	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2A **Sec:** **Ter:**	**The inspectors identified several material deficiencies on the Spent Fuel Pool Cooling System and an Emerg** The inspectors identified several material deficiencies on the Spent Fuel Pool Cooling System and an Emergency Diesel Generator. Plant personnel had missed prior opportunities to identify the material condition deficiencies. The active leak from the Spent Fuel Pool Cooling System component was easily accessible and the fuel oil line had wear indications which provided evidence that it had been rubbing on the adjacent component during past Emergency Diesel Generator 1-2 operations. (Section M2)
Dockets Discussed: 05000255 Palisades						
02/28/1999	1999001	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**Development of Technical Specification Surveillance Test Procedure RO-128-2, "Emergency Diesel Generator** Development of Technical Specification Surveillance Test Procedure RO-128-2, "Emergency Diesel Generator 1-2 24-Hour Load Test," and the pre-evolution preparation activities that were conducted lacked rigor regarding attention to detail. Consequently, several editorial changes to the procedure were required after the test was commenced which delayed test completion. (Section M1)
Dockets Discussed: 05000255 Palisades						
02/28/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**The self-assessments that were conducted in the third and fourth quarters of 1998 regarding the 13-week wor** The self-assessments that were conducted in the third and fourth quarters of 1998 regarding the 13-week work management process were self-critical and effective. (Section M7)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
02/28/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**The observed maintenance activities were completed in accordance with applicable procedures and the acti** The observed maintenance activities were completed in accordance with applicable procedures and the activities were frequently observed by plant supervision.
Dockets Discussed: 05000255 Palisades						
02/25/1999	1999001-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 2B **Sec:** **Ter:**	**CORE EXIT THERMOCOUPLES SWAPPED DURING REACTO RHEAD INSTALLATION** The licensee identified, following the 1996 refueling outage, that the connectors for an environmentally qualified Core Exit Thermocouple and a non-environmentally qualified Core Exit Thermocouple were swapped during reactor vessel head installation. Inspector follow-up on the licensee's evaluation for this issue revealed that the Technical Specification requirements for incore detectors were met. However, the applicable procedure was determined to be inadequate. This non-repetitive, licensee-identified and corrected violation was treated as a Non-Cited Violation. (Section M8.4)
Dockets Discussed: 05000255 Palisades						
02/25/1999	1999001-02	**Pri:** MAINT **Sec:**	Self	NCV	**Pri:** 3A **Sec:** **Ter:**	**FAILURE TO FOLLOW SURVEILLANCE PROCEDURE** On December 26, 1998, Technical Specification Test Procedure RI-47, "Rod Withdrawal Prohibit Interlock Matrix Check," Step 5.5.1, was not completed as written due to ineffective self checking and a lack of rigor regarding attention to details. In addition, procedure format weaknesses contributed to the occurrence of the error. This non-repetitive, licensee-identified and corrected violation was treated as a Non-Cited Violation. (Section M8.6)
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**EMERGENT EQUIPMENT ISSUES.** Plant data indicated that the nonsafety-related control rod drive cooling system was incorrectly configured for several years which demonstrated a lack of configuration control. Also, the containment sump screen was not welded to the frame along 1/3 of the screens length as assumed in previous engineering calculations. This demonstrated a lack of system design knowledge by engineering personnel.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**LOW PRESSURE SAFETY INJECTION SYSTEM TESTING.** Engineering personnel failed to recognize how the acceptance criteria's validity would be impacted during past revisions to low pressure safety injection system test Procedure QO-8B. Consequently, an issue emerged during the 1999 refueling outage that required extensive testing and detailed engineering analysis to prove that the low pressure safety injection system was operable. The resultant operability assessment was considered thorough.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**CONTROL ROD DRIVE MECHANISM REPAIRS.** Engineering personnel developed a detailed troubleshooting and repair plan in response to the one control rod that failed to drop into the core as designed, during the planned manual reactor trip on October 15, 1999. The repair scope was appropriately expanded when new information was learned.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
12/16/1999	1999012	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**CONDUCT OF ENGINEERING - GENERAL** Engineering personnel pro-actively supported the refueling outage activities through timely and thorough support for emergent issues. Engineering personnel resolved the issues in a methodical, deliberate, and conservative manner which demonstrated a positive focus on safety, consistent with past observations.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**CONTROL ROD DRIVE SEAL HOUSING LEAKS AND CRACK INDICATIONS.** During the refueling outage, the licensee identified control rod drive seal housing assembly leaks and evidence of crack indications on 30 of the 45 seal housing assemblies. Appropriate corrective actions to repair the seal housing assemblies were initiated to ensure compliance with the applicable American Society of Mechanical Engineers Code requirements. Reference LER 50-255/99-004.
Dockets Discussed: 05000255 Palisades						
12/16/1999	1999012	**Pri:** ENG **Sec:** OPS	NRC	NEG	**Pri:** 1A **Sec:** 3A **Ter:** 4B	**LOW PRESSUE SAFETY INJECTION SYSTEM TESTING.** Engineering and operations personnel demonstrated an ineffective questioning attitude during past low pressure safety injection system testing.
Dockets Discussed: 05000255 Palisades						
12/01/1999	1999-004-00	**Pri:** ENG **Sec:**	Licensee	LER	**Pri:** 5C **Sec:** **Ter:**	**CONTROL ROD DRIVE SEAL HOUSING LEAKS AND CRACK INDICATIONS** On October 16, 1999, following shutdown of the reactor for the 1999 refueling outage, inspection of reactor head components revealed that 30 of the 45 seal housing assemblies contained small circumferential cracks. Three seal housing tubes also contained small axial cracks. The cracking has been determined to be transgranular stress corrosion cracking, probably resulting from inadequate post weld heat treatment which left residual stresses of sufficient magnitude to support cracking. Approximately 1 year earlier, cracking in a control rod drive seal housing was discovered which the licensee considered an isolated occurrence. This event was reported in LER 98-014. The licensee repaired all 45 seal housing assemblies for reuse during the next operating cycle.
Dockets Discussed: 05000255 Palisades						
11/09/1999	1999015-02	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4B **Sec:** **Ter:**	**ISI FLAW EVALUATION FOR CLASS 2 MSS-8-MSV-1S1-209 WELD DID NOT MEET TS 6.5 REQUIRMENTS** Overall, the inspectors concluded that flaw evaluations of indications found during nondestructive examinations were performed in accordance with plant procedures and 1989 ASME Code requirements. However, one violation of regulatory requirements was identified for a Class 2 main steam weld flaw evaluation which did not meet 1989 Code requirements as required by plant technical specifications and an NCV was issued. While the evaluation was deemed technically acceptable, relief from Code requirements had not been requested.
Dockets Discussed: 05000255 Palisades						
11/03/1999	1999011	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Engineering Involvement Following Control Rod 14 Failure to Drop Into Core** Engineering personnel actively supported and tracked troubleshooting, inspection, and repair efforts after Control Rod 14 failed to fall into the core on October 15, 1999, following the reactor trip signal. Control Rod 14 failed to fall into core because of a failed bearing in the control rod drive mechanism. The planned scope of inspections and repairs for the control rod drive mechanisms was thorough. The licensees root cause evaluation was in progress.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region III
PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
11/03/1999	1999011	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Installation of Temporary Modification on Trisodium Phosphate Baskets** Temporary Modification 99-023 that installed a splash guard on the trisodium phosphate baskets in containment was completed in accordance with plant procedures. An appropriate safety analysis was completed that supported installation of the temporary modification. **Dockets Discussed:** 05000255 Palisades
09/21/1999	1999010	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4C **Sec:** **Ter:**	**AUXILLARY FEEDWATER PUMP PACKING GLAND LEAKOFF.** The auxiliary feedwater pump procedure's scope and clarity for monitoring the packing glands for minimum leakoff, and for performing packing gland adjustments by operations personnel were weak. **Dockets Discussed:** 05000255 Palisades
09/21/1999	1999010	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**LEAK FROM SAFETY INJECTION TANK T-82B MOTOR OPERATED ISOLATION VALVE.** Engineering personnel demonstrated a rigorous questioning attitude regarding a leak from a Safety Injection Tank T-82B Motor Operated Isolation Valve. The personnel evaluated the leak's impact on other equipment, including the leak's impact on the operability of the trisodium phosphate baskets. **Dockets Discussed:** 05000255 Palisades
09/21/1999	1999010	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**AUXILLARY FEEDWATER PUMP PACKING GLAND LEAKOFF.** Thorough and timely communications were demonstrated among engineering, maintenance, and operations personnel regarding inadequate packing gland leakoff during a monthly test of Auxiliary Feedwater Pump P-8A. **Dockets Discussed:** 05000255 Palisades
08/11/1999	1999009	**Pri:** ENG **Sec:** MAINT	NRC	WK	**Pri:** 4B **Sec:** 2A **Ter:**	**BORIC ACID LEAK INSPECTION PROGRAM** The Boric Acid Leak Inspection Program was ineffectively implemented as evidenced by the number of discrepancies that were identified by the inspectors. A lack of ownership contributed to the program's ineffectiveness. Also, engineering personnel were not pro-active in resolving problems for components that were included in the program. Inspectors identified that a maintenance activity to clean and inspect a shutdown cooling spool piece flange was performed on the incorrect flange. **Dockets Discussed:** 05000255 Palisades
06/30/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**System Engineering support during the emergent maintenance activity on Emergency Diesel Generator 1-2 w** System Engineering support during the emergent maintenance activity on Emergency Diesel Generator 1-2 was thorough and pro-active. (Section E2.1) **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
05/21/1999	1999004	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel's initial operability recommendation for Pressurizer Power Operated Relief Valve PRV** Engineering personnel's initial operability recommendation for Pressurizer Power Operated Relief Valve PRV-1043B was not thorough. Information available from various sources regarding the status and operating characteristics of PRV-1043B was not integrated into the operability recommendation. Consequently, the operability recommendation did not address conflicting information. (Section E2.2) **Dockets Discussed:** 05000255 Palisades
05/21/1999	1999004	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 5A **Sec:** **Ter:**	**Engineering personnel's positive questioning attitude in December 1998 identified that the Primary Coolant P** Engineering personnel's positive questioning attitude in December 1998 identified that the Primary Coolant Pump Oil Collection System was inadequate. However, the questioning was not rigorous in that they failed to identify that oil would be left in the collection tank after it was drained. Also, precise measurements of collection tank dimensions were not obtained. Consequently, the oil collection tank's useable capacity was less than that reported in Licensee Event Report 98-011. Adverse safety consequences were considered minimal. (Section E2.1) **Dockets Discussed:** 05000255 Palisades
05/21/1999	1999004	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering conducted extensive testing regarding Main Steam Isolation Valve CV-0510 failing to fully close** Engineering conducted extensive testing regarding Main Steam Isolation Valve CV-0510 failing to fully close during required surveillance testing in cold shutdown. Engineering personnel's analysis was thorough and concluded that the root cause was excessive packing friction. Operability recommendations provided by engineering personnel were appropriate. (Section 2.1) **Dockets Discussed:** 05000255 Palisades
05/21/1999	1999004	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel provided ample support during repairs to the Pressurizer Power Operated Relief Valve** Engineering personnel provided ample support during repairs to the Pressurizer Power Operated Relief Valve position indications. (Section E2.2) **Dockets Discussed:** 05000255 Palisades
05/21/1999	1999007-01	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4B **Sec:** **Ter:**	**FAILURE TO ANALYZE COMPONENT COOLING WATER SYSTEM FOR MAXIMUM POST LOSS OF CW ACCIDENT** CCW design temperatures exceeded during a loss of coolant accident (LOCA). During preparation for the architect-engineer inspection, the license recognized that the previous two revisions of the post-LOCA containment analyses of record had predicted CCW temperatures in excess of the CCW design temperature and that the CCW system had not been analyzed for these higher temperatures. Following identification, the licensee reanalyzed the system piping and components and demonstrated that the system was capable of meeting its design function. The inspector had no concerns regarding the licensee's corrective actions to resolve the issue. The failure to ensure that the CCW system was analyzed for the maximum temperatures which would occur followin a LOCA constitutes a violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control." Criterion III requires, in part, that measures be established to assure that the design basis for structures, systems, and components important to safety is correctly translated into specifications, procedures, and instructions. Contrary to the above, from 1994 through March 1998, the design basis for the CCW system, a system important to safety, was not correctly translated into the system specifications in that the containment analyses of record indicated a higher CCW temperature than that for which the system was analyzed and designed. This licensee identified and corrected Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. No further licensee actions are necessary regarding this issue. **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX
By Primary Functional Area

Region III
PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
05/06/1999	1999005	**Pri:** ENG **Sec:**	NRC	MISC	**Pri:** 4C **Sec:** **Ter:**	**The information obtained during the inspection will be applied in the preparation of an NRC safety evaluation** The information obtained during the inspection will be applied in the preparation of an NRC safety evaluation on the response of the licensee to Generic Letter 96-05. (Section E1.1) **Dockets Discussed:** 05000255 Palisades
05/06/1999	1999005	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Based on a review of sample motor-operated valves (MOVs), licensee submittals, calculations, test packages,** Based on a review of sample motor-operated valves (MOVs), licensee submittals, calculations, test packages, procedures, engineering analyses, trend reports, and condition reports, the inspectors determined that the licensee had established and was implementing a program to provide continued assurance that MOVs within the scope of Generic Letter 96-05 were capable of performing their design-basis safety functions. (Section E1.1) **Dockets Discussed:** 05000255 Palisades
05/06/1999	1999005	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Positive aspects of the Generic Letter 96-05 periodic verification program for MOVs were observed, including** Positive aspects of the Generic Letter 96-05 periodic verification program for MOVs were observed, including: (1) trending program for MOVs provided both qualitative and quantitative trending of MOV performance, (2) MOV program was well-documented, and (3) the use of outside personnel on the Nuclear Performance Assessment Department assessment who were knowledgeable of MOVs provided insights into the program and added to the effectiveness of the review. (Section E1.1) **Dockets Discussed:** 05000255 Palisades
05/06/1999	1999005-01	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4C **Sec:** **Ter:**	**VALVE FACTOR METHODOLOGY FOR DYNAMICALLY TESTED VALVES IN ERROR** The valve factor calculations for the dynamically tested MOVs were in error, resulting in calculating non-conservative valve factors. The error in the valve factor calculations was potentially significant in that the valve's calculated thrust margins were non-conservative, however, no operability concerns were identified with the MOVs in question. (Section E1.1) **Dockets Discussed:** 05000255 Palisades
04/09/1999	1999003	**Pri:** ENG **Sec:**	NRC	NEG	**Pri:** 4B **Sec:** **Ter:**	**Engineering personnel generated a condition report eight weeks after the third stage on primary coolant pun** Engineering personnel generated a condition report eight weeks after the third stage on primary coolant pump P-50A seal failed which was not timely. Also, engineering personnel were not pro-active in providing the operating crew with valuable information regarding the known vulnerabilities of the seals. Consequently, the information could not be incorporated into appropriate pre-evolution briefings to serve as a potential mitigating factor. (Section E2.1) **Dockets Discussed:** 05000255 Palisades
04/09/1999	1999003	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4A **Sec:** **Ter:**	**The zinc injection system modification package was completed in accordance with the licensee's modificatio** The zinc injection system modification package was completed in accordance with the licensee's modification process with a couple of minor administrative exceptions. The system was installed, tested, and placed into service without any significant problems. (Section E1.1) **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
04/09/1999	1999003	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering support was effective in resolving emergent issues involving an emergency diesel generator, hig** Engineering support was effective in resolving emergent issues involving an emergency diesel generator, high pressure safety injection pump, and a heater drain pump check valve. Also, the root cause evaluation for a condition report regarding the failure of the third stage of primary coolant pump P-50A pump seal was thorough. (Section E2.1) **Dockets Discussed:** 05000255 Palisades
02/28/1999	1999001	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Reactor Engineering personnel thoroughly evaluated the failure of the Feedwater Loop "B" ultrasonic flow m** Reactor Engineering personnel thoroughly evaluated the failure of the Feedwater Loop "B" ultrasonic flow measuring probe and provided appropriate recommendations regarding operability and plant operations. (Section E1) **Dockets Discussed:** 05000255 Palisades
02/28/1999	1999001	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**System Engineering personnel provided effective support to operations and maintenance during performance** System Engineering personnel provided effective support to operations and maintenance during performance of Technical Specification Test RO-128, "Emergency Diesel Generator 1-2 24-Hour Load Run." (Section E2) **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	MISC	**Pri:** 1C **Sec:** **Ter:**	**RADIATION PROTECTION AND CHEMISTRY CONTROLS - REFUELING ACTIVITIES.** Overall, accumulated radiation dose for the 1999 refueling outage was higher than the original dose goals established prior to the start of the refueling outage. Emergent equipment issues extended the outage which contributed to the increased dose. **Dockets Discussed:** 05000255 Palisades
12/16/1999	1999012	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**RADIATION PROTECTION AND CHEMISTRY CONTROLS - GENERAL** Radiation protection personnel pro-actively supported ongoing activities in the 1999 refueling outage. Radiation protection technicians consistently challenged radiation workers and utilized several tools, such as remote monitoring, in an effort to maintain radiation dose as low as reasonably achievable during the refueling outage. **Dockets Discussed:** 05000255 Palisades
11/03/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Radiological Support During Refueling Outage** Radiation technicians actively challenged workers prior to entry into the radiological controlled area. Also, a heightened awareness of accumulated dose among individual work groups was evident which resulted in more interaction with radiological protection personnel to strive to maintain dose as low as reasonably achievable. **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
11/03/1999	1999011	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3B **Ter:**	**Radiation Training** The "Back-to-Basics" training regarding fundamental radiation work practices was effective in that the use of mock-ups reinforced radiological work practices. Also, site management actively supported the training.
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 2A **Ter:**	**Plant Walkdowns and Observation** Radiological postings were well maintained and accurately reflected the area radiological conditions. High and locked high radiation areas were controlled consistent with station procedures and regulatory requirements. Effective contamination control practices were in use and radiological controls for work activities were as prescribed by the ALARA plan and RWP (Section R4.2).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:** 3C	**Control and Oversight of Radiological Work** Radiation protection (RP) staff oversight and control of radiological work and management of RP resources for the outage was effective. Some communication problems arose but were identified and addressed by the licensee without significant dose consequence. Containment lead radiation protection technicians (RPTs) did not always challenge workers sufficiently to meet RP management expectations (Section R1.3).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 3B **Ter:** 3C	**Alara Program Implemenation** The ALARA program was generally implemented effectively, as ALARA plans were well developed and sufficiently thorough. ALARA initiatives and associated engineering controls were properly established, and efforts to reduce dose, prevent the spread and intake of radioactive materials and limit personnel contamination events were successful (Section R1.2).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 3B **Ter:** 3C	**Radiation Worker Performance** Radworker performance was good given the relative inexperience of the craft work force. The C&RS staff addressed radworker performance problems effectively (Section R4.1).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 3C **Ter:** 1C	**Outage Radiation Protection Organization** The RP management structure provided oversight that contributed to the effectiveness of the RP outage program (Section R6.1).
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** 1A **Ter:** 4B	**Source Term Reduction** Source term reduction strategies continued to be implemented effectively. The licensee's source term and dose reduction evaluation was well planned and the strategies including the zinc injection program were reducing dose rates (Section R1.4).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** 3C **Ter:**	**Outage Staffing, Training and Qualifications** Outage staffing and training for the RP program were generally effective. The selection process for contractor radiation protection technicians (CRPTs) was rigorous, and the training of contract RP staff adequately prepared workers for assigned outage tasks (Section R5.1).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3C **Sec:** 1C **Ter:**	**Radiological Planning for Outage** The Chemical and Radiological Services (C&RS) department was actively involved in the work planning process and aggressively maintained an effective interface with the work control organizations. Outage dose was maintained reasonably low given the overall scope of work and was attributed to aggressive dose management practices, sound ALARA initiatives and generally good oversight of radiological work (Section R1.1).
Dockets Discussed: 05000255 Palisades						
10/26/1999	1999016	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5B **Ter:** 5C	**Nuclear Performance Assessment During Outage** Nuclear Performance Assessment Department (NPAD) assessment activities during the early stages of REFOUT99 appeared to be well planned and executed (Section R7.1).
Dockets Discussed: 05000255 Palisades						
10/22/1999	1999017-01	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** **Ter:**	**INADEQUATE VEHICLES SEARCH** THE INSPECTOR IDENTIFIED A NON-CITED VIOLATION IN WHICH, SECURITY PERSONNEL FAILED TO SEARCH EASILY ACCESSIBLE STORAGE COMPARTMENTS ON TWO VEHICLES. ONE FAILURE RESULTED FROM PERSONNEL ERROR. THE OTHER FAILURE OCCURRED BECAUSE THE OFFICE DID NOT HAVE A QUESTIONING ATTITUDE REGARDING THE SEARCH OF SOME COMPARTMENTS. CORRECTIVE ACTIONS WERE IMPLEMENTED. (SECTION S1.2)
Dockets Discussed: 05000255 Palisades						
10/22/1999	1999017-02	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** **Ter:**	**PHYSICAL BARRIER - PROTECTED AREA** THE INSPECTOR IDENTIFIED THAT A LICENSEE ESTABLISHED COMPENSATORY MEASURE FOR A DEGRADED VEHICLE DENIAL BARRIER WAS NOT IMPLEMENTED IN ACCORDANCE WITH A SECURITY PLAN REQUIREMENT. THIS FINDING WAS IDENTIFIED AS A NON-CITED VIOLATION. COMPENSATORY MEASURES WERE ESTABLISHED AND CORRECTIVE ACTION IS CONTINUING. (SECTION S1.3)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
09/21/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**SIGNIFICANT LOSS OF OFFSITE COMMUNICATION CAPABILITY UNUSUAL EVENT** Declaration of the Unusual Event on September 7, 1999, was unnecessarily delayed. There was ineffective communication following initial discovery that the offsite commercial telephone lines were lost. Also, there was diminished perceived significance because emergency use satellite telephones were available.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**EMERGENCY PLAN EXERCISE** A lack of rigor and poor attention to detail contributed to deficiencies regarding Emergency Plan Implementing procedures and simulator modeling of the failed fuel monitor.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**SIGNIFICANT LOSS OF OFFSITE COMMUNICATION CAPABILITY UNUSUAL EVENT.** Emergency response personnel conducted a thorough investigation following discovery that the offsite commercial telephone lines were not available. The ensuing emergency event on September 7, 1999, was accurately classified as an Unusual Event and the required notifications were completed in a timely manner following declaration. Actions initiated to ensure that the minimum required emergency response personnel could be achieved were considered pro-active and demonstrated a positive focus on safety.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**EMERGENCY PLAN EXERCISE** Emergency planning personnel effectively used the September 8, 1999, exercise to satisfy the training objectives. The post exercise critique was self-critical and demonstrated an appropriate threshold for identifying deficiencies.
Dockets Discussed: 05000255 Palisades						
09/21/1999	1999010-01	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** 3B **Ter:**	**FAILURE TO FOLLOW RADIATION PROTECTION PROCEDURES ON CONTAMINATION CONTROL** The inspectors identified several instances where operations personnel failed to perform required frisking activities for contamination control, resulting in a Severity Level IV Non-Cited Violation. Although the instances did not result in the significant spread of contamination outside of the contamination area, deficiencies in operations personnel knowledge of basic radiation protection requirements were demonstrated.
Dockets Discussed: 05000255 Palisades						
09/01/1999	1999014	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**CRSD PLANNING AND SCHEDULING, AND NAPD OVERSIGHT.** The Chemical and Radiological Services Department (CRSD's) on-line (non outage) Planning and Scheduling Program provided effective coordination and established appropriate radiological control provisions over on-line work activities. The CRSD also appeared to be effective in ensuring that radiation protection issues and As-Low-As-Reasonably-Achievable (ALARA) controls were integrated into the planning and scheduling of the 1999 refueling outage. In addition, the Nuclear Performance Assessment Department's (NPAD) planned oversight of CRSD activities during the 1999 refueling outage was well planned and of sufficient scope to assess the performance of the radiation protection program.
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
08/11/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**RADIOLOGICAL POSTINGS** The inspectors identified two separate instances when the same radiological posting for a contaminated area in the Spent Fuel Pool Fan Room fell on the floor from its designated position. The Chemical and Radiological Staff secured the posting with the proper fasteners to prevent reoccurrence. The licensee subsequently decontaminated the area, eliminating the need for the posting.
Dockets Discussed: 05000255 Palisades						
06/30/1999	1999008	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Radiological protection personnel and security personnel provided thorough support during the transport of V** Radiological protection personnel and security personnel provided thorough support during the transport of Ventilated Storage Cask #15 to the dry fuel storage area on June 18. (Section S8)
Dockets Discussed: 05000255 Palisades						
05/21/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Radiological protection personnel's efforts in challenging radiation workers to work smarter and more efficie** Radiological protection personnel's efforts in challenging radiation workers to work smarter and more efficiently, and in highlighting ALARA principles were effective. Consequently, the actual radiation dose received during the outage was 20 percent less than what was projected. (Section R5)
Dockets Discussed: 05000255 Palisades						
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**The inspectors noted that the RP staff did not maintain a procedure to ensure consistent and appropriate imp** The inspectors noted that the RP staff did not maintain a procedure to ensure consistent and appropriate implementation of the scaling factor determination program, which the RP management planned to address. (Section R1.2)
Dockets Discussed: 05000255 Palisades						
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Some problems were noted, however, with the resolution of findings identified by the quality assurance depa** Some problems were noted, however, with the resolution of findings identified by the quality assurance department and by the RP staff. Specifically, the inspectors identified that some findings were not addressed due to oversights in entering the issues into the licensee's corrective action program. In addition, the licensee failed to identify problems with shipping papers and waste manifests, which were identified by the NRC inspectors. (Section R7.1)
Dockets Discussed: 05000255 Palisades						
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Licensee practices for radioactive waste processing ensured effective implementation of the radioactive was** Licensee practices for radioactive waste processing ensured effective implementation of the radioactive waste management program. The staff processed wastes in accordance with a process control program, and station personnel provided effective oversight of vendor activities. Although still under development, the licensee also supported a waste minimization plan. (Section R1.1)
Dockets Discussed: 05000255 Palisades						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The licensee established and implemented an effective program for classification of radioactive wastes.** The licensee established and implemented an effective program for classification of radioactive wastes. The RP staff's methodologies for determining the waste classification of radioactive waste shipments were technically sound. (Section R1.2) **Dockets Discussed:** 05000255 Palisades
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff demonstrated effective planning and oversight of work activities for the reactor coolant pump s** The RP staff demonstrated effective planning and oversight of work activities for the reactor coolant pump seal replacement and pressurizer man way removal. Planning documents contained appropriate work instructions and RP controls, which were effectively communicated to the work crew. In addition, the workers demonstrated proper radiation protection practices. (Section R1.4) **Dockets Discussed:** 05000255 Palisades
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The RP staff demonstrated effective planning and oversight of work activities for the reactor coolant pump s** The RP staff demonstrated effective planning and oversight of work activities for the reactor coolant pump seal replacement and pressurizer man way removal. Planning documents contained appropriate work instructions and RP controls, which were effectively communicated to the work crew. In addition, the workers demonstrated proper radiation protection practices. (Section R1.4) **Dockets Discussed:** 05000255 Palisades
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**The licensee's training program was consistent with DOT and NRC requirements and was sufficient to ensure** The licensee's training program was consistent with Department of Transportation and NRC requirements and was sufficient to ensure that the staff was properly prepared to handle, package, and ship radioactive material. Although the RP staff's current assessment of this area had identified some weaknesses, the licensee was evaluating actions to correct the issues, which had been entered into the licensee's corrective action system. (Section R5.1) **Dockets Discussed:** 05000255 Palisades
05/12/1999	1999006	**Pri:** PLTSUP **Sec:**	NRC	STR	**Pri:** 1C **Sec:** **Ter:**	**Generally, the licensee established and implemented an effective and comprehensive audit program of the ra** Generally, the licensee established and implemented an effective and comprehensive audit program of the radioactive waste processing and the radioactive materials shipping programs. Internal reviews were of sufficient scope and depth to identify problems. (Section R7.1) **Dockets Discussed:** 05000255 Palisades
05/12/1999	1999006-01	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** 1C **Sec:** **Ter:**	**ERRORS AND OMISSIONS ON NRC UNIFORM LOW-LEVEL WASTE MANIFEST** Radioactive material and waste shipping documents and manifests contained errors and omissions of required information, resulting in a Severity Level IV Non-Cited Violation of regulatory requirements. In particular, the inspectors identified errors in the RP staff's activity calculations and in the documentation of these determinations. The inspectors also noted that the problems associated with the shipping manifests and documentation were similar to previous NRC inspection findings in this area, which indicated that the licensee had not taken adequate corrective actions to address these findings and to prevent recurrence. (Section R1.3) **Dockets Discussed:** 05000255 Palisades

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area

Region III

PALISADES

Date	Source	Functional Area	ID	Type	Template Codes	Item Title / Item Description
05/12/1999	1999006-02	**Pri:** PLTSUP **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**FAILURE TO POST REQUIRED CAUTION SIGNS IN AREAS CONTAINING RADIOACTIVE MATERIAL** The licensee identified that containers of radioactively contaminated sand had not been posted in accordance with NRC requirements. The inspectors concluded that the licensee was properly evaluating the incident. (Section R2.2)
Dockets Discussed: 05000255 Palisades						
05/12/1999	1999006-03	**Pri:** PLTSUP **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**FAILURE TO LABEL CONTAINERS OF RADIOACTIVE MATERIAL** The licensee identified that containers of radioactively contaminated sand had not been labeled in accordance with NRC requirements. The inspectors concluded that the licensee was properly evaluating the incident. (Section R2.2)
Dockets Discussed: 05000255 Palisades						
04/09/1999	1999003	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The Emergency Preparedness Drill conducted on March 17, 1999, was an effective training tool which accom** The Emergency Preparedness Drill conducted on March 17, 1999, was an effective training tool which accomplished the planned objectives. Also, the post drill critique in the Technical Support Center was self-critical. (Section P5)
Dockets Discussed: 05000255 Palisades						
02/28/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**The fire brigade effectively used an industry event to conduct training for a hydrogen explosion in the main g** The fire brigade effectively used an industry event to conduct training for a hydrogen explosion in the main generator and resultant fire. (Section F.5)
Dockets Discussed: 05000255 Palisades						

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.