

Commonwealth Edison Company
1400 Opus Place
Downers Grove, IL 60515-5701

FOIA/PA REQUEST

Case No:

97-171

Date Rec'd:

5-13-97

Action Off:

Pugh

Related Case:

ComEd

May 7, 1997

Mr. Russell A. Powell
Director, Freedom of Information Services
U.S. Nuclear Regulatory Commission
Office of Administration
Mail Stop T-6 D4
Washington, D.C. 20555

Re: Freedom of Information Act Request

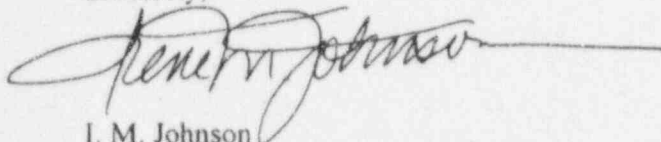
Dear Mr. Powell:

Pursuant to 5 U.S.C. § 552(a)(3) and 10 C.F.R. § 9.23(b), please provide copies of the current "Plant Issues List" also known as the "Plant Issues Matrix" related to each of the following facilities: Braidwood Nuclear Power Station Units 1 & 2 (Docket Nos. 50-237/249), Byron Nuclear Power Station Units 1 & 2 (Docket Nos. 50-454/455), Dresden Nuclear Power Station Units 1, 2 & 3 (Docket Nos. 50-237/249), LaSalle County Nuclear Power Station Units 1 & 2 (Docket Nos. 50-373/374), Quad Cities Nuclear Power Station Units 1 & 2 (Docket Nos. 50-254/265), and Zion Nuclear Power Station Units 1 & 2 (Docket Nos. 50-295/304). It is my understanding that the U.S. Nuclear Regulatory Commission (N.R.C.) Regional Division of Reactor Projects maintains these Plant Issues Lists or Plant Issues Matrices in database form to track violations, reportable events, key inspection findings, program strengths and weaknesses and significant equipment problems for each N.R.C. licensed commercial nuclear power plant.

I would appreciate that any readily available materials be provided as soon as possible. In any case, I look forward to receiving your response to this request within the time prescribed by statute.

I agree in advance to pay any reasonable fees associated with this request. However, I request that you promptly notify me if you anticipate that the cost will exceed \$500.00. I can be reached by telephone at (630) 663-2096.

Sincerely,



I. M. Johnson
Licensing Operations Director
Nuclear Operating Division

IMJ/jte

9706250155 970623
PDR FOIA
JOHNSON97-171 PDR

PLANT ISSUES MATRIX

20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/10/1997	Self-Revealed	*****	Unit 2 forced outage due to auxiliary contact switch problems with 4 kV breakers.	Equipment Malfunction	97006 (draft)
3/29/1997	*****	*****	Unit 3 was shut down to commence planned refueling outage.	*****	IR 97006 (draft)
3/3/1997	NRC	Plant Support	High radiation and high contamination area worker briefings were thorough. Personnel working in the radiation protection area had a good understanding of radiation work permit requirements.	Teamwork/Skill Level	96016
3/3/1997	NRC	Engineering	The review of several open operability evaluations for both units indicated that the evaluations, equipment status, and schedule to restore the systems or components to fully operable status appeared reasonable.	Other/NA	96016
2/26/1997	Licensee	Operations	Unit 3 unit supervisor left the confines of the control room for 6 minutes while working on loop select logic problem. The Unit 2 unit supervisor noted the absence and recalled the individual to the control room.	Personnel Performance Deficiency	IR 97004
2/13/1997	Licensee	Engineering	LPCI loop select logic was set nonconservative (900 vs. 940) due to procedural error. This item was identified as part of the 11/21/96 CAL actions.	Inadequate Procedure/Instruction	IR 97004
2/10/1997	Licensee	Plant Support	Actual tampering with security equipment. Security guard site access authorization revoked.	Personnel Performance Deficiency	ENS 31759
2/9/1997	Licensee	Maintenance	Transposed calibration data resulted in reversal of low flow trip and reset setpoints on the HPCI low flow switch.	Personnel Performance Deficiency	IR 97004
2/8/1997	NRC	Operations	Following a mispositioned (one notch in vs. one notch out) control rod issue operations management did an assessment and concluded that the control rod mispositioning, when viewed with other recent events, indicated a decline in operations performance. Management did not increase power (which was down for a condensate demineralizer service unit problem) until the corrective actions were started.	Conservative Decision	IR 97004
2/5/1997	Licensee	Maintenance	Licensee determined that Unit 3 indicated total core flow was significantly below actual.	Personnel Performance Deficiency	MR 3-97-0018

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 5
FOIA- 97-171

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PLANT ISSUES MATRIX

20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/30/1997	NRC	Plant Support	A violation involving a failure to properly limit personnel access authorization to a vital area was identified by the inspector.	Inadequate Oversight	IR 97002
1/30/1997	NRC	Plant Support	Security force members showed a good working knowledge of security requirements and team work between different organizational levels within the security organization.	Teamwork/Skill Level	IR 97002
1/30/1997	Licensee	Plant Support	A non-cited violation involved a failure to terminate a security badge in a timely manner was identified by the licensee. This failure demonstrated weak coordination between corporate and site security.	Teamwork/Skill Level	IR 97002
1/30/1997	NRC	Plant Support	Security intrusion equipment was observed to be working as designed. A good working relationship existed between the security organization and maintenance groups.	Teamwork/Skill Level	IR 97002
1/29/1997	NRC	Operations	Operators were attendant to the panels, knowledgeable of the reasons for lit annunciators, and aware of activities in the plant.	Teamwork/Skill Level	97004
1/29/1997	*****	*****	Unit 3 reactor critical after forced outage.	*****	
1/29/1997	NRC	Operations	The startup of Unit 3 was performed safely with most communications and command and control being good.	Teamwork/Skill Level	97004
1/27/1997	Licensee	Engineering	Several piping systems found outside code allowables per NRC GL 96-06.	Engineering/Design Deficiency	ENS 31670
1/24/1997	NRC	Operations	Operators were attendant to the panels, and knowledgeable of the reasons for lit annunciators, and aware of plant activities.	Teamwork/Skill Level	IR 96016 (draft)
1/20/1997	NRC	Engineering	Knowledge of MOV site engineering team was good, as was corporate interfaces.	Teamwork/Skill Level	96015
1/20/1997	NRC	Engineering	Self assessments in the MOV area provided good technical findings and were beneficial in improving the MOV program. However, the tracking of corrective actions, was not formalized until after the MOV self-assessment.	Teamwork/Skill Level	96015

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/17/1997	Licensee	Maintenance	I&C technician erroneously set the setpoint for the Unit 2 45% reactor power bypass for the load reject/turbine trip scram signal nonconservatively at a pressure corresponding to approximately 50% power. Existed for approximately 4 days.	Personnel Performance Deficiency	ENS 31617
1/15/1997	NRC	Engineering	The inspector considered the implementation of the ASME code, Section XI, Class MC requirements, in containment coating inspection procedures, to be a positive step toward maintaining the torus and containment material condition.	Self-Critical	IR 97003
1/15/1997	NRC	Engineering	The inspector was unable to determine appropriate corrective actions for torus pitting (pitting repairs and/or pitting characterization) had been performed as assumed in the bounding engineering calculations.	Other/NA	IR 97003; URI
1/15/1997	NRC	Engineering	The inspector identified a pump installed in the Unit 2 torus basement that lacked installation documentation and for which an installation safety evaluation had not been performed. 10 CFR 50.59 violation issued.	Inadequate Oversight	IR 97003; NOV
1/15/1997	NRC	Maintenance	Control room ventilation project personnel completed significant repairs with good coordination between the ventilation group and other plant personnel.	Team work/Skill Level	96016
1/9/1997	Licensee	Engineering	Primary containment electrical penetrations never subjected to type B local leak rate test due to breakdown of modification process. Both units affected.	Inadequate Oversight	LER 23797001
12/20/1996	Licensee	Engineering	ECCS systems may be susceptible to NPSH problems due to suction strainer design being based on an incorrect head loss value. Design was based on 1 foot drop across strainers, new calcs show a 5.5 foot drop. Licensee op eval was operable but degraded. Operators will throttle back flow if cavitation is observed; sufficient flow will be available. Licensee to submit an emergency TS change to take credit for 2 psi containment overpressure and limit torus and (CCSW) service water temp. to 75 F to ensure adequate NPSH. Long term a new analysis will be done and torus and service water restored to 95 F. LER 23796022	Engineering/Design Deficiency	ENS Call 31495

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Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/19/1996	NRC	Maintenance	The licensee failed to do post-modification testing on the Unit 2/3 main control room HVAC system.	Inadequate Oversight	96014
12/13/1996	NRC	Maintenance	Repair of the reactor recirculation pump motor was completed successfully in a well controlled manner.	Teamwork/Skill Level	96016
12/13/1996	NRC	Plant Support	An assembly drill was successfully run.	Teamwork/Skill Level	IR 96016 (draft)
12/9/1996	Licensee	Plant Support	Failure to declare refuel floor radiation monitor inoperable and take technical specifications required action due to inadequate 10 CFR 50.59 safety evaluation. A design issues worksheet was not used as intended because the procedure failed to require it.	Inadequate Procedure/Instruction	LER 23796021
12/6/1996	NRC	Engineering	Inspector review of two temporary alterations identified some problems with implementation and technical evaluations. This is an unresolved item.	Personnel Performance Deficiency	IR 96014
12/6/1996	NRC	Maintenance	Significant repair work on the 3B reactor recirculation pump motor was well executed and managed.	Involved Management	IR 96014
12/6/1996	NRC	Operations	NRC identified housekeeping and problem identification weakness in Unit 3 LP heater bay.	Personnel Performance Deficiency	IR 96014
11/27/1996	Self-Revealed	Maintenance	Unit 2 HPCI was declared inoperable due to water in the oil. Water leaks were found in the tube oil cooler, and a rag was discovered in the cooler water box which blocked significant portions of the cooler tube openings. Licensee suspected the rag was present since construction. Reference ENS 31390; LER 23796018	Personnel Performance Deficiency	IR 96014
11/26/1996	Self-Revealed	Plant Support	Computer accounting system failed at the beginning of the plant assembly drill causing confusion. A thorough drill critique identified deficiencies and corrective actions.	Equipment Malfunction	IR 96014
11/25/1996	NRC	Engineering	During review of the EDG test valve ejection, the inspectors noted that the system engineer failed to incorporate all vendor data into the vendor equipment technical information program.	Personnel Performance Deficiency	IR 96014; VIO

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20-May-97

Dresden

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11/24/1996	Licensee	Maintenance	Stop work order was issued in response to the procurement and use of non-safety-related parts. The was partially in response to the 3A CRD pump isolation valve which had a pinhole leak.	Personnel Performance Deficiency	IR 96014
11/21/1996	NRC	Operations	Operators used a conservative approach to evaluate a turbine control valve which was stuck closed. The plant operations review committee performed a thorough review of the turbine control valve test plan.	Conservative Decision	96016
11/21/1996	Licensee	Maintenance	Stop work order issued due to contractors not adhering to facility safe work practices. The stop work was of short duration.	Personnel Performance Deficiency	IR 96014
11/15/1996	Self-Revealed	Plant Support	Unit 1 Diesel Driven Fire Pump failed surveillance. The cause was a closing of the fuel supply solenoid valve that occurred when a power lead to the valve vibrated off. The inspectors subsequently identified that the local diesel fuel storage tank level float was not working correctly. The inspectors also requested information about the level switches calibrations and the licensee determined that the switches were not in the calibration program.	Equipment Malfunction	IR 96014
11/8/1996	NRC	Plant Support	Deficiency 96201-05. The ISI identified that some licensee workers were not aware of the radiological conditions in their work areas and that these work areas were not restored to prework conditions after completing the work.	Personnel Performance Deficiency	ISI
11/8/1996	NRC	Maintenance	Deficiency 96201-20. The procedures used to test the control room HVAC system and boundaries were not appropriate to circumstances, contrary to 10 CFR Part 50, Appendix B, Criterion V.	Inadequate Procedure/Instruction	ISI
11/8/1996	NRC	Engineering	Deficiency 96201-28. Failure to implement commitments to GL 83-28 and GL 90-03. This issue has been cited.	Inadequate Oversight	ISI
11/8/1996	NRC	Operations	Control room operators properly controlled operational activities, such as surveillance tests, strictly followed procedures in most circumstances, and communicated effectively.	Teamwork/Skill Level	ISI

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Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/8/1996	NRC	Plant Support	Deficiency 96201-02. Failure to survey the work area (Unit 2 hotwell, Unit 3 reactor building overhead) and assess the potential radiological hazards were contrary to the requirements of the radiation work permit and 10 CFR 20.1501.	Personnel Performance Deficiency	ISI
11/8/1996	NRC	Plant Support	The 1996 exposure goal of 440 person-rem was the lowest exposure goal established at Dresden Station. As of November 7, 1996, the station accrued 376 Rem.	Teamwork/Skill Level	ISI
11/8/1996	NRC	Engineering	Deficiency 96201-21. The failure to perform a prompt operability determination for CRI/VAC within the time specified by DAP 07-31. Subsequent differential pressure measurements of the surrounding area showed that 1/8 iwg was not maintained.	Personnel Performance Deficiency	ISI
11/8/1996	NRC	Engineering	The team's review of the DSD, FSAR, and ECCS calculations showed that the licensee did not have net positive suction head available calculations that reflected the licensed plant configuration. The team's review of the existing calculations, which provided some information about NPSH, showed a number of errors in the design control of assumptions and inputs.	Engineering/Design Deficiency	ISI
11/8/1996	NRC	Plant Support	From January 1, 1996 through November 11, 1996, the licensee reduced the number of hot spots from 84 to 42 and planned to reduce this number to about 20 by the end of the Unit 3 1997 refueling outage.	Involved Management	ISI
11/8/1996	Other	Maintenance	Testing weaknesses resulted in the failure to detect degraded systems and components. Longstanding programmatic problems with the in service test (IST) program were not comprehensively addressed from 1987 to 1996. Relief valve setpoints differed significantly, in some cases, from design pressures established for safety-related systems. Opportunities to address the IST program deficiencies, early in 1996, were not promptly recognized and evaluated. The licensee and ISI team identified additional testing concerns involving the 125 Vdc batteries, and the 250Vdc batteries, and ventilation systems.	Inadequate Oversight	ISI

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20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/8/1996	NRC	Engineering	The ISI team identified that the licensee was unable to maintain the design basis of the containment cooling service water system under certain conditions, and identified significant weaknesses in the licensee's control of design basis calculations, including a number of errors and nonconservative design assumptions. LER 23796020	Engineering/Design Deficiency	ISI
11/8/1996	NRC	Maintenance	PIFs were not written when required after the results of the oil sample exceed the acceptance criteria; or when the Unit 3 ECCS keep fill pump discharge check valve failed open during post-maintenance testing.	Personnel Performance Deficiency	ISI
11/8/1996	NRC	Engineering	Deficiency 96201-19. Failure to test the Unit 2, 125 Vdc battery at the specified amperage value is contrary to the requirements of procedure DES 8300-28. The failure to demonstrate performance of an acceptable service test of the Unit 2, 250 Vdc battery is contrary to the requirements of TS 4.9.A.3.	*****	ISI; LER 23796019
11/8/1996	NRC	Maintenance	Two limit switches were not reworked and the PMTs were not reperformed contrary to the work instructions, work to repair the electrical cabinet for the 2/3 emergency diesel generator (EDG) fan was not performed IAW the work instructions.	Personnel Performance Deficiency	ISI
11/8/1996	NRC	Engineering	Deficiency 96201-13. ISI identified numerous examples of the failure to perform safety evaluations per 10CFR 50.59. Examples include 1) potential USQ regarding CCSW flow and 20 psid during a LOCA, 2) a 50.59 evaluation was not performed to change the alignment of several HPCI valves positions. 3) Inadequate 50.59 for changing HPCI isolation setpoints. 4) Failure to properly evaluate the HPCI steam trap replacement with an orifice. 5) Failure to perform safety evaluations for installed temporary alterations.	Engineering/Design Deficiency	ISI
11/8/1996	NRC	Plant Support	Deficiency 96201-03. Failure to specify a maximum stay time on a radiation work permit and maintain locked high radiation area doors locked contrary to TS 6.12.2 and 10 CFR 20.1601	Inadequate Oversight	ISI
11/8/1996	NRC	Operations	Overall, operator performance was a noteworthy strength.	Teamwork/Skill Level	ISI

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20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/8/1996	NRC	Engineering	Deficiency 96201-22. The ISI identified numerous examples of the failure to translate the design into drawings, specifications, and procedures, contrary to the requirements of 10 CFR Part 50, Appendix B, Criterion III. CAL issued. Examples included omission of electrical loads in the 125 VDC battery sizing calculation, cable lengths and resistances incorrect, nonconservative 250 VDC battery sizing calculation (it did not accurately determine battery duty cycle loading).	Engineering/Design Deficiency	ISI; CAL
11/8/1996	NRC	All/Multiple	Deficiency 96201-14. The ISI identified numerous examples of the failure to implement corrective actions contrary to the requirements of 10 CFR Part 50, Appendix B, Criterion XVI. These examples include the failure to address longstanding IST issues (SWSOPI valve deficiencies identified by NRC in 1993), CREV deficiencies, and SBLC VAT vulnerabilities closed with no action.	*****	ISI
11/8/1996	NRC	Plant Support	Deficiency 96201-06. Contaminated stanchion found in uncontrolled area. Failure to maintain control of radioactive material contrary to the requirements of 10 CFR 20.1802	Inadequate Oversight	ISI
10/26/1996	Self-Revealed	Maintenance	A manual reactor trip was initiated in response to the loss of the 3B Reactor Recirculation Pump. Licensee took plant to cold shutdown during troubleshooting. Cause was ground on "C" phase of pump motor stator due to insulation breakdown. Root cause appeared to be a wire labeling strap that was found in stator windings and damaged the insulation. Material probably entered motor in 1990-1991 when the endbell was removed for maintenance.	Equipment Malfunction	IR 96014
10/26/1996	Self-Revealed	Operations	The plant response to the loss of a single reactor recirculation pump was in accordance with expectations and plant design. The control room operators followed procedures and conducted an orderly shutdown.	Equipment Malfunction	IR 96014
10/18/1996	NRC	Operations	The facility was operated in a safe manner with good communication. Minor discrepancies continue to occur and attention to detail type issues were observed.	Personnel Performance Deficiency	IR 96013

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20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/18/1996	Licensee	Engineering	From January 1995 through May 1995, Unit 3 primary containment leakage was greater than 0.6 La due to leakage past the inboard and outboard MSL drain primary containment isolation valves. The root cause was attributed to poor maintenance instructions for valve assembly and lack of licensee experience with Anchor Darling double disk gate valves. Reference LER 24995007	Teamwork/Skill Level	IR 96013; App Vio
10/18/1996	NRC	Plant Support	The contaminated material control program has improved since April 1995. However, corrective actions such as minimizing the number of "outside" RPAs and effectively controlling all outside RPAs have not been fully implemented. Continued improvement in the control of contaminated material was needed.	Inadequate Oversight	IR 96013
10/18/1996	NRC	Engineering	Design engineering response to isolation condenser support and feedwater anchor issues was good.	Teamwork/Skill Level	IR 96013
10/17/1996	NRC	Engineering	10 CFR Part 50, Appendix B, Criterion V, violation issued for inadequate maintenance procedure for 4kV breakers. Inspectors found that a more thorough OPEX program review of industry initiatives may have identified the hardened grease issue before Dresden's 3A LPCI pump breaker failed.	Personnel Performance Deficiency	IR 96012; NOV
10/17/1996	NRC	Engineering	1) Lack of 125 VDC and 250 VDC breaker to breaker coordination for nonsafety related loads. 2) Dresden's actions to address cable ampacity concerns have been slow in resolving this issue.	Engineering/Design Deficiency	IR 96012; 2 URIs
10/17/1996	NRC	Engineering	"Hot Shorts" Apparent Violation.	Inadequate Oversight	IR 96012; APP VIO
10/15/1996	Self-Revealed	Plant Support	Poor job and OOS planning resulted in minor flooding and the extension of the east fire main out-of-service boundary. The planners did not take in to account the fact that slip joint piping was installed on the portion of the system that was being worked on. After the OOS was hung and the intended section of piping removed, the slip joint upstream of the isolation point gave way and resulted in the flooding.	Inadequate Procedure/Instruction	IR 96013

PLANT ISSUES MATRIX

20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/15/1996	Self-Revealed	Engineering	U-2/3 EDG Ventilation Fan Power Supply Breaker Inoperable. Fire in a breaker control power transformer on the U-2 side of the alternate power supply breaker for the "swing" EDG ventilaton fan. 7 day LCO. U-3 side of EDG not affected. Weak initial root cause evaluation resulted in additional troubleshooting. The event demonstrated the licensee's difficulty in identifying root causes of equipment failures. LER 24996016	Equipment Malfunction	IR 96013
10/8/1996	Licensee	Engineering	System Engineering found that the control room could not be pressurized to the required pressure with respect to adjacent areas. Both units entered a 14 day administrative LCO. System declared "operable but degraded" on 10/21. Licensee continued to repair leaks. Inoperability of Control Room HVAC being considered for escalated enforcement. Additional references ENS 31109; LER 23796017; ISI	Engineering/Design Deficiency	IR 96014; App Vio
10/8/1996	Licensee	Engineering	RWCU System for Both Units Outside Design Basis. Licensee determined that if the pressure reducing valve (PRV) failed open, and the high pressure isolation instrumentation both failed, the downstream low pressure piping would be overpressurized. If the PRV failed open, it would drop a maximum of 900 psig (as designed). In order to avoid overpressurizing the downstream piping (with a concurrent instrument failure) the PRV would need about 950 psig drop. Licensee isolated RWCU on both units and installed a mechanical gag (temp alt.) on the PRV for each unit. RWCU was returned to service. The RWCU system did not satisfy the current licensing requirements for systems that had a direct interface with the reactor coolant system since a single pressure switch was used to initiate the isolation of both the inboard and outboard containment isolation valves.	Engineering/Design Deficiency	ENS 31115

PLANT ISSUES MATRIX

20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/2/1996	Licensee	Maintenance	<p>U-3 HPCI system declared inoperable due to a high area temperature reading during a surveillance and identification of a HPCI oil system problem. One of four instruments was reading above licensee administrative limits (of 120 deg. F).</p> <p>During U-3 HPCI test, the Vdc aux oil pump found off. The "high oil pressure shut-off" pressure switch had been reset to about 75 psig. in 9/96 (was about 86 psig). Pressure from shaft driven oil pump was about 75 psig, so aux pump tripped due to high pressure, as expected. LER 24996015</p> <p>During U-3 HPCI test, the Vdc emergency oil pump would not start, Breaker problem.</p>	Equipment Malfunction	ENS 31083; IR 96013
9/30/1996	Licensee	Operations	Material deficiencies included service water strainers backwash function in manual instead of automatic mode (an operator work around), and an inadequate traveling screen wash nozzle spray pattern allowing for some fish carry-over into service water system.	Inadequate Procedure/Instruction	96013
9/30/1996	*****	*****	Special NRC Independent Inspection Team begins first 2 week onsite inspection. Interim exit 10/11/96. Back onsite 10/28 with interim exit 11/8/96. Public Exit planned for 12/12/96 at the Dresden site.	*****	Special NRC Inspection
9/30/1996	NRC	Maintenance	The inspector noted that DOS 6600-01, "Diesel Generator Surveillance Tests," verified that the compressors start at 220 psig, not 250 psig as indicated by the UFSAR. The licensee indicated that the UFSAR would be revised to read that the receiver pressure was maintained greater than or equal to 220 psig.	Inadequate Procedure/Instruction	96013
9/28/1996	Self-Revealed	Operations	U-2 & 3 Power Reduction Due to "Shad" (fish) Run. Licensee reduced power on both units due to high D/P on service water strainers. Strainers were fouled due to a fish run. Power was reduced to avoid equipment high temperatures. No temperature increases were identified. No problems with circulating water or main condenser vacuum. Last fish run on 10/2/96	Conservative Decision	IR 96013; OPEN

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/27/1996	NRC	Maintenance	The inspectors reviewed the past and current data tables for action requests (ARs) and work requests (WRs) both for outage and non-outage, planned and corrective backlogs. Each time this has been done the true backlog picture gets a little clearer. This latest recoding may establish a better standard for categorizing backlog items, and was to match the ComEd sites better.	Other/NA	96013
9/26/1996	Licensee	Maintenance	The plant entered a 7 day LCO action statement when U-2 HPCI was declared inoperable due to the pump discharge temperature exceeding 150F. The cause of the increase is being investigated. In the past, this has been due to discharge check valve leakage.	Equipment Malfunction	ENS Call (31061); OPEN
9/25/1996	Self-Revealed	Maintenance	The 3A CRD pump inboard seal exhibited leakage. The 3A CRD pump discharge valve (3-301-1A) would not provide an isolation boundary and a decision was made to replace the non-safety related valve. One week after the repairs, a pin-hole leak appeared in the body of the replaced valve. The initial corrective actions was to establish a freeze-seal boundary to allow for valve replacement. This failed and the licensee decided to encapsulate the entire discharge valve. The encapsulation vessel allowed continued facility operation. Seven PIFs were written to document the breakdowns in engineering, maintenance, work control, procurement, and quality control for the original replacement.	Personnel Performance Deficiency	96013
9/20/1996	NRC	Operations	Unit 3 NRC drywell closeout found some minor debris, broken hanger, inappropriately covered condensing pots. The licensee resolved all issues.	Personnel Performance Deficiency	96013
9/10/1996	Self-Revealed	Maintenance	U-3 Group 1 Isolation Due to Falling Object Bumping Main Steam Line Flow Instrument. While hoisting equipment through an open floor plug in the reactor building (in one of the LPCI/Core Spray corner rooms) a stanchion, that was support a safety barrier rope, fell through the opening. The stanchion struck the high steam flow instrument lines and a Group 1 Isolation occurred. All valves operated as designed.	Personnel Performance Deficiency	ENS Call (30989); IR 96013 OPEN

PLANT ISSUES MATRIX

20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/9/1996	Self-Revealed	Maintenance	U-2 Control Rod J-13 Fully Scramed During Surveillance Testing. U-2 was at about 84 percent power during main steam line radiation monitor 1/2 scram functional testing. While testing RPS channel A, control rod J-13 fully inserted into the core from position 48. Power dropped to about 81 percent. The licensee stated that no thermal limits were exceeded. Scram solenoid pilot valves replaced and rod tested satisfactorily. Small amount (9 grams) of foreign material found in diaphragm. Licensee considers this an isolated event.	Equipment Malfunction	ENS Call (30984) OPEN
9/7/1996	Self-Revealed	Maintenance	Time Delay Relays for U-3 Lo-Lo Level ATWS Signal Failed to Trip within Required TS Tolerance. Three of four time delay relays failed the surveillance. The relays were replaced. The licensee concluded that U-2 was not subject to the same failure. U-2 relays tested about 1 year ago. During the trouble shooting, after the time delay setpoint was adjusted, the relays would not consistently trip within the required tolerance. The root cause investigation was continuing.	Equipment Malfunction	ENS Call (30978) OPEN
9/1/1996	NRC	Engineering	U-3 EDG fuel oil transfer pump discharge guage over-ranged. Third time in previous 8 months. The guage does not have a safety related function. Further indication of license's problems in identifying and resolving root causes.	Inadequate Oversight	IR 96013
8/30/1996	NRC	Operations	A procedure "posted" in the plant was identified as not being the latest revision. Continued inspector follow up of this condition is planned.	Inadequate Procedure/Instruction	IR 96009/IFI
8/30/1996	NRC	Operations	A violation was issued for failing to meet Unit 3 emergency diesel generator operability requirements.	Inadequate Oversight	IR 96009/NOV
8/30/1996	NRC	Maintenance	A violation was issued for failure to follow procedural requirements in calculating specific gravity for the Unit 3, 125 Vdc battery performance test. This was another example of calculation errors during a 125 Vdc battery test.	Personnel Performance Deficiency	IR 96009/NOV
8/30/1996	Licensee	Maintenance	All work was stopped for concerns about worker safety when a potentially lethal shock from a 4kV source was detected. The work stoppage for personnel safety was a conservative response.	Conservative Decision	IR 96009

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20-May-97

Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/30/1996	Licensee	Maintenance	A non-cited violation was identified for conducting surveillance test of secondary containment leakage in greater than 5 mph wind.	Inadequate Procedure/Instruction	IR 96009/NCV
8/30/1996	NRC	Engineering	Followup to AIT Inspection Report 50-249/96008 identified one example of failure to take effective corrective actions for past equipment failures and one non-cited violation for minor procedural deficiencies.	Inadequate Procedure/Instruction	IR 96006/NCV
8/30/1996	Licensee	Engineering	A non-cited violation was identified for a non-conforming condition regarding the reactor protective system scram pilot solenoid valve indicating lights.	Engineering/Design Deficiency	IR 96009/NCV
8/30/1996	NRC	Operations	A violation was identified for Electrical Bus 33-1 undervoltage special test procedure which was not properly reviewed.	Inadequate Oversight	IR 96009/NOV
8/30/1996	NRC	Engineering	Further evaluation of licensee's use of compression fittings from various vendors is warranted after several examples of mixed compression fittings were discovered in the facility.	Engineering/Design Deficiency	IR 96009/URI
8/30/1996	NRC	Plant Support	Continued problems were observed regarding Radiation Protection Technician (RPT) performance. During movements of radioactive waste, workers received unplanned intakes of radioactive material due in part to the poor performance of the RPT assigned to the job. One violation was identified as a result of this evolution.	Personnel Performance Deficiency	IR 96009/NOV
8/27/1996	Licensee	Engineering	U-3 Corner Room Support Steel Anchor Bolts Missing Since Original Construction, Anchor bolts not installed on main support beams in each of the rooms as designed. A bolt head was "tack welded" to the "corner angle." Purpose of bolts was to restrain lateral movement. Licensee repairing the connections.	Other/NA	RI Observation; OPEN
8/27/1996	*****	*****	U-2 STARTUP. Minor problems during startup included two control rods declared inoperable due to sticking (i.e. require a high air pressure to move), HPCI pump discharge temperature high due to check valve leakage (repeat problem), and turbine trip during EBC control test due to failed fuse.	*****	IR 96009

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/23/1996	Self-Revealed	Maintenance	Unexpected Opening of Two LPCI Minimum Flow Valves While Filling 3A HX. Root cause was failed check valve in deepfill system. Valves were reopened within 3 to 5 minutes.	Inadequate Procedure/Instruction	LER 50-249/96-011;ENS Call (30916)
8/22/1996	NRC	Maintenance	System engineers were not consistently providing early schedule inputs to the work planning process. This frequently resulted in schedule changes prior to beginning work.	Inadequate Oversight	IR 96006
8/19/1996	Licensee	Engineering	Accident Analysis for RWCU HELB Outside Containment. The concern is that Part 100 dose limits may be exceeded during worst case conditions i.e. I-131 dose equivalent at maximum TS limit). Dresden and Quad Cities do Not have automatic isolation of RWCU on room temperatures or flow, only low reactor vessel level and high drywell pressure. Licensee's compensatory actions included developing administrative procedures to manually isolate RWCU if local area temperatures exceeded 150 deg. F within 10 minutes.	Engineering/Design Deficiency	RI Observation; OPEN
8/9/1996	Self-Revealed	Maintenance	120 Vac Electrical Shock During Maintenance on Bus 23. Maintenance personnel not wearing proper protective safety equipment. Cause was expectations not clearly understood to verify that terminals were de-energized prior to cleaning and maintenance activities and to wear proper safety equipment. Tagout was correct.	Personnel Performance Deficiency	RI Observation; OPEN
8/8/1996	Licensee	Engineering	Through-Wall Leak on Inlet Nozzle of U-3 A-RWCU Loop, B-NRHX. Leak identified during asbestos removal project of U-3 RWCU system. Licensee later identified indications on U-3 B-RWCU Loop, B-NRHX, but no leak. Probable cause is IGSCC. Licensee plans to perform weld overlay ASME Code repairs on leak.	Equipment Malfunction	OPEN
8/8/1996	Licensee	Maintenance	Foreign Material Discovered in 2A SDC Loop. During inspection of 2A SDC pump discharge check valve, licensee determined that several pieces of the valve were missing. Also identified debris in piping near the valve. Licensee performing a loose parts analysis for U-2 operation. U-2 recirculation system is not in service. On 8/20, licensee identified hinge pin and lock washer missing from 2B SDC pump discharge check valve.	Equipment Malfunction	OPEN

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Dresden

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/7/1996	NRC	Operations	Inadequate Administrative Controls in Licensed Operator Requalification Program. Multiple examples (5) of SROs being removed from requalification program and later reinstated without NRC notification. Licensee required to amend individual license if person was removed from program. An example would be for a rotation to INPO. NRC identified one example and licensee reviewed records and identified remainder. All SROs had received appropriate refresher training and completed re-activation watches prior to performing licensed SRO duties.	Inadequate Procedure/Instruction	IR 96009/NOV
8/6/1996	Self-Revealed	Engineering	Containment Cooling Service Water (CCSW) Flow Through 3A LPCI Heat Exchange Not Achieve Required flow of 7000 gpm with 2 CCSW pumps. (USFAF Section 6.2.1.3.2) Actual was 6900 gpm. Also, the 3A CCSW pump packing overheated during test. U-2 and U-3B LPCI HXs all greater than 7000 GMP flow with 2 CCSW pumps. Licensee cleaned tubes and adjusted HX outlet flow control valve. Flow test 8/23 resulted in 6975 gpm. ENS call retracted 8/28. Licensee determined that since one train of LPCI was capable of 7000 gpm flow (3B HX) and was operable when 3A train failed, U-3 was within design basis. NRC reviewing the evaluation.	Engineering/Design Deficiency	ENS Call; OPEN
7/30/1996	Licensee	Maintenance	Electromatic Relief Valves 3-0203-3B and E pressure switches found out of tolerance due to setpoint drift.	Other/NA	LER 50-249/96-010
7/25/1996	Self-Revealed	Maintenance	Electrical Shock During Maintenance on Bus 34 (a 4KV safety bus). During inspection of Bus 34, system engineering received minor electrical shock due to not following electrical safety procedures and using proper safety equipment. Tagout of bus was correct. Licensee stopped all onsite work due to concerns with personal safety.	Personnel Performance Deficiency	IR 96009
7/23/1996	Self-Revealed	Maintenance	U-3 480 VAC Circuit Breaker Failed to Remotely Close on First Attempt. Cause appeared to be stiff grease on roller latch bearing. Several of this type of breaker (GE model AK-75) had been overhauled by GE when the "RM-9 trip circuit" modification was performed. This breaker had not had the modification. Identified when licensee was re-energizing Bus 33-1 (after cubicle & breaker overhall). Last PM was 1994. This issue is related to the 4kV breaker problems.	Equipment Malfunction	IR 96006/URI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
7/23/1996	Licensee	Engineering	Potential Leak Path to Bypass Containment (Post Accident) and Potential Increase in Part 100 Dose Rates. Licensee was re-evaluating IN 90-78 and determined a potential backleakage path from reactor recirculation seals through CRD system to HCU's. Preliminary evaluation indicated that the Control Room Dose Limits, Part 50, App. A, General Design Criteria 19 may be exceeded. Licensee plans to modify the procedures to isolate this potential flow path by reducing the response from 4 hours to 1.5 hours	Engineering/Design Deficiency	LER 50-237/95021-02
7/23/1996	Self-Revealed	Maintenance	Electrical Maintenance Without Proper Work Package or Equipment Results in Small Fire. Electrical maintenance personnel removing air conditioning compressor from service building roof using torch. Not have work package, compressor not depressurized, and no fire extinguisher. Small oil fire occurred with minor injuries to personnel. Work control process failed and poor personnel performance.	Inadequate Oversight	IR 96009
7/23/1996	Licensee	Maintenance	Degraded Security Barrier from U-2 Heater Bay (Protected Area) to Radwaste Tank Area (Vital Area). Maintenance removed the security barrier to inspect the pipe tunnel between the two areas. Work package had step to inform Security prior to removing the barrier. Security was not informed when barrier was removed. Appropriate compensatory measures were taken.	Inadequate Oversight	LER 50-237/SO3
7/20/1996	Licensee	Operations	U-2/3 EDG Given Manual Start Signal in Error During Special Test. During a special test of U-2/3 EDG, operator inadvertently moved the control switch to the Start position vice the Auto position as required by the procedure. The EDG had been running unloaded in the cooldown cycle when the error occurred. The EDG remained unloaded and was subsequently placed back in the cooldown cycle. There was no apparent damage to the EDG or control circuit.	Personnel Performance Deficiency	LER 50-237/96-012

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
7/15/1996	Licensee	Operations	U-3 and U-2/3 EDGs Out of Service at the Same Time. U-2/3 EDG was inoperable to bus 33-1 during 4KV switchgear maintenance (beginning on 6/23/96). The U-3 EDG was taken out of service for 4 hours to perform routine monthly operability surveillance while U-2/3 EDG was still inoperable. TS 3.9.D requires that one EDG remain operable with the plant in cold shutdown. Cause is unanticipated increase on 4 KV breaker work scope.	Inadequate Oversight	LER 50-249/96-009; IR 96009
7/12/1996	NRC	Engineering	SDC pump room electrical penetrations exceeded the temperature limits specified in the UFSAR.	Engineering/Design Deficiency	IR 96006/URI
7/12/1996	NRC	Engineering	Unit 2 and Unit 3 Reactor Building Ventilation does not meet the flow requirements in the UFSAR.	Engineering/Design Deficiency	IR 96006/URI
7/12/1996	NRC	Plant Support	Psychological evaluation of on-site contractor employees and site hired licensee employees was not performed in accordance with procedure. NCV for failure to follow procedure.	Personnel Performance Deficiency	IR 96006/NCV
7/12/1996	NRC	Plant Support	Licensee failed to take monthly tritium samples on Unit 1 Main Chimney and the Units 2/3 Main Chimney and Reactor Building Vent Stack between July 1995 and May 1996. NOV for violating TS 4.8.A.2 (Unit 1) and TS 4.8.1 (Units 2 and 3).	Personnel Performance Deficiency	IR 96006/NOV
7/12/1996	NRC	Plant Support	Weaknesses noted in HRSS surveillance procedure regarding acceptance criteria and actions to be taken if a surveillance test fails.	Inadequate Procedure/Instruction	IR 96006/IFI
7/12/1996	Licensee	Operations	Special Report Concerning Inoperable Recombiners was issued.	Other/NA	IR 96006/IFI
7/8/1996	Self-Revealed	Plant Support	Internal Contamination of 2 Contract Personnel Working in Radwaste Stock Bay. Licensee was performing cleanup of material in radwaste stock bay. During a "slow time" the licensee decided to do some additional cleanup in the area. Personnel opened a couple of bags of material that were not covered by the original job RWP. Not sure if the bags were properly marked as contaminated material. Personnel not use proper RP controls or monitoring when opening bags.	Inadequate Oversight	IR 96009/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
7/1/1996	Licensee	Operations	Possible Operator License Exam Compromise. Licensee found copies of NRC exam in training building copier. Exam was under security agreement and should have been under lock and key. [REDACTED]	Other/NA	RI Observation
					EXEMPTION 5
6/28/1996	Self-Revealed	Engineering	Loss of U-2 Annunicators for 8 minutes due to a fault on Line 1207. When power restored, "loss of annunicator power" alarm for control board 902-4 and 902-7 remained. Unit 2 was shutdown at the time.	Equipment Malfunction	IR 96006/IFI
6/21/1996	Self-Revealed	Operations	U-3 Isolat on Condenser Group V Isolation Valves Automaticly Closed due to spurious signal. Root cause unkonwn. Isolation occured during re-alignment of system during normal U-3 shutdown.	Equipment Malfunction	IR 96006, LER 50-249/96008
6/21/1996	Licensee	Operations	Failure to Perform TS Surveillance on Nuclear Instruments During U-3 Shutdown. During the power descension, the Unit Supervisor (US) informed Instrument Maintenance department of shutdown. The US did not direct the IM staff to preform the surveillances that were required during a plant shutdown. Recent SRM and IRM calibrations had been performed satisfactorily on 6/5/96.	Personnel Performance Deficiency	LER 50-249/96-007
6/20/1996	Licensee	Engineering	U-3 SHUT DOWN. The unit was shut down due to licensee's concerns with relaibility of 4KV safety related breakers.	Conservative Decision	IR 96006
6/12/1996	*****	*****	U-3 Synchronized to the Grid.	*****	*****
6/11/1996	Self-Revealed	Maintenance	3A LPCI Pump Breaker Not Open on First Attempt. Pump running for torus cooling. Breaker not open on first two attempts from control room. Trip solenoid had been energized. Opened on third attempt. Cause for the specific breaker failure was the trip latch roller bearing was binding due to hardened grease. Generic cause was inadequate maintenance of 4kV breakers.	Inadequate Procedure/Instr uction	IR 96006/URI
6/10/1996	*****	*****	DRESDEN UNIT 3 STARTUP	*****	*****
6/7/1996	Licensee	Plant Support	Licensee failed to take required service water grab sample while the service water radiation monitor was inoperable.	Personnel Performance Deficiency	IR 96006/NCV, LER 50-237/96008

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
6/1/1996	Licensee	Operations	Licensee delayed U-3 startup until the U-2 feedwater control system investigation had concluded that there were no concerns on U-3.	Conservative Decision	IR 96006
5/31/1996	Self-Revealed	Engineering	U-2 Manual Scram During Feedwater Control System Testing. While modifying the logic on the new "Bailey" Feedwater Control system (i.e. to make a change to a gain calculation) the 2B FRV unexpectedly closed. Operators manually tripped reactor when vessel level dropped below predetermined point. A violation for failure to follow procedures was issued	Engineering/Design Deficiency	IR 96006/NOV; LER 50-237/96009
5/28/1996	*****	*****	U-2 STARTUP.	*****	*****
5/25/1996	Self-Revealed	Engineering	U-2 SHUTDOWN. The unit was shutdown to repair feedwater control system power supply. The failed power supply was identified during 3-element level control testing.	Equipment Malfunction	IR 96006
5/25/1996	NRC	Plant Support	Inadequate RP Records. The licensee failed to keep adequate records and information important to the safe and effective decommissioning of the facility, particularly with regard to spills and the spread of contamination in and around the facility. NOV for failure to follow 10 CFR 50.75(g).	Personnel Performance Deficiency	IR 96004/NOV
5/25/1996	NRC	Plant Support	Inadequate Radiological Surveys. Several items in the radioactive waste tank rooms and infrequently accessed high radiation areas in the radioactive waste building were not identified on the survey map for entry; therefore, no survey information was available for them. NOV for failure to perform surveys to identify radiological hazards incident to workers.	Personnel Performance Deficiency	IR 96004/NOV
5/25/1996	NRC	Plant Support	A contractor employee was authorized unescorted access to the facility based on previous access. The inspector concluded that a full background check was required in accordance with the security plan.	Inadequate Procedure/Instruction	IR 96004/IFI
5/25/1996	NRC	Plant Support	Security equipment maintenance backlog appears excessive.	Inadequate Oversight	IR 96004/IFI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/21/1996	NRC	Operations	Loose Fibrous Material in U-3 Drywell. The inspectors identified loose fibrous insulation in the U-3 drywell which had been installed as a temporary heat shield as early as 1986. Station procedures required following Reg Guide 1.33, Revision 2, Appendix A which recommends the removal of all loose fibrous insulation from the drywell. The insulation was removed. NOV for failure to follow procedures.	Inadequate Oversight	IR 96004/NOV
5/20/1996	Self-Revealed	Engineering	U-3 Reactor Scram Signal While Shutdown Due to Trip of 3B Reactor Protection System MG. A thermal overload in the 3B RPS MG drive motor had tripped resulting in the loss of RPS Bus A, a full scram, and the auto start of the A SBGT train with the associated reactor building isolation. The cause was determined to be high ambient temperature and less than optimum design application of the thermal overload relay and heater.	Equipment Malfunction	LER 50-249/96006
5/18/1996	Self-Revealed	Maintenance	Unit 3 Diesel Generator Auto-Start Due To Electrical Maintenance Department Personnel Error. Electrical maintenance department contract personnel took continuity readings on the wrong terminal points for Bus 34 main feed breaker. These contacts are connected to the DG auto-start circuitry. The U-3 EDG ran successfully, and no equipment damage resulted. NCV for failure to follow procedure.	Personnel Performance Deficiency	IR 96004/NCV; LER 50-249/96005
5/15/1996	Self-Revealed	Engineering	3B Feedwater Regulating Valve Failure, Reactor Trip, and Emergency Core Cooling System Actuation. Reactor vessel level transient due to FRV valve stem separation. HPCI injection and Group I (MSIVs) isolation. Two Gp. I valves automatically reopened due to failed relays when Gp. I signal was reset. Augmented Inspection Team was dispatched. NOV for inadequate corrective actions for failed relays and NCV for inadequate operating procedures in IR 96009.	Equipment Malfunction	IR 96008; LER 50-249/96004
5/6/1996	Self-Revealed	Maintenance	2B SFP Pump Tripped Due to High D/P in Demin-filter. Cause was inlet AGV not opening when required. Concerns with SFP system were previously identified in as URI 50-237;249/ 95014-01 and closed in IR 96002.	Equipment Malfunction	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/1/1996	Licensee	Operations	U-3 System Checklists. Licensee began a detailed review and walkdown of U-3 system checklists. 10 person team. Part of corrective actions from NRC identified problems with U-2 checklists. NOV 50-237;249/96004-01	Involved Management	IR 96004/NOV
4/26/1996	Self-Revealed	Maintenance	U-2 HPCI Inoperable. HPCI was inoperable due to a leak in the main steam supply drain line. The drain line goes to the main condenser. Cause of leak was flow accelerated corrosion. History of leaks in this line (U-3 also) since 1980s.	Inadequate Oversight	LER 50-237/96-007-00
4/22/1996	Licensee	Maintenance	Failure to Follow Maintenance Work Procedures. A body-to-bonnet leak was repaired as a minor work item on feedwater check valve 2-220-62B. Minor work is permitted only on components which do not compromise the AMSI or ISI pressure boundary and which have little potential for personnel injury. This valve was under full reactor feed pressure. NOV 50-237;249/96004-03B was issued for failure to follow procedure.	Personnel Performance Deficiency	IR 96004/NOV
4/20/1996	*****	*****	U-2 RESTART.	*****	*****
4/18/1996	Self-Revealed	Maintenance	UNIT 2 SHUTDOWN. The unit was shutdown because of inability to meet allowed LCO time for HPCI system testing. Unit 2 HPCI discharge line would cool to less than 150 F as required by procedure due to leakage past the 2-2301-7 check valve.	Equipment Malfunction	LER 50-237/96002
4/17/1996	NRC	Plant Support	Chemical Agent Canisters (A Response Weapon) Inoperable. Sixty-six percent of chemical agent canisters issued to the station security force were inoperable. The security plan requires that all canisters be operable. A violation (NOV 50-237;249/96004-10) was issued for failure to follow the security plan.	Equipment Malfunction	IR 96004/NOV
4/17/1996	Licensee	Operations	Improper Interpretation of TS Surveillance Interval. Licensee personnel inappropriately applied a 25 percent "grace period" to a service water grab sample frequency. The grab sample was required as part of a TS action statement for an inoperable service water radiation monitor; therefore, a NCV (50-237;249/96004-04) was issued for violating TS 3.2.F.3.	Personnel Performance Deficiency	IR 96004/NCV
4/15/1996	*****	*****	U-2 RESTART FROM D2R14.	*****	*****

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/10/1996	Self-Revealed	Maintenance	APRM Circuit Card Maintenance. Licensee canabilized resistors that were thought to be spares to replace failed resisitors on the same APRM card. The resisters were in fact in use and the result was in a larger than expected APRM gain change. The root cause was determined to be a problem with the vendor drawing which had been incorporated into the surveillance procedure. This item was considered an additional example of electrical drawing deficiencies (URI 50-237;249/95015-07).	Inadequate Procedure/Instr uction	IR 96004
4/10/1996	Self-Revealed	Plant Support	Low Level Intake During Maintenance. One radiation worker received a low level intake of radioactive material during U-2 drywell basement cleaning. The root cause was determined to be poor radiation protection technician coverage. A violation (NOV 50-237;249/96004-08A) was issued for failure to perform surveys to determine the radiological hazards incident to workers.	Personnel Performance Deficiency	IR 96004/NOV
4/4/1996	Licensee	Operations	U-2 Recirculation Loops Cross-Tie Valve. The 2 inch valve in the equalizing piping was found about 10% open during checklist review in response to NRC finding. License requires that valve is shut. Unit 2 was not in operation at the time; however, had the licensee not re-performed the system checklist, a license violation could have occurred. This was one of the findings that led to a NOV for Inadequate Corrective Actions for deficiencies in system checklists. (50-237;249/96004-01)	Inadequate Procedure/Instr uction	IR 96004/NOV
3/31/1996	Licensee	Plant Support	Radwaste Supervisor Tested Positive for Alcohol During "for-cause" FFD testing. Individual was denied unescorted site access pending review.	Personnel Performance Deficiency	ENS CAll (30211)
3/29/1996	NRC	Plant Support	PVC usage in the plant was not well controlled. Specifically, no 10 CFR 50.59 evaluation was done to address the increased PVC loading in the Fire Hazards Analysis. Resolution of this issue will be tracked under URI 50-237;249/96002-09.	Inadequate Procedure/Instr uction	IR 96002/URI
3/29/1996	Self-Revealed	Maintenance	Inadequate Corrective Action on 4kV Breakers. Numerous linkage problems in 4kV breakers and poor root cause analyses have been reported dating back to 1989. A NOV (50-237;249/96002-06A) was issued for failure to take prompt corrective actions.	Personnel Performance Deficiency	IR 96002/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/29/1996	Licensee	Maintenance	The revised peak loading of the duty cycle was not reflected in the battery service tests performed during outages in 1995-1996 (Unit 2) and 1994 (Unit 3), and the testing was inconsistent with the design peak loading.	Other/NA	96004
3/29/1996	NRC	Plant Support	Emergency Lighting. An inspector review of emergency light surveillances performed since 1994 indicated that the licensee failed to follow procedure when performing the 8-hour discharge test. There were 26 examples in 1994 and 21 examples in 1995. A NOV (50-237;249/96002-05B) was issued for failure to follow procedure. Additional problems with the emergency lights were noted and will be tracked under IFI 50-237;249-96002-10.	Personnel Performance Deficiency	IR 96002/NOV and IFI
3/29/1996	NRC	Engineering	UFSAR Deviations. Deviations were noted for locked closed containment isolation valves, diesel fuel oil tank overflow, ACAD system, toxic gas analyzer, and HPCI dedicated suction. The resolution of these deviations will be tracked under URI 50-237;249/96002-11.	Engineering/Design Deficiency	IR 96002/URI
3/29/1996	NRC	Engineering	Untimely Resolution of Operability Evaluations. No engineering proposal has been submitted to date in order to resolve the lack of the automatic purge mode for control room ventilation as described in the UFSAR. URI 237;249/96002-07 was issued to track this deviation.	Engineering/Design Deficiency	IR 96002/URI
3/29/1996	Licensee	Engineering	Numerous licensee-identified UFSAR discrepancies remain to be resolved. These items were discovered through the licensee's 1993 UFSAR rebaselining effort. URI 50-237;249/96002-08 will track these issues.	Engineering/Design Deficiency	IR 96002/URI
3/29/1996	NRC	Maintenance	Skill of the craft weaknesses has resulted in numerous examples of slowed work completion and potential for personnel injury. Assessment of skill of the craft will be ongoing.	Personnel Performance Deficiency	IR 96002
3/27/1996	Self-Revealed	Operations	Inadvertent Manual Scram While in Refuel Mode During Planned Periodic Surveillance Testing Due to Human Error. While performing a planned instrument calibration on the drywell high pressure scram and containment isolation switches, the operator reflexively manually scrambled the unit when an expected half-scram was received.	Personnel Performance Deficiency	IR 96002; LER 50-237/96006

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/26/1996	*****	*****	SMM SCREENING MEETING	*****	*****
3/25/1996	Licensee	Maintenance	One EMD personnel received uptake during work on U-2 drywell sump pump motor. EMD personnel not wait for RPs to take air sample.	*****	RI Observation
3/18/1996	Self-Revealed	Maintenance	U-2/3 diesel fire pump inoperable due to engine coolant leak identified during weakly maintenance run. (Operable 3/21)	*****	RI Observation
3/15/1996	NRC	Operations	Discrepancies were identified in the Unit 2 Drywell during "close-out" walkdown. Examples included missing screws form EQ electrical boxes, MOV covers not secured, and miscellaneous debris. This issue is unresolved pending review of the licensee's corrective actions. (URI 50-237/96002-01).	Inadequate Oversight	IR 96002/URI
3/15/1996	NRC	Operations	Improper control of feedwater heater controllers. The control room operators were staging mechanical "jams" to keep the feedwater heater switches in the pull-to-stop position if a loss of feedwater heaters were to occur. The use of "jams" was not allowed by station procedures, and the "jams" were removed from the control room.	Personnel Performance Deficiency	IR 96002
3/15/1996	Self-Revealed	Operations	Incorrect Operator Aid results in reactor level problem. Operators using an incorrect operator aid caused an unexpected three inch drop in reactor vessel water level due to instrument error not reflected on the aid. The aid has been corrected.	Inadequate Procedure/Instruction	IR 96002
3/15/1996	NRC	Maintenance	Discrepancies were identified in the Unit 2 Drywell during "close-out" walkdown. Examples included missing screws form EQ electrical boxes, MOV covers not secured, and miscellaneous debris. This issue is unresolved pending review of the licensee's corrective actions. (URI 50-237/96002-01).	Inadequate Oversight	IR 96002/URI
3/12/1996	NRC	Engineering	Unit 2 refuel outage was extended again to implement structural steel modifications to LPCI corner rooms. The licensee initially identified the failure to meet Code requirements in early 1994, but, did not plan on doing work until NRC questioned timeliness of corrective actions.	Inadequate Oversight	IR 95015\URI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/7/1996	Self-Revealed	Operations	U-2/3 diesel fire pump inoperable due to cold weather. When low area temperature alarm annunciates, temperature already below operable setpoint. Modification earlier in year changed area temperature required for operability. Alarm setpoint not changed.	Engineering/Design Deficiency	RI Observation
3/7/1996	Self-Revealed	Engineering	U-2/3 diesel fire pump inoperable due to cold weather. When low area temperature alarm annunciates, temperature already below operable setpoint. Modification earlier in year changed area temperature required for operability. Alarm setpoint not changed	Engineering/Design Deficiency	RI Observation
3/5/1996	Licensee	Maintenance	U-3 HPCI inoperable. Eng. determined that during HPCI startup, the main steam line drain valve leak had potential to become worse. Leak was associated with 2/27/96 HPCI leak. Restored next day.	Equipment Malfunction	LER 50-249/96-002
3/4/1996	Self-Revealed	Maintenance	2A CCSW pump packing leak.	Equipment Malfunction	RI Observation
3/4/1996	Licensee	Maintenance	Excessive oil found in U-2 EDG air box after planned maintenance. Also, SRI identified multiple minor material deficiencies after maintenance.	Inadequate Procedure/Instruction	RI Observation
3/4/1996	Licensee	Operations	ACAD compressor inoperable. Identified at day 9 of a 7 day administrative (DATR) LCO. Not TS or 10 CFR 50.44. Additional ACAD issues are discussed in IR 96002 (IFI 50-237;249/96002-04).	Personnel Performance Deficiency	RI Observation
3/3/1996	NRC	Operations	Discrepancies between UFSAR and locked valve program. (Discussed in IR 96002.) The licensee failed to adequately implement the station's locked valve program resulting in several plant configuration problems. Numerous Corrective Action Requests, PIFs, and violations have previously been issued; therefore, a violation of 10 CFR Part 50, Appendix B, Criterion XVI was issued (NOV 50-237;249/96004-02). The licensee has reviewed the locked valve issue along with the station checklist issue in order to identify and correct deficiencies.	Other/NA	IR 96004/NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/3/1996	NRC	Operations	Multiple problems found on "completed" U-2 startup checklists including some independently verified valves found out of position. (Discussed in IR 96002.) The licensee's initial review and corrective actions were ineffective; therefore, a violation of 10 CFR Part 50, Appendix B, Criterion XVI was issued (NOV 50-237;249/96004-01). The licensee's second review had broader scope.	Other/NA	IR 96004/NOV
3/3/1996	Self-Revealed	Operations	2C condensate and booster pump 4kV breaker not close. Breaker not properly "racked in." Additional 4kV breaker problems are being tracked under NOV 50-237;249/96006-06A.	Personnel Performance Deficiency	RI Observation
3/3/1996	Self-Revealed	Maintenance	Foreign material (rag) found in 2A CCSW pump. Foreign material in the system has been a recurring problem with CCSW dating back to late 1994; therefore, a violation of 10 CFR Part 50, Appendix B, Criterion XVI was issued (NOV 50-237;249/96002-06B). The rag in the CCSW system was due to poor FME control during maintenance on the 2/3 diesel fire pump which shares the same suction bay as all of the CCSW pumps.	Inadequate Oversight	IR 96002/NOV
3/3/1996	Self-Revealed	Maintenance	2C condensate and booster pump 4kV breaker not close. Breaker not properly "racked in." Additional 4kV breaker problems are being tracked under NOV 50-237;249/96002-06A.	Personnel Performance Deficiency	RI Observation
3/3/1996	Licensee	Operations	Licensed operator signed a routine APRM surveillance as complete and satisfactory when 6 of 8 channels were above limits.	Personnel Performance Deficiency	RI Observation
2/29/1996	Licensee	Maintenance	Both trains of control room ventilation degraded. A-train fan motor[] B-train does not have backup cooling water supply.	Equipment Malfunction	RI Observation
2/29/1996	Licensee	Engineering	Non-environmentally qualified connectors on U-2 post-accident radiation monitor in drywell. Checking U-3 & Quad Cities. Additional U-2 drywell concerns are being tracked under URI 50-237/96002-01.	Inadequate Procedure/Instruction	RI Observation
2/29/1996	Licensee	Operations	Incorrect cation resin added to tank in radwaste system. Wrong resin was delivered.	Personnel Performance Deficiency	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/28/1996	Licensee	Maintenance	Problem with U-3 reactor recirculation MG set ventilation dampers. The resulting high temperature required about 35% rapid load drop.	Equipment Malfunction	RI Observation
2/27/1996	Self-Revealed	Engineering	U-2 SDC system tripped. Apparently due to spurious high temperature signal from a reactor recirculation loop thermo-couple (T/C).	Equipment Malfunction	RI Observation
2/27/1996	Self-Revealed	Maintenance	U-2 RWCU system leak (about 100 gal/hr) into reactor building drain tank. Leak was past an isolation valve.	Equipment Malfunction	RI Observation
2/27/1996	Licensee	Maintenance	Pin-hole size leak in U-3 HPCI drain line to condenser. Found during rounds.	Equipment Malfunction	RI Observation
2/27/1996	Licensee	Operations	New work request added to existing out-of-service tagout. Isolation boundaries were inadequate for new work.	Inadequate Procedure/Instruction	RI Observation
2/26/1996	Licensee	Plant Support	Inadequate compensatory actions after security intrusion detection system became inoperable due to weather. Supervisor's error.	Personnel Performance Deficiency	ENS CallIR 96002\Open
2/25/1996	Licensee	Operations	Latch on fire door found taped over.	Personnel Performance Deficiency	RI Observation
2/25/1996	Licensee	Operations	Configuration control problems (tagging) during integrated leak rate testing (ILRT)	Personnel Performance Deficiency	RI Observation
2/24/1996	Self-Revealed	Engineering	U-2 SDC system tripped. Cause was apparently due to spurious high temperature signal from a reactor recirculation loop thermo-couple (T/C). Repeat problem.	Equipment Malfunction	RI Observation
2/24/1996	Licensee	Operations	Multiple self-check errors found in performance of Unit 3 CRD accumulator OOS tagout.	Personnel Performance Deficiency	RI Observation
2/23/1996	Self & Lic.	Maintenance	Unit 3 down power to fix material condition problems: 3A FRV re-injection, 3B reactor recirculation pump low oil level, and replace 8 CRD SSPVs.	Equipment Malfunction	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/23/1996	Self-Revealed	Engineering	3D CCSW pump discharge check valve leaking back by resulting in failure of keep fill system. Foreign material (wood) found in hinge of valve. This was used as one of the examples of NOV for inadequate corrective actions. (50-237;249/96002-06B)	Equipment Malfunction	IR 96002/NOV
2/19/1996	Licensee	Engineering	Control Room HVAC and Operating Procedures Not Meet UFSAR Design. System was designed so upon toxic gas detection system actuation, the B train of Control Room HVAC would shift to the recirculation mode and pressurize the control room ventilation envelope. The concern was that during a LOOP and/or LOCA, power to the toxic gas analyzer would be lost. The consequence would be that the equipment needed to pressurize the control room in the event of toxic gas would be unavailable. The licensee procedures to relign the systems within the required time frame were inadequate.	Engineering/Design Deficiency	IR 96002; LER 50-237/96003
2/16/1996	NRC	Operations	While running two simultaneous Unit 3 diesel generator surveillances, the inspector noted that different kW loading was required for each test. The operators were unaware of the different requirements for the surveillances in progress. An NOV (50-237;249-96002-05A) was issued for failure to follow procedure.	Personnel Performance Deficiency	IR 96002/NOV
2/13/1996	NRC	Plant Support	Resin Spill in Radwaste Building that was Approximately 1 year Old Identified by RIHP inspector. The Radwaste barrel storage area was a contaminated, locked high radiation area. Licensee had identified spill on survey map about 1 year earlier. Issue was initially documented as URI 50-237;249/95015-10. NOV for failure to perform adequate surveys (50-237;249-96004-08B)	Inadequate Oversight	IR 96004/NOV
2/13/1996	Self-Revealed	Engineering	U-2 SDC System Pumps Tripped. Apparent cause was spurious high temperature signal from a reactor recirculation loop thermo-couple.	Equipment Malfunction	RI Observation
2/11/1996	Licensee	Maintenance	Mechanic used a hardened steel center punch to remove a gasket from the U-2 reactor vessel flange. Gasket had already been removed. A one inch gouge was put in flange. A licensee QC inspector was present when the mechanic used the punch.	Personnel Performance Deficiency	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/10/1996	Self-Revealed	Operations	Auxiliary operator inadvertently started U-3 EDG during routine local control panel lamp check. Operator failed to utilize self-checking in the performance of his duties.	Personnel Performance Deficiency	IR 95015; LER 50-249/96001
2/8/1996	Licensee	Maintenance	Safety bus fuse configuration OOS problems. Continuing examples of problems. No details.	Personnel Performance Deficiency	RI Observation
2/6/1996	NRC	Operations	Work Authorized When Valve Was Not in Required Position. Maintenance had been authorized to begin for a LPCI valve even though the actual valve position did not match the position identified on the OOS card on control room switch. Example of a Violation for failure to follow Work Request procedure (50-237;249/95015-02C).	Personnel Performance Deficiency	IR 95015/NOV
2/5/1996	Self-Revealed	Operations	Well water system freezing problems due to extreme cold weather. Plant operations were effected due to inability to make more water combined with low CST level.	Engineering/Design Deficiency	RI Obsv.
2/2/1996	Self-Revealed	Maintenance	Loss of ventilation on U-3 recirculation motor generator (MG) sets when both operating fans tripped. Reactor power was rapidly reduced to about 60 percent. Damper linkage contributed to the failure.	Equipment Malfunction	IR 95015
2/2/1996	Self-Revealed	Operations	U-2 EDG Tripped on Engine High Temperature due to Slow Response by Non-licensed Operator. Output breaker not close during test. EDG running unloaded without cooling water. Operator not trip the EDG prior to the high temperature trip. This was contrary to management's expectation.	Personnel Performance Deficiency	IR 95015
2/2/1996	Self-Revealed	Operations	Proper Operator Response to Loss of Ventilation on U-3 Recirculation Motor Generator Sets. Reactor power was rapidly reduced to about 60 percent.	Teamwork/Skill Level	IR 95015
2/1/1996	Self-Revealed	Engineering	Uninterruptible power supply (UPS) battery low temperature due to low Rx building ambient temperatures. Temperature control problems with UPS room are longstanding.	Engineering/Design Deficiency	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/1/1996	Licensee	Operations	Non-licensed equipment attendant left the U-2 drywell access door unlocked. Drywell is a locked high radiation area. Violation for failure to lock a high radiation area (50-249/95015-09).	Personnel Performance Deficiency	IR 95015/NOV
1/30/1996	Self-Revealed	Maintenance	U-2 Groups II & III (RWCU & SDC) isolations and SBGT initiation during testing, not reportable. ABT failed to return power source due to failed contact. Occured on 02/3/96 also.	Equipment Malfunction	IR 95015
1/30/1996	Self-Revealed	Operations	Groups II and III Isolation and SGTS Initaition During Maintenance. Contacts in instrument bus ABT shorted during maintenance. (Occured on 2/3/96 also.) Concern was that even though the the potential for the loss of the instrument bus was high and this was identified during the pre-job breif, the licensee continued to conduct several other tasks (such as CRD timing & vessel cavity draining) in paralle during the maintenance. Non-conservative decision making.	Inadequate Oversight	IR 95015
1/27/1996	Licensee	Operations	Fuel Bundle Mis-oriented by 90 deg. During D2R14. The fuel was in the correct core location but mis-orientated. The major concern was that 3 people on the refueling bridge missed the error. Next crew identified error. NCV for failure to follow procedures (50-237;249/95015-01).	Personnel Performance Deficiency	IR 95015/NCV
1/24/1996	NRC	Operations	OOS "Test Cards" Not Placed on Control Switches of 2F and 2G Drywell Coolers. Example of a Violatoin for failure to follow OOS procedure (50-237;249/95015-02C)	Personnel Performance Deficiency	IR 95015/NOV
1/18/1996	NRC	Operations	Multiple Examples of Problems with 4Kv Breaker Storage. Breakers racked out & not restrained, no FME covers, and non-EQ breaker put into safety related cubicle. Licensee begins Level II investigation. Example of a Violation for failure to follow procedures (50-237;249/95015-02E)	Personnel Performance Deficiency	IR 95015/NOV
1/18/1996	NRC	Maintenance	U-2/3 EDG Air Lock Door (Secondary Containment) Found Ajar Multiple Times. Door would not fully shut after each use. Long-standing material condition deficiency.	Equipment Malfunction	IR 95015

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/18/1996	NRC	Operations	U-2/3 EDG Air-Lock Door (Secondary Containment) Ajar on Multiple Occasions. Door ajar on multiple occasions. RP personnel stationed at a desk near door were aware that door was open. RP personnel had not taken actions to close door. This occurred twice within a 30 minute period. These were additional examples of personnel living with poor material conditions.	Personnel Performance Deficiency	IR 95015
1/18/1996	NRC	Maintenance	Several 4kV Breakers Found Unrestrained. Several breakers that had been removed from cubicles were found unrestrained. Electrical maintenance personnel stated that the problem would be corrected. Two days later, several of the breakers were found unrestrained again. Example of a Violation for failure to follow procedures (50-237;249/95015-02E).	Personnel Performance Deficiency	IR 95015/NOV
1/17/1996	NRC	Engineering	Unauthorized Modification in U-3 Torus Catwalk Area. Ventilation ducting was supported by temporary rigging (cable) which had been in place since 9/92. Work request had originally been to repair the permanent supports for the ventilation ducting. The work request was closed in 12/92. Since work request was closed and rigging was not controlled under any plant procedures, this was considered a modification to the plant. NCV for inadequate procedures (50-237;249/95015-04). This example demonstrated a continued weakness in licensee's ability to implement system walkdowns.	Inadequate Procedure/Instruction	IR 95015/NCV
1/16/1996	Licensee	Maintenance	Early Identification of Overheated U-3 Main Generator Exciter Brushes. Electrical maintenance personnel identified heat related discoloration of brushes. The early identification allowed for the replacement of the brushes on-line prior to a significant problem occurring.	Teamwork/Skill Level	IR 95015
1/16/1996	Self-Revealed	Maintenance	U-2/3 Diesel Fire Pump Cracked Discharge Flange. This was identified during modification testing. Another example on poor material condition.	Equipment Malfunction	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/16/1996	Self-Revealed	Maintenance	Loss of Pressure & Flow Indication of 2D CCSW Pump During Testing. Root cause never identified. This was used as one of the examples for a Violation of 10 CFR Part 50, App. B, Criteria XVI for failure to take adequate corrective actions for foreign material intrusion into the CCSW system. (50-237;249/96002-06B)	Other/NA	IR 96002/NOV
1/13/1996	Self-Revealed	Operations	Inadequate OOS Boundary. Maintenance personnel determined that the section of the instrument air system piping being removed for repairs was pressurized. Example of a Violation for failure to follow OOS procedure. (50-237;249/95015-02A)	Inadequate Procedure/Instr uction	IR 95015/NOV
1/13/1996	Self-Revealed	Maintenance	U-2 EDG Output Breaker Failed to Close During Testing. Cause was position indication interlock from a cross-tie breaker had failed due to damaged linkage. The U-2 EDG breaker would not have auto closed. The licensee's continued failure to identify the root causes for 4kV breaker problems over several years (1989 to present) was an example of a Violation of 10 CFR Part 50, App. B, Criteria XVI. 50-237;249/96002-06A.	Inadequate Oversight	IR 96002/NOV; LER 50-237/96001
1/8/1996	Self-Revealed	Maintenance	Loose Relay Cover Panel Falls Off Causing a U-3 Half Scram. Relay cover holddown clip broken, cover fell shorting contacts and caused a half scram. Licensee found a second loose cover. Cause was poor maintenance practice for restoring equipment.	Personnel Performance Deficiency	IR 95015
1/7/1996	Self-Revealed	Engineering	Feeder breaker (27-4) to non-safety related MCC for spent fuel pool cooling demineralizers tripped due to bus overloading.	Engineering/De sign Deficiency	RI Observation
1/7/1996	Self-Revealed	Maintenance	U-3A feedwater regulator valve body to bonet steam leak. As of 2/27/96 multiple injections of sealant used to repair leak. On 4/27/96, the 3A FRV inlet isolation valve was shut to reduce leakage.	Equipment Malfunction	RI Obsv. F/U in IR 96008
1/5/1996	Self-Revealed	Maintenance	3A Service Water pump motor failed, cause age-related and lack of cleaning.	Equipment Malfunction	RI Obsv.
12/27/1995	NRC	Maintenance	U-3 SBTG supply line to Rx building ventilation flange (behind 3A MG set) was missing 4 bolts.	Personnel Performance Deficiency	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/26/1995	Self-Revealed	Maintenance	U-2 Recirculation Pump Discharge Isolation MOVs (5A & B) Found Overheated. No other details.	Equipment Malfunction	RI Obsv.
12/22/1995	Licensee	Maintenance	U-2/3 diesel fire pump stuffing box not installed. Shortly thereafter wrong oil used in gearbox.	Personnel Performance Deficiency	RI Obsv.
12/21/1995	NRC	Maintenance	U-1 SFP Poor Housekeeping. Electrical extension cord & tools approx. 1 foot from edge of pool.	Personnel Performance Deficiency	RI Observation
12.18/1995	*****	*****	Chairman Jackson, Hub Miller, and others visit Dresden station for plant tour and to discuss licensee performance.	*****	*****
12/17/1995	Self-Revealed	Engineering	Unusual E ent declared due to hydrogen leak into Radwaste building. H2 from tank farm to U-2 main generator.	Equipment Malfunction	IR 95014
12/15/1995	Self-Revealed	Maintenance	U-2 torus strainer plugging identified as part of post outage torus cleaning process after LPCI run.	Equipment Malfunction	RI Obsv.
12/15/1995	Licensee	Maintenance	Undersized bolts on both U-2 Core Spray recirc. flow line flanges.	Personnel Performance Deficiency	RI Obsv.
12/14/1995	NRC	Maintenance	U-2 (2A & 2B) SDC pump flanges missing bolts. Numerous other deficiencies identified on RWCU, SDC, & SFP systems.	Equipment Malfunction	IR 95014
12/14/1995	NRC	Operations	U-2 protected pathway incorrectly posted as 2A SDC vice correct 2B SDC.	Personnel Performance Deficiency	IR 95104
12/14/1995	NRC	Maintenance	U-2 FPC room - unauthorized temp. alt. (pipe supports).	Personnel Performance Deficiency	IR 95014
12/14/1995	NRC	Maintenance	Emergency lighting surveillance not done.	Personnel Performance Deficiency	IR 95104

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/11/1995	Self-Revealed	Maintenance	U-3 RWCU pressure control valve failed open when shifting control to manual. RWCU relief valve opened. 5 in. Rx vessel level decrease. RWCU sys. auto isolated.	Equipment Malfunction	IR 95014
12/11/1995	Self-Revealed	Plant Support	5 fire hydrants found frozen.	Equipment Malfunction	R1 Obsv.
11/29/1995	Self-Revealed	Maintenance	Both U-3 SFP pumps tripped. Root cause was high pressure in demin-filter. Cause of high pressure was valve leakage from U-2 SFP cooling system.	Equipment Malfunction	IR 95014\URI
11/27/1995	Licensee	Maintenance	Licensee identified MCC 38-3 breaker trip setting not properly set.	Personnel Performance Deficiency	IR 95014
11/27/1995	Self-Revealed	Maintenance	Both U-2 SFP pumps tripped. Root cause not determined. Poor initial investigation.	Equipment Malfunction	IR 95014
11/17/1995	Licensee	Engineering	CRD Scram Discharge Volume gallery platforms did not meet UFSAR allowable stresses.	Engineering/Design Deficiency	IR 95015 LER 95002
11/17/1995	Licensee	Engineering	CRD Scram Discharge Volume gallery platforms did not meet UFSAR allowable stresses.	Engineering/Design Deficiency	IR 95015\LER 95022
11/12/1995	Self-Revealed	Maintenance	While attempting to use the B train of Offgas for the first time in 8 years, H2 fire ignited do to accumulation of resin fines upstream of recombiner.	Inadequate Oversight	IR 95014
11/10/1995	*****	*****	U-2 refueling outage activities stopped by station management to refocus the outage management effort.	*****	*****
11/9/1995	NRC	Maintenance	Pipe hangers for two 18 in. offgas lines in U-2 low pressure heater bay not made up.	Personnel Performance Deficiency	R1 Obsv.
11/6/1995	*****	*****	U-3 startup.	*****	*****
11/2/1995	Licensee	Operations	Diver authorized in U-2 circ water pit with no OOS tags hung. No entry made.	Personnel Performance Deficiency	R1 Obsv.

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/1/1995	Licensee	Maintenance	Wrong size impeller installed on 2A LPCI pump.	Personnel Performance Deficiency	RI Obsv.
10/31/1995	Licensee	Engineering	Motor Control Center (MCC) feed breaker found with incorrect current trip setpoint.	Personnel Performance Deficiency	IR 95012\IR 95014\LER 95020 URI & NCV ENS call
10/29/1995	Self-Revealed	Maintenance	U-3 manual trip due to loss of circulating water (CW) system due to fish clogging intake screens for one CW pump and one traveling screen failure. At the time another CW pump was out of service and the plant was relying on the remaining two.	Equipment Malfunction	IR 95011\LER 95019
10/24/1995	NRC	Maintenance	High vibrations on CRD system.	Equipment Malfunction	IR 95012
10/20/1995	Licensee	Engineering	U-2 scram discharge instrument volume found susceptible to single failure. Appeared to be the result of error made in modification change in mid 1980's. U-3 not affected.	Engineering/Design Deficiency	IR 95012\LER 95019\NCV URI ENS call
10/13/1995	Licensee	Maintenance	Non-like-for-like washer installed in 4kV breaker not documented in work package.	Personnel Performance Deficiency	IR 95012
10/12/1995	Self-Revealed	Maintenance	U-3 HPCI inoperable due to exhaust pot high level alarm. Caused by procedure not requiring draining of drain pot prior to slow start testing.	Inadequate Procedure/Instruction	IR 95012\LER 95018
10/10/1995	Licensee	Maintenance	Poor communication resulted in CCSW suction bay level float being removed.	Personnel Performance Deficiency	IR 95012
10/10/1995	Licensee	Maintenance	Inadequate PMT on CRD D-5 resulted in non-cited violation. Neutral leads were swapped and not identified until next surveillance test.	Personnel Performance Deficiency	IR 95012\NCV
10/7/1995	Self-Revealed	Maintenance	Failure to perform post-maintenance test (motor rotation check) on shutdown cooling MOV resulted in valve operator damage.	Personnel Performance Deficiency	IR 95012\NOV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/7/1995	*****	*****	U-3 plant startup.	*****	*****
10/1/1995	Self-Revealed	Maintenance	U-3 generator exciter breaker secondary contacts damaged during breaker installation. Cause was failure to follow maintenance procedures.	Personnel Performance Deficiency	IR 95012
9/30/1995	*****	*****	Steve Perry, ComEd VP-BWR, assumed duties as Dresden Site VP. Tom Joyce started a 6 month rotation with INPO.	*****	*****
9/28/1995	Self-Revealed	Maintenance	U-3 PLANT TRIP. Trip was due to loss of generator excitation. The cause was a failed resister in excitation circuit.	Equipment Malfunction	IR 95010\LER 95017\ENS call
9/20/1995	Licensee	Maintenance	Wrong valve opened by VOTES test personnel at local control station. Failure to verify through self-check proper valve label prior to operation.	Personnel Performance Deficiency	RI Obsv.
9/16/1995	*****	*****	U-3 STARTUP.	*****	*****
9/15/1995	Licensee	Maintenance	A sys. eng. opened a breaker for a U-2 transformer and protective relaying circuit without operations knowledge or approval.	Personnel Performance Deficiency	RI Obsv.
9/12/1995	Self-Revealed	Maintenance	UNIT 3 SHUTDOWN. Operations initiated U-3 shutdown due to HPCI drain problems.	Equipment Malfunction	IR 95010
9/11/1995	Self-Revealed	Maintenance	U-3 HPCI inoperable. Exhaust drain pot failed to properly drain from previous surveillance. Cause identified as relay/switch failure.	Equipment Malfunction	IR 95010\LER 95016
9/9/1995	Self-Revealed	Maintenance	Increasing temperature trend on 3D ERV tailpipe.	Equipment Malfunction	IR 95010
9/7/1995	Self-Revealed	Maintenance	U-3 startup. 3A RWCU pump degraded - low pressure flow.	Equipment Malfunction	IR 95010
9/5/1995	Self-Revealed	Operations	Group V isolation received while restoring a U-3 Isolation Condenser to standby due to inadequately filling condenser.	Personnel Performance Deficiency	IR 95010\LER 95015\NCV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/1/1995	Licensee	Plant Support	Shipped contaminated material (RWCU piping) offsite above DOT limits. Contaminated circuit breaker shipped offsite to non-licensed facility.	Personnel Performance Deficiency	IR 95011\IR 95010
5/28/1995	Self-Revealed	Maintenance	Inboard and outboard MSL drain primary containment isolation valves: Failure to maintain primary containment leakage less than or equal 0.6 La from at least January 1995 to May 28, 1995, with the U-3 reactor critical, is an Apparent Violation. The cause for the inboard valve leakage was low spots on the valve's seat due to poor alignment (i.e., fit up) of the disk to seat. The root cause appeared to be poor maintenance instructions for valve assembly and lack of licensee experience with Anchor Darling double disk gate valves. The cause for the outboard valve leakage was the valve disk's lower wedge was missing and the stem was bent. The licensee determined that the failure mechanism of the outboard valve was excessive thrust applied during manual handwheel operation during Unit 3 refueling outage 13. The root cause was attributed to an inadequate design modification review in June 1994 that failed to identify that low torque values (about 33 ft-lbs) would damage the valve during normal handwheel operation. A contributing cause was informal controls for manual handwheel operation of motor operated valves.	Personnel Performance Deficiency	50-249/96013-01 VIO

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Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/29/1997	*****	*****	Unit 1 turbine generator returned to service after repair to several valves in the feedwater and EHC system.	*****	IR 97006 (draft)
3/21/1997	*****	*****	Unit 1 turbine generator taken offline to repair moisture separator drain tank level control valves. After the turbine was tripped, high flow in the turbine's EHC system resulted in a decision to shut down the reactor on March 22.	*****	IR 97002 (draft)
3/17/1997	NRC	Operations	Improvements were noted to provide more stringent control room access, reduce incoming phone calls, and reduce the general noise level.	Involved Management	IR 97002 (draft)
3/17/1997	NRC	Maintenance	The inspectors identified problems with implementation of the maintenance rule. Specifically, the identification of MPFF events and the failure to promptly evaluate the Unit 2 CAM system status as (a) (1) under the rule. Long standing issues regarding repetitive regulator failures and water intrusion in the CAM had not been resolved.	Personnel Performance Deficiency	IR 97002 (draft)
3/17/1997	*****	*****	Unit 1 turbine returned to service after replacement of the failed 108D relay.	*****	IR 97002 (draft)
3/17/1997	NRC	Plant Support	Plant water chemistry was good, but problems with hydrogen gas supply, condenser leaks, and reactor water cleanup system problems caused chemistry transients.	Equipment Malfunction	IR 97002 (draft)
3/17/1997	Other	Plant Support	A second event within 12 months of contaminated material generated onsite and found offsite was discovered by a scrap metal processing plant radiation detector.	Inadequate Oversight	IR 97002 (draft)
3/17/1997	NRC	Maintenance	1C and 1D RHRSW pump overhaul activities were performed well.	Teamwork/Skill Level	IR 97002 (draft)
3/17/1997	NRC	Maintenance	The 2A control rod drive pump was rebuilt twice in 1996 and is still out of service for high vibration and seal leakage.	Personnel Performance Deficiency	IR 97002
3/17/1997	NRC	Maintenance	Numerous rotating equipment problems exist including including the 1A reactor feed pump which has been out of service for over 3 months, the 1B reactor feed pump which has a seal leak after just being overhauled, the 1A reactor water cleanup pump and the 2A CRD pump.	Equipment Malfunction	IR 97002

Information in this record was deleted in accordance with the Freedom of Information Act, exemptions 2, 5, 7C, 7D, 7E, 7F, 7G, 7H, 7I, 7J, 7K, 7L, 7M, 7N, 7O, 7P, 7Q, 7R, 7S, 7T, 7U, 7V, 7W, 7X, 7Y, 7Z, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 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1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2

PLANT ISSUES MATRIX

21-May-97

Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/11/1997	*****	*****	Unit 1 was conservatively shut down after the 108D [scram] relay failed during testing.	*****	IR 97002 (draft)
3/7/1997	NRC	Operations	Operators failed to comply with TS action statement after the 108D KPS relay failed. TS required channel be placed in trip condition within 1 hour; however, operators reset the trip for t-shooting 1 and 1/2 hours after initial failure.	Personnel Performance Deficiency	IR 97002 (draft) VIO
3/7/1997	NRC	Operations	The inspectors identified that additional exhaust fans were not started in response to positive turbine building pressure as required by annunciator procedures. Since the fans were out of service, operators opened the turbine building roll up door instead.	Personnel Performance Deficiency	IR 97002 (draft) VIO
2/28/1997	*****	*****	Unit 2 was shut down about 8 hrs earlier than planned for a refueling outage. The TS required shutdown was entered into after 4 of 5 ADS valves failed the required stroke times in the closed directions. Failed closure times were slightly above acceptable. The shutdown was in accordance with procedures and well executed.	*****	IR 97002 (draft)
2/28/1997	Self-Revealed	Operations	A Unit Two shutdown was required due to four of five power operated relief valves failing to meet inservice testing closing time requirements specified by plant procedures.	Equipment Malfunction	IR 97002 (draft)
2/27/1997	Self-Revealed	All/Multiple	An inadvertent HPCI initiation occurred on Unit 2 during the performance of an IM surveillance. The surveillance was not intended to be performed during power operations. Operator response to the unexpected HPCI initiation was good.	Inadequate Procedure/Instr uction	IR 97002 (draft)
2/27/1997	Self-Revealed	Maintenance	Unit Two HPCI inadvertently started, with possibility of injection, due to a problem with automatic depressurization system surveillance testing.	Inadequate Procedure/Instr uction	IR 97002 (draft)
2/14/1997	NRC	Plant Support	A routine security inspection identified two cited violations and two non-cited violations. The cited violations included an inadequate vehicle search and an inadequate security barrier. The NCVs involved fitness for duty procedures and an inattentive security officer.	Personnel Performance Deficiency	IR 97004 (draft); NOVs

PLANT ISSUES MATRIX

20-May-97

Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/5/1997	NRC	Plant Support	Several examples of a failure to follow radiological procedures for posting/control of contaminated areas and radioactive material.	Personnel Performance Deficiency	IR 97003 (draft)
2/5/1997	NRC	Plant Support	Overall management oversight of the area radiation and continuous air monitors was weak.	Inadequate Oversight	IR 97003 (draft)
1/27/1997	NRC	Maintenance	The inspectors observed some operator knowledge and procedural weaknesses during the performance of the CREVS monthly surveillance test. The operations department did not promptly update the procedure and train operators on the current system status.	Inadequate Oversight	IR 96020
1/27/1997	NRC	Engineering	WEAKNESS: Problems identified with the licensee's operability evaluation for the shared EDG start failure (evaluation did not arrive at root cause resolution or provide effective followup action) and with methodology for determining EDG reliability data (poor component trending). An inspector followup item initiated to review licensee's root cause assessment, corrective actions and resolution of reliability testing.	Inadequate Oversight	IR 96020/E1.1; IFI 254/265-96020-04
1/27/1997	Licensee	Operations	Some decline in control room operator performance was noted during the inspection period. Operators mispositioned a control rod during control rod exercising and misaligned one train of the standby gas treatment system.	Personnel Performance Deficiency	IR 96020; NOV
1/27/1997	Self-Revealed	Maintenance	The shared emergency diesel generator experienced a failure to stop and a failure to start. The stop failure was attributed to a failed governor solenoid and the failure to start was an air start motor problem. Both failed components were repeat problems with the EDG system.	Equipment Malfunction	IR 96020
1/27/1997	NRC	Plant Support	The inspectors identified that the flow switch and pressure indicator for the service water effluent radiation monitor did not have a required calibration frequency.	Inadequate Procedure/Instruction	IR 96020
1/27/1997	Licensee	Engineering	ENS Call (31671): SEVERAL PIPING SECTIONS FOUND OUTSIDE UFSAR DESIGN ALLOWABLES per GL 96-06.	Engineering/Design Deficiency	

PLANT ISSUES MATRIX

20-May-97

Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/27/1997	NRC	All/Multiple	Management oversight was not always adequate to ensure consistent quality operability evaluations were being performed and validated for key systems.	Inadequate Oversight	IR 96020
1/27/1997	NRC	Maintenance	The licensee failed to ensure that control room ventilation was adequately testing using RHRSW.	Inadequate Procedure/Instruction	IR 96020
12/23/1996	Licensee	Engineering	ENS Call (31503): ECCS SUCTION STRAINER NOT BUILT IN ACCORDANCE WITH DESIGN. UFSAR assumed the maximum headloss across the ECCS suction strainer as 1-foot d/p at rated flow (10,000 gpm). The installed strainer's analytical model used 5.8-foot d/p at rated flow. The 50.59 evaluation used 5.5 and 3.4 psig containment over-pressure for short and long term calculations, respectively. System declared operable, but degraded with no USQ. An amendment change was planned. An inspector followup item initiated to review the limits on over-pressure since specific values were not included in the UFSAR.	Engineering/Design Deficiency	IR 96020/E2.2; LER 96025; IFI 254/265-96020-06
12/13/1996	NRC	Maintenance	Inadequate System Logic Functional Test for Control Room Ventilation Isolation System. Based on resident inspector's questions, licensee reviewed logic test and determined that existing surveillance had not adequately tested complete logic circuit. Licensee revised test and successfully completed surveillance. RIII DRS initial investigation determined that revised test appeared adequate. Additional references ENS 31452, LER 96-024	Inadequate Procedure/Instruction	IR 96020; NOV
12/6/1996	NRC	Engineering	VIO SL IV (Criterion XI "Test Control"): Failed to incorporate TS requirements into applicable surveillance procedures for Control Room Emergency Filtration System Charcoal Adsorber.	Inadequate Procedure/Instruction	IR 96017/E3.1
12/6/1996	NRC	All/Multiple	Repeat problems with feedwater heater level control valves and gland steam condenser level control valves necessitated increased operator intervention, caused increased personnel radiation exposure, redirected previously scheduled maintenance activities, and impacted unit operation.	Equipment Malfunction	IR 96017
12/6/1996	NRC	Operations	The U-1 circulating water travelling screens maintenance was not well coordinated from a risk perspective.	Inadequate Oversight	IR 96017

PLANT ISSUES MATRIX

20-May-97

Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/6/1996	Licensee	Maintenance	During overhaul and modification of the 2D RHRSW pump, the licensee identified and corrected a significant number of problems including deficiencies in vendor supplied parts. Mechanics initially installed the pump seal housing improperly. Final test results indicated that the overhaul effort was successful.	Inadequate Oversight	IR 96017
12/6/1996	NRC	Operations	Operations exhibited good control of switchyard work	Involved Management	IR 96017
12/6/1996	NRC	Operations	Operations scheduling failed to ensure cold weather preparations were completed before the onset of cold weather.	Inadequate Oversight	IR 96014
12/6/1996	NRC	Operations	Operations failed to ensure a surveillance test for HPCI operability was performed in a timely manner.	Inadequate Oversight	IR 96014
12/2/1996	Self-Revealed	Maintenance	U-2 reduced power to less than 15 percent due to problems with RWCU system isolation valve packing leak.	Equipment Malfunction	IR 96017
11/26/1996	Self-Revealed	Maintenance	Shared standby diesel generator inoperable to Unit 2 due to a relay problem.	Equipment Malfunction	IR 96017
11/26/1996	NRC	Engineering	[REDACTED] (EA 96-530; Criterion III "Design Control" and 50.59): Two apparent violations regarding the safety-related function of the reactor building siding.	Inadequate Oversight	IR 96019/EI.1.b.iii & iv EXEMPTION 5
11/24/1996	NRC	Maintenance	Design Control NOV for improper bolts used in two RHRSW pumps.	Engineering/Design Deficiency	IR 96017; NOV
11/24/1996	Licensee	Maintenance	The control room emergency filtration system was declared inoperable because CREFs airflow was below the required minimum. Followup action included adjusted CREFs airflow and calibrating the permanent plant instrument loop. Previously the flow indication was not calibrated against an actual air flow measurement.	Inadequate Procedure/Instruction	ENS Call 31377; LER 96023
11/12/1996	Self-Revealed	Operations	LPCI declared inoperable after pump discharge check valve failed to reseal, resulting in loss of line fill pressure. Discharge piping repressurized approx. 1/2 hour later and LPCI was declared operable. Additional references ENS 31320; LER 26596003	Equipment Malfunction	IR 96017

PLANT ISSUES MATRIX

20-May-97

Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/28/1996	Licensee	Engineering	██████████ EA 96-531; TS, Criteria XI "Test Control" and 50.59) ENS Call (31227): INOPERABLE CONTROL ROOM EMERGENCY VENTILATION SYSTEM. Three apparent violations concerning the CREVS; 1) TS LCO exceeded, 2) Post-modification and surveillance tests failed to ensure system met UFSAR requirements and 3) Inadequate safety review concerning a change to the UFSAR for control room HVAC calculations.	Inadequate Oversight	IR 96017/E2.1; LER 96022 EXEMPTION 5
10/27/1996	Self-Revealed	Maintenance	U-2 main turbine taken off-line due to problems with moisture separator drain tank level control valves. Foreign material found on valves caused two valves to stick open.	Equipment Malfunction	IR 96017
10/26/1996	NRC	Maintenance	Inspectors found unqualified workers supervised by vendor representatives during repairs on the shared emergency diesel generator.	Personnel Performance Deficiency	IR 96014;VIO
10/26/1996	NRC	Maintenance	Mechanical maintenance workers failed to follow procedures while working on an emergency diesel generator air start motors. Rework was required, and the supervisor was not informed.	Personnel Performance Deficiency	IR 96014; VIO
10/26/1996	NRC	Maintenance	The licensee showed some progress in the implementation of the work control process, as evidenced by some corrective maintenance backlog reduction and improved schedule adherence.	Teamwork/Skill Level	IR 96014
10/26/1996	NRC	Maintenance	Maintenance work on the 1C RHRSW pump and shared standby diesel generator were well coordinated and executed according to schedule.	Teamwork/Skill Level	IR 96014
10/26/1996	NRC	Maintenance	The inspectors found poor supervisory oversight for work on the shared emergency diesel generator.	Inadequate Oversight	IR 96014
10/26/1996	Licensee	Maintenance	Quad Cities put a hold on all parts received from the ComEd Central Receipt Inspection and Test (CRIT) facility based on a number of problems with parts received.	Other/NA	IR 96014
10/26/1996	*****	*****	SALP 13 ENDS (7/23/95 - 10/26/96)	*****	*****

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/26/1996	Licensee	Maintenance	The licensee installed incorrect bolt material in the 1C and 2C RHRSW pumps due to inadequate control of vendor processes. Other examples involving inadequate control of vendor processes and materials were identified. Violation of 10 CFR Part 50, App. B, Criteria III, for use of incorrect bolt material.	Inadequate Oversight	IR 96017; NOV
10/23/1996	Licensee	Operations	The inspectors concluded that panel monitoring by control room operators was good in detecting the U-2 number 1 combine intermediate valve (CIV) not fully open, but monitoring could have been better in detecting generator swings produced during troubleshooting activities. Operations' response to the CIV drifting closed was conservative.	Teamwork/Skill Level	IR 96014
10/11/1996	NRC	Operations	An NRC initial license examination was administered to eight individuals; three who had applied for Reactor Operator licenses and five who had applied for Senior Reactor Operator Licenses. One Reactor Operator applicant failed the written portion of his examination and was denied an operating license. All other applicants passed all portions of their examinations and were issued Reactor Operator or Senior Reactor Operator licenses.	Personnel Performance Deficiency	IR 96302
10/11/1996	NRC	Engineering	STRENGTH: GOOD QUESTIONING ATTITUDE BY SYSTEM ENGINEER led to the identification and subsequent repair of a design deficiency in the safety-related portion of the control room HVAC system. Original design deficiency led to system inoperability.	Other/NA	IR 96014/E1.1; LER 96021
10/11/1996	Licensee	Engineering	ENS Call (31142): INOPERABLE CONTROL ROOM (CR) HVAC SYSTEM (Train B). The CR HVAC system is safety-related; however, the refrigeration condensing unit's (RCU) crankcase heater was powered from a nonsafety-related MCC 16-3. In this condition, it was not assured that the RCU would be able to perform its design function under all conditions. The crankcase heater was replaced with a safety-related heater, the power supply was rewired to safety-related MCC 18-4, and the CR HVAC system returned to operable status on 10/27/96. An unresolved item was initiated to followup CR HVAC system design discrepancies.	Engineering/Design Deficiency	IR 96014/E1.1; LER 96021; URI 254/265-96014-04

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/10/1996	NRC	Plant Support	A new EP Coordinator was hired and was providing good support to the program. Emergency Response Organization personnel appeared knowledgeable about their responsibilities, procedures, and emergency actions.	Involved Management	IR 96011
10/10/1996	NRC	Plant Support	The licensee successfully performed the 1996 biennial exercise, with only minor problems related to (1) classification of the Unusual Event, (2) slow initial NRC notifications, and (3) simulator fidelity and exercise controller problems.	Teamwork/Skill Level	IR 96011
10/10/1996	NRC	Maintenance	One of the primary causes for 4kV breaker failure was hardened grease in the trip latch roller bearing. At Quad, the licensee had incorporated applicable vendor information into the maintenance procedure and were addressing 4kV breaker concerns in an acceptable manner.	Other/NA	IR 96011; IR 96008
10/10/1996	NRC	Plant Support	STRENGTH: Radiological environmental monitoring program (REMP) was good.	Other/NA	IR 96011
10/10/1996	NRC	Plant Support	Post outage task force identified several weaknesses in the work control and planning processes, which were similar to past NRC observations. Specifically, previous station and industry experience was not effectively used to identify emergent work, and some known work was not appropriately identified. (Also see IRs 96004 & 96006)	Inadequate Oversight	IR 96011
10/10/1996	NRC	Plant Support	A licensee radworker performance task force attributed the majority of the events to poor radworker skills, a complicated work process, and ineffective past root cause evaluations. Long term corrective actions were being developed, but short term actions (increased training, tailgate sessions, etc.) have resulted in an improving trend.	Other/NA	IR 96011
10/9/1996	Licensee	Maintenance	ENS CALL: UNIT 2 HPCI DECLARED INOPERABLE. The licensee could not determine if the system was filled and vented. Per TS 3.5.a.3, Unit 2 entered a 14 day LCO. A thorough root cause by engineering staff helped to resolve problems associated with improper venting of the system.	Equipment Malfunction	ENS Call 31122; IR 96014; LER 265-96002

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/30/1996	NRC	Plant Support	The 1A fire pump LCO took several days longer than planned due to poor review and oversight. The 1B pump LCO was planned poorly and never needed to be taken out of service for the work performed. Fire protection LCOs are "administrative" and treated less aggressively than TS LCOs. (9/96)	Inadequate Oversight	RI Observation
9/27/1996	NRC	Plant Support	The NRC identified that the licensee failed to adequately implement all vehicle access control requirements.	Personnel Performance Deficiency	IR 96013; NOV
9/27/1996	NRC	Plant Support	Some material deliveries into protected area were not adequately controlled while unattended. This resulted in a NOV.	Personnel Performance Deficiency	IR 96013; NOV
9/27/1996	NRC	Plant Support	Effective management support activities was evident in equipment upgrades (hand geometry, new security computer), maintaining sufficient resources (experienced and professional personnel), and continuing tactical training and drill activities.	Involved Management	IR 96013
9/23/1996	NRC	Operations	Leaving the Safe Shutdown Makeup Pump in service during a Unit 1 startup in September 1996. Removal would have increased risk factor for both Units.	Conservative Decision	IR 96012
9/23/1996	NRC	Operations	Inspectors identify lack of sensitivity to potential seismic concerns. NCV issued.	Personnel Performance Deficiency	IR 96012 NCV
9/23/1996	Licensee	Operations	Unit 1 operators were noted to have knowledge deficiencies re RCIC condenser drain valve operation during Unit 1 startup.	Personnel Performance Deficiency	IR 96012
9/23/1996	NRC	Maintenance	Inspectors note that several equipment problems which affected startup would have been identified earlier if more thorough post maintenance testing had been performed.	Personnel Performance Deficiency	IR 96012
9/23/1996	Licensee	Engineering	A FW isolation valve experienced spring pack hydraulic lock. The inspectors and the licensee independently identify other important to safety valves with similar spring pack features.	Engineering/Design Deficiency	IR 96012

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/23/1996	Licensee	Engineering	A pressure switch associated with an SRV failed due to heat buildup. Switch lagged because vendor manual warning was not communicated to ladders.	Inadequate Procedure/Instruction	IR 96012
9/23/1996	NRC	Maintenance	During the feedwater regulating isolation valve spring pack repair work in September 1996, the valve engineer was knowledgeable and provided assistance and oversight for the troubleshooting and repair work.	Teamwork/Skill Level	IR 96012
9/23/1996	NRC	Engineering	Inspectors identify that the licensee LLRT program does not include temperature compensation as required by applicable code to which the licensee is committed.	Personnel Performance Deficiency	IR 96012 NCV
9/14/1996	Self-Revealed	Plant Support	Actions taken by radiological protection in response to the spill were good. The licensee had not yet determined how the spill occurred. This is an URI pending review of the licensee's corrective actions and root cause evaluation.	Teamwork/Skill Level	IR 96012; URI
9/10/1996	Self-Revealed	Maintenance	Foreign material plugged a moisture separator drain level control valve. Unit 1 turbine taken off line to clean out the valve.	Personnel Performance Deficiency	IR 96012
9/9/1996	Licensee	Maintenance	Workers failed to implement procedural controls and excavated 13.8 kV line.	Personnel Performance Deficiency	IR 96012
9/8/1996	Self-Revealed	Maintenance	1C RHRSWP experienced 2 gpm seal leakage. 1D RHRSWP decalred inoperable due to hot bearing. VIO issued for RHRSWP worked without quantitative acceptance criteria for seal dimensions.	Personnel Performance Deficiency	IR 96012 NOV
9/7/1996	Self-Revealed	Operations	ENS call. Booster fans for the 'B' train of control room ventilation failed to start. LER 96020	Other/NA	IR 96012; URI
9/7/1996	Self-Revealed	Maintenance	Newly installed U-2 FWRV controller experienced instability/slow response at low power. Vendor modified software. Repeat of problem with U-1 modification.	Personnel Performance Deficiency	OPEN
9/6/1996	Self-Revealed	Operations	High dose rate alarms were received on refueling floor. Crane operator snagged an LPRM in fuel pool due to inattention to detail. LPRM was drawn near fuel pool surface by crane hook.	Personnel Performance Deficiency	OPEN

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/6/1996	Self-Revealed	Operations	Refueling floor crane operator "snagged" an LPRM in the fuel pool due to inattention to detail. The LPRM was brought near the pool surface by the crane hook. High dose rate alarms received on refueling floor.	Personnel Performance Deficiency	RI Observation
9/6/1996	*****	*****	Unit 1 desynchronized to the grid following QIR14 and extended maintenance period.	*****	*****
9/4/1996	Licensee	Maintenance	Main Steam Line Radiation Monitor functional test not performed within frequency established for Technical Specification when in refueling mode due to incomplete documentation of a Technical specification Interpretation	Inadequate Oversight	LER 96019
9/4/1996	Licensee	Operations	ENS call. Licensee entered and exited an NUE based on determination that a TS action statement for RPS surveillances had not been met. Licensee subsequently determined that action statement did not apply. Licensee mis-applied GL 87-09 upon initial identification of apparently missed surveillances. LER 50-254/96018	Inadequate Procedure/Instruction	IR 96012
9/2/1996	Self-Revealed	Maintenance	New MSIV solenoids operate erratically. ASCO representative identifies mismatching of plunger assembly. Mode change required for valve repair. Part 21? VIO issued for lack of quantitative acceptance criteria for MSIV solenoid stem travel.	Equipment Malfunction	IR 96012; NOV
8/27/1996	Self-Revealed	Maintenance	Unit 1 remained at about 140 psig (TS grey area) for several days due to inability to successfully complete RCIC and HPCI overspeed trip tests. Several minor problems with turning gear auto-disengage and barometric condensers complicated evolution.	Personnel Performance Deficiency	IR 96012
8/27/1996	Self-Revealed	Engineering	Exhaust from swing EDG caused ventilation for SBO DG battery and day tank rooms to secure. NRC observed that control room operators responded in a passive manner. Issue turned over to DRS for followup.	Engineering/Design Deficiency	RI Observation

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/26/1996	Licensee	Maintenance	Licensee revised acceptance criteria for RCIC overspeed test. The test required numerous attempts before meeting the success criteria. Factors contributing to the difficulty of passing the established criteria included use of a hand-held tachometer, first time evolution of overhauling the turbine since commercial operation of Unit 1, change in practices of using contract or vendor personnel, and the vendor manual instructions were not clear.	Inadequate Oversight	IR 96012
8/25/1996	Licensee	Engineering	Operators trip U-1 during startup due to rise in indicated water level. Transient caused by BPVs coming open because of nonlinear calibration of EHC at low pressure. LER	Personnel Performance Deficiency	IR 96012
8/25/1996	Self-Revealed	Operations	Unit 2 alternate 125 VDC battery drained due to operators leaving failed trickle charger attached.	Personnel Performance Deficiency	IR 96012
8/23/1996	Licensee	Engineering	ENS call. Licensee retroactively declares secondary containment inoperable due to broken bolts on blow-out panels. Engineering slow to report problem. LER 96016	Engineering/Design Deficiency	IR 96012; URI
8/23/1996	Licensee	Engineering	Licensee's initial screening of degraded secondary containment blow-out panel bolts failed to identify all applicable UFSAR accident analysis requirements.	Personnel Performance Deficiency	IR 96012; URI
8/22/1996	NRC	Plant Support	The overall quality of the station and corporate self assessments, audits and surveillance of the Emergency Preparedness program were excellent in scope and depth.	Involved Management	IR 96008
8/22/1996	Licensee	Engineering	Nine long-standing technical issues were identified and addressed by the licensee (e.g. degraded voltage, cable ampacity, hot shorts, HPCI keep fill line support, and swing EDG rating) during the summer's forced outages. Five of these issues had not been corrected in a timely manner.	Inadequate Oversight	IR 96008
8/22/1996	*****	Plant Support	Overall performance of 1996 EP exercise considered very good.	*****	IR 96011
8/22/1996	NRC	Engineering	Licensee is using an area radiation monitor in lieu of 10 CFR 70.24 required criticality monitor. Licensee attempting to provide technical justification.	Other/NA	IR 96011; URI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/22/1996	Licensee	Engineering	While reviewing the failure of the Unit 2 HPCI discharge check valve to open during testing, licensee determined that installed test mechanisms did not cycle valve flapper through its full movement (30 deg. instead of 75 deg.).	Engineering/Design Deficiency	IR 96011; NCV
8/22/1996	Licensee	Plant Support	Licensee task force concluded that ALARA dose goals were exceeded (950 vs. 700 rem.) due to poor outage planning and work scope growth (not reasonably foreseen).	Inadequate Oversight	IR 96011
8/22/1996	Licensee	Operations	Two operators failed to position a condensate demineralizer drain valve in the required position. Feedwater flow to reactor not significantly affected.	Personnel Performance Deficiency	IR 96011
8/22/1996	Licensee	Engineering	A high energy line break of 6" RWCU piping (Monticello identified scenario) was found to be outside the bounding conditions of the UFSAR. Licensee responding to NRR request for information and description of planned actions.	Engineering/Design Deficiency	IR 96011; URI
8/22/1996	Licensee	Maintenance	A maintenance mechanic started to disassemble a lubricating oiler for the Unit 2 SBDG cooling water pump by mistake. The work package required workers to replace a lubricating oiler on the Unit 1/2 SBDG cooling water pump. Example of NOV for failure to follow procedures. (Initially identified as URI 96008-05)	Personnel Performance Deficiency	NOV 96011-04a
8/22/1996	Licensee	Maintenance	Severe plugging of vessel bottom head drain line results in inaccurate bottom head temperature indication.	Inadequate Oversight	IR 96011
8/22/1996	Licensee	Engineering	Licensee identified that the rupture disk downstream of the 4D code safety relief valve had ruptured. No indication of relief valve lifting of leak-by was found. Condition attributed to DWEDS piping arrangement.	Engineering/Design Deficiency	IR 96011
8/16/1996	Licensee	Engineering	ENS call. Unit 2 HPCI whip pipe restraint determined to have been incapable of restricting applied design loading due to incorrectly installed anchor bolts. Temporary Alteration installed.	Engineering/Design Deficiency	IR 96011; URI
8/15/1996	*****	*****	Unit 2 synchronized to the grid.	*****	*****

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
8/11/1996	Self-Revealed	Maintenance	ENS call. Poor reassembly of HPCI discharge check valve led to excessive leakage (14 gpm) from mechanical joint. HPCI declared inoperable.	Personnel Performance Deficiency	IR 96011
8/9/1996	Licensee	Engineering	Both diesel driven fire water pumps were declared inoperable because of zebra mussel fouling of the inlet strainers. Biocide injection point was downstream of fire water pump suction point in water bay. LER 96013	Engineering/Design Deficiency	IR 96011; URI
8/9/1996	Self-Revealed	Maintenance	1D RHR Service Water Pump experiences bearing failure (seal last worked in 9/93) due to mud in seal. Shaft also found to be incorrectly sized.	Personnel Performance Deficiency	IR 96011
8/9/1996	Licensee	Operations	Operations management discontinued a U-2 startup pending the evaluation of a breaker calibration test device. Electricians identified a disparity between digital and analog readings on the device and were concerned that some safety related breaker's trip setpoints had been set non-conservatively.	Conservative Decision	IR 96011
7/29/1996	Licensee	Maintenance	Licensee identified and resolved problems with safety related battery mounting fixtures. Batteries being grounded by buildup of salt in styrofoam padding.	Engineering/Design Deficiency	RI Observation
7/29/1996	Licensee	Maintenance	Workers miswired power supply breaker for 1A LPCI outboard isolation valve. QA inspectors signed that wiring was correct. Breaker smoked during post maintenance testing.	Personnel Performance Deficiency	IR 96011; NOV
7/12/1996	Licensee	Engineering	Supports for nonsafety-related portions of reactor building ventilation supply ductwork were not installed. This condition placed safety-related portions of ductwork outside UFSAR basis. Condition identified in 1991; modifications made in 1996.	Inadequate Oversight	IR 96008; URI
7/12/1996	NRC	Engineering	Licensee identified that a portion of HPCI keep fill line was not safety-related. Licensee's initial disposition of that condition was satisfactory. Inspectors questioned that conclusion.	Engineering/Design Deficiency	IR 96008; URI
7/12/1996	Licensee	Operations	Operator failed to open one of the suction valves for 2D RHR pump while establishing shutdown cooling flow.	Personnel Performance Deficiency	IR 96008; NCV

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
7/12/1996	NRC	Maintenance	Maintenance activities of U-2 instrument air compressor involved poor work practices and was poorly controlled.	Inadequate Oversight	IR 96008
7/12/1996	Licensee	Engineering	Licensee upgraded EDG fuel oil system to safety-related in 1991. The safety-related portion of the system was supposed to be physically isolated from nonsafety-related fuel oil systems. Licensee failed to take action until 1996. LER 96012.	Inadequate Oversight	IR 96008; URI
7/10/1996	Licensee	Maintenance	Worker removed oiler from wrong EDG cooling water pump (no OOS required).	Personnel Performance Deficiency	IR 96011; NOV
7/8/1996	Licensee	Engineering	ENS call. 107 valves required for Appendix R Safe Shutdown are susceptible to "hot shorts." An earlier opportunity to identify this issue was missed during licensee assessment of IN 92-18.	Engineering/Design Deficiency	IR 96008; URI
7/5/1996	Licensee	Operations	Operator works radiological (non-safety related) ventilation fans without an OOS.	Personnel Performance Deficiency	IR 96011
7/3/1996	Licensee	Operations	Operators failed to identify a condition which rendered the shared emergency diesel generator output breaker inoperable to Unit 1 for a period of three shifts.	Personnel Performance Deficiency	IR 96008; NCV
6/30/1996	NRC	Maintenance	NRC inspectors identify that plant procedures and training applicable to use of compression type fittings do not incorporate all vendor recommended installation instructions.	Inadequate Procedure/Instruction	IR 96008; URI
6/11/1996	Licensee	Engineering	ENS call. Licensee determined that U-1 EDG fuel oil transfer pump was inoperable due to degraded voltage issue.	Engineering/Design Deficiency	OPEN
6/11/1996	Licensee	Engineering	Gallery steel platforms associated with safety-related equipment were inadequate to withstand design basis seismic loading. Licensee originally identified condition in 1978 but never implemented necessary modification. LER 96010. Modification completed in summer 1996.	Engineering/Design Deficiency	IR 96008; URI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
6/7/1996	Self-Revealed	Plant Support	Over 200 rem resulted from emergent engineering issues during the U-1 outage. Specifically: the installation of structural steel supports to the unit 1 and 2 residual heat removal (RHR) systems; increase in Inservice Inspection (ISI) scope due to signs of IGSCC in reactor recirculation (RR) system piping; addition of weld overlays, on RR piping, based on indications of cracking; and additional valve work identified during local leak rate testing. (Unit 1 outage)	Inadequate Oversight	IR 96004
6/4/1996	*****	*****	Senior Management Meeting	*****	*****
6/3/1996	Licensee	Engineering	OLD DESIGN DEFICIENCY DISCOVERED. In reviews for upcoming mod to upgrade cables to safety related buses, the licensee found that incorrect cable lengths were assumed for the Unit 2 emergency diesel generator (EDG) fuel oil transfer pump. The licensee declared the Unit 2 EDG inoperable since 5/92.	Engineering/Design Deficiency	ENS Call
5/29/1996	NRC	Engineering	AFTER NRC INTERVENTION, LICENSEE DISCOVERED REACTOR BLDG OUTER WALL (DAMAGED BY HIGH WINDS 5-10-96) DOES NOT MEET UFSAR DESIGN REQUIREMENTS. Licensee committed to replace siding prior to unit startup.	Other/NA	IR 96006
5/28/1996	Licensee	Maintenance	During post-maintenance testing of residual heat removal service water pump, licensee noted problems with the inboard bearing seal. Maintenance personnel determined that the seal centering clips were not removed and the collar set screws were not tightened as required by the work package. Example of a violation for failure to follow procedure. (Issue first identified as URI 96008-07)	Personnel Performance Deficiency	IR 96011; NOV
5/24/1996	NRC	Engineering	ENS CALL. U2 operated in unanalyzed condition with HPCI turbine discharge vacuum breakers isolated.	Engineering/Design Deficiency	IR 96008
5/23/1996	Licensee	Engineering	ENS CALL. U1 AND U2 LPCI INJECTION VALVES INOPERABLE UNDER DEGRADED VOLTAGE SCENARIOS. The licensee found the condition while preparing mod for MCC 29-2 cable pull. Cable length information in data base used for original voltage calculations was non-conservative. LER 96009	Engineering/Design Deficiency	IR 96008; URI

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/17/1996	Self-Revealed	Maintenance	2A CRD pump exhibits high vibration after only 40 hours of service following complete rebuild. Rotor found to contain incorrect material and incorrect shims.	Personnel Performance Deficiency	IR 96012; IR 96008
5/17/1996	Licensee	Maintenance	ENS CALL. B CR HVAC INOPERABLE. Controlling at 82 degress F vs. required band 70 to 80 degrees F.	Equipment Malfunction	IR 96006
5/16/1996	NRC	Engineering	ENGINEERING TEST DIRECTOR INATTENTIVE DURING TEST IN CONTROL ROOM. During lull in activities inspector found individual apparently asleep. Identified by IDNS inspector.	Personnel Performance Deficiency	IR 96006; IFI
5/12/1996	Licensee	Maintenance	3 of 6 alternate rod insertion soleniod vent valves on U-2 failed to open during testing.	Equipment Malfunction	IR 96006
5/12/1996	Licensee	Maintenance	3 OF 6 ALTERNATIVE ROD INSERTION VENT VALVES FAILED TO OPEI, DURING TESTING ON UNIT 2. Vent valve solenoids replaced. Licensee still performing root cause analysis.	Equipment Malfunction	IR 96006
5/10/1996	Self-Revealed	Plant Support	ENS CALL. ALERT DECLARED DUE TO REACTOR BUILDING DAMAGE AS A RESULT OF HIGH WINDS. 27 emergency sirens without power due to loss of power. Unit 2 shutdown due to degraded secondary continment but able to maintain required - .25 inch d/p. Conservative call by operations.	Other/NA	IR 96006
5/6/1996	Self-Revealed	Operations	CONTRACTOR ELECTRICIAN SHOCKED DUE TO FAILURE TO VERIFY DEAD LEADS AND OPERATOR NOT TAKING BREAKER OUT OF SERVICE PROPERLY.	Personnel Performance Deficiency	IR 96006
5/6/1996	Licensee	Maintenance	UNIT 1 CONTROL ROD DRIVE HEADER VALVE LEAKS DUE TO SEAT DAMAGE. This valve had just been replaced during outage.	Equipment Malfunction	IR 96006
5/6/1996	Self-Revealed	Maintenance	CONTRACTOR ELECTRICIAN SHOCKED DUE TO FAILURE TO VERIFY DEAD LEADS AND OPERATOR NOT TAKING BREAKER OUT OF SERVICE PROPERLY.	Personnel Performance Deficiency	IR 96006
5/1/1996	Self-Revealed	Engineering	3 OF 5 RBCCW TCVs STUCK DUE TO SILT FOULING OF LOW TOLERANCE VALVE INTERVALS. Valves previously replaced by engr due to poor performance.	Personnel Design Deficiency	IR 96006

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
5/1/1996	NRC	Engineering	PREDECISIONAL ENFORCEMENT CONFERENCE REGARDING APPARENT FAILURE TO PROVIDE ADEQUATE DESIGN CONTROLS TO MAINTAIN LPCI CORNER ROOMS' STRUCTURAL STEEL DESIGN MARGINS. The licensee initially identified the failure to meet design requirements in 1991.	Involved Management	IR 96005; IR 96007; APP VIO
5/1/1996	Self-Revealed	Engineering	LEAKING SSPVs CAUSED INABILITY TO RESET UNIT 1 SCRAM SIGNAL. SSPVs were not adequately tested for seating ability prior to installation.	Equipment Malfunction	IR 96006
4/30/1996	Self-Revealed	Maintenance	FIRE IN 1B PIIR ROOM DUE TO INADEQUATE PROTECTION FOR FLammable MATERIAL WHILE TORCH CUTTING. Damage to electrical cables, but fire was put out quickly by fire watch.	Personnel Performance Deficiency	IR 96006
4/29/1996	Self-Revealed	Maintenance	MECHANIC WAS INJURED WHILE INSTALLING REACTOR HEAD BOLTS DUE TO SAFETY DEVICE ON AIR "WRENCH" BEING DISABLED AND WRENCH USED IMPROPERLY.	Personnel Performance Deficiency	IR 96006
4/29/1996	Licensee	Maintenance	REACTOR HEAD SET AND PARTIALLY BOLTED ONE BOLT HOLE OUT OF ALIGNMENT. Technicians improperly aligned head to wrong mark.	Personnel Performance Deficiency	IR 96006; NCV
4/25/1996	NRC	Operations	Operators incorrectly used a procedure change form to perform the "Control Rod Drive Scram Air Header Test." Original test required no fuel in vessel during test. A procedure change form was issued to allow test with fuel in vessel. Violation for change of intent of procedure without adequate review.	Personnel Performance Deficiency	IR 96006; NOV
4/18/1996	Self-Revealed	Operations	One U-2 rod moved in wrong direction due to problem with notch override switch.	Equipment Malfunction	IR 96006
4/17/1996	Licensee	Plant Support	UNAUTHORIZED ACCESS INTO FACILITY BY INDIVIDUAL BY TAILGATING THROUGH ACCESS. Intentional tailgating by contractor employee was caught immediately by security.	Personnel Performance Deficiency	IR 96004
4/10/1996	Licensee	Maintenance	SBLC SQUIB VALVE DID NOT FIRE. FOUND LOOSE WIRE IN CR CABINET. Wire later improperly soldered - problem recurred.	Equipment Malfunction	IR 96004

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
4/10/1996	Licensee	Maintenance	CONTRACTOR HORSEPLAY DURING CRD REBUILD AND INTENTIONAL BYPASS OF RAD MONITOR. RP tech identified, and contractor sent offsite.	Personnel Performance Deficiency	IR 96004
3/24/1996	Licensee	Operations	POOR COMMUNICATIONS RESULTED IN AN EQUIPMENT OPERATOR REMOVING THE BACKUP N2 TO U-1/2 EDG DAMPERS IN LIEU OF THE U-1 BACKUP N2. Operator acknowledged error and quickly corrected. No effect to equipment operability.	Personnel Performance Deficiency	IR 96004
3/20/1996	Licensee	Maintenance	CONTRACTOR EMs ASSEMBLED SWEDGELOK FITTINGS INTO HOKE FITTINGS ON HCUs. EMs not trained on improper practice of mixing matching fittings.	Personnel Performance Deficiency	IR 96004
3/19/1996	Licensee	Maintenance	U-2 HPCI declared inoperable due to apparent problems with auxiliary oil pump. Actual problem was with control room annunciation circuit.	Equipment Malfunction	IR 96004
3/18/1996	Licensee	Maintenance	THE MAIN FEED FROM BUS 19 TO BUS 18/19-5 (LPCI SWING BUS) CAUGHT FIRE. Found bad coil in contactor.	Equipment Malfunction	IR 96004
3/15/1996	Licensee	Operations	ESF ACTUATION DURING OOS. Operator removed wrong fuses in RPS bus; resulted in ESF actuation, RB ventilation stopped, SBTG auto started. All primary containment group III actuated components operated per design.	Personnel Performance Deficiency	IR 96004
3/5/1996	Licensee	Plant Support	SCOTT CO. EMERGENCY SIRENS INOPERABLE DUE TO ERROR MADE BY PERSONNEL IN SCOTT COUNTY IOWA SHERIFF'S OFFICE.	Equipment Malfunction	ENS Call; IR 96004
3/4/1996	Self-Revealed	Maintenance	U-2 CONDENSATE DEMINERALIZER MASTER FLOW CONTROLLER OSCILLATIONS. Resulting pressure changes almost reached low suction pressure trip of condensate booster pump.	Equipment Malfunction	IR 96002; Open
3/4/1996	Self-Revealed	Maintenance	U-2 MAIN TURBINE CONTROL VALVE #2 OSCILLATING. Problem with servo-motor. Power rapidly reduced to < 45%. Turbine offline next day for repairs.	Equipment Malfunction	IR 96002; IR 96004

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Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/4/1996	Self-Revealed	Maintenance	SAFETY RELATED "B" CONTROL ROOM HVAC TRAIN REMOVED FROM SERVICE DUE TO SUPPLY AND EXHAUST DAMPERS FAILED OPEN. Failed relay replaced.	Equipment Malfunction	ENS Call; IR 96002
3/3/1996	Licensee	Operations	Out of Service Error on Shared EDG. During planned maintenance of shared EDG with circuits associated with U-1 EDG, license incorrectly wrote and hung an OOS to remove fuses that would disable the shared EDG overcurrent protection during auto startup from the U-2 EDG circuits.	Personnel Performance Deficiency	IR 96004; NOV
3/3/1996	Licensee	Operations	DURING PLANNED MAINTENANCE ON U-1/2 SBDG CIRCUITS ASSOCIATED WITH U-1, THE OVERCURRENT PROTECTION RELAY FUSES FOR THE U-1/2 SBDG WERE REMOVED PER THE OOS INSTRUCTIONS. The OOS stated that removing the fuses would disable the U-1/2 overcurrent protection during an auto startup from U-2 circuits. The U-1/2 SBDG would not have auto started and loaded to Unit 2.	Personnel Performance Deficiency	IR 96002; Open
2/28/1996	Self-Revealed	Maintenance	U-1/2 SBDG INOPERABLE DUE TO FAILED BREAKER FOR OIL CIRCULATING PUMP AND FAILED LUBE OIL HEATER.	Equipment Malfunction	IR 96002; Open
2/25/1996	Licensee	Maintenance	B-TRAIN OF CONTROL ROOM VENTILATION SYSTEM INOPERABLE DUE TO LOW REFRIGERANT PRESSURE. Problem due to valve seat leaks inhibiting freon from collecting in condensor after operating service water system. Identified during operator rounds.	Equipment Malfunction	ENS Call ; IR 96002; LER 96011
2/24/1996	Licensee	Engineering	CRACK (6 - 8 inch) NEAR THERMAL SLEEVE ON U-1A CORE SPRAY PIPING BETWEEN THE CORE SHROUD AND THE REACTOR VESSEL.	Equipment Malfunction	RI Observation
2/22/1996	Self-Revealed	Maintenance	U-1 STANDBY DIESEL GENERATOR (SBDG) INADVERTANT STARTUP DURING OVERSPEED TESTING. After test, overspeed signal reset with local startup switch was in "start" position.	Inadequate Procedure/Instruction	ENS Call; IR 96002; LER 50-254/96003

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/21/1996	Licensee	Engineering	PROCEDURE DEFICIENT FOR SAFETY RELATED "B" CONTROL ROOM HVAC. If LOOP/LOCA occurred, no control room emergency ventilation system booster fan to maintain positive pressure in control room. Procedures modified to remove relay to ensure booster fan starts. LER 96002	Engineering/Design Deficiency	ENS Call; IR 96002
2/10/1996	Licensee	Operations	MULTIPLE, INTENTIONAL BRIEF VIOLATIONS OF CONTAINMENT INTEGRITY AND VOLUNTARY ENTRIES INTO TS 3.0.A FOR LEAK RATE TESTING TORUS ISOLATION VALVES. Indications of weak operations mgmt oversight/sensitivity of primary containment function and weak knowledge of 3.0.A administrative requirements.	Inadequate Oversight	IR 96002; URI; NOV; Open
2/10/1996	*****	*****	STARTED U-1 REFUEL OUTAGE Q1R14 (SCHEDULED FOR 77 DAYS)	*****	*****
2/7/1996	Self-Revealed	Maintenance	U-1 LOAD REDUCED DUE TO 3/4 INCH RELIEF VALVE LIFTING IN LOW PRESSURE FEEDWATER HEATER STRING. Valve gagged shut. Heater string bypassed. Condition corrected during Q1R14.	Equipment Malfunction	IR 96002; Open
2/6/1996	Self-Revealed	Maintenance	U-1 HIGH PRESSURE COOLANT INJECTION (HPCI) GLAND SEAL CONDENSER EXHAUSTER TRIPPED DURING SURVEILLANCE. Defective circuit breaker.	Equipment Malfunction	IR 96002; Open
2/3/1996	Licensee	Operations	SAFETY RELATED "B" HVAC SYSTEM INOPERABLE DUE TO EXTREME COLD TEMPERATURE (-28 DEG F). 14 day LCO exited later in day. New technical specifications will eliminate exterior temperature requirement.	Engineering/Design Deficiency	ENS Call; IR 96002; Open
1/30/1996	Self-Revealed	Maintenance	U-1 HPCI INOPERABLE DUE TO AUX. OIL PUMP CYCLING ON & OFF DURING SURVEILLANCE. Problems due to coordination of pressure switch setpoint and relief valve setpoint.	Equipment Malfunction	ENS Call; IR 96002; Open
1/29/1996	Licensee	Engineering	U-2 SBDG INOPERABLE DUE TO FUEL OIL TRANSFER DRIFTING PRESSURE SWITCH SYSTEM CHECK VALVE. Missing personnel failing to adequately track surveillance tests.	Personnel Performance Deficiency	IR 96002; Open

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/24/1996	Licensee	Operations	CHEMICAL RELEASE (SODIUM BISULFITE) INTO MISSISSIPPI RIVER DUE TO CHEMISTRY TECHNICIAN DISTRACTED FROM CHEMICAL INJECTION SECURING SEQUENCE/PROCEDURE.	Personnel Performance Deficiency	ENS Call; IR 96002; Open
1/23/1996	Self-Revealed	Maintenance	BOTH UNITS COMMENCED DOWNPOWER (0835) DUE TO INADEQUATE LEVEL IN CIRCULATING WATER FOREBAY. Inlet trash rake clogged with debris from Mississippi river. Trash rake broken. Both diesel fire pumps inoperable due to inadequate forebay level (less than 568'6"). The RHRSW & SBDG cooling water pumps need 566'3". Downpower stopped at 1115 when debris removed from trash racks.	Equipment Malfunction	ENS Call; IR 96002; Open
1/22/1996	Licensee	Maintenance	THE "B" CONTROL ROOM HVAC SYSTEM CHILLER HEAD HEAT EXCHANGER (HX) IMPROPERLY INSTALLED YEARS AGO. Identified by maintenance and corrected. Heat exchanger efficiency reduced but not inoperable.	Personnel Performance Deficiency	IR 96002; Open
1/15/1996	Licensee	Engineering	COMPUTER ROOM IN AUXILIARY BUILDING EXCEEDED MAXIMUM DESIGN BASIS FOR FIRE LOADING DUE TO SLICE ELECTRICAL DATA BASE IMPROPERLY CHARACTERIZING CABLE LENGTH AND CABLES UNDER FLOOR NOT ACCOUNTED FOR.	Engineering/Design Deficiency	ENS Call; IR 95010; URI
1/10/1996	Licensee	Maintenance	CUT ON BOTTOM GASKET OF ELEMENT IN THE 2G CONDENSATE DEMINERALIZER. Result was high d/p on post strainer and removal from service. This is a continuing problem for operators.	Personnel Performance Deficiency	IR 95010
1/4/1996	Self-Revealed	Maintenance	SHARED "A" DIESEL FIRE PUMP TRIPPED ON OVERSPEED DUE TO OILY RESIDUE ON MAGNETIC PICKUP IN CONTROLLER.	Equipment Malfunction	IR 95010
1/3/1996	Self-Revealed	Maintenance	LEAK OF 2A MOISTURE SEPARATOR DRAIN TANK LEVEL INSTRUMENT PIPING DUE TO CORROSION OF DEGRADATION OF FLEXIBLE PIPE. Reduced power to 25% replace flex pipe.	Equipment Malfunction	IR 95010

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/1/1996	Self-Revealed	Maintenance	U-1 MAIN GENERATOR TRANSFORMER COOLING FAN TRIPPED. Forced load reduction to troubleshoot and repair. If 1 fan trips, entire group of 6 fans trip. Breaker tripping coordination problem. Occurred summer 1995 too. Problem not yet resolved - need mod to replace molded case circuit breakers.	Equipment Malfunction	IR 95010
1/1/1996	NRC	Engineering	U-2 RCIC TRIP THROTTLE VALVE CORRECTIVE ACTIONS WERE NOT PERFORMED AS PLANNED BY OPERATIONS FOR A PREVIOUS EVENT.	Inadequate Oversight	IR 95010
12/31/1995	Self-Revealed	Maintenance	Loss of control room annunciator audible alarms due to a computer failure (a condition repeated several times in 1995).	Equipment Malfunction	IR 95010; RI Observation
12/28/1995	Self-Revealed	Maintenance	U-2 stator water cooling temperature control valve failed. Controlling manually.	Equipment Malfunction	IR 95010
12/23/1995	Licensee	Maintenance	U-1 power reduced to repair an air leak to IC2 feedwater heater level control valve.	Equipment Malfunction	IR 95010
12/22/1995	Licensee	Operations	Inadvertant start of residual heat removal (RHR) pump. PIF written that described unexplained RHR system alarms when RHR service water (SW) pump started during surveillance. Investigation determined RHR pump was actually started.	Personnel Performance Deficiency	IR 96002; IR 96012; NCV
12/20/1995	Licensee	Operations	U-2 RHRSW to safety related control room chillers isolated for about 1.5 years. Check valves did not pass enough flow, so licensee isolated RHRSW. Additionally, no controls or restrictions put on U-1 RHRSW to insure a supply to chillers.	Inadequate Oversight	IR 95010
12/19/1995	NRC	Engineering	U-1 HPCI solenoid valve on air operated valve (AOV) drain valve (I-2301-28) for steam line inlet drain pot not oriented correctly. Seismic qualification questionable in that orientation.	Personnel Performance Deficiency	IR 95010; NOV; LER 95009
12/12/1995	Licensee	Operations	Operator opened the IC RHRSW pump discharge valve past limits in operating procedure. The valve seat guide was broken.	Personnel Performance Deficiency	IR 95010

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/7/1995	Licensee	Maintenance	Mechanics damaged pump impeller to 1C RHRSW pump during maintenance.	Personnel Performance Deficiency	IR 95009
12/6/1995	Self-Revealed	Maintenance	U-1 HPCI steam inlet supply valve failed inservice testing (IST) during routine surveillance. Opened too slow.	Equipment Malfunction	IR 95009; LER 95008
12/5/1995	Self-Revealed	Maintenance	Loss of ENS phones.	Equipment Malfunction	ENS Call; IR 95009
11/30/1995	Self-Revealed	Maintenance	U-2 HPCI failed during surveillance. Discharge flow & pressure oscillations.	Equipment Malfunction	ENS Call; IR 95009
11/29/1995	Self-Revealed	Maintenance	U-2 shut down due to electro-hydraulic control (EHC) leak on supply line to #1 turbine control valve (TCV). Leak repaired & U-2 restarted.	Equipment Malfunction	ENS Call; IR 95009
11/23/1995	*****	*****	U-2 STARTUP AND MAIN GENERATOR SYNCHRONIZED TO GRID	*****	*****
11/22/1995	Self-Revealed	Operations	U-2 startup activities problems: i) reactor operator (RO) mispositioned a switch on nuclear instruments (IRM); result was a half-scam signal. Self-check error. ii) Operators improperly marked required steps as N/A and entered procedure at wrong step. Result was the generator trip during startup.	Personnel Performance Deficiency	IR 95009
11/19/1995	Self-Revealed	Maintenance	U-2 SBDG inoperable due to slow startup during surveillance (11/19 & 11/20/95).	Equipment Malfunction	IR 95009
11/16/1995	Licensee	Maintenance	Steam leaks in U-1 heater bay. Leaks on 1C1 & 1C2 heater vent piping. Flow Accelerated Corrosion (FAC) engineers not informed.	Equipment Malfunction	IR 95009
11/14/1995	Licensee	Engineering	Nuclear engineers developed wrong rod pull sheets. Poor review of new software implementation. Rod worth minimizer (RWM) prevented rod movement.	Personnel Performance Deficiency	IR 95009
11/13/1995	*****	*****	U-1 STARTUP AND GENERATOR SYNCHRONIZED TO GRID	*****	*****

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/13/1995	NRC	Maintenance	Steam leak in U-1 heater bay on 2 inch line. Two inch or less had been identified by FAC program as susceptible to corrosion in 9/95. Unit 1 refueling outage 14 (Q1R14) had not included plans to inspect any of the piping 2 inches or smaller that were susceptible and not modelled. Also, offgas loop seals blown again. The drain from 1B moisture separator not working. Charcoal beds got wet, but operable.	Inadequate Oversight	IR 95009
11/9/1995	Self-Revealed	Maintenance	U-1 start up. Main steam line drain valve (220-1) packing leak identified during startup. U-1 shut down next day.	Equipment Malfunction	IR 95009
11/4/1995	Self-Revealed	Maintenance	U-1/2 SEDG failed to start on surveillance. Time delay relay in protection circuit failed.	Equipment Malfunction	IR 95009; IF1
11/3/1995	Self-Revealed	Maintenance	U-2 SBDG operable. Air starting motors were identified as the root cause of the U-2 SBDG starting problems from 8/95 to 10/95.	Other/NA	IR 95009; URI
11/3/1995	Self-Revealed	Maintenance	U-1 C & D inboard main steam isolation valves (MSIV) failed to close on spring press alone during "fail safe" testing. Replaced valve stem packing; valves passed.	Equipment Malfunction	IR 95009
11/1/1995	Licensee	Maintenance	Shared instrument air compressor placed on limited service due to increased vibration and temperature indications.	Equipment Malfunction	IR 95009
11/1/1995	NRC	Maintenance	Boron deposits on U-2 standby liquid control (SBLC) relief valves. Heat trace elements for U-2 SBLC not set at the appropriate temperatures.	Personnel Performance Deficiency	IR 95009
11/1/1995	Licensee	Maintenance	U-1 "1E" drywell cooler power supply cable experienced a high current condition. Cable replaced.	Equipment Malfunction	IR 95009

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/1/1995	NRC	Maintenance	Numerous examples of scram valve limit switches not properly aligned. Many previously identified and not corrected; some were recently identified. The limit switches provided scram valve position indication to control room operators. Did not affect of the operability of the scram valves.	Personnel Performance Deficiency	IR 95009
			Hydraulic control unit (HCU) directional control valve solenoids interfered with scram inlet valve stroking.		
11/1/1995	NRC	Maintenance	Water leaking on to a 13.8 kV transformer and on top of the U-1 SBDG output junction box in the turbine building after a heavy rain. Similar leaks found in the turbine building previously. The licensee corrected the immediate issue when informed, but not the overall problem.	Equipment Malfunction	IR 95009
11/1/1995	Self-Revealed	Engineering	U-2 SBDG ventilation fan tripped due to undersized thermal overloads. Overloads replaced with higher rated overloads.	Engineering/Design Deficiency	IR 95009
11/1/1995	Self-Revealed	Maintenance	Clogged drain on U-1 offgas moisture separator resulted in moisture carryover into the absorber beds.	Equipment Malfunction	IR 95009
10/31/1995	NRC	Operation	Interim administrative control to prevent overloading safety bus feeder breakers not implemented.	Inadequate Procedure/Instruction	IR 95009
10/26/1995	Self-Revealed	Maintenance	Smoke from motor control center (MCC) 28-2 feeder breaker to hydrogen seal oil current transformer.	Equipment Malfunction	RI Observation
10/25/1995	Self-Revealed	Maintenance	U-2 "2G" drywell cooler fan blade failure. Destroyed ventilation ductwork and cooling water (RBCCW) piping. SRI tour in drywell noted cooler was still leaking even after isolated. High nitrites in torus from leak.	Equipment Malfunction	IR 95009
10/24/1995	Self-Revealed	Maintenance	U-2 SBDG failed to start on monthly routine surveillance test. Root cause attributed to air start motor degradation. Root cause evaluation was better, but had not identified performance criteria for air start motors.	Equipment Malfunction	IR 95009

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Quad Cities

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/23/1995	Self-Revealed	Plant Support	Rock Island sirens inoperable due to lightning damage. Same cause as Whiteside City in 9/95. Emergency planning was not aware if corrective actions were being taken to fix root cause.	Other/NA	ENS Call; IR 95009
10/23/1995	Licensee	Maintenance	Licensee stopped all but essential maintenance activities to re-evaluate the work control process.	Other/NA	IR 95009
10/22/1995	Licensee	Engineering	U-1 & 2 susceptible to a single failure in the scram logic for the scram discharge instrument volume. BOTH UNITS were SHUT DOWN since the identified condition was outside the plant's design basis. Problem first identified at Dresden U-2.	Engineering/Design Deficiency	IR 95009; NCV; LER 95007
10/21/1995	Self-Revealed	Maintenance	U-2 EHC leak on #1 TCV and the turbine was taken off-line for repair. During the recent refuel outage, new fittings from GE were installed as part of a modification.	Equipment Malfunction	IR 95009
10/20/1995	Licensee	Maintenance	Maintenance personnel identify oil leak into service water side of U-1 reactor recirculation motor generator (MG) set HX.	Equipment Malfunction	IR 95009
10/18/1995	Self-Revealed	Maintenance	U-2 HPCI failure during surveillance due to oscillations with pressure, turbine speed, and flow. Minor flow oscillations had been occurring since the last refueling outage. ADDITIONALLY, inlet drain pot high level alarm stayed in after start. Drain valve AOV 2-2301-28 did not open.	Equipment Malfunction	IR 95009; IFI; LER 95008
10/17/1995	Licensee	Maintenance	Licensee identified brittle wires to U-1 SBDG time delay relays.	Equipment Malfunction	RI Observation
10/16/1995	Self-Revealed	Maintenance	Unit 2 primary containment isolation AOVs (2-220-44 and -45) failed to close and failed the local leak rate test.	Equipment Malfunction	IR 95009; IFI; LER 95008
10/12/1995	Self-Revealed	Maintenance	U-2 "C" condensate booster pump outboard bearing running hot due to improper installation of seal.	Personnel Performance Deficiency	RI Observation
10/5/1995	Licensee	Maintenance	U-2 power reduced to repair TCV and turbine bypass valve (TBV) components.	Equipment Malfunction	IR 95007

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/4/1995	Self-Revealed	Engineering	480 Vac U-2 MCC (29-2) tripped on overload during routine operations. Normal loads exceeded 300 amp rating. Emergency loads also exceeded breaker ratings on some of the other safety MCCs. Similar event at Dresden in 1994. Quad only addressed one MCC (28-2). Quad had data to indicate problem on MCC 29-2.	Engineering/Design Deficiency	IR 95007; NOV III; LER 95006
10/4/1995	Self-Revealed	Maintenance	U-2 HPCI inoperable due to not going on turning gear. No root cause identified.	Equipment Malfunction	IR 95007
10/1/1995	Self-Revealed	Maintenance	U-2 TCV #2 continued to oscillate.	Equipment Malfunction	IR 95007
10/1/1995	Licensee	Engineering	Four U-1 motor operated valves (MOV) susceptible to cracked motor-rotors due to IGSCC. Motors replaced. One of the four indicated potential cracked rotor during diagnostic testing.	Equipment Malfunction	IR 95007
10/1/1995	Licensee	Maintenance	U-2 CRD cart elevator malfunctioned during replacement of CRD K-7. Result was workers receiving extra dose (Oct/Nov 1995).	Equipment Malfunction	IR 95009
9/29/1995	Self-Revealed	Maintenance	U-2 TCV #2 began oscillating.	Equipment Malfunction	IR 95007
9/29/1995	Licensee	Maintenance	Craft performing acid etching in the SBO building used too high a concentration of muriatic acid and damaged exposed copper conductors. U-1 SBO battery charger trip. Damage to both units.	Personnel Performance Deficiency	IR 95007; IFI
9/26/1995	Self-Revealed	Maintenance	U-2 SBDG failed to start during routine surveillance. Licensee attributed cause to fuel oil priming pump. Poor root cause evaluation.	Equipment Malfunction	IR 95007; URI
9/18/1995	Self-Revealed	Maintenance	U-2 reactor core isolation cooling (RCIC) inoperable following routine surveillance run due to over pressure in suction piping. Leaking isolation valves.	Equipment Malfunction	IR 95007
9/12/1995	Self-Revealed	Plant Support	Sirens in Whiteside City inoperable due to lightning damage to radio control unit.	Other/NA	ENS Call; IR 95007
9/4/1995	Self-Revealed	Engineering	U-1 HPCI inoperable due to slow stroke times on three AOVs. Engineering evaluated the stroke increase as acceptable.	Equipment Malfunction	IR 95007

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
9/2/1995	*****	*****	U-2 STARTUP	*****	*****
8/28/1995	Licensee	Operations	U-2 SBDG started slower than "usual." Identified by operators. Licensee review of issue was shallow.	Equipment Malfunction	IR 95009
8/25/1995	Self-Revealed	Maintenance	U-2 trip from 60% power while testing pressure regulator in EHC system. Identified off-set problem in modification implemented per GE service information letter (SIL).	Engineering/Design Deficiency	IR 95006; IFI; LER 95005
8/18/1995	Self-Revealed	Maintenance	U-1 reactor recirculation pump speed increased unexpectedly resulting in a momentary power level above 102.5 %.	Equipment Malfunction	ENS Call; IR 95006
8/17/1995	*****	*****	U-2 STARTUP	*****	*****
8/16/1995	Licensee	Plant Support	Installation of hand geometry and protected area land vehicle protective systems.	Other/NA	IR 95009
8/12/1995	Licensee	Maintenance	Control room chiller compressor failed due to freon leak. Hole at a sil-brazed joint.	Equipment Malfunction	ENS Call; IR 95006
8/12/1995	Self-Revealed	Maintenance	U-2 turbine taken off line and reactor shutdown to repair a leak in the EHC system and repair relief valve seat leakage.	Equipment Malfunction	IR 95006
8/6/1995	Self-Revealed	Operations	High reactor water level transient during feedwater regulating valve testing. Operators failed to scram U-2 when a previously discussed parameter exceeded the trip criteria.	Personnel Performance Deficiency	IR 95006
8/5/1995	*****	*****	U-2 GENERATOR SYNCHRONIZED TO GRID	*****	*****
8/2/1995	*****	*****	U-2 STARTUP	*****	*****
7/31/1995	Self-Revealed	Maintenance	U-2 shutdown during startup due to TBV oscillations. The GE SIL was installed during maintenance without a proper review prior to its incorporation into the plant.	Personnel Performance Deficiency	IR 95006
7/29/1995	Self-Revealed	Maintenance	U-2 shut down due to TBV oscillations.	Equipment Malfunction	IR 95006
7/27/1995	*****	*****	U-2 STARTUP AFTER VACUUM PRESSURE SWITCH AND TBV REPAIRS	*****	*****

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DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
7/26/1995	Licensee	Maintenance	All four U-2 condenser vacuum pressure switches were out of TS tolerance. Pressure switches replaced during outage due to problems with drift. New switches also prone to drift. Licensee changed setpoint and increased calibration frequency.	Personnel Performance Deficiency	ENS Call; IR 95006
7/26/1995	Self-Revealed	Maintenance	U-2 shutdown due to TBV oscillations.	Equipment Malfunction	IR 95006
7/24/1995	Self-Revealed	Maintenance	U-2 reactor recirculation pump speed increase due to test equipment problems. Power increased about 5 %.	Equipment Malfunction	IR 95006
7/22/1995	*****	*****	SALP 12 ENDED (12/26/93 - 7/22/95).	*****	*****
7/20/1995	*****	*****	U-2 STARTUP AFTER Q2R13 COMPLETED.	*****	*****

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/23/97	Licensee	OPS	Licensee announced delay in planned restart until Spring 1998. Delay attributed to not receiving requested budget allocation. As a result, the licensee layed-off a significant number of contractors. The licensee also de-unitized the organizational structure to free up additional resources.	-----	-----
04/14/97	NRC	OPS	CAL supplement issued to include specific commitments by the licensee to address human performance problems in operations, material condition issues affecting startup, and deficiencies in engineering support to operations that have been identified by the NRC and licensee.	-----	-----
03/21/97	NRC	OPS	The licensee failed on May 23, 1996, to notify the NRC of the permanent reassignment of a licensed individual to a position which did not require a license. The inspectors also identified that the status of licenses could not be readily verified by the shift manager, informal communications were used to inform site personnel of changes in license status, and lists used to control licenses were inaccurate. No instances were identified where an operator inappropriately assumed a licensed position.	programmatic	IR97003
03/21/97	NRC	MAINT	Work instructions for inspecting the steam tunnel check dampers did not contain appropriate qualitative or quantitative acceptance criteria.	procedure	IR97003

A/1

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
03/21/97	NRC	PS	Inspectors observed poor housekeeping due to work activities in several high radiation and high contamination areas including reactor water cleanup heat exchanger and filter/demineralizer rooms, radwaste tunnels, and radioactive waste storage areas.	human performance	IR97003
03/21/97	Licensee	ENGR	Failure to perform IST testing of RHR containment spray isolation valves in correct direction (safety function) required by ASME code during two surveillance intervals. Incorrect revision to procedure following earlier recognition that safety function of valves was in opposite direction.	procedure	IR 97003
03/21/97	NRC	MAINT	EDG testing in accordance with a maintenance procedure was delayed when operators identified that the procedure had not been revised to reflect changes in an operating surveillance procedure and because of equipment nomenclature deficiencies.	procedure	IR97003
03/13/97	Licensee	OPS	Due to significant weaknesses in command and control, communications, and control panel awareness demonstrated during licensee simulator evaluations, licensee management suspended several licensed ROs and SROs from licensed duties pending remediation training.	human performance	PNs
03/05/97	----	----	Licensee implemented unitized organizational structure.	-----	-----
03/03/97	NRC	OPS	During testing of the 2A EDG, the nuclear station operator failed to follow procedure by recording the time that the EDG reached rated load instead of the time that the EDG output breaker was closed.	human performance	IR97003

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
03/01/97	NRC	OPS	A surveillance procedure contained incorrect acceptance criteria (contrary to statements in the UFSAR) for lake level. An Unusual Event was declared after the licensee identified that lake level had been allowed to rise above the level of flood protection barriers in the plant.	procedure	IR97003
03/01/97	NRC	OPS	Poor material condition of the lake make-up and blowdown system contributed to an Unusual Event. Operators had been reluctant to secure the cooling lake makeup pumps knowing the difficulty involved in restarting the pumps, thus allowing lake level to rise. After identifying lake level above plant flood barrier design limits, draining the lake was delayed due to a blowdown valve that had been broken for some time and had a history of frequent repairs.	material condition	IR97003
02/28/97	NRC	PS	Chemistry housekeeping was generally good and technicians used good sampling techniques and radiation protection practices.	+	IR97005
02/28/97	NRC	PS	Reactor water chemistry was effectively controlled and the analytical capability of the laboratory was good, with sampling and analytical equipment well maintained.	+	IR97005
02/28/97	NRC	PS	Although chemistry department self-assessments were causing the licensee to address problems in procedural adherence and interdepartmental communications, site quality verification reviews and audits did not identify similar problems.	human performance	IR97005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/28/97	NRC	PS	Effluent activity released and associated dose were appropriately calculated and the effluent monitoring instrumentation, with the possible exception of the wide range gas monitor, was well maintained. Inspectors found no problems with calculated releases. Gaseous and liquid effluent monitors were in good operating condition, within calibration, and had appropriate setpoints. A number of recent minor problems with wide range gas monitors resulted in a lack of confidence in the reliability of the monitors.	+	IR97005
02/28/97	NRC	OPS	The licensee failed to perform required testing of the 1A residual heat removal (RHR) pump shutdown cooling suction valve, 1E12-F006A, within the required test interval. Operations personnel lacked attention to detail when reviewing the surveillance procedures.	human performance	IR97003
02/27/97	NRC	OPS	The "0" EDG was tested at rated load for 56 minutes, four minutes less than the 60 minutes operating time required by the procedure.	human performance	IR97003
02/26/97	NRC	MAINT	Two equipment deficiencies were identified by the inspectors and the licensee during the EDG 1A testing. Rework of the jacket water cooling heat exchanger, service water flange gasket which had been replaced while the diesel generator was out-of-service, resulted from inadequate maintenance practices. In addition, the licensee identified that inappropriately sized fuses had been installed in the EDG ventilation exhaust damper control circuitry.	human performance	IR97003

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/25/97	Licensee	MAINT	Required surveillance testing of the Unit 1 RHR pump 1A discharge high/low pressure switch was not performed within the required time interval because a work control scheduler failed to follow the scheduling procedure.	human performance	IR97003
02/23/97	NRC	PS	A radiation protection technician did not ensure reasonable efforts were made to prevent the spread of contamination from the contaminated areas in the Unit 1 "A" and "B" heater drain pump rooms prior to releasing them for use. No controls were in place to prevent ground water from flowing from the posted contaminated areas to adjacent clean areas.	human performance	IR97005
02/23/97	NRC	PS	Hoses and ropes in the radioactive waste building and Unit 1 "A" heater drain pump room breached a contaminated area boundary without being taped or tied securely where they exited the area.	human performance	IR97005
02/23/97	NRC	PS	The boundaries of two sample sinks in the chemistry laboratory that were posted as potentially contaminated areas did not have the contaminated area boundaries delineated by rope or tape.	human performance	IR97005
02/23/97	NRC	PS	Inspectors observed poor housekeeping due to work activities in several high radiation and high contamination areas including reactor water cleanup heat exchanger and filter/demineralizer rooms, radwaste tunnels, and radioactive waste storage areas.	human performance	IR97005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/23/97	Licensee	PS	Several material condition problems involving liquid radwaste processing equipment including leaking bottles of sulfuric acid, significant corrosion of an acid day tank, and a number of radwaste control panel deficiencies. The licensee was developing a plan to address radwaste material condition problems.	material condition	IR97005
02/21/97	Licensee	ENGR	The licensee did not test the start of the control room and auxiliary electric equipment room ventilation system fans during diesel generator LOCA load sequence testing due to a mis-interpretation of the term "auto-connected loads" in TS.	human performance	LER 97006
02/20/97	Licensee	ENGR	Operating procedures did not ensure that a drywell floor bypass path was not created or that over-pressurization of the standby gas treatment system would not occur during a LOCA with containment venting in progress.	procedure	LER 97005
02/20/97	NRC	MAINT	Due to a non-conservative test methodology, calibration procedures for the rod block monitor did not ensure that the monitor would be enabled before reaching 30 percent power.	procedure	LER 97008
02/14/97	Licensee	ENGR	Testing involving air flow measurements for the main control room (CR) and auxiliary electric equipment room (AEER) ventilation system was not conducted in accordance with the methodology prescribed in the TS.	procedure	LER 97004
02/12/97	Licensee	ENGR	A lake blowdown flow instrument (used for liquid radwaste discharges) had been replaced in 1994 with inadequate design controls.	programmatic	IR97003

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/11/97	NRC	OPS	The inspectors observed an operator removing a breaker from service without having the required procedure available at the work location. This was an additional example of the violation issued in NRC Inspection Report 96018 for failing to follow procedures (50-373/97018-02; 50-374/97018-02). The inspection also revealed that operators did not know the expectation regarding the use of "reference use" procedures.	human performance	IR97003
02/08/97	Licensee	MAINT	Licensee management stopped work associated with the General Electric SBM (switchboard, miniature) switch replacement project. Noted problems included inconsistent work methods, testing procedure problems, and receipt inspection deficiencies. Although this was considered an appropriate action, the deficiencies that resulted in the stop work order indicated that previously identified weaknesses within the licensee's maintenance processes continued to exist.	programmatic	IR97003
02/06/97	NRC	OPS	A control room operator and unit supervisor were unaware of actions implemented during an RHR surveillance and did not expect resulting alarm that was received. A control room operator was also not aware of the RHR configuration and its basis when questioned by an inspector.	human performance	IR96020
02/06/97	NRC	OPS	Performance of a non-licensed operator did not meet licensee management expectations during a shift briefing. The operator was unable to communicate work priorities, equipment status, or problems to be resolved.	human performance	IR96020

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/06/97	NRC	MAINT	Over-pressurization of waterleg pump discharge piping on HPCS narrowly averted by operator action when equipment failed during a surveillance.	material condition	IR96020
02/06/97	NRC	MAINT	RHR pump inservice test surveillance procedure did not ensure repeatable reference flow rate was used as required by the ASME code.	procedure	IR96020
02/04/97	Licensee	ALL	Corrective actions to address work control process deficiencies and specific equipment problems continue to be weak. The Site Quality Verification organization has had a Corrective Action Request open on the ineffective corrective action program since late 1993 and the licensee has not demonstrated the ability to fix the problem.	programmatic	IR96020
02/04/97	NRC	PS	Site quality verification personnel were effective in actively pursuing the occurrence of an improperly disabled fire door, successfully using this event to demonstrate continued programmatic deficiencies with the work control process, and ensuring broader licensee corrective actions.	programmatic	IR96020
02/03/97	NRC	ENG	Station minor modifications performed on components and system using Nuclear Design Information Transmittal forms rather than the process defined in administrative procedures. Some did not have written safety evaluation screenings required by the administrative procedures. Examples included EDG flange bolts, shutdown panel brackets, and control room sealing.	programmatic	IR96019

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/03/97	NRC	ENG	Site appendix for nuclear design information transmittal procedure did not receive onsite review in accordance with administrative procedures.	procedure	IR96019
02/02/97	Licensee	ENGR	Potential unanalyzed condition due to opening doors to filter housings to CR/AEER refrigeration unit condensing coils to melt snow accumulation.	design control	LER 97002
02/01/97	Self-disclosing	OPS	A non-licensed operator failed to follow a fire protection surveillance procedure, resulting in a deluge of an unit auxiliary transformer.	human performance	IR96020
01/31/97	Licensee	OPS	An uncontrolled waste sludge tank level increase was caused by an poor operator self-checking when he missed a page in the procedure.	human performance	IR96020
01/27/97	NRC	All	LaSalle placed on NRC watch list and letter issued to ComEd pursuant to 10 CFR 50.54(f).	-----	-----
01/22/97	NRC	OPS	During interviews some operators stated that they did not have confidence in the ability of the licensee's formal problem identification and resolution process to fix identified problems. As a result, these operators did not use the process.	programmatic	IR96020
01/21/97	NRC	OPS	Operator failed to install and tighten bolts that helped secure cubicle doors to Division 3 switchgear frames, contrary to procedure.	human performance	IR96020

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/17/97	NRC	PS	Conduct of security activities was professional with marked improvements in: communications among all levels of the security organization, definition of roles and responsibilities of staff members, reduction of administrative and other duties that distracted supervisors, and procedure development. Senior site security management involvement was good. However, spirit of teamwork continued to be lacking.	+	IR97002
01/17/97	NRC	PS	Non-cited violation issued involving an unescorted visitor in the protected area for approximately one hour.	human performance	IR97002
01/17/97	NRC	PS	Security staff identified an increase in the number of security doors left unsecured after use and responded promptly and effectively in conducting a root cause analysis of these events.	+	IR97002
01/17/97	NRC	PS	Audit requirements of the security plan were met. Audits performed in September and November 1996 were effective in addressing and evaluating the security program.	+	IR97002
01/17/97	NRC	PS	Security staffing was adequate. Key personnel changes were made in top management positions since the previous security inspection.	+	IR97002
01/15/97	Licensee	ENGR	Crack indications identified on two Unit 2 jet pump risers.	material condition	RIs
01/13/97	Licensee	ENGR	Control room radiation monitor logic doesn't meet single failure criteria due to inadequate evaluation during 7/93 modification to prevent spurious actuations.	design control	IR96020

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/08/97	Licensee	ENGR	Loose parts monitoring system has been inoperable since 1985 when the automatic recorder was removed, contrary to the SER, after it failed	design control	LER 97001
12/30/96	Self-disclosing	MAINT	25 gallon oil spill near screen house due to poor material condition of rented air compressors being used to sparge air into plant intake to prevent ice buildup on racks.	material condition	ENS Call
12/27/96	NRC	OPS	A control room operator was not using the most current revision of a procedure attachment to record surveillance test data.	human performance and programmatic	IR96020
12/27/96	NRC	OPS	Operator removed the wrong breaker from service while isolating a battery charger for maintenance. Operator failed to question a discrepancy between the OOS and the plant labeling.	human performance	IR96020
12/17/96	Licensee	ENGR	Division 2 RHRSW outside design basis. Failure of nonsafety related dike could lower lake level enough to cause waterhammer and failure of RHRSW.	design control	LER 96020
12/13/96	Licensee	ALL	Completion of licensee's independent self assessment (ISA) and announcement of extended shutdowns on both units	Long term performance problems	-----
12/13/96	Licensee	ENGR	Thermal overload bypass circuit design for 16 RHR valves did not meet UFSAR requirements. Thermal overloads are not bypassed when the operators are required to remote manually operate the valves under accident conditions.	design control	LER 96022
12/10/96	Licensee	ENGR	During audit licensee identified use of bolts on safety systems that were included as fraudulent on DOE notification. Testing showed some outside hardness and carbon content.	procurement	ENS Call

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/05/96	Licensee	ALL	Licensee announcement of unitization of organization to better focus on performance problems	Long term performance problems	Morning Report
11/28/96	NRC	MAINT	no acceptance criteria in monthly EDG slow start surveillance for evaluating potentially degraded air start motor. Operations was not cognizant of the reason for recording the data. Potentially degraded air start motor and EDG if test data not timely reviewed.	procedure	IR96018
11/27/96	Licensee	MAINT	Diesel fire pumps declared inoperable due to surveillances not performed at required frequency.	procedure	ENS Call
11/26/96	NRC	OPS	Operator did not have procedure at work site during testing of EDG auxiliaries.	human performance	IR96018
11/15/96	Licensee	ENGR	Licensee failed to take appropriate action to address SBM switch problems following 1979 GE notification and other reviews in 1990 and 1995.	corrective action	IR96018
11/06/96	Licensee	ENGR	Potential hot shorts due to control room fire could result in mechanical damage to several MOVs required to achieve and maintain hot shutdown. (Affects 10 RCIC and 5 RHR valve on each unit.) Inadequate response to IN 92-18.	design control	LER 96016
11/06/96	Licensee	MAINT	Main control room possibly outside design basis due to inadequate surveillance procedure that did not measure dP across all applicable spaces next to control room.	design control	IR96018
11/04/96	Licensee	ENGR	RHR pump seal coolers do not meet design pressure requirements because requirements were not included in original purchase specifications.	design control	LER 96018

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/30/96	Licensee	MAINT	480 V switchgear feedbreakers to Unit 1, Division II MCC 136X1 and 136X2 degraded condition (mechanical trip interlocks primed to trip in seismic event) due to failure to take timely corrective action for similiar event in July 1995. EM procedure not revised to check mechanical interlock disengages (required air gap) when a breaker is fully racked to connect in its cubicle until 2/96, after these breakers were installed. MCCs supplied Div II EDG support equipment, SGTS loads, essential lighting, main steamline valve logic, control room and aux electrical room HVAC.	procedure	IR96018
10/25/96	NRC	MAINT	Several plant housekeeping conditions existed that had the potential to adversely impact plant operations, such as the use of duct tape where it could interfere with valve operation. These conditions were also indicative of poor worker practices.	human performance	IR96013
10/25/96	NRC	PS	Several examples of the failure to adhere to required radworker practices. The inspectors were concerned that actions taken by the licensee to address problems with radworker practices and radiological housekeeping conditions, were not sufficient to ensure long-term and consistently good performance in these areas.	Human performance	IR96013
10/25/96	NRC	ENGR	Informal process for review, approval, and prioritization of engineering requests was ineffective in ensuring the timely completion of engineering work. Many old ERs not resolved and in review status. Several actions from 1994 RCIC rupture disk event had not been taken.	programmatic	IR96013

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LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/23/96	Licencee	MAINT	GE performed liquid penetrant examination on incorrect HPCS safe end to reactor nozzle weld: due to lack of specifying weld location in work package and poor lighting. Licensee conducted 24 hour ISI standdown.	Procedure	IR96017
10/18/96	NRC	PS	Continuing weaknesses with contractor oversight, work control and planning, and self checking with respect to radiological controls. Examples from L2R07 included a station RPT failing to post the RWCU room as a high radiation area, unnecessary dose expended on installation of recirculation piping plugs (improperly sized and had to replace, and periodic re-entries to reinflate plugs due to air leakage), and a failure to document in a PIF two contractors receiving facial contamination while traversing an areas outside their work area.	Programmatic and human performance	IR96014
10/18/96	NRC	PS	Station dose for 1996 was 953 rem as of 10/96, significantly above the 728 rem goal. The increase was attributed to emergent/unplanned work and material condition improvement efforts.	Programmatic	IR96014

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LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/18/96	NRC	PS	Good ALARA controls for exposure control (teledosimetry, remote monitoring via camera, hydrolazing), but several weaknesses in work control process regarding review and implementation of ALARA plans and RWP which may result in additional worker exposure. RWP radiological holdpoints sometimes less conservative than that in ALARA plan. information on ALARA plans and RWPs often unclear or not applicable, a single RWP used to control several activities on some jobs when multiple RWPs would be more consistent with ALARA principles.	Programmatic	IR96014
10/16/96	Licensee	MAINT	EDG fuel oil not analyzed in accordance with TS due to procedure deficiencies. Verification of kinematic viscosity for new fuel not done and analysis of old fuel not always done at correct frequency.	Procedure	LER 96013
10/16/96	Licensee	MAINT	Substantial foreign material identified in silt layer of Unit 2 suppression pool with potential to clog ECCS strainers. Inadequate correction action to Bulletin 95-02.	Programmatic	IR96013/ IR96018
10/15/96	Self	OPS	Inadequate cold weather preparations caused freezing and the resultant rupture of several station heat supply coils on reactor building ventilation, turbine building ventilation, and radwaste building ventilation. The ability to maintain heat to the buildings was a challenge throughout the winter months while replacement equipment was procured and installed.	Programmatic and human performance	-----

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/13/96	NRC	OPS	Licensed operator lesson plans did not address SER commitment to operate CR and AEER charcoal filters in the event of high radiation at the air intake.	Programmatic	IR96018
10/12/96	self-disclosing	OPS	Equipment operators did not follow out-of-service instructions resulting in the wrong battery charger being de-energized.	Human Performance	IR96013
10/10/96	Licensee	ENGR	Auxiliary Electric Equipment Room found to not meet GDC 19 habitability requirements due to failure to understand the design and licensing basis. 1995 removal of MSIV leakage control system did not analyze AEER dose and in fact hadn't been implemented since plant startup. Also could not maintain FSAR required dP for AEER.	Programmatic	IR96013/ IR96018
10/10/96	NRC	MAINT	Inadequate freeze seal maintenance procedure. Workers establishing a freeze seal on an emergency diesel generator (EDG) cooling water line demonstrated a good questioning attitude in identifying that the subject procedure did not contain the required information. However, a maintenance department first line supervisor attempted to resolve the problem by explaining the intent of the procedure rather than seeking a formal work package clarification or procedure revision.	Procedure/ human performance	IR96013
10/10/96	NRC	PS	Maintenance worker was not wearing required protective clothing while in a contaminated area. The worker was wearing rubber gloves and rubber shoe covers but did have on cloth gloves or cloth shoe covers.	Human performance	IR96013

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/09/96	Licensee	MAINT	Failure to follow work request instructions which resulted in installation of jet pump plugs in the wrong reactor recirculation loop. A fuel handling supervisor demonstrated poor procedural adherence practices by continuing with jet pump plug installation even though he was aware that a required drawing was missing from the work package.	Human Performance	IR96013
10/08/96	NRC	ENGR	Potential weakness in the licensee's implementation of NRC guidance (GL 91-18) on TS-required equipment operability. Licensee's program overly reliant on TS surveillance test results for operability determinations.	Inadequate Procedure/ Instruction	IR96016
10/07/96	NRC	PS	Inspectors identified that various hoses crossing a contaminated area boundary in the 2D heater drain (HD) pump room were not secured. The licensee corrected the condition, however, on October 11, the inspectors again identified hoses breaching a contaminated area boundary in the 2A HD pump room that were not taped or secured.	Human performance	IR96013
10/02/96	NRC	MAINT	Failure of maintenance workers to follow a procedure during reassembly of the O EDG service water strainer which resulted in excessive leakage of a strainer backwash valve, necessitating rework. Documentation in the rework package was not thorough, representing an impediment to good root cause analysis.	Human Performance	IR96013
09/29/96	NRC	MAINT	Failure to follow work practices required by fire protection procedures for ensuring a safe welding environment. Combustibles in area of welding.	human performance	IR96013

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/29/96	licensee	OPS	Four channels of the IRM trip function were inadvertently removed from service under an OOS for the APRM trip function (trip functions shared a common RPS contact which was jumpered out of service). Compliance with the RPS technical specification was achieved fortuitously (scram inserted for unrelated work).	human performance	IR96016
09/28/96	Licensee	OPS	Inadequate review of OOS checklist results in TS violation. EDG taken OOS and primary containment vent and purge downstream isolation dampers to purge air filters deactivated to comply with TS. OOS cleared for maintenance and dampers also inadvertently cleared although EDG inoperable.	human performance	LER 96008
09/28/96	licensee	OPS	Irradiated fuel movement was conducted outside the applicable TS requirements (while Containment Purge and Ventilation system valves were in a condition where one valve functional but inop., the other valve closed but energized). When the condition was identified, the on-duty operators misinterpreted the TS time clock, and thought that they were in an 8-hour LCO rather than non-compliance.	human performance	IR96016
09/28/96	licensee	ENGR	Some WKM 70-13 AOVs would not close under their design basis dynamic loads. The inspectors determined that the problem had not been formally documented by a PIF and had not received a formal operability assessment in March or April 1996 as required by plant procedures.	human performance	IR96016

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/28/96	licensee	ENGR	A proactive and thorough preventive maintenance initiative led to identification of a potentially generic concern with the effective diaphragm area and spring preload (spring to close) of WKM Model 70-13 AOV actuators. These AOV actuators were used in the RCIC (steam drains) and PCIS systems at LaSalle. Problem initially identified in March/April 1996.	Self-Critical	IR96016
09/24/96	NRC	ENGR	The size of the pump impeller for the "A" RHR Service Water Pump was increased using a maintenance work request and by-passing the change control process. This resulted in increased pump pressure and flow which involved work-arounds and finally improper in service testing of the RHR service water pumps.	design control	IR96011
09/24/96	NRC	ENGR	Licensee did not understand design basis for service water system based on number of calculations using different assumptions, the existence of calculations for non-installed equipment, and using out-dated information in calculations.	design control	IR96011
09/24/96	NRC	ENGR	Licensee did not understand basis for TS surveillance requirements in lake screen house. When sediment levels above those allowed by TS were discovered, licensee first leveled silt so that level was under TS requirement and then removed without governing procedure or instruction. Also, surveillance procedure required only portion of lake screen house be tested.	design control	IR96011

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/24/96	NRC	ENGR	The pump casing material on the service water spent fuel pool makeup pumps was changed from carbon steel to stainless steel using a maintenance work request without using or involving the design control process.	design control	IR96011
09/24/96	NRC	ENGR	Calculations VY-004, ATD-0375 and 3C7-089-001 did not include heat piping heat loads even though a modification had changed the system to take suction from only the suppression pool which is a hot water source.	design control	IR96011
09/24/96	NRC	ENGR	Licensee did not recognize adverse trend on 2B RHR heat exchanger performance, had not balanced flows through the heat exchangers, and had no service water corrosion detection program for the system.	Programmatic	IR96011
09/24/96	NRC	ENGR	UFSAR not updated for license amendment to increase allowable suppression pool temperature in July 1989. Several other incorrect statements noted in UFSAR.	Programmatic	IR96011
09/24/96	NRC	OPS	Licensee performed a thorough review of technical specification clarifications, deleted several, and identified a few cases where amendments were necessary.	Procedures	IR96010/ IR96011
09/15/96	NRC	ENGR	Engineering personnel did not identify a potential water hammer problem with the RHR heat exchangers. After questions were raised by the NRC, the licensee initiated an engineering evaluation, the results of which indicated that a water hammer problem existed in the RHR service water system. Both Units 1 and 2 remain shutdown until a "keep-fill" system modification is installed to correct this problem.	design control	IR96011

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/22/96	self-disclosing	MAINT	U1 S/D due to turbine control valve problems.	material condition	IR96010
09/20/96	-----	-----	Unit 2 shutdown for Refueling Outage	-----	IR96013
09/19/96	NRC	OPS	Failure to follow the general procedure for shutdown and to initiate a procedure change reflecting the actual shutdown process used. Shifted recirculation pumps to slow speed using instrument surveillance procedure versus operating procedure.	human performance	IR96013
09/17/96	self-disclosing	ENGR	Spurious Unit 2 RWCU isolation on high differential flow. Long term recurring problem that had not been resolved.	human performance	IR96013
09/07/96	self-disclosing	MAINT	Reactor building ventilation control system malfunction causing difficulty in maintaining required reactor building differential pressure.	material condition	IR96010
09/06/96	self-disclosing	MAINT	Failed backwash valve for EDG "0" was challenge to operators.	material condition	IR96010
08/20/96	self-disclosing	PS	Administrative overexposure when rawaste operator failed to note alarming electronic dosimeter due to high noise levels. (Previous overexposure in 1993 due to same reason.) Need or operator in vacinity of tank draining had not been communicated to radiation protection department.	personnel performance and poor corrective action	IR96014
08/19/96	NRC	ENGR	Corrective actions to address a licensee identified problem with weak root cause analysis and troubleshooting techniques were being slowly implemented and appeared to have limited effect. This issue was identified in a corrective action record more than two years ago and has also been discussed in several NRC inspection reports.	personnel performance	IR96010

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
08/19/96	self-disclosing/ NRC	ENGR	Failure of the RCIC rupture disc. Inadequate corrective actions from similar 1994 event. (Apparent Violation) Failure to install drain line tap and procedurally check for water. Following second failure, root cause team recommendations to PORC were weak and included preconditioning of the RCIC system, and corrective actions continued to be slow and lacked management involvement.	programmatic	IR96010/ IR96013
08/18/96	self-disclosing	MAINT	#2 turbine control valve closed unexpectedly and immediately reopened. Challenge to operators.	material condition	IR96010
08/14/96	self-disclosing/ NRC	ENGR	Weak root cause analysis of 0 DG failure. Root cause team was narrowly focused on one component as causing the failure and recommended non-conservative actions to PORC.	weaknesses in root cause analysis	IR96010
08/14/96	NRC	MAINT	Inadequate documentation of safety related work performed on the essential service water strainers during the service water event.	personnel performance	IR96009
08/08/96	licensee	PS	Unescorted visitor in protected area due to inadequate transfer of escort responsibilities.	personnel performance	IR96002
08/08/96	self-disclosing	MAINT	Break identified in lake makeup line. Challenge to operators, engineering and maintenance organizations.	material condition	IR96010
08/02/96	licensee	OPS	Failure to conduct TS surveillance on eight manual primary containment isolation valves. They had not been checked monthly, but were controlled administratively and checked every 18 months.	procedure deficiency	IR96007

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
07/31/96	NRC	MAINT	Corrective actions taken as a result of the service water event did not prevent unauthorized work on equipment such as the strainer flow measurement and excavation of the cooling lake dike.	personnel performance	IR96009
07/31/96	licensee	PS	Missed Firewatch due to poor OOS: the initiator and reviewer of the fire impairment did not properly identify the fire protection equipment that was to be taken OOS.	human performance	IR96007
07/24/96	licensee	PS	A deliberate violation of the security plan was identified involving the removal of a security badge from the protected area and subsequent effort to surreptitiously return the badge to inside the protected area.	human performance	IR96004
07/22/96	self-disclosing	OPS	Unplanned entry into TS 3.0.3 due to loss of containment air particulate and noble gas monitors due to materiel condition problems and work control weaknesses.	materiel condition/ work control	IR96007
07/22/96	licensee	OPS/MAINT	Several OOS errors occurred in a short period of time and the operations manager initiated an OOS standdown. Individually, the OOS errors were insignificant, but together represent a negative trend.	human performance	IR96007
07/14/96	NRC	MAINT	Inadequate Maintenance procedure for reassembly of the Unit 2 RHR service water strainer	procedural deficiency	IR96009
07/--/96	NRC	ENGR	The size of the non-essential service water strainer screens were larger than the size specified in the UFSAR.	design control	IR96009

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
07/--/96	NRC/ licensee	ENGR	For years, the EDG service water strainer backwash flow was set considerably below the minimum of 250 gpm as required by Section 9.2.1.2 of the UFSAR. Under these conditions, there was no assurance that the strainer backwash would have functioned as designed.	design control	IR96009
07/02/96	licensee	RP	Inadequate evaluation of radiological controls for drywell at power entry to inspect IRMs. Higher than expected dose rates on May 22 entry not assessed prior to July 1-2 entry. Also didn't consider Information Notice 88-63 on effects of incore irradiation of IRMs.	Programmatic	IR96014
06/--/96	NRC	MAINT	Inadequate control or work allowed a foam sealant to be injected in the service water tunnel	work control	IR96009
06/29/96	-----	OPS	Both Units were shutdown due to foam sealant in service water tunnel	-----	IR96007
06/26/96	self-disclosing	OPS/ MAINT	Unit 1 Reactor scram and MSIV isolation during IM surveillance of MSIV hi flow dp switches (SOR switch). Violation issued for failure to take corrective actions, one previous event and PIF without corrective action.	IM work practice deficiency and procedure weakness	IR96007
06/24/96	NRC	ENGR	Failure to initiate prompt actions to remove the sealant material from the service water tunnel and system after the service water clogging events resulted in extended risk of significant reactor cooling problems.	personnel performance	IR96008

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
06/24/96	NRC	ENGR	Inadequate problem documentation by system engineers contributed to the mis-classification of lake screen house crack sealant work. This work activity affected operability of the essential service water and the ultimate heat sink for both units.	personnel performance	IR96009
06/24/96	NRC	ENGR	Operability evaluation for second service water event was weak. Testing of the foam sealant did not simulate water tunnel condition. Licensee did not challenge vendor information. No thorough tunnel inspection.	personnel performance weakness in root cause	IR96008
06/24/96	self-disclosing	all	Second power decrease due to service water problem due to low service water header pressure. Power reduced to 77%.	work control weakness	IR96007 IR96008 IR96009
06/22/96	NRC	PS	Maintenance of the Post Accident Sampling System and line organization self-assessments of the chemistry and REMP programs had improved.	programmatic	IR96005
06/20/96	NRC	ENGR	Operability Evaluation for essential service water was weak: problems with service water pressure were initially thought to be due to "corn cob" sandblasting material. Op Eval was narrowly focused and not thorough.	personnel performance in conducting root cause	IR96008
06/19/96	NRC	OPS	Inadequate procedures for the backwash of non-essential service water strainers hampered operators when responding to the strainer clogging events. Additionally, no instructions for manual backwash of the essential service water strainers were included in other operating procedures	procedures	IR96009
06/19/96	NRC	OPS	STRENGTH: Control room operator response during the service water clogging events was good.	Teamwork/ Skill Level	IR96009

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
06/19/96	NRC	OPS	Licensee did not make a prompt operability determination when there were indications that the foam sealant material might not float as assumed in the original operability evaluation. Even after foam material was discovered on the bottom of the service water tunnel, plant management did not immediately declare the associated safety systems inoperable.	personnel performance	IR96009
06/19/96	NRC	OPS	Regional NRC management had to influence the decision to expand the scope of the licensee's service water system investigation to include inspecting at least one essential service water system strainer. After finding relatively large pieces of sealant material in the inspected strainer, the NRC again had to become involved in the decision to verify the strainer backflush capability and to place both units in cold shutdown.	personnel performance	IR96009
06/19/96	self-disclosing	all	First power decrease due to service water problem due to foam sealant injection in the lake screen house. Service water header pressure dropped requiring power reduction on both units to 77%.	work control weakness	IR96007 IR96008 IR96009
06/15/96	self-disclosing	OPS/PS	Failure of the radwaste evaporator causes spill of highly contaminated water and sludge and creates a high radiation area.	materiel condition	IR96006
06/13/96	NRC	OPS/ENGR	The drywell post-accident H ₂ /O ₂ (hydrogen/oxygen) monitors were not being operated consistent with the UFSAR, and the 50.59 had not been performed. The operators were given directions per "night orders" to operation the monitors in this configuration.	management deficiency	IR96006

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
06/11/96	NRC	PS	Contrary to RP requirements, high pressure water hoses running from inside the reactor building under the trackway doors to an outside high pressure spray system, were left unattended. The hoses were used during source term reduction activities and were a potential unmonitored release pathway.	personnel performance	IR96006
06/05/96	licensee	PS	Six individuals were granted protected area unescorted access authorization without the full background investigation being conducted within 180 days in violation of 10 CFR 73.56.	personnel performance	IR96005
05/31/96	NRC	ENGR	Multiple differences between plant equipment configurations and the associated system descriptions in the Updated Final Safety Analysis Report (UFSAR) were not identified and corrected.	management deficiency	IR96011/ IR96009
05/28/96	licensee	OPS	Control Rod Mispositioned by an operator due to the failure to self-check. QNE immediately identified and corrected the error.	personnel performance deficiency	IR96006
05/28/96	self-revealing	MAINT	Unit 2 EHC Instrument Line Leak caused by fatigue failure initiated a fire alarm and required swapping EHC train.	equipment malfunction	IR96006
05/24/96	NRC	PS	Numerous deficiencies with implementation of the REMP program were identified. The licensee also did not describe corrective actions for deviations from the REMP sampling requirements in the 1995 annual report, as required by the ODCM.	programmatic	IR96006

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
05/24/96	NRC	PS	Plant water chemistry control was good with improvements noted in reactor water sulfate levels, however, feedwater iron levels remained above average and material condition problems continued to impact chemistry	programmatic	IR96006
05/24/96	licensee	PS	Missed Firewatch: an auxiliary building firewatch was missed for 7 hours. The watchperson thought that the watch was no longer required when a fire impairment was removed. He was unaware that there was another fire impairment which required the watch.	personnel performance deficiency	IR96005
05/20/96	self-revealing	OPS	Unit 2 Forced Outage Due to #3 Turbine Control Valve (TCV) and #1 Bypass Valve (BPV): On 04/24 during routine cycling of TCVs, the #3 TCV stuck shut due to mechanical binding in the shutoff valve. The unit was run at reduced power due to this condition. A maintenance outage was planned, however, the spurious opening of BPV #1 caused the unit to be shut down on 5/21. The cause of the #1 BPV problems were a failed card (max combined flow limiter), the pre-amp, and the servo-valve.	equipment malfunction	IR96005
05/16/96	self-revealing	OPS	Operator out-of-service error almost necessitated Unit 2 scram: when tagging out a condensate transfer pump, the operator mistakenly closed the common suction valve to the CRD pumps.	personnel performance deficiency	IR96005
05/13/96	licensee	OPS	Operating Department Individual Entered Radwaste Truckbay without Dosimetry: the individual did not perform a self-check. Dose received was minimal.	personnel performance deficiency	IR96005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
05/12/96	self-revealing	OPS	Unit 1 manual scram due to high vibration on the turbine bearing #11 and 12: the cause of the high vibration was improper clearances on the stationary oil deflectors on both bearings. These were supplied by GE as part of the Turbine Supervisory Instrumentation Modification. Unit 1 was restarted on 5/16 and synched to the grid on 5/17.	equipment malfunction	IR96005
05/06/96	self-revealing	OPS	Unit 1 Synch to the Grid following L1R07: problems with EHC calibration and reactor chemistry slowed startup significantly.	*****	IR96005
04/27/96	NRC	PS	Personnel Failure to Report Aberrant Behavior: the inspectors determined that a security individual had exhibited aberrant behavior (chiseling a hole in a cinder block wall with a pocket knife, and making statements to another watchmen about being destructive when he is bored) and it was not problem report to management as a potential FFD concern.	personnel performance deficiency	IR96005
04/22/96	self disclosing	PS	Second resin intrusion event: This one due to Unit 2 condensate polisher.	material condition	IR 96005
04/22/96	NRC	OPS	Degraded RCIC Support Not Evaluated in a Timely Manner: the inspectors identified that a degraded RCIC support was not evaluated properly. An operator identified the condition on 4/6; however, engineering was not informed until 4/22 when they performed an evaluation which concluded RCIC was operable.	personnel performance deficiency	IR96005
04/21/96	licensee	MAINT	Failure to Perform a Tech Spec Surveillance: operations failed to perform weekly surveillance of the manual scram pushbuttons (LOS-RP-W1).	personnel performance deficiency	IR96005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/21/96	licensee	OPS	Improper Hanging of an Out-Of Service: the 2A condensate transfer pump was inadvertently isolated rather than the 2A condensate makeup pump. Before the error was recognized the reactor operator attempted to start the condensate transfer pump but quickly identified the pump was not performing correctly and shut it down. No damage to the pump was sustained.	personnel performance deficiency	IR96005
04/21/96	self-revealing	MAINT	Unit 1 Chemistry Excursion during Startup: the unit was started up on 4/21 and later that day a chemistry excursion occurred due to a resin intrusion. The internals of a check valve in the RWC system was replaced during the outage. A machining defect on the valve casing caused the valve disk is stick open during startup. This problem should have been identified while working on the valve.	skill of the craft and post maintenance test	IR96005
04/17/96	licensee	MAINT	High vibration on 2A CRD Pump following maintenance Delayed Maintenance on 2B CRD pump: while disassembling the 2A CRD pump, the mechanics did not question that a coupling bolt was missing and subsequently reassembled the pump and coupling as they found it.	personnel performance deficiency	IR96005
04/17/96	self-revealing	MAINT	Unit 1 Shutdown after attempting startup following L1R07: Unit 1 was started up on 4/13, however, due to calibration problems with the EHC turbine speed control system the turbine could not achieve 1800 rpm. The unit was shut down on 4/17.	inadequate procedures - rework	IR96005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/16/96	NRC	PS	Response facilities were in an excellent state of operational readiness. Material conditions had improved significantly. Emergency equipment inventories and maintenance were good, with timely corrective actions taken when deficiencies were identified.	material condition	IR96004
04/16/96	NRC	PS	The material condition of the Operations Support Center had significantly improved.	material condition	IR96004
04/16/96	NRC	PS	Emergency communications capability was very good.	programmatic	IR96004
04/16/96	NRC	PS	A violation of 10 CFR 50.59 was identified pertaining to the failure to evaluate the emergency response effect of new site structures on the accuracy of the meteorological monitoring system. This represents a long standing discrepancy with the UFSAR.	personnel performance	IR96004
04/16/96	NRC	PS	The 1995 cumulative dose of 520 rem was the lowest in recent history, and both non-outage station dose and individual worker exposures continued to decline.	management	IR96004
04/16/96	NRC	PS	Improvement in ALARA planning was noted with the use of cameras and shielding and the incorporation of Limerick Station "lessons learned" in radwaste modification work.	personnel performance	IR96004
04/16/96	NRC	PS	Unit 1 drywell dose rates (20-100 mrem/hr) remained constant due to Zinc injection.	management	IR96004
04/16/96	NRC	PS	Problems with schedule adherence, work scope control, and rework resulted in additional dose during the Unit 1 refueling outage (11 rem was accrued from r work activities alone)	personnel performance	IR96004

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/16/96	NRC	PS	Problems with interdepartmental communication, shielding installation, and tool availability delayed several maintenance activities and impacted RP coverage.	personnel performance	IR96004
04/16/96	licensee	OPS	Reactor Operator Removed Key from Mode Switch: this placed the unit into a Tech Spec action statement. Operator was not "thinking" and did not understand the consequences of his actions. He was terminated based on past performance problems.	personnel performance deficiency	IR96004
	NRC	OPS	A temporary alteration (TA) of the 2B diesel generator caused a local alarm which operators identified and ignored. The TA defeated the motor driven fuel pump function of a backup to the engine driven pump for approximately five years and no action was taken by operators to correct the annunciator response procedures.	Personnel Performance Deficiency	IR96005
04/16/96	licensee	OPS	Operators created a workaround to automate generating the weekly list of switchyard deficiencies to counter the slow resolution of the deficiencies.	materiel condition/ Personnel Performance Deficiency	IR96004
04/16/96	NRC	OPS	Inadequate temporary procedure changes of controlled LaSalle Operating Procedures (LOP) located in the relay house were used twice without proper review or approval. The procedures were for testing relays in the switchyard and improper performance of the procedure could result in tripping one of four 345 kV offsite power	Inadequate Procedure/ Instruction	IR96004

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/16/96	NRC	OPS	Operators took the "0" diesel generator (DG) out of service during testing on Unit 1 to prevent an automatic DG start. However, should the DG be required to operate during a potential accident on Unit 2, the DG would have needed to be manually started by operators. The operators, although not in violation of Technical Specifications, "worked around" a degraded condition to complete the testing.	Personnel Performance Deficiency	IR96004
04/16/96	NRC	OPS	STRENGTH: Heightened level of awareness briefings were generally thorough. Operators maintained good control of control room activities.	Teamwork/ Skill Level	IR96004
04/16/96	Self-Revealed	MAINT	Weak procedures led to the inadvertent de-energizing of the security uninterruptible power supply during performance of preventive maintenance.	Inadequate Procedure/ Instruction	IR96004
04/15/96	licensee	PS	Six Managers and Three INPO Personnel Violate RWP: these people accessed the refuel floor, a posted high radiation area. The RWP they were on did not allow access to high radiation areas.	human perform.	IR 96004
04/12/96	licensee	OPS	Amertap Pumps Found Deadheaded: during a walkdown by the system engineer, he identified that the operators had not properly restored the equipment following a weekly surveillance. As a result, the pumps were deadheaded for 24 hours and a seal leak on the A pump had degraded.	human perform. and materiel condition	IR 96005

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/12/96	self-disclosing	MAINT	Painter Inadvertently Tripped an RPS Bus: the painter accidentally bumped the EPMA breaker. This caused the trip of the RPS bus, containment isolation, and a half scram. When the painter recognized what he did, he inappropriately reset the breaker.	human perform.	IR 96004
04/09/96	self-disclosing	MAINT	ESF Actuation While Valving in RVLIS: a Division III actuation occurred due to a pressure spike while IMs were valving in RVLIS. The 1B DG started and HPCS pump started and injected into the vessel for 14 seconds. Reactor level went from 44 to 58 inches. Violation for failure to take adequate corrective actions to prevent recurrence. A previous identical event occurred on Unit 2 on May 3, 1995. (Not reportable because the test considered the possibility of the actuation and pre-planned for it.)	unknown, licensee has not determined	IR 96004
04/04/96	NRC	MAINT/PS	Violation for Failure to Comply with Procedures: the inspectors observed hot work (cutting, grinding, welding) not being conducted per procedure. There were combustibles in the area and not properly covered.	human perform.	IR 96004
04/03/96	self-disclosing	MAINT	ESF Actuation during Excess Flow Check Valve Testing: a instrument rack spike caused a Unit Division II initiation (1A DG, and B and C RHR pumps started). Initial cause appears to be procedure problem. (Not reportable because the test considered the possibility of the actuation and pre-planned for it.)	procedures, possibly other root causes	IR 96004

PLANT ISSUES MATRIX

LASALLE

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/02/96	self-disclosing	MAINT	FME Plug in Stator Water Cooling System: after returning the system to service following work during the outage, it did not operate properly. The cause was a FME plug left in the system piping.	human perform.	IR 96004
04/01/96	licensee	MAINT	Failure to Complete Tech Spec Surveillance within Required Time: all aspects of the Tech Spec required response time test surveillance for Unit 1 Division 2 could not be completed during the originally scheduled time (03/13) due to safety concerns. Poor communications led to the failure to complete all aspects of this test before it was past 1.25 date (04/03).	human perform. and work control	IR 96004

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/22/97	NRC	Ops	AIT (inspection completed on 3/7/97) determined that, during 2/21/97 reactivity manipulation event, there was a total breakdown in command and control by operations supervision resulting from (1) inadequate communications between operators, operations supervision, operations management, and nuclear engineering department personnel, and (2) the failure of operations supervision, operations management, and plant management to provide clear direction to the operating crew regarding the planned shutdown. The licensee also took inadequate corrective actions to precursor events and after this event did not implement adequate immediate corrective actions.	Human performance	97007
04/14/97	NRC	Ops	CAL supplement issued to include specific commitments by the licensee to address human performance problems in operations, material condition issues affecting startup, and deficiencies in engineering support to operations that have been identified by the NRC and licensee.	-----	-----
03/26/97	NRC	Plant Support	Tygon tubing associated with yellow containment (leak collectors) did not have radiation tape or radioactive material markings at various locations in the auxiliary building.	Human performance	97009
03/25/97	NRC	Plant Support	Individual removing protective clothing containers from the fuel building did not use a survey instrument to survey each bag of contaminated clothing.	Human performance	97009

"+" indicates a positive attribute/occurrence.

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
03/25/97	NRC	Plant Support	Inadequate control of contaminated boundaries (cords and hoses not properly secured) in auxiliary building and turbine buildings. Improper postings.	Human performance	97009
03/21/97	NRC	Plant Support	Overall effectiveness of licensee's emergency preparedness facilities, equipment, training, and organization was good. Licensee personnel performed conservatively during actual activations of the Emergency Plan.	+	97008
03/21/97	NRC	Plant Support	Quality assurance oversight of the emergency preparedness program was good. However, contrary to 10 CFR 50.54(t) annual reviews of the emergency preparedness program did not address the adequacy of the offsite interface with the State of Illinois.	Programmatic	97008
03/17/97	Licensee	Ops	Significant voiding in Unit 2 reactor vessel had been occurring since 2/18/97 which was approaching level that could challenge NPSH for shutdown cooling. Licensee had unnecessarily taken vessel level instrumentation out-of-service. Problem occurred despite several previous generic communications and a similar (but less significant) event on Unit 1 in 9/96.	Human performance	97002
03/11/97	Self	Maint	Unusual event declared for Unit 1 loss of offsite power due to a system auxiliary transformer trip upon the failure of a pressure sensor.	Material condition	97008
02/28/97	Self	Maint	During reassembly of the diesel driven fire pump, the discharge flange was cracked as a result of overtorquing the bolts.	Procedure	97005

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/28/97	Self	Ops	Unusual event declared when a U.S. National Weather Service weather balloon instrumentation package landed across the Unit 2 Switchyard System Auxiliary Transformer.	-----	97008
02/25/97	NRC	Ops	NRC AIT arrived on site to investigate 2/21/97 event involving inadequate control of reactivity manipulations. CAL issued which requires, prior to startup of either unit, that the licensee discuss investigation results, performance issues, and corrective actions with the NRC and implement a remediation plan.	Human performance	97006/ 97007
02/25/97	NRC	Maint	2B EDG work instructions contained incorrect torque value.	Procedures	97002
02/25/97	NRC	Ops	Licensee staff failed to recognize the potential significance of a hydraulic transient that occurred while performing RHR valve testing.	Human performance	97007
02/24/97	Licensee	Ops	Unusual Event declared due to plant not being brought to cold shutdown condition as required by TS for inoperable reactor coolant flow transmitters. Instrumentation had been taken OOS on 2/22/97 without operators realizing TS ramifications, causing them to not enter cold shutdown when required by TS. (Plant was already in hot shutdown.) Exited UE when cold shutdown reached on 2/25/97. This event demonstrated similar weak operating practices, which included poor command and control, and training deficiencies, that contributed to the occurrence of the February 21 reactivity management event.	Human performance	97002/ 97007

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/21/97	Self	Ops	During plant shutdown, reactor operator withdrew control rods without proper oversight. Breakdown of teamwork and command and control of evolution.	Human performance/ program	97002
02/21/97	Self	Maint	Unit 1 shutdown commenced due to failure of diesel-driven containment spray to start within design time during surveillance. (Circuit failure.)	Human performance	97002
02/21/97	NRC	Ops	Licensee failed to test both starting trains of "C" contaminated spray pump.	Human performance	97002
02/21/97	NRC	Ops	Licensee failed to implement changes to testing procedures for "C" containment spray pump in response to 1993 violation.	Human performance	97002
02/16/97	Self	Maint	Electrician received an electric shock due to poor work practices.	Human performance	97002
02/13/97	Self	Maint	A fuel oil leak occurred during post-maintenance testing of the 2A EDG due to maintenance personnel failing to tighten a fitting.	Procedure	97005
02/13/97	NRC	Ops	Abnormal operations procedure for loss of service water did not address confirmed emergency diesel generator heat exchanger fouling due to fire system debris.	Procedure and material condition	97005
02/13/97	NRC	Eng	Additional discrepancies identified with recirculation sump configuration with respect to drawings.	Program	97002
02/13/97	Self	Maint	Licensee determined that 2A EDG failed to start due to starting air control valve not opening was caused by improper installation of a shipping plug.	Design control	96020/ 95005

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/13/97	Licensee	Eng	Unit 1 and 2 4KV and 480V buses declared inoperable due to seismic concerns of disconnected breakers.	Program	97002
02/11/97	Self	Maint	Maintenance personnel overtorqued EDG 2A cooler outlet flange which resulted in a service water leak through a crack. Overtorquing has been a recurrent problem.	Procedure	97005
02/10/97	Licensee	Plant Support	Inaccurate boron concentration results for the refueling water storage tank resulted in the licensee starting to shutdown Unit 1 in accordance with an LCO action statement. Following a dilution, procedure inadequacies resulted in a lack of mixing and recirculation of the tank.	Program/ procedure	97002
02/07/97	NRC	Plant Support	The conduct of security operations was good, with continued improvements in the organization's professionalism and communications. Security contract staff shortages in the nuclear security officer and access control inspector positions were eliminated, resulting in a reduction in the use of overtime and an increase in tactical response drills conducted. Generally, contract security force performance was good. Personnel errors were few and moderate in significance.	+	97004
02/07/97	NRC	Plant Support	A review of security related problem identification forms (PIF) indicated a continuing need to promote worker personal accountability in the areas of badge control and vital area door control. A security drill to evaluate performance in the conduct of warehouse package searches showed a lack of worker understanding of basic expectations.	Human performance	97004

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
02/06/97	Licensee	Ops	Due to inadequate pre-evolution briefing the pressurizer surge line was cooled down at an unexpected high rate during a RCP swap.	Human performance	97002
02/05/97	Licensee	Maint	SQV identified programmatic breakdown of I&C department control of the classification of periodic calibration of plant instrumentation program.	Program	97002
02/05/97	NRC	Maint	Licensee failed to take adequate corrective actions to resolve cause of water in auxilliary feedwater pump bearing.	Human performance	96020
02/05/97	NRC	Maint	Licensee failed to adequately address impact of incorrect oil being added to the 2B containment spray pump.	Human performance	96020
02/01/97	NRC	Ops	Two examples of weaknesses in the Eagle 21 failure abnormal operating procedure which would make recovery from a steam generator level transient at low power more difficult.	Procedure	96020
01/27/97	NRC	All	Zion placed on NRC watch list and letter issued to ComEd pursuant to 10 CFR 50.54(f).	-----	-----
01/27/97	Self	Maint	2A EDG experiences loss of lube oil. Cylinder liner crack and piston failure identified.	Material condition	96020/ 95005
01/27/97	Self	Maint	2A EDG surveillance aborted due to trip chart recorder not hooked up properly. (Repeat occurrence.)	Human performance	96020/ 95005
01/24/97	Licensee	Eng	Generic Letter 96-06 applicable for Zion: pipe stresses outside design limits but operable for SW supply to RCFCs and expansion of water in isolated piping.	Design control	ENS

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/22/97	NRC	Plant Support	Since April 1996, two of seven persons authorized to approve/release contaminated material shipments had not successfully completed the annual training as required by the administrative procedure.	Human performance/program	96021
01/22/97	NRC	Plant Support	Radiation protection procedures concerning radioactive material shipping were not updated to be consistent with the April 1, 1996 revisions to the NRC and DOT requirements.	Human performance/program	96021
01/22/97	NRC	Plant Support	Since January 1996, the licensee had not followed procedures which ensured that the activity of radioactive wastes were accurately determined in accordance with 10 CFR 61.55(a)8. Although the licensee had an annual requirement to analyze resins to determine radionuclide scaling factors, the steam generator blowdown and primary resin scaling factors had not been determined in over two years.	Human performance/program	96021
01/22/97	Licensee	Plant Support	The licensee suspended all shipping of radioactive material and radioactive waste. Based on NRC findings, senior plant management were not confident in the radiation protection department's ability to ship materials in accordance with procedures and the regulations.	Human performance/program	96021
01/22/97	NRC	Ops	Instances of non-conservative licensee actions with respect to EDG and motherhood LCOs due to licensee interpretations.	Human performance	RIs
01/22/97	Self	Eng	2B EDG abnormally high lube oil temperatures caused by fouled heat exchangers. (Repeat occurrence.)	Material condition	96020/ 95005

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/22/97	NRC	Plant Support	The April 1996 SQV audit of the radioactive material program was not thorough and failed to identify fundamental weaknesses in the program.	Program	96021
01/21/97	Licensee	Eng	Plant not analyzed for design stresses and loads for PORV lift transient. (Possible conflict with previous licensee correspondence.)	Design control	ENS
01/21/97	NRC	Ops	Operator did not follow abnormal operating procedure in response to Eagle 21 failure event.	Human performance	96020
01/20/97	-----	---	Unitization of plant organization implemented.	-----	-----
01/19/97	Self	Maint	2B EDG tripped on high turbocharger lubricating oil ratio, due to excessively cold EDG room temperature.	Material condition	96020/ 95005
01/18/97	Self	Maint	Multiple problems with Eagle 21 digital control system: Several occasions had problems with bistables including channel trips. One failure resulted in reactor pressure transient.	Material condition	RIs
01/18/97	Self	Maint	1A EDG surveillance aborted due to strip chart recorder not hooked up properly.	Human performance	96020/ 95005
01/18/97	Self	Maint	1A EDG manually tripped due to freezing of jacket water level sensing line.	Material condition	96020/ 95005
01/17/97	Licensee	Maint	EDG discharge check valves not tested as required by IST program.	Programmatic	96020

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/17/97	Licensee	Ops	Failure to perform EDG hot restart surveillance within load range specified by TS since initial plant operation. In addition, the EDG starting air discharge check valves had not been tested as required by the IST program.	Procedure	RIIs
01/14/97	Self	Maint	Poor work practices and acceptance of unexpected plant conditions resulted in a delay in recognizing a personnel safety hazard during containment spray system maintenance. A control room operator failed to communicate the abnormal position of two containment spray system valves, which delayed investigation of the condition.	Human performance	96020
01/14/97	Self	Ops	Failure of operators to follow OOS procedure resulted in inadequate protection of Unit 1 containment spray system maintenance activities.	Human performance	96020
01/11/97	Self	Ops	Corrective maintenance on volume control system valves delayed Unit 2 downpower to investigate recirculation sump cover.	Material condition	96020
01/10/97	NRC	Eng	Engineering slow to recognize and appropriately evaluate impact of lack of vent holes in containment sump covers.	Human performance	96020
01/08/97	-----	---	Unit 2 outage extended to address numerous issues including containment coating, material deficiencies, and program reviews.	-----	96020

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
01/08/97	NRC	Plant Support	Poor planning and coordination in the preparation of a shipment of radioactive waste resulted in the halt of the evolution. A current analysis had not been performed for the waste stream. Licensee personnel also inadequately directed the carrier's vehicle near a contamination boundary, which resulted in the carrier's vehicle striking and moving the boundary and brushing against a container of resin within the contaminated area.	Human performance/ Program	96021
01/08/97	NRC	Plant Support	Operations personnel failed to follow radiation protection contamination control procedures. The individual removed an item from a contaminated area without either containing the item or having a qualified person survey the item. Plant management indicated that this was a routine operations practice.	Human performance	96021
01/02/97	NRC	Ops	Licensee failed to perform safety evaluation of open operability assessments (15) prior to mode change.	Program	96020
12/31/96	Licensee	Eng	Numerous deficiencies identified with cable tray configuration (previous Safety System Outage Modification Inspection findings).	Material Condition/ Program	96020
12/26/96	Licensee	Eng	Licensee identified that several valves were not tested as required by IST program.	Program	96020

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/24/96	NRC	Plant Support	Access to safety related equipment continued to be significantly encumbered by high source radiological source term and contamination. A large number of contaminated areas within the Auxiliary Building, i.e. residual heat removal pump and heat exchanger rooms, centrifugal charging pump rooms, and radioactive waste tank and pump rooms impeded operator and plant staff access.	Material condition/Program	96021
12/24/96	NRC	Ops	Containment coatings (paint) not in conformance with UF ³ AR and potential ECCS screen fouling.	Material contition/Program	96020
12/16/96	NRC	Ops	Inspectors identified numerous equipment deficiencies in Unit 2 containment (e.g. pipe supports damaged, missing fasteners, frayed cables, cracked weld on RCP oil collection device, etc.)	Material Condition	96020
12/12/96	Licensee	Eng	RCS loop vent and drain valves (8 valves) had never been tested under the IST program.	Program	96020
12/09/96	-----	Plant Support	The licensee shipped radioactive material to the Byron site with contact radiation levels which exceeded regulatory limits. The licensee's survey indicated contact dose rates of 0.7 mrem/hr; however, the shipping papers indicated contact dose rates were less than 2 mrem/hr. As a limited quantity shipment, dose rates are required to be no greater than 0.5 mrem/hr.	Human performance/Program	96021
12/05/96	----	-----	Licensee announces planned unitization of organizational management structure.	-----	-----

"+" indicates a positive attribute/occurrence.

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/04/96	NRC	Plant Support	Good performance was observed during the December 4, 1996 medical drill, with the exception of some minor problems in contamination control. Communications and coordination with offsite response personnel ensured that the simulated casualty was well understood. Contamination control practices were good; however, a potentially contaminated security officer was not well controlled.	Human performance/Program	96021
12/04/96	NRC	Plant support	Radiological housekeeping and contaminated area boundaries were not well controlled. Several areas within the Auxiliary Building were identified having protective clothing strewn about the area, unsecured hoses crossing contaminated area boundaries, hoses containing fluids (within contaminated areas) not leading to collection devices, and pump leakage in the horizontal pipe chases.	Human performance	96021
11/28/96	Self	Maint	Inadequate maintenance procedure resulted in damage to the 1A AFW pump turbine inboard bearing.	Procedures/ Human performance	96017
11/27/96	NRC	Maint	Inspector identified untorqued connection on containment air hydrogen loop isolation valve.	Program	96017
11/24/96	Licensee	Eng	Discrepancy between UFSAR and actual clearances for water level above and below fuel assemblies during fuel transfers.	Program	96017/ 96020
11/22/96	-----	-----	Licensee completed onsite Independent Safety Assessment.	-----	-----
11/22/96	Licensee	Eng	Spring tension on Unit 2 PORV's changed without using appropriate design process.	Human performance	96020

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/20/96	Self	Eng	During RPS and ESF response time testing, system engineer inadvertently shorted a contact resulting in actuation of several Unit 2 containment isolation valves. Engineer needed longer leads and opted to use some already connected (a shortcut). Disconnected from test box instead of relay panel first.	Human performance	LER 96010
11/14/96	Licensee	Ops	Recurring overtime policy violations (previous DET item)	Procedures/ Program	96017
11/11/96	NRC	Maint	Licensee failed to address operability for TS battery surveillance tests with parameters outside test acceptance criteria: Occurred on 11/11, 11/4, 10/7 and 4/1/96	Human performance	96017
11/07/96	NRC	Eng	Inspectors identified that licensee failed to assess the operability of safety-related pipe supports in a timely manner.	Human performance/ Material Condition	96017
11/07/96	NRC	Maint	Failure to implement prompt corrective actions for steam generator tubes: with weld zone indications before returning the generators to service following the 1995 refueling outages. The licensee's safety focus in managing steam generator tube degradation has improved when compared to the 1995 refueling outage. However, the inspectors had concerns with four tubes in SG C with ET indication lengths greater than existing calculations allowed for tube structural integrity and the causes of the potential SG tube leakage identified for ten tubes during the secondary side SG pressure testing.	Human performance	96013

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/07/96	Licensee	Eng	Fuel movements took place during Z2R14 and all previous refuel outages without pipe tunnel exhaust ventilation path routed through the charcoal filters. Caused by removal of a block wall between fuel handling building and containment to facilitate moving equipment.	Design control	96017/ 96020
11/06/96	NRC	Maint	Inspector identified gas cylinder improperly secured to seismic scaffolds.	Program	96017
11/06/96	NRC	Ops	Licensee identified that operating procedure for unisolating and filling a reactor coolant loop from the refueling cavity violated TS surveillance requirement to account for residual water in the drained loop, sample the refill water for boron, and sample the loop for boron prior to opening the loop stop valves. Violation occurred each time evolution performed since 1983.	Procedure	LER 96025
11/04/96	NRC	Maint	Inspector identified examples of thread engagement criteria not met for conduit support for feedwater isolation valves.	Human performance	96017
11/03/97	Self	Ops	Operation of out-of-service valve resulted in spill of 400 gallons of RWST water: Inappropriate operator response to material condition problem on valve reach rod indication.	Human Performance/ Material Condition	96017

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/01/96	NRC	Plant Support	The conduct of security operations was professional: with marked improvements in the clarity and thoroughness of shift turnovers and staff communications in general. NRC observed functional tests of the perimeter alarm system and protected area ingress search equipment demonstrated the operability of the equipment. X-ray operators responded promptly and effectively to the discovery of actual contraband during ingress search. A tour of plant security areas showed good worker security awareness.	+	96018
11/01/96	NRC	Plant Support	Security contract staff shortages: in the contract security organization continued to result in the use of overtime and adversely impacted the ability of the training organization to conduct response team exercises.	Program	96018
10/31/96	Self	Maint	Poor work practices and inadequate maintenance procedures resulted in five protective trips of the 2A EDG during post maintenance testing	Procedures/ Human performance	96017
10/28/97	Licensee	Maint	Maintenance personnel added the incorrect oil to the 2B containment spray pump	Human performance	96020
10/28/96	Licensee	Ops	Missed TS surveillance caused by failure to recognize inoperable "0" emergency diesel generator. Unit 2 control switch placed in PTL per operating procedure for bus outage but not readily apparent that would affect operability for Unit 1.	Procedure	96017

"+" indicates a positive attribute/occurrence.

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/28/96	Self	Eng	LLRT failure indicated that Unit 2 Appendix J Type B leakage exceeded TS requirements during previous operating cycle due to inadequate review of 2A safety injection pump discharge relief valve closed piping functional capability. When penetration was added to Appendix J program in 1995, licensee failed to note there was an already identified active leak. Subsequently recieved NOED to not test until next refuel outage.	Human Performance	LER 96009
10/26/96	NRC	Plant Support	Poor operability of radiation monitors: chronic operability problems, inaccurate control room indications, lack of station commitment in implementing action plans.	Material Condition/Program	96016
10/24/96	NRC	Plant Support	The radiological condition of the plant was poor.: Access to many areas containing safety related equipment was impeded by high radiation levels and/or high contamination levels. No clear plan for addressing these conditions was identified by the inspector.	Material Condition/Program	96016

"+" indicates a positive attribute/occurrence.

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/24/96	NRC	Plant Support	During the Unit 2 refueling outage, radiation worker contamination control practices and the control of radiological postings and boundaries were good; however, the licensee continued to identify radiation worker ALARA issues. Although pre-job ALARA briefings were very detailed, problems were identified concerning the content of some ALARA plans and radiation work permits. Examples included entrance to the inside missile barrier (IMB) area was very congested on several occasions and licensee's initial ALARA plan and RWP for the C cold leg LSIV repair contained several typographical errors that affected the radiological hold points and contained certain unclear instructions to workers.	Program	96016
10/24/96	NRC	Plant Support	The licensee did not use the appropriate environmental lower limit of detection (LLD): for liquids when analyzing liquid samples for licensed radioactivity prior to unconditional release. Licensee documentation did not indicate that licensed material was unconditionally released from the restricted area.	Procedure	96016

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/24/96	NRC	Plant Support	Problems were identified concerning the licensee's calibrations of the radiation monitoring system. The reliability of the Control Room radiation monitoring display system and the licensee's control of the system's configuration was poor. Several large differences between as found and as left calibration data. radiation monitor display system used an incorrect internal conversion constant. calibration data for the containment purge monitor indicated a failure to meet acceptance criteria but the individual performing the calibration incorrectly noted that the conditions were within the acceptance criteria, resulting in corrective actions not being accomplished.	Material Condition/ Human Performance	96016
10/24/96	NRC	Plant Support	The licensee provided effective control and documentation of effluent releases.: Offsite dose calculations for radioactive releases were performed in accordance with the licensee's Offsite Dose Calculation Manual.	Human Performance	96016
10/24/96	NRC	Plant Support	The Control Room and Fuel Building/ Auxiliary Building ventilation testing program was well implemented by the engineering staff. The material condition was good as evidenced by satisfactory testing results and high operability. The inspectors identified a single occurrence of incorrect information in the licensee's Electronic Work Control System concerning a Technical Specification surveillance.	+	96016

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/23/96	NRC	Ops	Operation of reactor at greater than 100 percent power (3250 MW thermal): due to incorrect licensee interpretation of license condition.	Procedure	96017
10/15/96	NRC	Ops	Inspectors identified leaking service water motor cooler resulted in pump being declared inoperable.	Material Contidion	96017
10/15/96	NRC	Ops	Licensee failed to implement corrective actions for an inoperable battery exhaust ventilation system.	Program	96017
10/08/96	Self	Maint	Contractor cross connected service air with demineralized water: allowing water into service air system. Bypassed work controls.	Human Performance	96014
10/07/96	NRC	Plant Support	Personnel deployment strategy devised by security for protecting against an external adversary with the characteristics of the NRC design basis threat was not adequate.	Program	96018
10/07/96	NRC	Plant Support	Generally command and control of the response force during the security drills was poor indicating a need for additional tactical training or shift drilling.	Human Performance	96018
10/07/96	Self	Ops	Equipment attendants (EA) isolated the backup air supply to RHR valves 2HCV-RH606 and 2HCV-RH618 instead of the main air supply during out-of-service: due to incomplete knowledge of intended configuration.	Human Performance	96014

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PLAN: ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/06/96	Licensee	Ops	During shutdown of the 1A DG the operator incorrectly reduced generator power: from 4 MW to 0 MW instead of required 1 MW and failed to hold generator power at 1 MW for 15 minutes due to inattention to detail. Similar error on 9/9/96.	Human Performance	96014
10/05/96	Self	Maint	poor material condition of check valves: resulted in two radioactive gas releases in the auxiliary building and the Unit 1 containment.	Material Condition	96014
10/05/96	NRC	Eng	Temporary fan was attached by duct tape on the Unit 2 manipulator crane: over the refueling cavity while fuel assemblies were being moved.	Design Control	96014
10/05/96	Licensee	Ops	Unit 1 inadvertently entered a TS LCO: for the penetration pressurization system when a technician lifted a Unit 2 leak located at the "O" pp air compressor. Not recognized immediately until pointed out by SQV personnel in the control room. (Good finding by SQV)	Procedure	96014
09/26/96	Self	Eng	500 gallons of water was inadvertently drained: from the Unit 2 RWST to the transfer canal during testing performed by system engineering.	Procedure	96014
09/25/96	Self	Maint	Instrument air lost to the Unit 2 containment: as a result of a poorly planned maintenance activity to install valve blocks on the instrument air containment isolation valves.	Procedure	96014

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/24/96	Self	Plant Support/ Ops	Technical specification violation when an RPT incorrectly positioned filter paper causing a SPING to enter low-flow fail mode.: Core alterations and containment atmosphere purge continued with the failure going unnoticed by operators despite alarm. Licensee did not have an operable radiation monitor capable of automatic isolation of the containment purge/vents.	Human Performance	96016
09/23/96	Self	Eng	System engineer signed off the step in TSGP 97 without performing the associated action that ensured energization of undervolt relay 427TD1 before de-energizing relay SDR/27-2. Caused actuation of 2A service water pump breaker.	Human Performance	96014
09/22/96	Self	Ops	3,000 gallons of demineralized water were sprayed inside containment: due to failure to verify that valves off the demineralizer water header were closed prior to opening the demineralized water containment isolation valves.	Procedure	96014
09/22/96	Licensee	Plant Supt	Licensee failed to perform compensatory sampling: when ODCM radiation monitor (2RT-PR25) was out of service.	Material Condition/ Human Performance	96016
09/19/96	-----	---	Unit 2 shut down for refuel outage.	-----	-----

"+" indicates a positive attribute/occurrence.

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/18/96	Licensee	Ops	Inadvertent Unit 1 entry into TS LCO: for containment isolation valves during stroke testing of the 2A steam generator atmospheric relief valve. Acceptability of valve stroke time was not evaluated by the personnel performing the test. The operators and the unit supervisor did not recognize that exceeding the valve data required the valve to be considered inoperable.	Human Performance/ Procedure	96014
09/17/97	NRC	Ops	Exceeded TS LCO required action time interval: of eight hours between verifications of offsite power availability during 2B DG outage. Four additional examples identified for earlier DG outages. Caused by incorrect understanding of Technical Specifications.	Human Performance	96014
09/16/96	NRC	Ops	Operator continued to pull control rods even though control board rod demand and rod position indication deviated greater than 12 steps: on several occasions during withdrawal of shutdown banks. Did not enter AOP or investigate rod position indication problems. Caused by deficiencies in communication of expectations for conduct of startup, in command and control during rod withdrawal, and in operator sensitivity to possible rod misalignment due to known position indication problems.	Human Performance	96014

PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/15/96	Self	Ops	Upplanned LCO entry when Equipment Attendant partially disassembled the 2B safety injection (SI) pump component cooling water flow transmitter: in an effort to reset the SI pump cooling water low flow annunciator. Caused by inadequate equipment attendant communications and understanding of duties.	Human Performance	96014
09/10/96	NRC	Maint	Quality control (QC) inspection for the torquing of the 2B emergency diesel generator jacket water cooler end cover was not independent since the QC inspector set the torque wrench for each torque increment.	Human Performance	96014
09/09/96	Self	Maint	EDG 2A declared inoperable due to fouling of HXs: Attributed to 8/14/96 backflush of fire protection header. Previous 5/59/96 fouling of EDG 2A HXs attributed normal accumulation between cleanings.	Procedure	96014
09/05/96	NRC	Maint	Procedure VT-3/4-1, revision 2, "VT-3/4 Visual Inspection Performed for Section XI," was used for an inspection and did not specify acceptance criteria for clearances between the building structure and the pipe support baseplate. Consequently, the visual examinations performed were inadequate in that they failed to identify several cases of clearances between the building structure and the support baseplate that were not within established criteria specified in procedure NWSP-S-05.	Procedure	96013

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
08/26/96	Self	Maint	Unit 1 shutdown due to failure to install the hypoid gear locating key for two PORV block valve drive sleeves: during the 1995 Unit 1 refueling outage. This resulted in a PORV block valve tripping on thermal overloads.	Human Performance\ Procedure	96014
08/25/96	NRC	Eng	Single failure of blackout detection control circuit would prevent automatic sequencing of 4 KV and 480 volt safe shutdown loads during LOOP.	Design control	LER 96022
08/22/96	NRC	Eng	Over 100 discrepancies between UFSAR and as-built and operated plant, which were identified during licensee's UFSAR conformance review, were not formally documented: for resolution due to inadequate procedures and failures to follow procedure.	Procedure	96011
08/22/96	NRC	Eng	Breakdown in modification package closure process: Nine safety related and 19 non-safety related modifications installed and placed in service although not authorized by operations and not received appropriate post modification testing.	Program/ Human Performance	96011
08/22/96	NRC	Eng	Ineffective 10 CFR 50.59 safety evaluation process: Multiple failures to perform safety evaluations, and inadequate safety evaluations.	Program/ Human Performance	96011
08/22/96	NRC	Eng	Weak and inadequate operability assessments: Three of 12 reviewed were deficient, such as not evaluating operability at design flow conditions for charging pump degradation noted during ECCS testing.	Program/ Human Performance	96011

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
08/22/96	NRC	Eng	Trending of equipment problems and resolution of recurring equipment problems was weak: Repeated failures of containment spray sodium hydroxide spray additive tank level indication, radiation monitors, and the reserve feed breaker for Unit 2 ESF busses without adequate followup and action. Trending by system engineers such as lube oil analysis was inconsistent.	Program/ Human Performance	96011
08/22/96	NRC	Eng	Numerous inappropriate technical specification interpretations (TSIs): Four examples of using TSIs versus required TS amendments with several others changing the intent of the TS.	Program/ Human Performance	96011
08/22/96	NRC	Eng	Management expectations were not clearly defined, nor understood by engineering staff: For example, management expected system engineers to evaluate lube oil analysis sample results, even though engineers had not been trained or qualified.	Human performance	96011
08/21/96	NRC	Ops	Significant number of rod position indication system problems during Unit 1 startup: Resulted in weak command and control when numerous personnel clustered around process computer.	Material Condition	96010
08/18/96	Self	Maint	Unit 1 reactor trip when MSIV closed greater than 10% due to failure of limit switch: causing shrink in the ID steam generator and a low low trip signal. Poor preventive maintenance on limit switch.	Program	96010

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
08/16/96	Self	Ops	Operator inadvertantly overflowed lake discharge tank: caused by failing to fully close LDT inlet isolation valve valve causing backup of 7000 gallons onto floor of auxiliary building. (Repeat of January 20, 1996 event.)	Human Performance	96010
08/16/96	NRC	Maint	Maintenance personnel failed to adequately document missing part: during 1B centrifugal charging pump shaft driven oil pump inspection.	Human Performance	96010
08/15/96	Self	Ops	Licensed operators failed to include valve in partial clearing of OOS: on aux steam system which resulted in cross-tying aux steam with service air system.	Human Performance	96010
08/07/96	Licensee	Eng	Engineering personnel failed to include necessary supporting information in operability assessment: to justify conclusion that 1B charging pump was operable with degraded shaft-driven oil pump.	Human Performance	96010
08/05/96	NRC	Maint	Scaffold around 1B containment spray pump: obstructed operation of pumps discharge valve. Corrective actions inadequate from June 17, 1996 event	Human Performance	96010
07/31/96	NRC	Ops	Fallen radiological postings and obscured radioactive material posting.	Human Performance	96010
07/30/96	Licensee	Ops	Fuel handling personnel inadvertently dropped two new fuel assemblies: during receipt inspection due to an inadequate rigging step in procedure.	Programs Procedures	96010

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
07/26/96	Licensee	Ops	Non-licensed operator misaligned 2B diesel generator air regulation isolation valve: while performing a valve lineup verification. Good finding by maintenance engineer walking down diesel.	+	96010
07/26/96	Licensee	Plant Supt	Licensee failed to perform compensatory sampling: when ODCM radiation monitor (1RE-0015) was out of service. See also 7/5/96 event.	Material Condition/ Human Performance	96016
07/26/96	Licensee	Plant Supt	Procedure failed to specify actions to meet technical specification action statement: when containment high radiation monitor was inoperable during maintenance TS not violated since other monitor was operable.	Procedures	96010
07/15/96	Self	Ops	Unit 2, excessive load placed on the 2B EDG during performance of the monthly TS surveillance: caused by NSO manipulation of controls. This is a repeat of the May 19 event.	Human Performance	96008
07/12/96	Licensee	Ops	Failure to perform post-maintenance testing: on a Unit 2 containment isolation valve following repairs to the valve's open limit switch.	Human Performance	
07/09/96	NRC	Plant Supt	Longstanding plant practice of improperly transporting chemistry samples: without surveying the materials for surface contamination.	Program	96008
07/05/96	Licensee	Plant Supt	Failure to obtain and analyze sample: when TS radiation monitor (OR-PR07) was out of service.	Material Condition/ Human Performance	96016

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
07/01/96	NRC	Plant Supt	Replacement of the 1A DG CO2 discharge timer rendered the automatic function of the CO2 system inoperable: status was not recognized by fire protection, operations, and electrical maintenance personnel.	Procedures	96008
06/24/96	Licensec	OPS	Both Unit 1 reactor coolant drain tank (RCDT) pumps were deadheaded: due to the failure to realign RCDT flow path following a placement of an OOS for the holdup tank (HUT) maintenance activity.	Human performance	96008
06/23/96	NRC	Eng	System engineer slow in initiating a PIF: for holes in ductwork in the fuel transfer canal area and any bypass flow around the charcoal bed.	Human performance	96008
06/21/96	NRC	Ops	Good communications and coordination among: fuel handling, radiation protection, and decontamination personnel during the filtration unit retrieval evolution.	+	96008
06/18/96	Lic	Engrg	System engineer identified that scaffolding: could potentially affect the operation of two governor control valves in the Unit 1 high pressure turbine area.	+	96008
06/13/96	NRC	Ops	One of two Unit Supervisor's command and control during the dynamic simulator examinations was a weakness.: Additionally, the lack of attention to detail, lack of self checking, and failure to use Annunciator Repsonse procedures contributed to several JPM failures.	Training	96008
06/12/96	Lic	Ops	Returned containment isolation valve to service without recognizing and performing appropriate post-maintenance testing	Human performance	96014

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
06/12/96	Self	Ops	Portable filtration unit fell seven feet onto the transfer canal island: due to a radiation protection technician's (RPT) improper rigging of the unit.	Human performance	96008
06/10/96	Lic	Plant Support	An individual, who was not a qualified radiation protection technician, alarmed a radiation detection device, failed to notify radiation protection personnel, and removed the contamination.	Human performance	96016
06/10/96	Lic	Plant Support	Radiation worker performance and adherence to radiation work permits and procedures were weaknesses during the fuel canal decontamination.	Human performance	96008
06/10/96	NRC	Plant Support	Water chemistry program was consistent with industry guidelines, and chemistry staff provided good reviews and analysis of primary and secondary chemistry data.	Program Human performance	96008
05/21/96	NRC	Ops	Operator Work Around List was not routinely reviewed by licensed operators: to ensure awareness of all plant conditions.	Program	96008
05/21/96	NRC	Ops	The operations staff received insufficient training on the newly implemented computer systems for administrative control of work activities: (Electronic Work Control System (EWCS)), and the PT-14 system for tracking OOS equipment and the workaround list.	Training	96008

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
05/19/96	Self	Maint	Operators were challenged when several components did not perform as expected during Unit 2 shutdown for inoperable EDGs: Specifically, low power reactor trip block, P-7, did not actuate requiring operators to trip reactor, moisture separator reheater control system could not be placed in manual operation requiring local operator action to close valves. 2C main feedwater pump could not be placed on turning gear.	Material Condition	96007
05/19/96	Self	Ops	Unit 2, 2A Emergency Diesel Generator Output Breaker Reverse Power Trip: caused by NSO manipulation of controls.	Human Performance	95007
05/19/96	Self	Ops	Unit 2, 2B Emergency Diesel Generator Failure: due to zebra mussel fouling in the lube oil heat exchanger and intake air heat exchangers.	Material Condition	96007
05/15/96	Self		Mixed bed demineralizer temperature excursion: the letdown demin inlet divert valve, and the CCW letdown heat exchanger temperature control valve, responded sluggishly while establishing Unit 1 letdown flow. The temperature of the resin reached 148 °F for several minutes.	Material Condition	
05/08/96	Lic	Plant supt	Security contractor falsified employee background checks.	Human performance	LER 96-S01
04/25/96	Lic	Plant supt	U2 Inoperable containment air lock door exceeded 24 hour LCO: RP technicians making containment entries experienced problems with the air lock door over a period of days. No PIF, no AR written, & Ops/Engineering not notified until 4/25	Human performance	96007

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/21/96	Self		1C low pressure turbine reheat stop and intercept valves failed to remain closed: following turbine trip testing during Unit 1 startup.	Material Condition	96007
04/20/96	Self	Maint	Two EHC oil spills occurred due to maintenance mechanics: installing bolts of an incorrect length for the moisture separator reheat intercept and stop valves orifices.	Human performance	96007
04/15/96	Self		Unit 1 reactor trip: low flow sensed on two of three RCS loop flow transmitters. Root cause of trip was entrapped gases in the loop flow sensing lines, which have never been routinely vented post outage.	Material Condition	96007
04/10/96	NRC/Lic		All six containment spray additive (CS) eductor throttle valve positions different from the positions specified in System Operating Instructions: Licensee was not aware of discrepancy until NRC pointed it out: subsequent licensee analysis determined system was operable.	Material Condition	96006
04/08/96	Lic		Isolation valve seal water system check valves had not been tested: for their closing function in accordance with the IST program since the Unit 1 refueling outage in Fall 1995. Identified by licensee IST engineer during data review for Unit 2 outage.	Personnel Performance	96006

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PLANT ISSUES MATRIX

ZION

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
04/02/96	NRC	Maint	Four loose bolts on the 'O' DG after maintenance and modification work: had been completed on the DG. This deficient condition did not render the DG inoperable as the post-maintenance test (PMT) had not been performed yet on the DG.	Personnel Performance	

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PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/10/97	*****	*****	Branch 3 PPR Meeting	*****	
2/7/97	NRC	Plant Support	Certain chemistry QC procedures and PASS surveillance procedures were inadequate: (1) they did not contain acceptance criteria to determine the acceptability of surveillance results and (2) they did not ensure the validity of high purity germanium detector calibrations (as recommended by RegGuide 1.33, Appendix A).	Inadequate Procedure	97003
2/7/97	NRC	Plant Support	Weaknesses in the analytical chemistry interlaboratory program were identified: (1) analytical results were not compared and reported in a timely manner and (2) the licensee did not always resolve analysis results which were not in agreement with program acceptance criteria.	Inadequate Procedure	97003

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/7/97	NRC	Plant Support	Excellent primary and secondary systems water chemistry program. During 1996, the concentrations of chloride and fluoride in the primary systems were maintained between 3-5 parts per billion. Effective control of chemical intrusions and secondary system additives reduced the potential for system corrosion and decreased radiological source term. The licensee experienced some circulating water intrusions in July 1996 (unit 1) and February 1996 (unit 2), which corresponded to minor, short term increases in the concentrations of sodium and chloride in the steam generators.	Program	97003
2/5/97	NRC	Plant Support	PASS maintenance items were not resolved in a timely manner. In June 1995, the licensee identified a problem with the containment air sampling panel (CASP) circuitry which had sometimes resulted in the disablement of a radiation monitor. When the gas partitioner module was connected to the AC outlet within the CASP (as directed by procedure) or the light within the CASP panel was activated, radiation monitor 1PR11J (containment atmosphere) was disabled.	Program Equipment Malfunction	97003

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/5/97	NRC	Plant Support	Chemistry PASS training was very interactive and the discussions were thorough. The trainer emphasized the potential radiological conditions of a PASS sample and the sample system.	Training	97003
2/4/97	NRC	Plant Support	Chemistry technicians demonstrated good analytical techniques and knowledge of procedure requirements and references.	Personnel Performance	97003
2/4/97	NRC	Plant Support	Chemistry technicians were verifying QC performance tests for laboratory instruments with an uncontrolled aid. The licensee did not perform a periodic review to ensure that the aid was consistent with the data base as required in BwAP 550-25.	Program	97003
2/4/97	NRC	Plant Support	Statistical biases in fourth quarter 1996 and first quarter 1997 chemistry instrument QC data were not resolved in a timely manner. These biases potentially indicate minor problems concerning the instrument calibration or the calibration standard or an instrument operability problem.	Program/ Personnel Performance	97003
2/3/97	NRC	Plant Support	Two aluminum (Al) standards were improperly labeled with respect to the procedure required shelf-life.	Personnel Performance	97003

PLANT ISSUES MATRIX

BRAIDWCOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
1/2/97	NRC	Maintenance	Inspectors identified that the work package was not present at the work site for the 1C heater drain pump. Also the foreman could not explain the purpose of the procedure steps.	Personnel/ Procedure Adherence	96021
12/31/96	NRC	Maintenance	The inspectors observed that the surveillance on the 2B RHR pump was performed in a competent and well controlled manner. However the licensee failed to ensure that a required change to the surveillance procedure was made prior to use.	Personnel/ Procedure Adequacy	96021
12/23/96	NRC	Engineering	Lack of complete understanding of regulatory requirements: Understanding of the ASME code and the applicable generic letter guidance was poor when a through wall flaw was identified in the 1A essential service water system in that the train had not been removed from service nor had any corrective action been taken.	Personnel Performance Deficiency	96021
12/19/96	NRC	Operations	Inspectors observed operators add lubricating oil to the 2B Emergency Diesel Generator in violation of a procedure. Operators were unaware of the procedures existence.	Personnel Performance	96021
12/9/96	NRC	Maintenance	Inspectors identified several carts secured to safety-related equipment. This was also identified by the inspectors on 11/4/96.	Procedure Adherence and Corrective Actions	96021

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/5/96	Licensee	Plant Support	The alarm setpoints for the fuel handling incident radiation monitors were not in accordance with Technical Specification Table 3.3-6 (i.e. 10 mrem/hr). The as found setpoints were 100 mrem/hr (alert) and 2000 mrem/hr (high alarm). (97003)	Personnel Performance	LER. 97003
12/1/96	Licensee	Maintenance	Two spent fuel assemblies were mispositioned in the spent fuel pool.	Procedure Adherence	96021
11/18/96	NRC	Operations	During turbine valve exercise, control room operators demonstrated poor performance in the following areas: <ul style="list-style-type: none"> • Reactivity control and management. • Alarming annunciator response, and • Teamwork between NSO and shift engineer. 	Personnel Performance Deficiency	96019
11/18/96	NRC	Maintenance	Failure to follow procedure: while installing manways and diaphragm plate for Unit 1 IC Steam Generator.	Personnel Performance Deficiency	96019
11/14/96	Licensee	Engineering	Questioning attitude: A system engineer demonstrated a knowledge of expected system performance and a questioning attitude to detect electronic noise effecting vibration readings on a diesel oil transfer pump since the vibration measurements initially obtained met the acceptance criteria.	Team work/ Skill level	96019

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
11/11/96	Licensee	Engineering	Through self assessment, system engineer identified problems with drawings from construction phase. control and instrumentation drawings depicted power leads to the control room dampers hydromotors inaccurately.	Personnel Performance Deficiency	96019
11/6/96	*****	*****	Branch 3 PPR meeting.	*****	
10/25/96	Licensee	Engineering	The licensee's efforts to evaluate steam generator tube integrity by assessing growth rates for this type of cracks by historical eddy current data reviews/comparisons and in-situ pressure testing was indicative of an aggressive program.	Teamwork/Skill level	96017
10/19/96	NRC	Operations	Several indicators of poor communication and operation practices were evident during drain-down evolution for mid-loop operation and nozzle dam installation. <ul style="list-style-type: none"> • Blockage of the pressurizer manway vent pathway • Creation of a loop seal on the reactor head vent pathway • Exclusion of an additional drainage verification method from the drain down procedure. 	Personnel Performance Deficiency	96019
10/12/96	Licensee	Operations	Power-operated relief valve inadvertently lifted: when operators overfilled pressurizer during cooldown and depressurization of Unit 1.	Inadequate Procedure Instruction	96018

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/12/96	Licensee	Maintenance	Performance of maintenance without necessary documentation: Licensee personnel landed 125 VDC lead in reverse polarity on an instantaneous prepositioning board for 1B Diesel Generator.	Inadequate Procedure Instruction	96019
10/04/96	Licensee	Maintenance	Two safety injection vent and drain valves and two LLRT connectors were not included in primary containment integrity verification surveillance procedure.	Inadequate Procedure Instruction	96014
10/3/96	Licensee	Engineering	Questioning attitude by operators: The licensee observed cooler than normal temperatures in the Unit 1 essential switchgear room. An inadequate PMT failed to reveal that control relay contacts were configured incorrectly.	Inadequate Procedure/ Instruction	96019
09/30/96	NRC	Engineering	High number (14) of temporary alterations installed in the plant for greater than 18 months: however, good progress toward reduction of the total number of temporary alterations was made.	Engineered Design Deficiency	96014
09/23/96	Licensee	Maintenance	Severe lube oil leakage from 1A motor-driven feedwater pump when placed in operation following a lengthy idle period: identified when the licensee was performing repairs to the 1C turbine driven feedwater pump.	Equipment Malfunction	96014
09/23/96	NRC	Operations	Prompt action by the Unit 1 reactor operator prevented a significant plant transient: after a failure of the master feedwater pump controller.	Other/NA	96014

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
09/11/96	Licensee	Operations	Diesel Generator Fuel Oil Tank room sprayed with water: non-licensed operators mispositioned valve while performing surveillance.	Personnel Performance Deficiency	96014
09/11/96	Licensee	Operations	Fuel pool cooling pump found turned off for 5 hours. Fuel pool temp went up 7 degrees (below alarm setpoint)	Personnel Performance Deficiency	
09/10/96	NRC	Operations	Failure to use updated procedure: while performing monthly operability surveillance for Unit 1 diesel generator.	Inadequate Procedure Instruction	96014
09/06/96	NRC	Engineering	Lack of complete understanding of regulatory requirements: A lack of complete understanding of the 10 CFR 50.59 requirements when returning the unit to service with the Unit 1 cold leg reactor coolant stop valve degraded without documenting a 10 CFR 50.59 safety evaluation.	Personnel Performance Deficiency	96019
09/06/96	NRC	Operations	Unit 2 pre-surveillance essential service water to diesel jacket water cooling valve manipulation: performed prior to the start of the diesel generator monthly surveillance.	Personnel Performance Deficiency	96012
08/30/96	Self-Revealing	Operations	IC condensate booster pump destroyed: when operator inadvertently shut the suction valve instead of the discharge valve.	Personnel Performance Deficiency	
08/25/96	Licensee	Operation	Mispositioned boric acid tank recirculation throttle valve: found open while transferring boric acid between tanks.	Personnel Performance Deficiency	96012

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
08/21/96	NRC	Operations	Failure to perform independent verification: by operators performing valve manipulations during the 2B DG monthly surveillance.	Personnel Performance Deficiency	96012
07/31/96	NRC	Operations	Unit 1 undocumented testing: of the essential service water valve to diesel jacket water cooling valve prior to diesel generator start.	Personnel Performance Deficiency	96012
07/03/96	Licensee	Engineering	Several roll-up fire doors for rooms containing safety-related equipment failed to close: when outside air ventilation was supplied during surveillance testing.	Engineered Design Deficiency	96014
06/17/96	Licensee	Operations	Spent fuel improperly repositioned: in the spent fuel pool into a configuration that was not bounded by the existing criticality analysis, but was subsequently analyzed to be acceptable, however was later moved.	Personnel Performance Deficiency	
06/07/96	Licensee	Operations	Missed diesel fuel oil sample: required by Technical Specification due to sample scheduling.	Personnel Performance Deficiency	
06/04/96	Licensee	Operations	Fire Protection Appendix R Design Discrepancies: due to erroneous evaluation during preparation of original analysis regarding the operation of the of the VC dampers during a fire.	Personnel Performance Deficiency	
06/03/96	Licensee	Operations	Failure to maintain differential pressure between the Aux Building and atmosphere: due to an inadequate controls process.	Personnel Performance Deficiency	

PLANT ISSUES MATRIX

BRAIDWOOD

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
05/23/96	Licensee	Operations	Failure to Enter Tech Spec 3.0.3: due to the failure of the Unit Supervisor and the Unit NSO to recognize that both the containment floor drain leak detection system flow transmitter and containment atmosphere radiation monitor skid were simultaneously inoperable	Personnel Performance Deficiency	
05/06/96	Self-Revealing	Operations	2A Auxiliary Feedwater Pump Inadvertent Start: after being placed in Local on the remote shutdown panel due to the 2B steam generator level being below the Lo-2 setpoint. The 2A AFW pump had been placed in pull-to-lock on the main control panel.	Personnel Performance Deficiency	
4/3/96	Licensee	Engineering	Poor engineering practice: The acceptance criteria change to the 1A RHR pump surveillance procedure was not incorporated into all of the procedures that were affected by the change.	Personnel Performance Deficiency	96014
03/96	Licensee	Maintenance	Maintenance on Flow Orifice With Incorrect Work Authorization: partially disabling the only operable Unit 2 safety injection pump. The other safety injection pump was also out of service for planned maintenance, with the unit at full power.	Personnel Performance Deficiency	96005

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
3/10/97	*****	*****	Branch 3 PPR meeting	*****	
3/7/97	NRC	Plant Support	Inspectors found that training on the post accident sample system had not been conducted as required on 6mo. intervals. Had been conducted annually.	Personnel Performance	97003
3/5&6/97	NRC	Plant Support	Inspectors had to prompt chem. techs. to prevent errors while sampling reactor coolant.	Personnel Performance	97003
3/5/97	NRC	Plant Support	Inspectors found chem. techs. not following procedures by not evacuating a vial for a gas sample.	Personnel Performance	97003
3/97	Licensee	Plant Support	The chemistry staff was found to be tracking the findings and taking appropriate actions to 1995 and 1996 SQV, corporate, and vendors audit findings.	N/A	97003
3/97	Licensee	Plant Support	In 1996, the chemistry line organization began a surveillance program to identify weaknesses in the chemistry program.	N/A	97003
3/1/97	Self Revealing	Maintenance	FME- Foreign Material Intrusion requires rework of two pumps. 1A CS pump had 3/8x1/4" particle in the shaft seal causing leakage during refill. 1B CS pump post maint. test run had high temp. on the thrust bearing and dirty oil, resulting from a large chip (1"x3") of paint between the thrust bearing and the housing. Both pumps had to be reworked to eliminate the FM resulting in a delay in plant startup.	Personnel Performance	97002

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
2/17/97	Self Revealing	Plant Support/Ops.	A radioactive waste operator transferred water from one of the release tanks to the regen waste tank and over-filled the regen waste tank. The operator did not monitor tank level during the transfer, and the high level alarm had been disabled by the receipt of the low level alarm. Consequently, the over-pressurization and deformation of the tank resulted in a spill of radioactive liquids to the floor drain system and in significant damage to the tank.	Personnel Performance	97002 and 97003
01/09/97	NRC	Plant Support	Maintaining water tight doors shut. Previous corrective actions to preclude unattended open water tight doors were ineffective in keeping the doors closed.	Corrective Actions	96012
01/97	NRC	Operations	SOV audits and assessments were positive contributors to oversight of station operations.	Personnel Performance	96012
12/96	NRC	Plant Support	The security plan did not accurately describe the location or correct description of the Vehicle Barrier System in all instances.	Other	96010
12/96	NRC	Plant Support	The Access Authorization Program was effectively implemented.		
12/31/96	Self revealing	Maintenance	An operator demonstrated a good questioning attitude in the identification of low flow in the 1B essential service water pump room cooler. However, the failure to properly use matchmarks to reassemble the cooler components could have been prevented by reasonable corrective action from other events.	Correctiv Actions	96012

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
12/30/96	NRC	Engineering	Modification w/out 10CFR50.59 evaluation. The inspectors identified that a surveillance procedure for the Containment Floor Drain Leak Detection System (IRF008) was implemented to compensate for the loss of alarm function without declaring the system inoperable or performing a safety evaluation.	Personnel Performance	96012
12/29/96	NRC	Engineering	Operators failed to identify the degraded condition of the containment floor drain leak detection system when the alarm was locked-in due to a secondary side steam leak.	Personnel Performance	96012
12/17/96	Licensee	Engineering	The licensee identified and aggressively pursued the motor control center spacer issue with Westinghouse. The operability assessment and corrective actions to install the spacers were timely and thorough.	Other/NA	96009
11/12/96	NRC	Engineering	Spent Fuel Pool (SFP) Boraflex. The inspectors concluded that the licensee's submittal, regarding SFP Boraflex degradation and the decision to "checker board" the SFP were not pursued in a timely manner until after discussions with the NRC.	Personnel Performance	96009

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/21/96	Licensee	Plant Support	On four separate occasions in October 1996, the licensee identified inadequate radiological postings: either the high radiation area posting or the contaminated area posting for the unit 1 volume control tank room was found to be on the valve aisle door. The licensee conducted a thorough investigation which reported that a contract individual admitted to "finding" and replacing postings which had fallen and "moving" postings which he believed were incorrect.	Personnel Performance	97003
11/96	NRC	Operations	The requalification training feedback system was good.	Other/NA	96011
11/96	NRC	Operations	The station auxiliary transformer switching and restoration operations were carefully planned and professionally executed.	Team Work Skill Level	96009
11/6/96	*****	*****	Branch 3 PPR meeting	*****	
10/7/96	NRC	Plant Support	A violation was issued due to a fire door being impaired without a Barrier/Fire Protection Systems Impairment Permit.	Personnel Performance Deficiency	96009
8/95 - 10/96	NRC	Operations	A lack of formal controls to limit examination material overlap was a weakness.	Other/NA	96011
10/15/96	NRC	Engineering	System engineering failed to appreciate or understand the importance of the surveillance test with respect to SX system operability.	Personnel Performance Deficiency	96009

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/15/96	NRC	Engineering	Inadequate corrective action to repair the trash racks since 1993 demonstrated a lack of knowledge of SX system design by the licensee and a willingness to operate with a degraded safety system.	Other/NA	96009
10/15/96	Licensee	Engineering	The licensee identified errors in the ultimate heat sink cooling tower basin makeup calculation. (It did not reflect the SX system design features since initial plant operation.) The 1991-1992 design basis reconstitution failed to identify this error.	Other/NA	96009
10/15/96	Licensee	Engineering	The licensee identified that silt levels in the SX cooling tower basin did not meet the surveillance acceptance criteria. Based on the excessive silt found on 10/15/96, the licensee determined that the SX system was inoperable when the plant relied on the deep well pumps for makeup capability.	Other/NA	96009
7/93 to 10/97	Self Revealing	Operations	Operations failed to recognize the significance of the reduced operability of the SX system due to the degraded trash screens in the SX cooling tower basins. This was even with the evidence of the damaged SX strainers caused by transported cooling tower fill material.	Corrective Actions and Personnel Performance	96009
10/15/96	NRC	Maintenance	Surveillance test OBVS SX-5 contained inadequate acceptance criteria to determine SX system operability.	Other/NA	96009

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
10/96	NRC	Operations	Licensee validation of examination material lacked comprehensive review as evident by errors detected during examination administration.	Personnel Performance Deficiency	96301
10/96	Self-Revealed	Operations	The applicants' effective use of communications during dynamic scenarios enhanced good teamwork.	Team Work Skill Level	96301
10/96	NRC	Plant Support	The Access Authorization Program and the Vehicle Barrier System were effectively implemented.	Team Work Skill Level	96010
09/05/96	NRC	Plant Support	10 CFR 20.1902(a) violation: A storage area in the Aux. building had rad levels in excess of 5 mrem/hr at greater than 30cm that was not posted.	Inadequate Procedure Instruction	96008
09/96	Self-Revealed	Plant Support	Licensee's control of Unit 2 outage dose was a strength.	Team Work Skill Level	96008
09/96	NRC	Operations Plant Support	Teamwork between rad protection, chemistry, and operations staff was effective in reducing source term in Unit 2.	Team Work Skill Level	96008
08/96	NRC	Operations	Unit 1 auxiliary feedwater trains (2) inoperable: "A" train was inop due to a surveillance when the "B" train was made inop due to the attachment of a strip chart recorder	Personnel Performance Deficiency	96006
07/96	Licensee	Operations	A loss of examination material control required the generation of replacement examination and resulted in a substantial delay in examination administration.	Other/NA	96301

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
07/02/96	Self-Revealed	Maintenance	Unit 1 manually tripped: in response to a loss of feedwater to the B steam generator. The startup feedwater supply valve failed closed due to a faulty solder connection on the instrument air line to the valve control.	Equipment Malfunction	96005
06/30/96	Self-Revealed	Maintenance	Unit 1 main turbine trip: due to failure of the teflon oil seal between the generator and the exciter. The reactor did not trip because power was below the 30 percent interlock.	Equipment Malfunction	96005
06/12/96	Self-Revealed	Operations	Unit 1 reactor coolant system excessive dilution: after a refueling outage with reactor partially drained; and with the reactor isolated from the steam generators.	Personnel Performance Deficiency	96005
05/96	Licensee	Engineering	Unit 1 steam generators each categorized as C-3: eddy current inspections found more than one percent of the tubes in each generator to be defective.	Equipment Malfunction	96004
05/23/96	Self-Revealed	Operations	Surge tank overflowed 7000 gallons into the floor drains: due to loss of station air, the makeup water supply valve to the component cooling water system surge tank failed open as designed.	Engineered Design Deficiency	96005
05/23/96	Self-Revealed	Operations	Operators manually trip Unit 2: due to loss of offsite power to Unit 1. Plant configuration had all non-essential cooling service water pumps and station air compressors powered from Unit 1.	Engineered Design Deficiency	96005

PLANT ISSUES MATRIX

BYRON

DATE	ID BY	SALP	DESCRIPTION	CAUSE	REF
05/23/96	Self-Revealed	Maintenance	Complete loss of offsite power to Unit 1: because of moisture intrusion into one of the bus ducts which caused a ground fault.	Equipment Malfunction	96005
04/96	Licensee	Operations	Inoperable safety injection accumulators: when occasionally cross-connected during periodic fill or pressurization operations.	Engineered Design Deficiency	96004
03/22/96	Licensee	Engineering	Containment spray chemical addition system: set to provide sodium hydroxide at a rate greater than allowed by TS.	Other/NA	96003
03/13/96	Self-Revealed	Operations	2A diesel generator tripped: when an operator inadvertently opened the DG output breaker instead of the governor adjust switch during the routine monthly surveillance.	Personnel Performance Deficiency	96003
03/13/96	Self-Revealed	Operations	NSO inadvertently adds boric acid to the reactor coolant system: during filling of the spent fuel pool transfer canal from the Unit 1 boric acid blender, resulting in a 2 ppm increase and a corresponding 0.7 degree F decrease in reactor temperature.	Personnel Performance Deficiency	96003