

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 2B <b>Ter:</b> 3A	<b>Preparation for cold weather conditions</b> The cold weather procedure was adequately revised for the new emergency feedwater pump building and implemented appropriately (Section O1.4).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Plant startup activities</b> Plant heatup, reactor startup, and low-power physics testing were conducted in a safety-conscious manner. Operators were methodical during evolutions and closely monitored plant parameters (Section O1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b> 5C	<b>Mode restraint activities</b> Licensee tracking and disposition of mode restraints were effective. Potential emergent mode restraints were effectively resolved in the corrective action program. Management hold point review meetings were thorough (Section O1.3).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 3A <b>Ter:</b> 5B	<b>Operators' response to a dropped control rod</b> Operators responded effectively to a plant runback caused by a dropped control rod. Bent rod drive connector pins and a degraded stator were diagnosed as the cause, necessitating a forced outage to repair. Problems were also noted with improperly connected control rod drive cooling water lines. Operators performed well during plant condition changes and no discrepancies were noted. The post-outage critique was an effective and self-critical review (Section O1.5).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Operator training activities</b> The content of the annual operating test and weekly written examinations was satisfactory. The licensee's feedback process and remedial training were satisfactory and re-evaluation testing appropriately addressed identified operator deficiencies. These portions of the licensee's operator requalification training program met the requirements of 10 CFR 55.59 (Section O5.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b> 5C	<b>Emergency feedwater pump 3 (EFP-3) conditions</b> The alignment of emergency feedwater pump 3 (EFP-3) and the overall condition of the EFP-3 building were satisfactory. Minor discrepancies with valve seals were noted but were appropriately addressed by the licensee (Section O2.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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11/06/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Fuel movement activities</b> Fuel movement was precisely controlled. Communications were consistently effective and utilized 3-way techniques (Section O1.5).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Refueling outage operating evolutions</b> Overall, operators performed very well during numerous significant refueling outage operating evolutions. Operators followed procedures and altered plant conditions methodically. Supervisory oversight of plant condition changes was thorough and consistent. Operational focus on shutdown reactor safety parameters was clear and consistent (Section O1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Rod drop testing activities</b> Rod drop testing was effectively controlled. Senior management oversight was continual. Operators closely monitored plant instrumentation and distractions were limited during the testing. Communications were complete and precise (Section O1.3).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Preparations for refueling outage</b> Preparations for refueling outage reactor coolant system inventory reductions were thorough. Dedicated oversight teams were established well in advance of the outage. Revised guidance, new operator aids, and a different initial draindown methodology were developed. The draindowns were closely supervised and operators were cognizant of all level indication instrument capability and readings. Level instrument performance was consistently accurate and stable, validating that previous concerns had been addressed. Temporary Instruction 2515/142 was completed to evaluate the licensee's analysis of Generic Letter 98-02 regarding reactor inventory control. The licensee's analysis was appropriate (Section O1.4).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 2B <b>Ter:</b> 3A	<b>Reactor Plenum Rigged Improperly</b> A non-cited violation was identified for incorrect attachment of the reactor plenum to the tripod lifting device. Detailed procedural guidance for attaching the plenum to the tripod was not followed by contract refueling personnel and the error was not detected by licensee refueling senior operators (Section O1.5).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007-02	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Failure to Properly Implement Procedure Results in Inadvertent Spent Fuel Pool Level Decrease.</b> Two non-cited violations were identified for operator errors involving poor procedure adherence that resulted in inadvertent water level decreases in the spent fuel pool and reactor coolant system. Operators responded promptly to the events and terminated the draindowns prior to any impact on reactor coolant or spent fuel cooling systems. Failure to properly implement procedures was the primary cause of these two events, but contributing causes included deficiencies in communications, poor self-checking techniques, and an outage schedule change which moved up some draining activities. Licensee investigations were thorough and corrective actions were prompt and appropriate (Section O1.6).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/06/1999	1999007-03	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Failure to Follow Procedure Results in Inadvertent Draining of the Reactor Coolant System</b>  Two non-cited violations were identified for operator errors involving poor procedure adherence that resulted in inadvertent water level decreases in the spent fuel pool and reactor coolant system. Operators responded promptly to the events and terminated the draindowns prior to any impact on reactor coolant or spent fuel cooling systems. Failure to properly implement procedures was the primary cause of these two events, but contributing causes included deficiencies in communications, poor self-checking techniques, and an outage schedule change which moved up some draining activities. Licensee investigations were thorough and corrective actions were prompt and appropriate (Section O1.6).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 4B	<b>Well controlled reactivity changes</b>  Full withdrawal of axial power shaping rods at end of core life was well controlled. Briefings were thorough and covered expected indications. Operators closely monitored all reactivity changes. A formal Operations program required reactor engineering guidance to operators to be written and approved by Operations management. Operations management control of information and guidance from other groups to the operating crews has significantly improved (Section O1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Quality Assurance audit activities</b>  Licensee Quality Assurance audit activities were broad and indicative of detailed questioning and familiarity with applicable standards and requirements. A licensee self-assessment on commitment tracking was thorough and indicated the licensee was effectively tracking outage commitments (Section O7.9).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> 5B <b>Ter:</b>	<b>Corrective action program</b>  The licensee's corrective action program, including problem identification and resolution, use of operating experience, self-assessment activities, safety review committees, and use of risk insights, was well understood and supported by management, appeared to be effective, and was functioning well. Improvements were identified in corrective action backlog and prioritization management, and in self-assessment implementation effectiveness (Sections O7.1-O7.8).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b> PLTSUP	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 1A <b>Ter:</b> 3A	<b>Preparations for Hurricane Floyd</b>  Preparations for Hurricane Floyd were very challenging due to the extensive amount of material staged for a pending refueling outage and ongoing construction of a new emergency feed pump facility. The licensee efforts were pro-active and resulted in the site being very well prepared for the possibility of a hurricane strike (Section O1.3).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006-01	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Two Examples of Failure to Meet Clearance Procedure Requirements</b>  A non-cited violation was identified for two examples of failure to fulfill clearance tagging program requirements. Electrical work was performed on a nitrogen heater with a closed 480 volt line breaker that was tagged open. Electricians did not discuss an unexpected energized status light with supervision and consequently did not identify the incorrect breaker position. In another example, active red tags were removed from electrical control panel switches. Training of contract workers did not explicitly ensure that red tags and components were not to be removed or manipulated. Although a definitive cause was not found for either event, the licensee investigations were prompt and comprehensive (Section O4.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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Region II  
CRYSTAL RIVER

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08/14/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5A <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Caution tag missing</b> NRC identified a missing caution tag. A previous licensee audit failed to identify associated discrepancies. Issues which resulted in the need for caution tags were not being prioritized for closure in order to remove the need for the tags for extended periods of time. The licensee's response to two recent clearance danger tag issues was prompt, pro-active, and thorough. (Section O4.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Use of three-way communication techniques</b> Control room operators consistently used three-way communication techniques, maintained high sensitivity to monitoring reactor controls, and demonstrated good control and awareness of plant evolutions. Control of temporary modifications was appropriate. A decision to reduce plant power on August 12 was preceded by thorough deliberations. Building operators exhibited good ownership of assigned areas. (Section O1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Operator requalification training on new emergency operating procedures</b> Operator requalification training on new emergency operating procedures was effective and included a large amount of preparatory work and coordination. Instruction methodologies and materials enhanced student knowledge and involvement. Associated simulator training reenforced classroom topics, and installation of planned plant upgrades on the simulator significantly enhanced the training. (Section O5.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5A	<b>LCO entry during surveillance testing</b> Operators performing a surveillance test were not aware that their actions had caused a Technical Specification Limiting Condition for Operation (LCO) for the Decay Heat Closed Cycle Cooling Water System to be applicable. However, the LCO time was not exceeded and the licensee's investigation was prompt and thorough. (Section O1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 5C	<b>Root cause investigation corrective action was closed to another process</b> NRC identified that a root cause investigation corrective action had been closed to another process, was not completed, and was under consideration for deletion by the subsequent process owner. (Section O8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b> 5A	<b>Questioning attitude by non-licensed operators</b> Non-licensed operators exhibited a questioning attitude when reviewing plant operation issues. The non-licensed operators were observed to be taking responsibility for housekeeping issues. On numerous occasions the non-licensed operators identified and removed miscellaneous equipment, such as unsecured ladders, which had been left behind from jobs being worked during the previous shift. (Sections O1.1 and O1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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07/03/1999	1999004-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 5A	<b>RCP power monitoring system effects on EFIC</b> A non-cited violation was identified for a 1995 failure to comply with Emergency Feedwater Initiation and Control system Technical Specifications due to a bypassed reactor coolant pump power monitor which affected the system's operability. This condition was identified by the licensee during review of a recent reactor coolant pump power monitor relay failure. (Section O8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 4B	<b>Response to a reactor coolant pump power monitor relay failure</b> Response to a reactor coolant pump power monitor relay failure was comprehensive. Operations, Maintenance, and Engineering personnel effectively communicated and coordinated the troubleshooting and repair efforts. Operations' implementation of Technical Specifications actions was conservative. (Section O1.3)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
05/22/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 3A <b>Ter:</b> 5B	<b>Operations response to emergent equipment problems</b> Operations response to emergent equipment problems was conservative and well planned. (Section O1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
05/22/1999	1999003-01	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> 4C <b>Ter:</b> 5A	<b>Missed TS surveillance testing</b> A Non-Cited Violation was identified which addressed a failure to meet Technical Specification requirements. Regulating rod groups were not verified to be within the insertion limits every four hours when the regulating rod insertion limit alarm was inoperable. The licensee identified and reported this condition in Licensee Event Report 50-302/99-001. (Section O8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 1A <b>Ter:</b> 2B	<b>Operations usage and interpretation of Technical Specifications</b> Improvements were made in Operations usage and interpretation of Technical Specifications (TS) by better screening of work, TS usage training, more tracking capability, and efforts to clarify TS Bases. However, Operations management expectations and processes for recording Limiting Condition for Operation entries were not yet fully refined. Recent problems involving correct TS usage and interpretation indicate that additional improvement is needed. (Section O4.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5A <b>Sec:</b> 3A <b>Ter:</b> 5B	<b>Inadequate Battery Charger Tagout</b> The licensee identified several performance problems that were indicative of poor individual performance and process procedure adherence. A Non-Cited Violation was identified for an inadequate equipment tagout. Licensee response to these problems was prompt and follow-up investigations were meticulous and thorough. Some issues were also identified regarding the expectations and practices for independence of tagout preparer and verifier. (Section O4.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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04/10/1999	1999002-02	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 1C	<b>Diesel generator TS applicability not recognized</b>  A Non-Cited Violation was identified for failure to recognize that an emergency diesel generator was inoperable during maintenance activities which included tripping an engineered safeguards channel. This condition was identified and reported by the licensee in Licensee Event Report 50-302/98-10-00. (Section O8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002-03	<b>Pri:</b> OPS <b>Sec:</b> MAINT	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Surveillance not completed within required time limit</b>  A Non-Cited Violation was identified for failure to perform a technical specification required surveillance within the prescribed time limit when a diesel generator was removed from service. This condition was identified and reported by the licensee in Licensee Event Report 50-302/98-12-00. (Section O8.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3C <b>Ter:</b> 1C	<b>Operations turnover process</b>  Changes to the Operations turnover process improved the quality of the crew turnover meeting by eliminating distractions present in the control room and allowing operators to challenge off-going shift turnover information. The changes also improved the transfer of information in the morning management meeting and more directly exposed the Nuclear Shift Managers to management expectations. (Section O1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b> 5A	<b>Operator actions on raw water check valve failure</b>  Operators alertly detected and initiated prompt action to isolate a raw water check valve failure. Operators had questioned the lack of an expected output pressure change during a pump shift, even though an alarm limit had not been reached. This was considered excellent verification of expected system response. (Section E8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Remote shutdown panel walkdown</b>  The remote shutdown panel was verified to be correctly aligned to support emergency usage. Several housekeeping problems and burned out panel light indicators were identified, indicating licensee tours of the room were not rigorous. (Section O2.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b> MAINT	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 3A <b>Ter:</b> 5B	<b>Power reduction for planned maintenance</b>  A significant power reduction for planned maintenance was controlled well. A failure of an Integrated Control System module was promptly diagnosed and mitigated. Operators were formal, procedures were appropriately utilized, control room access was strictly controlled, and augmented management oversight was constant. (Section O1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

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By Primary Functional Area

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/27/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b> OTHER	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>Quality Assurance audit of Corrective Action Program</b> The inspectors concluded that the licensee Quality Assurance group performed a comprehensive audit of the licensee Corrective Action Program. The results were consistent with inspector observations. The findings and conclusions were presented well in a detailed exit meeting. The response of licensee Corrective Action Program management to the findings was systematic and thorough. (Section O7.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b> OTHER	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Procedural discrepancies impacted candidate performance</b> The examiners noted several procedural discrepancies which impacted candidate performance. Applicants were required to interpret procedural steps and work around procedural problems. These procedure problems are similar to those noted in examination report 50-302/98-301. (Section 05.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b> OTHER	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b> 1C	<b>RO candidate performance on the written examination</b> The examiners concluded that RO candidate performance on the written examination was satisfactory with an average score was 85. SRO candidate performance was not as successful with an average score of 82. Overall performance on the operating test was satisfactory with isolated weaknesses noted in the area of EOP implementation. (Section 05.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/26/1999	1999301	<b>Pri:</b> OPS <b>Sec:</b> OTHER	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> 1C <b>Ter:</b>	<b>A submitted written examination and operating test</b> The examiners found that the as-submitted written examination and operating tests met the requirements of NUREG-1021. The approved written examination questions were noted to be adequate test items for measuring candidate understanding of systems and administrative knowledge. (Section O5.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Surveillance testing activities for the plant startup from the refueling outage</b> Surveillance testing activities for the plant startup from the refueling outage were well controlled and well planned due to accountable individuals assigned prior to the outage. Monitoring of nuclear services closed-cycle cooling system heat exchanger leakage was appropriate (Section M1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>The control complex habitability envelope integrated leak test</b> The control complex habitability envelope integrated leak test was conducted methodically and test results were satisfactory (Section M1.3).
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Region II  
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<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Response to emergent maintenance issues</b> The licensee responded adequately to two emergent maintenance issues during the refueling outage. Leakage in nuclear services closed cycle cooling heat exchangers was appropriately dispositioned and a scope reduction to planned emergency diesel generator maintenance was adequately justified (Section M1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Inservice inspection activities</b> Inservice inspection activities were being performed in accordance with code and licensee requirements (Section M1.5).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Corrosion monitoring program</b> A detailed flow assisted corrosion monitoring program was in place and implemented in accordance with procedural requirements (Section M1.6).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Hydrostatic testing activities</b> Inspectors identified that flow transmitters inside a hydrostatic test boundary had not been vented. Damage could have occurred due to isolation valve leakage. Licensee hydrostatic test guidance was not referenced when preparing and approving the test clearance. Operators were not familiar with guidelines for hydrostatic testing clearances (Section M1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 2A <b>Ter:</b>	<b>Surveillance test activities</b> Completed surveillance test packages demonstrated acceptable test results for emergency core cooling system relief valves and check valves (Section M1.3).
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Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
09/25/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 2A <b>Ter:</b>	<b>Valve seat leakage testing data</b> Review of valve seat leakage testing data indicated acceptable material condition for reactor coolant system isolation boundaries. No examples of inadequate maintenance or testing were identified during this review. No problems were identified during the review of machinery history which would indicate an adverse trend or degradation of the material condition of reactor coolant system pressure isolation valves. Monitoring associated with identified reactor coolant system leakage was acceptable(Section M2.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 5B <b>Ter:</b>	<b>Performance of maintenance activities</b> Performance of maintenance activities remained effective. Troubleshooting for the cause of a B Emergency Diesel Generator trip was controlled and systematic. All of the plant indications received on the trip were rigorously researched to ensure the causes were understood and corrected (Section M1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
09/25/1999	1999006-02	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Failure to Expand Sample for ASME Class 2 and 3 Relief Valves</b> A non-cited violation was identified involving a failure to perform additional testing of relief valves after testing identified the valves did not lift at setpoints, as required by ASME/ANSI OM-1987, Part 1 and maintenance procedures (Section M2.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Coordination between Operations, Maintenance, and Scheduling personnel</b> Significantly improved coordination between Operations, Maintenance, and Scheduling personnel resulted in effective planning and scheduling. Maintenance Rule unavailability results were more widely disseminated, which improved consideration of equipment out of service impacts by all licensee staff. (Section M1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3C <b>Ter:</b>	<b>Reactor coolant system leakage surveillances</b> The inspectors verified that reactor coolant system leakage surveillances were performed accurately and leakage was well within Technical Specification limits. Several minor administrative deficiencies were observed; however, the deficiencies did not adversely impact the current surveillance results. (Section M1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 4B	<b>Conduct of maintenance and surveillance testing activities</b> Maintenance and surveillance testing activities were generally conducted in a thorough and competent manner by qualified individuals in accordance with plant procedures and work instructions. Control of work to replace the white permissive light for makeup pump MUP-1B was anticipatory and effective. Good command and control and effective communications, by both the operating crew and Reactor Engineering, were observed during the performance of Moderator Temperature Coefficient surveillance activities. (Sections M1.1 and E1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/22/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Coordination of maintenance and surveillance testing activities</b> Maintenance and surveillance testing activities were conducted in a thorough and competent manner by qualified individuals in accordance with plant procedures and work instructions. Close coordination was maintained with the main control room during surveillance testing activities. (Section M1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Maintenance Rule requirements had not been given proper attention by all affected plant departments.</b> Maintenance Rule requirements had not been given proper attention by all affected plant departments. This indicated a declining awareness of the need for Maintenance Rule considerations when working on Maintenance Rule equipment. Precursor cards were written to correct this problem. (Section M1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Plant material condition</b> In general, plant material condition was good. Equipment was painted and protected with little evidence of leaks or corrosion. Overall, housekeeping measures were effective. (Section M1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Corrective maintenance and preventive maintenance activities</b> Corrective maintenance, preventive maintenance activities, and surveillance testing were performed in a quality manner in accordance with procedures by knowledgeable and experienced personnel. Maintenance supervision was closely involved with work activities and effective interface between maintenance and operations personnel was observed. Detailed and thorough pre-job briefings were conducted for all work activities. Work activities were properly documented. (Section M1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b> 1C	<b>Performance of maintenance activities</b> Performance of maintenance activities remained effective and pre-job briefs were conducted thoroughly. Planning and promulgation for important online system outages was thorough. Non-licensed operators displayed a strong questioning attitude during the fire protection system annual valve surveillance. (Section M1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b> ENG	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 3C	<b>Performance of corrective maintenance activities</b> Performance of maintenance activities remained effective. Pre-job briefings were thorough. Activities were routinely monitored by supervisors and component engineers. Excellent maintenance response was noted for a failed main steam pressure transmitter that caused a 72-hour Technical Specification action to be entered. Troubleshooting, planning, and replacement of the transmitter was timely. (Section M1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/25/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b> 4C	<b>Rod drop testing controls</b> Beginning of cycle rod drop time testing identified that one rod was out of specification. The licensee exercised the rod to flush blocked thermal barrier flowpaths and retested it. A detailed analysis evaluated the potential for future degradation to support declaring the rod operable. The licensee's analysis also concluded that the safety significance was minimal (Section E2.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
12/25/1999	1999008	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b> 5C	<b>Temporary modification activities</b> The temporary modification tracking system was detailed and effectively correlated with other systems such as work requests. The licensee had thoroughly addressed all open temporary modifications in their refueling outage planning (Section E1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Two failed yoke assemblies and a sheared radiator clutch drive shaft on the B EDG</b> Two failed yoke assemblies and a sheared radiator clutch drive shaft on the B emergency diesel radiator fan shaft were found by alert mechanics following overspeed testing. Fabrication problems with the yoke assembly were noted and addressed in corrective repair actions, but the initiating cause of the yoke failure was undetermined. Inspectors verified the physical evidence supported the licensee determination and noted the design ratings of the radiator drive train were adequate. Repair actions and long-term corrective actions were comprehensive and appropriate (Section E1.3).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Control rod assembly data</b> The licensee thoroughly analyzed large amounts of control rod assembly data to address problems identified by end-of-cycle rod drop testing, including several slow drop times. Fuel assembly bowing and thermal barrier induced hydraulic drag were attributed as causes. Corrective actions, including resetting hold-down springs and replacing thermal barriers, were appropriate (Section E1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4A <b>Ter:</b> 4B	<b>The engineering organization</b> The engineering organization was effective in designing and implementing major emergency feedwater, high pressure injection, and low pressure injection modifications. The modification packages were generally complete, accurate, and of good quality. Installation and testing were satisfactory, and problems were being appropriately identified and resolved (Section E1.4).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b> 3C	<b>Post-modification testing activities</b> Post-modification testing of major high pressure injection and low pressure injection system modifications was effective. Functional tests were detailed and reflected extensive preparatory work. Pre-job briefings were very thorough, management oversight was continuous, and test performance was methodical. Results were satisfactory and unexpected problems were appropriately dispositioned. Testing impact on critical shutdown plant safety functions was closely monitored and no problems occurred (Section E1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
09/25/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 4C <b>Ter:</b> 4B	<b>Implementation of controls to minimize primary coolant leakage sources outside containment</b> Implementation of controls to minimize primary coolant leakage sources outside containment were effective. Calculations and surveillance limits were conservative and licensee program commitments were fulfilled. Justification to exclude seal ring leakage from a makeup system isolation valve was appropriate. Recent improvements to the program included specific testing of makeup system piping for leakage and more pro-active leakage monitoring (Section E2.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4B <b>Ter:</b> 5C	<b>Diesel generator coolant microbiological growth</b> Engineering support for problems with diesel generator coolant microbiological growth was effective. Previous corrective actions were effective and a single accountable engineer was developing long-term solutions. Engineering support for a through-wall raw water leak was timely and provided essential input for an Operations operability determination. (Section E1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 4A <b>Ter:</b> 5A	<b>Year 2000 Checklist</b> The Year 2000 checklist, per Temporary Instruction 2515/141, was completed. At the time of the inspection, the Year 2000 project was 96 percent complete for equipment and applications, and the contingency planning was about 98 percent complete. Both programs were on target to be completed by their scheduled due dates. (Section E8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
05/22/1999	1999003	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 3B <b>Ter:</b>	<b>Engineering evaluations for emergent issues</b> Engineering evaluations to address emergent issues were thorough and of good quality. Engineers were knowledgeable of their assigned system.
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
05/18/1999	9905130165	<b>Pri:</b> ENG <b>Sec:</b> OTHER	NRC	LIC	<b>Pri:</b> 4C <b>Sec:</b> 4A <b>Ter:</b>	<b>Withdrawal of amendment request</b> Prior to FPC withdrawing this admendment request, the staff had identified that the licensing submittal was deficient in that the measures to ensure that decay heat (DH) system remained water solid were inadequate and the submittal did not provide verification that the valve opening timing design basis was adequate to assure the system would perform its safety function. The licensee response to a staff request for clarification on the deficiencies also was inadequate for similar reasons - the measures remained inadequate and nominal valve timing data was provided which did not address the design basis question.
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Resolution of issue with the position of two decay heat pump system valves</b> The licensee addressed a long-standing issue with the position of two decay heat pump borated water storage tank suction valves. The valves were restored to the open position after the licensee effectively re-evaluated a separate 10 CFR 50 Appendix R hot short concern for the reactor building sump suction valves. (Section E8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/27/1999	1999001-01	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> 4B <b>Ter:</b> 5C	<b>Inadequate 1991 corrective action results in raw cooling check valve failure</b>  The inspectors concluded the component failure analysis and corrective action plan for the failure of a raw water check valve were timely, thorough, and complete. The licensee system engineer identified that corrective actions for a previous identical failure of a check valve in 1991 were not adequate. Failure of the check valve resulted in degraded raw water cooling flow to both nuclear services closed cycle cooling heat exchangers. A Non-Cited Violation was issued for the previous inadequate corrective action. (Section E8.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Several examples of poor radiological practices</b>  Several examples of poor radiological practices were identified regarding dosimetry use by personnel, contaminated area work practices, visibility of reactor building radiation postings, and limited worker communication with the health physics staff (Section R1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>As Low As Reasonably Achievable program activities</b>  As Low As Reasonably Achievable program activities and initiatives for the refueling cycle were conducted in accordance with approved procedures with outage cumulative dose expenditure revised upward from original estimates due to elevated dose rates, inexperienced workers, and emergent work activities (Section R1.2).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b>	<b>Radiological controls activities</b>  Overall, radiological controls were maintained and implemented in accordance with the Updated Final Safety Analysis Report, Technical Specifications, license conditions, and 10 CFR Part 20 requirements. Excluding workers' internal exposures, licensee dose assessments associated with unanticipated contamination events were adequate (Section R1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
11/06/1999	1999007-04	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Failure to Conduct Timely and Accurate Analysis of Potential Radionuclide Intakes by Workers.</b>  A non-cited violation was identified for failure to conduct accurate and timely evaluations of worker exposure from potential radioactive material intakes. Occupational worker doses were determined to be within administrative and regulatory limits (Section R1.1).
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Implementation of radiological controls</b>  Radiological controls were implemented and maintained in accordance with Updated Final Safety Analysis Report, Improved Technical Specifications, and 10 CFR Part 20 requirements. (Section R1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>1998 Annual Effluent Release Report and Annual Radiological Environmental Monitoring Report</b>  The 1998 Annual Effluent Release Report and Annual Radiological Environmental Monitoring Report were submitted in accordance with Improved Technical Specifications and documented results demonstrated gaseous and liquid effluent processing and subsequent releases met established regulatory limits. (Section R3.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 2B <b>Ter:</b>	<b>Protected area change</b>  The licensee satisfactorily implemented and tested new and reconfigured equipment to the existing protected area to encompass the Nuclear Administration Building. The licensee conducted an effective search of the new area to ensure against unauthorized material and individuals. (Section S2.8)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Chemistry and operations personnel performance</b>  Chemistry and operations personnel demonstrated appropriate knowledge of procedural requirements, and proficiency in initiating and conducting a July 21, 1999, Waste Neutralizer Tank-1 release. Licensee programs to control effluent releases were implemented effectively with effluent radionuclide concentrations and resultant projected offsite doses within established regulatory limits and design objectives. (Section R1.3)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Security training program</b>  The licensee had a satisfactory security training program that incorporates tactical training with the required annual task and firearm requalification training. (Section S5.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3C <b>Ter:</b> 3A	<b>Health Physics oversight of work</b>  Health Physics staff oversight of radiological control area (RCA) work at the spent fuel pool was effective. Oversight was continuous and technicians were knowledgeable of the work and hazard scope. RCA entry point briefings contained detailed information on changes in radiological trends and were improved from previous observations. (Section R1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5C <b>Ter:</b>	<b>Radiological environmental monitoring program</b>  The radiological environmental monitoring program for airborne radionuclides and drinking water samples, and monitoring of direct radiation was implemented in accordance with the Offsite Dose Calculation Manual. Implementation of liquid drinking water sample preparation activities was inconsistent with previous corrective action guidance, however; the quality of the sample analyses was not affected. (Section R2.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/14/1999	1999005-02	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Failure to conduct FFD observed tests</b> Failure to obtain urine specimens under direct observation for an individual who was suspected of altering or substituting specimens for FFD tests conducted in 1997 and 1998 was identified as a non-cited violation.
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
08/14/1999	1999005-03	<b>Pri:</b> PLTSUP <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1C <b>Sec:</b> 4C <b>Ter:</b>	<b>PSP changes that decreased the effectiveness of the Plan</b> A non-cited violation was identified for the licensee's PSP submittal, Revision 7-0, which decreased the effectiveness of the Plan.
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>ALARA effectiveness</b> Occupational worker doses were within regulatory limits for calendar year 1998 and for year-to-date 1999. ALARA program implementation was conducted in accordance with approved procedures and year-to-date 1999 cumulative exposure met established goals. (Section R1.3)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 2A	<b>Implementation of radiological controls</b> Radiological controls were implemented and maintained in accordance with the Updated Final Safety Analysis Report, Technical Specifications, license conditions, and 10 CFR Part 20 requirements. (Section R1.2)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Radiological control practices</b> Workers demonstrated appropriate knowledge and application of radiological control practices. Area controls and storage practices at the radioactive material storage warehouse and tank facilities were adequate to protect public health and safety. (Section R1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
07/03/1999	1999004	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Mini-purge gaseous effluent radionuclide calculations</b> Evaluations and corrective actions regarding inaccurate mini-purge gaseous effluent radionuclide concentrations and associated dose calculations were appropriate. Offsite doses resulting from mini-purge gaseous releases using an incorrect flow rate in final dose calculations contained small errors but were well within regulatory limits. (Section R7.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II  
CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
05/22/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 3B	<b>Radiological control practices</b> Workers demonstrated appropriate knowledge and application of radiological control practices. Health physics technicians provided positive control and support of work activities in the Radiological Control Area. (Section R1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
05/22/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Emergency preparedness drill, including simulated Year 2000 complications</b> A licensee emergency preparedness drill, which included simulated Year 2000 complications, provided effective training and demonstrated adequate emergency plan implementation. (Section P1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b> 2B	<b>Air-sampling cartridge issue</b> Deficiencies were identified with respect to the age and material condition of the licensee's stock of silver zeolite air-sampling cartridges. The licensee missed opportunities to identify this problem through either operational experience information or routine surveillance of emergency supplies. (Section P1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Emergency preparedness program</b> The licensee's emergency preparedness program was being maintained in a state of operational readiness. Changes to the program since the last inspection were consistent with commitments and NRC requirements, and did not decrease the licensee's overall state of preparedness. (Section P1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
04/10/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Fire brigade readiness and response</b> During a fire drill in the cable spreading room, fire brigade readiness and response was improved from previously observed drills. While some deficiencies with drill modeling and control were noted, the conduct of the critique was more structured than previously observed drills and participants were more involved. (Section F5.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						
02/27/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 5A	<b>Security equipment testing</b> The inspectors determined that security equipment testing was performance-based, and search techniques were thorough and systematic. A minor vehicle barrier bollard spacing discrepancy was identified by the inspectors and was promptly addressed. Overall, the inspectors determined that the activities to relocate the Protected Area boundary were conducted rigorously and were well controlled. (Section S1.1)
<b>Dockets Discussed:</b> 05000302 Crystal River 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region II

CRYSTAL RIVER

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/27/1999	1999001-02	<b>Pri:</b> PLTSUP <b>Sec:</b> ENG	NRC	NCV	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 4B	<b>Wood scaffolding transient combustible loading</b> Licensee Fire Protection staff were not routinely involved with scaffold installation for consideration of transient combustible loading and fire suppression system impairment. Weekly surveillance reviews for transient combustible loading were of limited effectiveness. The licensee Fire Protection program review of scaffolding and control of transient combustibles was reactive and considered to be a weakness. Although the safety-significance of the deficiencies was limited by roving fire watches in effect for other issues, a non-cited violation was identified for the programmatic administrative problems. A corrective action plan initiated by the licensee was thorough and systematic. (Section F1.1,

**Dockets Discussed:**  
 05000302 Crystal River 3

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

## Legend

### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.