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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/18/1999	1999010	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 3A **Ter:**	**Control room operators responded appropriately to a nitrogen low pressure alarm, however, the cause of the** On November 18, 1999, the Unit 2 control room staff received an instrument nitrogen low pressure alarm and determined that it was the result of several nitrogen system valves being out of their correct position. The control room operators responded appropriately to the alarm and their immediate actions were good. The loss of configuration control was due to operator inattention to detail. (O1.4) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
12/18/1999	1999010	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** 3A **Ter:**	**Unit 1 start-up was conducted in a conservative, well controlled manner.** The November 13, 1999, Unit 1 reactor startup was conducted in a conservative, well controlled manner. Effective supervision and oversight were provided by senior management. This was a notable improvement when compared with the startup that was conducted on October 16, 1999. (O1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
12/18/1999	1999010	**Pri:** OPS **Sec:** MAINT	Licensee	NEG	**Pri:** 1A **Sec:** 2B **Ter:** 3A	**Operations and maintenance personnel did not appropriately control a calibration of the liquid poison tank v** On November 30, 1999, operations and maintenance personnel did not properly control the Unit 1 liquid poison system tank volume instrumentation. Prompt compensatory actions taken by the operations crew prevented a violation of Technical Specifications. Poor communications and coordination between the responsible maintenance and operations department personnel contributed to this failure to properly maintain equipment configuration control. (O2.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
12/18/1999	1999010	**Pri:** OPS **Sec:** MAINT	Self	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**Unit 1 operator appropriately identified and addressed a recirc pump seal problem.** Unit 1 operators appropriately identified leakage from the No. 14 reactor recirculation pump seal. The pump's mechanical seal had been replaced during an outage in October 1999. The recirculation loop was promptly isolated and the reactor returned to full power. The shift crew conducted an excellent brief for the loop isolation evolution and identified the need for changes to the operating procedures used to maneuver the plant through an area of pressure and power oscillations. (O2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
12/18/1999	1999-006-00	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1B **Sec:** 2B **Ter:** 3A	**Shutdown cooling water seal not established as required by Technical Specification 3.3.0** On November 9, 1999, while commencing a reactor plant start-up at Unit 1 from a planned maintenance outage, the plant staff identified that primary containment integrity had not been properly established, in that, the shutdown cooling system isolation valves were not closed and the associated breakers racked out in order to maintain a water seal. An NMPC investigation team thoroughly reviewed the event and determined that operator knowledge of primary containment integrity requirements was lacking and operating procedures did not provide sufficient guidance related to establishing primary containment integrity. In addition, the team identified two previous instances where primary containment integrity Technical Specifications were not satisfied and appropriately reported these events. (O1.2) Reference LER 99-006. **Dockets Discussed:** 05000220 Nine Mile Point 1

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10/30/1999	1999009	**Pri:** OPS **Sec:**	Licensee	NEG	**Pri:** 1B **Sec:** 3A **Ter:** 4C	**Unexpected reactor criticality.** On October 16, during a Unit 1 reactor plant startup, an unexpected reactor criticality was achieved during continuous withdrawal of the third rod in group 3. Initial operator response and the licensee's corrective actions were appropriate. The licensee identified a number of reactivity management performance weaknesses during this reactor startup. Unit 1 operations personnel did not use a conservative approach to reactivity management when a decision was reached to proceed with continuous control rod withdrawal instead of notch withdrawal when source range counts were near a predetermined value. In addition, reactor core physics data, including estimated critical position and 3D Monicore predictor data, was not used to aid in the conservative approach to criticality. Management and supervisor oversight was weak in that independent verification of critical tasks was not performed. (O1.4) **Dockets Discussed:** 05000220 Nine Mile Point 1
10/30/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**Unit 1 shutdown on October 8 was well performed.** The Unit 1shutdown on October 8 was conducted in a careful, deliberate manner. The operators were well briefed concerning challenges that existed due to degraded material condition of a recirculation pump motor generator set and the turbine control characteristics. (O1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1
10/30/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Unit 2 licensed operator requal training program acceptable.** The Unit 2 licensed operator requalification training program met the regulatory requirements of 10 CFR 55.59 based on a sampling review. The inspectors identified a problem in the Senior Reactor Operator (SRO) written exam with sampling from the content areas described in 10 CFR 55.43. The licensee took immediate action to address the issue in future exams and in their program description. Operating and written exam content incorporated risk insights, and was consistent with the program requirements. Exam overlap was acceptable. (O5.1) **Dockets Discussed:** 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Training records were well organized, training feedback process appears effective.** The training feedback process was found to be effective in capturing operator concerns and providing timely resolution. The remedial training records were well organized and indicated that individual and crew remediation was appropriate. Training attendance records were also well organized and indicated that missed training was made-up in a timely manner. (O5.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Licensed operator requal training effectively used lessons learned from recent events.** Lessons learned from recent operating history and plant events were being appropriately addressed through the licensed operator requalification training program. The training program included lessons to improve human performance and configuration control. (O7.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 1A **Ter:**	**Auxiliary operators performed watchstanding in an acceptable manner.** The inspectors accompanied both Unit 1 and Unit 2 auxiliary operators on various plant rounds in the turbine and reactor buildings. Auxiliary operators performed watchstanding duties in an acceptable manner. (O4.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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10/30/1999	1999009-01	**Pri:** OPS **Sec:** ENG	NRC	IFI	**Pri:** 1A **Sec:** 4B **Ter:**	**Use of process computer to determine control rod position on loss of full core display.** On October 4, operators promptly initiated alternate measures to monitor control rod position when a power supply failed resulting in all the indicating lights illuminating on the full core display, rod control drive push buttons, and 4-rod display. NMPC determined that the process computer was an acceptable alternate means to monitor control rod position while the power supply was being replaced. The use of the process computer as an alternate to the full core display to determine control rod position is an inspector follow-up item. (O1.2) **Dockets Discussed:** 05000410 Nine Mile Point 2
10/30/1999	1999009-02	**Pri:** OPS **Sec:** MAINT	NRC	NCV	**Pri:** 1A **Sec:** 3A **Ter:**	**Mark-up error on Line 6 work preparations.** On October 18, the inspector identified that the control switch for the 115 kV supply to the reserve transformer, Line No. 6, was in the open position and not in pull-to-lock as required by the protective tag. NMPC has experienced several recent occurrences of either inadequate protective tagging or component positioning errors associated with tagging. Because of the increased occurrence of configuration control issues, NMPC initiated an operations department stand down to re-emphasize holdout requirements, including independent verification. Additional corrective actions included increased field observations and procedure changes to reduce the potential for configuration control errors. The failure to ensure that a protective tag was properly applied was a non-cited violation. (O1.5) **Dockets Discussed:** 05000410 Nine Mile Point 2
10/30/1999	1999009-03	**Pri:** OPS **Sec:**	Licensee	IFI	**Pri:** 2B **Sec:** 3A **Ter:**	**Simulator performance of the operating crew and two individuals found unsatisfactory.** The licensee identified unsatisfactory crew and individual performances during the simulator exam. In the cases of unsatisfactory performance, the crew and individuals were remediated and retested satisfactorily before resuming license duties. The inspectors agreed with the evaluations and will review the results from the remainder of the annual exams to determine if any problem areas exist in training effectiveness. (O5.1) **Dockets Discussed:** 05000410 Nine Mile Point 2
10/30/1999	1999009-08	**Pri:** OPS **Sec:** PLTSUP	NRC	IFI	**Pri:** 1A **Sec:** 3A **Ter:**	**Control room response to toxic gas release.** On October 8, Unit 1declared an Unusual Event when the carbon dioxide suppression system was automatically discharged in the lower level of the administration building in response to an actual fire/smoke condition. The control room operators were slow to take action to verify the adequacy of the control room ventilation system line-up and to ensure that oxygen levels in the control room were properly maintained. (P1.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
09/11/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** **Ter:**	**Minor procedural violation led to valve being not locked open in the CRD system.** The inspector identified a back fill isolation valve associated with the control rod drive system open, but not locked in accordance with the system operating procedure. Control room staff response and resolution of this valve control issue were slow. This minor procedure violation was not subject to formal enforcement action. (Section O2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
09/11/1999	1999007	**Pri:** OPS **Sec:**	NRC	NEG	**Pri:** 1A **Sec:** 3A **Ter:**	**Poorly maintained administrative records in Unit 1 CR.** Although no operability or other safety concerns were identified, the core spray system and emergency diesel generator engineering support analyses files located in the Unit 1 control room were poorly maintained and did not readily support verification of the current status of corrective actions associated with each system. (Section O3.2) **Dockets Discussed:** 05000220 Nine Mile Point 1

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09/11/1999	1999007	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	NEG	**Pri:** 1B **Sec:** **Ter:**	**Poor operator administrative controls implementation associated with Unit 1 July 23 scram.** Following the July 23, 1999, reactor scram at Unit 1, the operators did not adequately document plant activities in the control room log book. In addition, although the control room operator responded promptly to a dual motor-driven feedwater pump trip, the alarm response procedures were not followed. These minor procedure violations were not subject to formal enforcement action. (Section O3.1)
09/11/1999	1999007	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	NRC	NEG	**Pri:** 1C **Sec:** **Ter:**	**Unit 2 Alarm Response Procedures for HPCS room flooding inadequate.** The Unit 2 alarm response procedure (ARP) for high pressure core spray pump room flooding did not provide appropriate guidance to operators for pump suction swapover. These procedural deficiencies were not subject to formal enforcement action. In addition, the inspector identified a few Unit 1 high pressure coolant injection ARP procedure steps that could be enhanced. These ARP issues were properly dispositioned by the licensee. (Section O3.3)
09/11/1999	1999007	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Systems walkdowns confirm HPCI and HPCS systems in proper standby configuration.** The inspectors found the Unit 1 high pressure coolant injection system and the Unit 2 high pressure core spray system were properly aligned to perform their required safety function. (Section O2.2)
09/11/1999	1999007	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	Self	POS	**Pri:** 1B **Sec:** 2A **Ter:**	**Operator response to the August 1 Unit 1 automatic scram was good.** On August 1, shortly after Unit 1 was taken critical, an automatic reactor scram occurred when an intermediate range neutron monitor (IRM) range selector switch was repositioned. The cause was determined to have been worn IRM selector switch contacts. Operator response was appropriate. (Section O1.3) Reference LER 99-05 and supplement 001.
09/14/1999	XXXX	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2	NRC	OTHR	**Pri:** **Sec:** **Ter:**	**April 7, 1999, Generic Fundamentals Examination high failure rate (9/14/99 NRC response to 5/11/99 NMPC let** NMPC found that the generic fundamentals topics were removed from the Unit 1 auxilary operator training program in 1997 - a program shortcoming. Also, the GFE program for licensed operator candidates needed to be upgraded. C/As included program improvements and enhancements to the process of selecting, preparing, and evaluating license class candidates.
07/31/1999	1999006	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	Self	NEG	**Pri:** 1A **Sec:** 3A **Ter:**	**Poor operator response to alarms and inadequate procedure contributed to energizing the normal station se** The reactor restart on June 30 was conducted in a conservative, well controlled manner and effective supervision and oversight was noted in addressing equipment performance problems. In contrast, during the July 23 startup, operators energized the normal station service transformer without cooling water. This error was caused, in part, by an inadequate operating procedure and by the operators' poor response to the associated transformer alarm.

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07/31/1999	1999006	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	NRC	NEG	**Pri:** 1B **Sec:** 3A **Ter:**	**Documentation and communications between shift crews was poor, poor judgement exercised when the RCI(** The documentation and communication between the crews of the reactor core isolation cooling (RCIC) system controller issues were poor following the June 24 automatic reactor shutdown. Specifically, operator logs did not contain any information regarding the RCIC controller problems and the observed problems were not verbally, or in the operator turnover sheets, communicated to the oncoming shift. Additionally, operators exercised poor judgement by placing the RCIC controller in automatic to validate previously confirmed improper system performance.
07/31/1999	1999006	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	NRC	NEG	**Pri:** 5A **Sec:** 5B **Ter:**	**Operator performance evaluation was adequate, with respect to assessment of operator response to the June** During the recovery from the June 24 automatic reactor shutdown, the control room staff operated the reactor core isolation cooling (RCIC) system with the flow controller in manual. The RCIC system operating and alarm response procedures contained some inconsistencies regarding operating the system in this mode, but operators were able to use their system knowledge to adequately maintain reactor vessel level. The licensee's July 13, 1999, evaluation of operator performance adequately identified and resolved the RCIC system operating procedure issues and was reasonably thorough and critical in assessing operator performance. The licensee acknowledged that their process to evaluate operator performance following a major plant event warranted improvements to ensure timely and effective corrective action.
07/31/1999	1999006	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	NRC	POS	**Pri:** 1B **Sec:** 3A **Ter:**	**Operator response to the June 24 scram was adequate.** On June 24, an automatic reactor shutdown from 100 percent power occurred at Unit 2 during maintenance on the feedwater control system. Operators placed the plant in a stable condition; overall, operator performance was adequate. Several equipment performance problems, combined with an off-normal plant electrical lineup, resulted in increased challenges to plant operators.
07/31/1999	1999006	**Pri:** OPS **Sec:** MAINT **Dockets Discussed:** 05000410 Nine Mile Point 2	Self	NEG	**Pri:** 1B **Sec:** 3A **Ter:** 2B	**Several equipment problems associated with RCIC were a distraction to the control room operators.** Several equipment problems associated with the reactor core isolation cooling (RCIC) system were evident during system operation subsequent to the June 24 automatic reactor shutdown at Unit 2. These degraded equipment conditions resulted in the control room staff declaring the RCIC system inoperable per Technical Specifications, but operators were able to compensate for these conditions and successfully operated the system to maintain reactor vessel level. These compensatory actions, collectively, were a distraction to the control room staff during the recovery from the automatic shutdown.
06/19/1999	1999005	**Pri:** OPS **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Uint 1 restart activities well conducted, good management oversight.** The reactor restart from the Unit 1 refueling outage was conducted in a conservative, well controlled manner. Effective supervision and oversight was provided by senior management. (O1.3)
06/19/1999	1999005	**Pri:** OPS **Sec:** MAINT **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Unit 1 reload activities performed well.** Unit 1 core reload was well performed with good communications, independent verification, and procedure use noted. (O1.2)

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05/08/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Unit 1 shutdown risk program well implemented.** The Unit 1 outage shutdown risk program was well implemented. The communication of plant protected equipment and safety system status was good. (O1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1
05/08/1999	1999004	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Unit 1 fuel off-load well controlled.** The Unit 1 fuel off-load was well controlled. Communications between the operators on the refuel bridge, as well as between the refuel bridge and the control room were observed to be good. (M1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1
05/08/1999	1999004	**Pri:** OPS **Sec:** MAINT	NRC	NEG	**Pri:** 5A **Sec:** 5B **Ter:** 5C	**Overall approach to identifying and resolving equipment problems acceptable.** Overall, NMPC's approach to identifying and resolving equipment performance problems following the April 24 Unit 2 reactor scram was acceptable. Positive aspects of NMPC's post-scram evaluation process included the establishment of multi-discipline teams to review equipment performance, the conduct of periodic status briefs, and the use of vendor services. Senior management effectively challenged their staff's post-scram analysis which contributed to a more rigorous evaluation and the re-creation of the event using the plant simulator. However, a few performance shortcomings related to the scram evaluation process were apparent. Although the overall process was thorough, equipment troubleshooting and failure analysis were not methodical. NMPC management recognized these shortcomings and was developing methods to improve its staff's problem solving skills. (O7.1) **Dockets Discussed:** 05000410 Nine Mile Point 2
05/08/1999	1999004	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Overall plant staff response to the April 24 reactor scram.** The April 24 Unit 2 automatic reactor shutdown from 100 percent power was characterized by the licensee and NRC staffs as a risk significant transient. The cause was determined to be a generator protection circuit relay failure which also resulted in a residual (slower) transfer to off-site power. The slow transfer caused large motor loads such as reactor feedwater pumps, reactor recirculation pumps, and condensate booster pumps to trip. Operator performance with respect to procedure use, communications, and control of plant equipment was good. Senior management oversight of scram recovery efforts was appropriate. Major equipment failures included the reactor core isolation cooling system and a partial loss of the uninterruptible power supply system. These equipment failures and other minor equipment problems did not significantly impact recovery efforts. (O1.2) Reference LER 99-05. **Dockets Discussed:** 05000410 Nine Mile Point 2
05/08/1999	1999004-01	**Pri:** OPS **Sec:**	Licensee	NCV	**Pri:** 2A **Sec:** **Ter:**	**Automatic Depressurization System nitrogen leakage in excess of TS surviellance limit.** Between March 5 and March 12, 1999, Unit 2 experienced two events where the automatic depressurization system nitrogen storage tanks had excessive leakage. NMPC failed to recognize that the leakage exceeded the allowed limit, and therefore, did not take the required limiting condition of operation actions. This was a non-cited violation of Unit 2 Technical Specification 3.5.1. (O8.2) Reference LER 99-03. **Dockets Discussed:** 05000410 Nine Mile Point 2

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03/27/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3A **Ter:**	**Auxiliary operator performance** NRC inspectors observed that Unit 2 auxiliary operators demonstrated a good questioning attitude while performing their watchstanding duties.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
03/27/1999	1999003	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1B **Sec:** **Ter:**	**Technical specification required shutdown** On February 17, a technical specification required shutdown was initiated at Nine Mile Point Unit 1 due to the emergency cooling system being declared inoperable. Operator actions associated with the shutdown were well controlled and deliberate. The shutdown was terminated when the Nuclear Regulatory Commission (NRC) granted enforcement discretion. (Section O1.2) Reference LER 99-02 and NCV 99-03-03 (Section E1.1).
Dockets Discussed: 05000220 Nine Mile Point 1						
03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Overall good problem identification process.** NMPC had an overall good problem identification process with a low threshold and high volume input. Categorization of the significance level of the findings, including evaluation of operability and reportability of identified findings, was generally good. The timeliness of DER dispositions has improved since the previous review of this area and root cause evaluations and corrective action development and implementation were generally good. Tracking and trending of findings, including evaluation of adverse trends has improved through implementation of numerous management initiatives including changes to the NMPC Business and Tactical Plans. No significant deficiencies were identified that had not already been self-identified and included in the DER program.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Station personnel knowledgeable of DER program and don't hesitate to use.** Station personnel at all levels of the organization were found to be generally knowledgeable of the DER program and were not hesitant to issue DERs for identified concerns. A few instances were identified where the extent of condition reviews were too narrowly focused. However, station audits and self-assessments continued to indicate areas for improved performance. NMPC was implementing corrective actions for this matter, including establishment of a new organization which is expected to provide improved oversight of correct action effectiveness.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Operations has good problem identification program.** NMPC's operations branch had a good problem identification program and was adequately addressing deficiencies identified. DERs in the area of operations training were properly processed via the DER system. None of the events documented in training DERs appeared to have resulted in the compromise of an exam. NMPC recognized the significance of the potential for compromise of examinations and took reasonable actions in response to these events.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**QA audits effective.** Quality Assurance (QA) audits were an effective element of the self-assessment process and were critical and thorough in evaluating station program areas including corrective actions for previously identified deficiencies
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03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Good operations self-assessment process.** Units 1 and 2 operations had good programs for tracking and performing self-assessments. The Operations department self-assessment process was comprehensive, and adequately contributed to problem identification and resolution. Operations management at both units were taking actions necessary to address the findings. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Onsite and Offsite Review Committees effective.** Onsite and offsite safety review committees provided good oversight of station activities. The Station Operations Review Committee (SORC) meetings were conducted with appropriate regard to safety. The Independent Safety Evaluation Group (ISEG) performed critical assessment of the performance of operations, maintenance, engineering, and technical support activities, and exhibited an appropriate safety focus for corrective action matters for site-wide activities. The Safety Review and Audit Board (SRAB) was an effective tool for identifying and assessing issues and was providing effective oversight of safety significant station activities. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002-03	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** **Sec:** **Ter:**	**Failure to implement timely corrective action.** The team concluded that, overall, the operability determination process and associated corrective actions were appropriate for the affected structures, systems, and components important to safety. However, in some instances, the licensee has failed to recognize the need for engineering involvement in an operability evaluation or failed to perform timely and adequate operability evaluations. Two Non-Cited Violations of 10 CFR 50, Appendix B, Criterion XVI were identified and were included in the licensee's corrective action program. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002-04	**Pri:** OPS **Sec:**	NRC	NCV	**Pri:** **Sec:** **Ter:**	**Failure to implement timely corrective actions.** Second example, see NCV 99-02-03 **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Control room and plant operator performance good.** The Unit 1 control room operator shift turnovers were well conducted, with formal communications, detailed briefs, and minimal distractions. Operators performing rounds were knowledgeable of plant conditions and demonstrated proper communication and watchstanding skills. (Section O1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 3B **Ter:**	**Watchstanding and system awareness** A Unit 1 operator identified a discrepancy between the two emergency condenser loop seal level instruments which represented good watchstanding and system awareness. The Unit 1 Technical Support staff adequately investigated this emergency condenser loop seal water level problem and developed appropriate corrective action. (Section O2.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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02/13/1999	1999001	**Pri:** OPS **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 1C **Ter:**	**Station Operations Review Committee** The Unit 1 Station Operations Review Committee (SORC) was appropriately focused on safety issues. The SORC members demonstrated a good questioning attitude and safety perspective. (Section O8.1)
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
02/13/1999	1999001	**Pri:** OPS **Sec:** ENG	NRC	POS	**Pri:** 1A **Sec:** 2A **Ter:**	**System walkdowns good.** System walkdowns and performance history reviews identified that the material condition of the Unit 2 hydrogen recombiner system was good, and that the system has demonstrated a high level of reliability. (Section O2.1)
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02/13/1999	1999001	**Pri:** OPS **Sec:** MAINT	NRC	POS	**Pri:** 1A **Sec:** **Ter:**	**Cold weather preps were appropriate.** Cold weather preparations were appropriately performed at Unit 2. The development of the Cold Weather Checklist was noted as a useful enhancement. (Section O1.2)
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
10/30/1999	1999009	**Pri:** MAINT **Sec:**	Self	NEG	**Pri:** 3A **Sec:** **Ter:**	**Unit 1 recirc pump seal replacement was not properly performed.** At Unit 1, the No. 11 recirculation pump mechanical seal developed leakage possibly due to age hardening. The seal was replaced, but poor procedural controls contributed to the seal being improperly installed, which resulted in rubbing and leakage from the new seal. The licensee shutdown the unit to replace the seal again at the end of the inspection period. (M1.1)
Dockets Discussed: 05000220 Nine Mile Point 1						
09/11/1999	1999007	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**At unit 2, two examples of poor work planning identified.** At Unit 2, two examples of poor work planning for maintenance activities were noted. An emergency diesel generator was inadvertently started and a reactor building ventilation damper was inadvertently operated. The lack of attention to process details, including second checks/independent verification, contributed to these unplanned equipment actuations. (Section M1.1)
Dockets Discussed: 05000410 Nine Mile Point 2						
09/11/1999	1999007	**Pri:** MAINT **Sec:**	Licensee	NOED	**Pri:** 2A **Sec:** 3A **Ter:**	**Inability to complete troubleshooting and repairs to RCS leakage detection system within the LCO results in N** On September 3, following troubleshooting and repairs to the reactor coolant leakage detection systems, and expiration of the Technical Specification allowed outage time (AOT), NMPC requested and was granted a Notice of Enforcement Discretion (No. 99-1-005) to extend the AOT by 24 hours to permit completion of post-work testing, thus avoiding a Unit 2 shutdown. The plant staff successfully restored the leakage detection systems to an operable status within the NOED time limit. Contributing to the licensee's need for the NOED was the instrumentation and controls technicians' unfamiliarity with the laptop computer and associated software used for the post-work testing. (Section M1.2)
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09/11/1999	1999007	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 2B **Sec:** 4B **Ter:**	**Unit 1 control rod insertion time testing procedural weaknesses.** The July 23, 1999, Unit 1 control rod scram insertion times satisfied Technical Specification limits. However, a few procedural guidance weaknesses were identified which may adversely impact the reactor engineering staff's program to accurately trend control rod insertion time performance. The reactor engineering staff appropriately documented these weaknesses for resolution. (Section M3.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
09/11/1999	1999007	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Adequate action plan to improve condensate demineralizer system performance.** The Unit 1 engineering staff had developed an action plan to improve condensate demineralizer performance, due to a history of high differential pressure and basket element failure problems. However, NMPC was slow to plan and inspect the sixth basket strainer elements, in spite of the identified problems and the increased risk of strainer element failure and potential adverse unit impact. (Section M2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
09/11/1999	1999007	**Pri:** MAINT **Sec:** OPS	Self	NEG	**Pri:** 1A **Sec:** 2B **Ter:** 3A	**Work control and operator performance problems contributed to the July 23 Unit 1 scram.** A number of work control and operator performance problems contributed to the July 23, Unit 1 scram during post-maintenance testing of the turbine mechanical pressure regulator (MPR). Work planning and control were poor in that equipment malfunction contingencies were not sufficiently developed and discussed prior to the testing. The control room operators' decision to continue testing with anomalous MPR response was not conservative. (Section O1.2) Reference LER 99-04. **Dockets Discussed:** 05000220 Nine Mile Point 1
07/31/1999	1999006	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** **Ter:**	**Recommended preventive maintenance not performed on breakers in switchyard.** A relay failure in the main generator backup protection circuit resulted in a partial loss of off-site power following the automatic reactor shutdown at Unit 2 and additional challenges to plant operators. NMPC's investigation into and identification of the cause was thorough. Although not a direct contributor to the relay failure, the investigation showed that certain recommended substation breaker preventive maintenance was not being performed by the off-site maintenance group. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**Troubleshooting efforts associated with the RCIC valve repair were poor.** Prior to July 2, troubleshooting efforts associated with the reactor core isolation cooling valve repair were poor, in that, logs did not fully reflect work done and the valve status was not adequately communicated to the oncoming shift. This resulted in the determination that the root cause of the problem had been found and that the valve had been repaired, when in fact, it was not. Unit 2 management and staff demonstrated poor judgement by rationalizing the anomalies associated with the valve maintenance as acceptable, rather than thoroughly investigating and resolving them. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:**	Self	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**Poor maintenance practices and weak valve maintenance procedures contributed to valve failures.** During the Unit 2 forced outage, position indication problems with the residual heat removal system containment isolation check valve (AOV39B) were repaired and the valve was tested satisfactorily. Subsequently, AOV39B failed to close when shutdown cooling was secured. Previous poor maintenance practices, including weak valve maintenance procedures contributed to the valve failure. **Dockets Discussed:** 05000410 Nine Mile Point 2

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07/31/1999	1999006	**Pri:** MAINT **Sec:**	Licensee	NEG	**Pri:** 2B **Sec:** 3A **Ter:** 5C	**RCIC injection valve performance deficiencies corrective actions were too narrowly focused.** Prior to the reactor core isolation cooling injection valve failures on July 2, the corrective actions to address valve performance deficiencies were narrowly focused. NMPC subsequently assembled a team which developed the root causes of the poor valve operating history and implemented appropriate corrective actions to resolve the technical problems. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 2A **Sec:** 3C **Ter:**	**RCIC reliability and performance was degraded due to weaknesses in maintenance and engineering support** The Unit 2 reactor core isolation cooling system reliability and performance was degraded as a result of weaknesses in maintenance and engineering support. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**Ineffective corrective action contributed to check valve poor operating history.** During the June 24 automatic reactor shutdown and again on July 2, the reactor core isolation cooling system injection containment isolation check valves exhibited a number of performance problems. The valves remained operable, but were degraded. Ineffective corrective actions contributed to the valves' poor operating history. Additionally, the installation of a modification to the indicator shaft was not implemented in a timely fashion. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:** ENG	NRC	NEG	**Pri:** 2B **Sec:** 3A **Ter:** 5C	**Maintenance and engineering staff performance associated with Anchor/darling testable check valves was w** Maintenance and engineering staff performance associated with the Anchor/Darling testable check valves was weak. A significant number of position indication problems due to mechanical interferences or mis-adjustments were documented and this negative equipment performance trend was not earlier recognized or evaluated. A timely installation of an approved 1992 modification would have prevented the improper reassembly of the RCIC system injection check valve in 1998. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:** OPS	Self	NEG	**Pri:** 1A **Sec:** 3A **Ter:**	**Limited pre-job briefing with respect to potential consequences of feedwater controler failure.** During the conduct of maintenance at Unit 2, a faulty manual control circuit in the feedwater controller failed which resulted in a reactor vessel level transient and caused an automatic reactor shutdown. Plant conditions were acceptable to perform the maintenance. However, the pre-job brief was limited, in that, it did not discuss the potential consequences of a controller failure. Reference LER 99-10. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** MAINT **Sec:** PLTSUP	Self	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**Inadequate sampling procedure degraded RCIC system operation.** Following the June 24 automatic reactor shutdown and manual initiation of the reactor core isolation cooling (RCIC) system, operators identified that the lube oil level was not visible in the sight glass. The low oil level was the result of oil not being added following an oil sample being taken. Subsequent lube oil analysis showed that there was no RCIC system degradation. NMPC revised the RCIC oil sample procedure to assure that proper oil level is maintained. **Dockets Discussed:** 05000410 Nine Mile Point 2

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07/31/1999	1999006-01	**Pri:** MAINT **Sec:**	NRC	NCV	**Pri:** 2B **Sec:** 3A **Ter:**	**Failure to have appropriate procedures to ensure proper performance and documentation of all required RCI** During the June 24 automatic shutdown transient at Unit 2, the reactor core isolation cooling (RCIC) system exhibited 200-300 gallon per minute flow oscillations with the controller in automatic. NMPC investigation showed that the flow controller had not been properly adjusted when it was replaced in 1996, in spite of available industry information on proper controller set-up. The controller out-of-adjustment condition, in conjunction with some air in the flow transmitter sensing lines, caused the flow oscillations. The failure to have appropriate procedures for tuning and calibration of the RCIC system was a non-cited violation and the result of past poor quality maintenance. Reference LER 99-08. **Dockets Discussed:** 05000410 Nine Mile Point 2
09/10/1999	1999-015-000	**Pri:** MAINT **Sec:**	Licensee	LER	**Pri:** **Sec:** **Ter:**	**INADVERTENT START OF DIVISION I DIESEL GENERATOR DUE TO PERSONNEL ERROR.** Inadvertent Start of Division I Diesel Generator Due to Personnel Error. The personnel performance issues associated with this LER were discussed in NRC Inspection Report 1999007. The inspector completed an on-site review of the LER and verified that corrective actions were completed and equipment issues that were identified were adequately addressed. The description and analysis of the event, as contained in the LER, were consistent with the inspectors' understanding of the event. The root cause and corrective and preventive actions, as described in the LER, were reasonable. **Dockets Discussed:** 05000410 Nine Mile Point 2
06/19/1999	1999005	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** 3A **Ter:**	**Poor conduct of maintenance on RCIC system contributed to it failure.** The reactor core isolation cooling (RCIC) system trip encountered during surveillance testing was the result of a poorly developed system flushing methodology. The subsequent on-line RCIC system maintenance outage was not effectively and efficiently executed to ensure the system unavailability time was minimized. NMPC's root cause determination for the RCIC turbine trip was reasonable and the corrective actions appropriately implemented and documented in the associated deficiency event reports. (M1.2 **Dockets Discussed:** 05000410 Nine Mile Point 2
06/19/1999	1999005	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:**	**Acceptable controls over NDE contractor and related activities.** Acceptable control of the technical details and appropriate oversight of the contractor performing the non-destructive examinations (NDE) of the core shroud at Unit 1 was noted. The contractor used state-of-the-art ultrasonic technology to detect and size weld indications and cracks. The contractor used acceptable means for the interpretation of the NDE data and the NDE personnel were determined to have been properly certified. (M2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
06/19/1999	1999005	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:**	**Unit 1 recirc pipe NDE appropriately conducted.** During the refueling outage for Unit 1, appropriate reviews of the indications detected in the recirculation piping safe-end to elbow and nozzle to safe-end welds were performed. (M2.2) **Dockets Discussed:** 05000220 Nine Mile Point 1
06/19/1999	1999005	**Pri:** MAINT **Sec:** ENG	Self	POS	**Pri:** 2B **Sec:** 4B **Ter:**	**Hydrostatic test reveals bottom head drain line crack.** During the Unit 1 reactor vessel hydrostatic test, a leak developed in the reactor vessel bottom head drain line. The cause was determined to be thermal stress induced fatigue which was caused by a system valve packing leak onto the adjacent downstream piping. The inspectors noted that the valve packing leakage was a long-standing material condition problem, the consequence of which was not fully recognized until the crack was identified, analyzed, and repaired. NMPC's corrective actions were acceptable. (M2.3) **Dockets Discussed:** 05000220 Nine Mile Point 1

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05/08/1999	1999004	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**ECCS strainer modification well controlled.** The installation of the emergency core cooling system torus suction strainers was well controlled. The work environment was clean, organized and good foreign material exclusion controls were in place. (M1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1
05/08/1999	1999004	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 1C **Sec:** 4B **Ter:**	**Appropriate conduct of NDE associated with core shroud.** Non-destructive examination personnel were qualified, and adhered to procedures while performing examinations. The core shroud and reactor vessel weld inspection plans were in accordance with the requisite NRC safety evaluation. Deficiencies identified during inspection activities were properly documented. A new surveillance program provided enhanced oversight of vendor activities. (M3.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
05/08/1999	1999004	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** 2A **Sec:** 5A **Ter:** 5C	**Effective equipment failure identification and resolution.** On April 24, a Unit 2 generator protection circuit relay failed which caused a reactor scram. NMPC effectively evaluated the cause and consequences of the relay failure and implemented acceptable corrective action. (M2.2) **Dockets Discussed:** 05000410 Nine Mile Point 2
05/08/1999	1999004-02	**Pri:** MAINT **Sec:**	Self	NCV	**Pri:** 1C **Sec:** 3A **Ter:**	**Unit 2 RCIC system failure during reactor scram transient.** During the Unit 2 scram, the reactor core isolation cooling (RCIC) system failed to operate as required and was manually tripped. This RCIC system failure was attributed to an inadequate maintenance procedure and the licensee's over-reliance on vendor support for a 1998 RCIC turbine trip throttle valve rebuild. The failure to ensure an adequate maintenance procedure was prepared and used to perform work on the RCIC system was a non-cited violation. Based on recent operating history, the RCIC system has exceeded its Maintenance Rule performance criteria. (M2.1) Reference LER 99-05. **Dockets Discussed:** 05000410 Nine Mile Point 2
03/27/1999	1999003	**Pri:** MAINT **Sec:**	NRC	NEG	**Pri:** 2B **Sec:** **Ter:**	**Maintenance planning deficiencies** During routine observations of maintenance activities, performance deficiencies with work planning, scheduling and preparation of work packages continue to be noted. For example, at Unit 1, while one emergency diesel generator was inoperable for planned maintenance, Cardox testing in the other emergency diesel generator room was performed that caused both emergency diesel generators to be declared inoperable. At Unit 2, the calibration of a feedwater temperature element caused an unexpected increase in indicated reactor core power. (Section M1.4) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/27/1999	1999003	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Work planning and scheduling risk assessment** NMPC's use of risk assessment during the work planning and scheduling processes indicated a good safety focus. Specifically, the insights gained from core damage frequency calculations at Unit 2, and from task-specific probabilistic risk assessments at both units were used by NMPC to minimize risk due to planned maintenance activities. (Section M1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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03/27/1999	1999003-01	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 3A **Sec:** **Ter:**	**Missed technical specification required channel functional test of the Unit 2 recirculation flow upscale rod blc** On March 4, the required technical specification surveillance tests for the recirculation flow upscale rod block were not completed at Nine Mile Point Unit 2. This missed surveillance requirement was due to an inadequate review during the development of the applicable instrumentation test procedure. This licensee-identified and corrected technical specification non-compliance is being treated as a Non-Cited Violation (NCV). (NCV 50-410/99-03-01) (Section M1.2) Reference LER 99-02. **Dockets Discussed:** 05000410 Nine Mile Point 2
03/27/1999	1999003-02	**Pri:** MAINT **Sec:**	Licensee	NCV	**Pri:** 1C **Sec:** **Ter:**	**Failure to complete the LSFT of the main steam line high radiation trip of the air removal pumps** The inspectors verified that the LER was completed in accordance with the requirements of 10CFR50.73. Specifically, the description and analysis of the event, as contained in the LER, were consistent with the inspectors' understanding of the event. The root cause and corrective and preventive actions as described in the LER were reasonable. Nonetheless, the failure to complete the LSFT of the main steam line high radiation trip of the air removal pumps is a violation of TS 4.3.2.2. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as LER 50-410/98-24 (NCV 50-410/99-03-02). **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Problem identification and corrective action for plant equipment and hardware issue good.** The problem identification and corrective actions for plant equipment and hardware issues was acceptable as indicated by the low backlog of non-outage equipment and hardware corrective maintenance items on both units. Both units continue to experience a range of self-identified maintenance problems with work packages and schedule coordination indicating the need for additional focused corrective actions. In particular, a frequent problem identified in work control DERs was less than adequate evaluation of the plant impact of planned work. Although Unit 1 was able to document an overall low work package error rate plant transients and unnecessary radiation exposure resulted as a consequence of some work performance errors. Unit 2 had not developed a process to self-review work package error rate. Nevertheless, corrective actions for each individual DER were appropriate. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Maintenance slef-assessments improved.** Units 1 and 2 improved its self-assessment in the area of maintenance. The maintenance self-assessment process was good and contributed to problem identification and resolution. NMPC identified that corrective actions for work practices issues has been ineffective. Maintenance management at both units were taking actions necessary to address findings. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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03/12/1999	1999002	**Pri:** MAINT **Sec:** ENG	NRC	POS	**Pri:** **Sec:** **Ter:**	**Safety systems in good material condition and system engineers on top of issues.** Safety systems selected for review exhibited good material condition including the portions of the station observed during the walkdown of each of the selected systems. No system hardware discrepancies or operating concerns were noted that were not previously identified by the licensee. The team found the DER use was generally acceptable. System Engineers were knowledgeable of their systems and were conversant with past and present operability issues and the DER program. System Engineers used the DER process as one means to identify and track problems associated with their system. NMPC was effectively utilizing trend analysis to identify maintenance rule related system performance problems. Both units were running their maintenance rule programs in a manner which facilitated the identification and correction of hardware deficiencies, including the use of industry experience from sources other than the site OE group. Corrective action plans for (a)(1) systems addressed the deficiencies which put the systems in (a)(1). Unit 1 was somewhat behind Unit 2 in the development of walkdown plans and system health reports.
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02/13/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 2B **Sec:** **Ter:**	**Maintenance planning** Two of the thirteen maintenance activities observed during this inspection period were inadequately planned. In one instance, a Unit 2 Station Shift Supervisor identified that an approved work order did not properly incorporate emergency diesel generator partial loading operating limits in support of work on the Division III switchgear. The second instance involved a Unit 2 work order associated with the lubrication of the reactor water cleanup system pump motor. The work order lacked detailed information regarding required tools and the amount of grease to be used. Consequently, the absence of this information resulted in the operator receiving unnecessary dose, which was inconsistent with good ALARA practices. (Section M3.1)
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
02/13/1999	1999001	**Pri:** MAINT **Sec:**	NRC	POS	**Pri:** 3A **Sec:** 4C **Ter:**	**New fuel receipt** Unit 1 new fuel receipt inspection and storage activities were performed well. Good use of procedures, thorough inspection, and good attention to cleanliness controls and communications were noted. Appropriate management and Quality Assurance staff involvement was noted. A potential oversight of reactor building crane inspection requirements was properly addressed. (Section M1.2)
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12/18/1999	1999010-01	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Failure to implement actions to promptly address a condition ad verse to safety (MSIV solenoid valve).** The failure to implement appropriate corrective actions at Unit 2 to prevent the installation of main steam isolation valve (MSIV) solenoid-operated-valves (SOVs) with ethylene propylene diene monomer (EPDM) seals was a non-cited violation of the corrective action requirements of 10 CFR 50 Appendix B. The inspectors also identified weakness in the calculations performed by NMPC to determine the qualified life of the MSIV SOVs. (E8.5)
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
12/18/1999	1999010-02	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Failure to test relays per TSs.** The failure to include all required relays in quarterly functional tests was a non-cited violation of Technical Specification surveillance requirements. Corrective actions were appropriate and additional, more broad-based corrective actions were being implemented as a result of previous licensee findings in the surveillance testing area. (E8.6) Reference LER 99-13.
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12/18/1999	1999010-03	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Failure to perform a safety evaluation when changing test requirements for fire detection equipment and bar** The identified exceptions were associated with surveillance testing of the fire pumps and fire detection systems, the timeliness of resolution of problems with fire protection panels at Unit 2, and questions regarding the qualifications of training personnel. With one exception, these items were self-identified during annual performance audits. NMPC's failure to perform a safety evaluation and change the Unit 1 FSAR, when revising test requirements for fire detection systems and barriers, was inspector identified. A non-cited violation was issued to document this failure to perform the requisite safety evaluation and FSAR change. (F2)
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10/30/1999	1999009-05	**Pri:** ENG **Sec:** MAINT	NRC	NCV	**Pri:** 1C **Sec:** 4B **Ter:**	**Failure to perform the required IRM surveillance test.** NMPC identified that a required Unit 1 nuclear instrumentation intermediate range monitor (IRM) surveillance test, validating IRM meter reading against rated thermal flux, was not being performed. Surveillance testing performed during the October 6, 1999, reactor shutdown resulted in the identification of needed gain adjustments on four of eight IRMs. The required gain adjustments and post-maintenance testing were successfully conducted and the IRMs performed well during the subsequent reactor startup. The failure to have performed the required testing was a non-cited violation. (E1.1)
Dockets Discussed: 05000220 Nine Mile Point 1						
10/30/1999	1999009-06	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Inadequate conduct of leak rate testing for automatic depressurization system nitrogen supply.** At Unit 2, licensee identified inadequate leak rate testing of the automatic depressurization system nitrogen supply was a non-cited violation. NMPC properly corrected and documented this problem in LER 50-410/99-06. (E8.1)
Dockets Discussed: 05000410 Nine Mile Point 2						
10/26/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Engineering supporting analyses were generally good, well documented bases for operability.** The team concluded the engineering supporting analyses generally provided a good, well documented bases to support component and system operability. However, one instance was identified where an engineering supporting analyses (ESA) would have been appropriate but was not requested by operations. (E2.3)
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10/26/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**Plant design changes and modifications were generally acceptable.** The team concluded that the design and implementation of plant design changes and modifications were generally acceptable. However, deficiencies in the design, review and implementation of the keep full modification for the Unit 1 emergency cooling system were identified and corrective actions associated with the modification were not implemented in a timely manner. (E1.1)
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
10/26/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**System engineers knowledgeable, system health reports good summaries, material condition generally good** System engineers were generally knowledgeable and involved in the resolution of system issues. System health reports provided good summaries of system status and overall performance. Material condition of plant systems was generally good. However, additional attention to detail during plant walkdowns appeared to be necessary to ensure discrepancies are promptly identified and corrected. (E2.1)
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10/26/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**Safety system functional inspections and assessments were generally thorough and clearly documented.** Safety system functional inspections and assessments (SSFI/SSFA) were generally thorough and clearly documented. Corrective actions for the SSFI/SSFAs findings were generally addressed in a proper manner. However, for one case involving the SSFI for the Unit 1 SFPC system, not all of the findings were properly entered into the corrective program as required by the station corrective action procedure NIP-ECA-01, "Deviation/Event Report." (E7.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/26/1999	1999008	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Appropriate controls and procedures for implementing requirements of 50.59.** NMPC has established appropriate controls and procedures for implementing the requirements of 10 CFR 50.59. Training and qualification of personnel has been established and was properly tracked. Applicability reviews and safety evaluations were performed when required and the overall quality of the work was good. (E3.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/26/1999	1999008-01	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Non-cited violation involving failure to implement procedure requirements.** The control and installation of currently installed temporary modifications was generally good. The number of installed temporary modifications was not excessive and did not significantly impact the operation of safety-related systems. However, a non-cited violation was identified for the failure to properly implement procedure GAP-DES-03 "Control of Temporary Modifications," on two occasions. Subsequent to the team findings, NMPC identified an adverse trend involving the control of temporary modifications and initiated an additional Deviation/Event Report (DER) to address this trend. (E2.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/26/1999	1999008-02	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 5A **Sec:** 5C **Ter:**	**Non-cited violation involving failure to implement adequate corrective actions.** The team concluded that the engineering resolutions for technical issues was generally acceptable. However, a non-cited violation was identified for the failure to implement the corrective action procedure requirements when evaluating a non-conforming condition associated with a Unit 1 intermediate range monitoring (IRM) range switch. The team also found that the implementation of corrective actions for issues involving a combination of engineering and other departments were not always effective or timely. For example, resolution of spent fuel pool cooling (SFPC) surge tank level controller failures was not effective. Also, two examples of Non-Cited Violations of the corrective action requirements of 10 CFR 50 Appendix B were identified involving inadequate control of tornado induced missiles and a failure to prevent recurrence of problems with the control of lubricants in safety-related equipment. (E2.4) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/26/1999	1999008-03	**Pri:** ENG **Sec:**	NRC	NCV	**Pri:** 4A **Sec:** 4C **Ter:**	**Non-cited violation involving failure to comply with design control requirements.** The team identified two examples of a non-cited violation where NMPC implemented changes to the Unit 1 facility without implementing proper design control measures. The examples included improperly leaving the spent fuel pool cooling pump suction strainers installed permanently and operation of the emergency service water temperature control valve bypass valve differently than described in the Final Safety Analysis Report (FSAR). The team also concluded that issues identified during the FSAR verification project were being properly resolved. (E3.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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10/26/1999	1999008-04	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** 4C **Ter:**	**Non-cited violation involving failure to implement in-service testing requirements.** NMPC thoroughly reviewed the causes of the in-service test (IST) program scope and test deficiencies reported in LERs 99-08, 99-09, 99-11, 99-12, and 99-14. Corrective actions were comprehensive and effective in identifying additional problems. The deficiencies reported in the LERs and additional IST deficiencies identified by the team are being treated as a Non-Cited Violation of the IST requirements of plant technical specifications. (E8.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
09/11/1999	1999007	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**Systems' engineers for Unit 1 HPCI and Unit 2 HPCS doing a good job.** The system engineers' periodic walkdowns and knowledge of their respective systems were adequate to support and maintain the Unit 1 high pressure coolant injection (HPCI) and Unit 2 high pressure core spray (HPCS) systems. The system engineers produced good quarterly system health reports which provided accurate summaries of system status and useful performance trend data. (Section E2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
09/11/1999	1999007-01	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4C **Sec:** 4B **Ter:**	**Failure to have properly calibrated the 13 flow control valve controller (violation of Appendix B, Criterion V).** The engineering staff thoroughly evaluated the technical aspects of the July 23 dual feedwater pump trip, including maintenance rule applicability, and identified the most probable causal factors. Appropriate corrective actions were taken or initiated prior to unit restart for the identified concerns. The failure to properly calibrate the No. 13 feedwater control valve following the RFO 15 setpoint setdown modification, contributed to the July 23 dual feedwater pump trip, and was treated as a non-cited violation. This modification associated error resulted in an avoidable challenge to the control room operators. (Section E1.1) Reference LER 99-04. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4B **Sec:** 4C **Ter:**	**Assumptions in IPE and PRA consistent with industry.** NMPC assumptions used to develop the individual plant examination for the frequency of loss of offsite power were not consistent with operating experience. NMPC updated its probabilistic risk analysis model and has submitted a revised individual plant examination to the NRC. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Failure rate data evaluation methodology used in the UNIT 2 PRA was appropriate.** The failure rate data evaluation methodology used in the Nine Mile Point Unit 2 probabilistic risk analysis (PRA) for the reactor core isolation cooling (RCIC) system was appropriate. The PRA assumptions regarding the loss of offsite power were consistent with plant operating practices. There was an increase in core damage frequency caused by the RCIC system malfunctions following the April 24, 1999, scram. The availability of multiple redundant systems to provide makeup to the reactor vessel mitigated the risk significance of this event. The RCIC system operation in the manual mode following the June 24 scram had an almost negligible effect on the core damage frequency. However, the aggregate of equipment malfunctions associated with the June 24 scram and the April 24 scram have risk significance and both scrams are being considered for inclusion in the NRC accident sequence precursor program. **Dockets Discussed:** 05000410 Nine Mile Point 2
07/31/1999	1999006-02	**Pri:** ENG **Sec:** MAINT	Licensee	NCV	**Pri:** 4C **Sec:** 4B **Ter:**	**Misapplication of ASME Code requirements for inservice testing (IST) program resulted in deletion of 26 valve** Misapplication of industry guidance during the development of the second ten-year interval inservice testing (IST) program at Unit 2 resulted in improperly deleting the requirement to conduct IST testing for 26 safety related valves. The valves were subsequently tested satisfactorily. Failure to conduct the required testing was a non-cited violation. Reference LER 99-14. **Dockets Discussed:** 05000410 Nine Mile Point 2

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08/18/1999	9906110065	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	LIC	**Pri:** **Sec:** **Ter:**	**NRC letter dated June 7, 1999, regarding modification to shroud tie rod upper spring brackets.** NMPC's proposed modification replaced the design function of a failed cap screw connecting the upper spring bracket of the upper spring of the core shroud tie rod assembly, and other cap screws that had the potential for future failure. The design complied with BWRVIP-02 as previously approved by the NRC staff, met the appropriate structural requirements of the ASME Code, used accepted materials, and included suitable provisions for potential loose parts. These provisions provided for prompt staff approval as an alternative ASME Code repair. After staff approval, NMPC repaired the springs on each of the four tie rods before restarting NMP1.
08/18/1999	9905050283	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	LIC	**Pri:** **Sec:** **Ter:**	**NRC letter dated April 30, 1999, regarding core shroud vertical weld contingency repair.** Licensee's design for a contingency repair was consistent with BWRVIP-02 as previously approved by the NRC staff, used materials and fabrication processes compatible with the reactor environment, was evaluated for appropriate loading combinations, included provisions to avoid loose parts, and future inspections will be to BWRVIP-07. These provisions provided for prompt acceptance by the NRC staff as an alternate repair to the ASME Code. After receiving staff approval, NMPC opted to implement a pre-emptive repair for vertical welds V-9 and V-10 before restarting NMP1.
08/18/1999	9903290146	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	LIC	**Pri:** **Sec:** **Ter:**	**NRC letter dated March 24, 1999, regarding RF015 core shroud and tie rod reinspection plan** Licensee's reinspection plan for the shroud welds and shroud repair components (tie rods) was consistent with and exceeded the inspection scope specified in NRC-approved BWRVIP doucments. The NRC staff found the plan acceptable without the need for any additional review information.
06/19/1999	1999005	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 3A **Sec:** 4B **Ter:** 5B	**Core shroud tie rod repair well conducted.** A core shroud tie rod upper spring assembly repair at Unit 1 was well conducted. A team approach to develop a repair plan, good utilization of mock-up training, and good radiological controls practices were noted by the inspectors. (E1.2)
06/19/1999	1999005	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 4B **Sec:** **Ter:**	**Repair efforts associated with core shroud repairs well controled.** Inspection of core shroud vertical and horizontal weld inspections at Unit 1 showed that required structural margins were satisfied. However, inspection results for the V10 weld showed some crack depth change. NMPC decided to pre-emptively repair the V9 and V10 welds using a contingency repair which was previously approved by the NRC. The installation of the repair clamp was well controlled. (E1.1)
06/19/1999	1999005	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 4B **Sec:** 5A **Ter:**	**Good identification of hoist trolley failure.** On May 18, while performing work on the Unit 1 refuel floor, the reactor building hoist trolley connection failed. The apparent cause of the failure was fatigue of the threaded rod connection. Previously conducted crane inspections were not sufficient to identify the equipment degradation and long-term corrective actions from a February 1988 failure had not been effective. (E1.3)

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06/24/1999	1999-007-00	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	Licensee	LER	**Pri:** 4B **Sec:** 4C **Ter:**	**VIOLATION OF TECHNICAL SPECIFICATIONS REGARDING ASME CODE SECTION XI CLASS 2 WELD INSPECTIC** Licensee appropriately identified and corrected an error in the ASME Code testing of HPCS system piping and pipe supports. Reference Section E8.1.
05/08/1999	1999004	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	Self	NEG	**Pri:** 1C **Sec:** 3A **Ter:**	**Inadequate design review of UPS modification.** During the Unit 2 reactor scram transient, one of the two reactor protection system uninterruptible power supplies (UPS) failed. Excessive currents, which caused the inverter DC power supply fuse to blow, were the result of a UPS design deficiency involving a newly installed maintenance bypass switch. NMPC identified that this vendor supplied UPS design change received an inadequate engineering design review. (E1.1)
05/08/1999	1999004	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Technical review of ECCS strainer modification thorough.** In the case of the Emergency Core Cooling System (ECCS) strainer modification, the technical scope of the design change was comprehensive, but the licensee's original review of an ECCS pump air ingestion calculation lacked thoroughness regarding a small break loss of coolant accident (LOCA) scenario and required a more detailed analysis and a revision of the supporting calculation. Additionally, the safety evaluation required revision to provide stronger bases for the conclusions contained therein regarding a large break LOCA. The licensee's review of air ingestion phenomena associated with the large break LOCA resulted in the conservative decision to declare inoperable, in the future, any ECCS pump placed in operation for surveillance testing or torus cooling. (E2.1)
05/08/1999	1999004-04	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	Licensee	NCV	**Pri:** 4B **Sec:** 1C **Ter:**	**Failure to maintain core thermal limits as required by TS.** From March 20 to March 23, 1999, Unit 1 operated with a maximum average planar heat generation rate (APLHGR) exceeding the limits specified by the technical specifications. This technical specification violation was non-cited. NMPC determined that the cause was the inadvertent processing of traverse in-core probe (TIP) data, due to inadequate computer system security on the 3D-Monicore system. Specifically, TIP data could be processed without authorization or operator knowledge from uncontrolled locations. Additionally, the oversight by station personnel with regards to reactivity management and core performance monitoring was poor, in that this discrepancy was not recognized for three days. (E4.1) Reference LER 99-03.
05/08/1999	1999004-05	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	Licensee	NCV	**Pri:** 1C **Sec:** 4B **Ter:**	**Failure to conduct the required ASME Code inspections.** The failure to conduct the required ASME Code inservice inspections of the reactor recirculation pump seal housing bolts and flange surfaces during the first and second ten-year inspection intervals was non-cited. (E8.1) Reference LER 98-19.
05/08/1999	1999004-06	**Pri:** ENG **Sec:** **Dockets Discussed:** 05000410 Nine Mile Point 2	Licensee	NCV	**Pri:** 4A **Sec:** 1C **Ter:**	**Failure to ensure that the service water intake de-icing capability is available during a control room fire.** NMPC self-identified and promptly corrected a condition which could have adversely affected the ability of the unit to achieve safe-shutdown, involving the Unit 2 service water intake de-icing heater control circuits which were not protected against a control room fire. This violation of License Condition 2.G was non-cited. (E8.3) Reference LER 99-04

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03/27/1999	1999003-03	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** **Ter:**	**Missed technical specification required pre-service weld inspection for the Unit 1 emergency condensers** On February 17, NMPC identified that the pre-service examinations for emergency condenser welds at Unit 1 were not completed and therefore, the technical specification surveillance requirements were not satisfied. NMPC interpreted the Code and erroneously concluded that the pre-hydrostatic examination met the Code requirements. Due to the improper application of the pre-service examination requirements of American Society of Mechanical Engineers (ASME) Section XI, technical specification surveillance requirements for the in-service inspection and testing were not satisfied. The NMPC requested, and was subsequently granted, enforcement discretion from the NRC because this action involved minimal or no safety impact and had no adverse radiological impact on public health and safety. This licensee identified and corrected non-compliance is a Non-Cited Violation. Reference LER 99-02. **Dockets Discussed:** 05000220 Nine Mile Point 1
03/27/1999	1999003-04	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** **Ter:**	**Failure to inspect two vertical welds in the lower core shroud** On March 5, NMPC determined that the weld inspections required by the boiling water reactor and internals project (BWRVIP) were not completed at Unit 1 for two vertical welds located in the lower core shroud. NMPC provided a timely and thorough assessment of the missed weld inspection and determined that the core shroud structural integrity would not be affected by the missed inspection. The failure to complete the core shroud weld inspections for the two vertical welds is a violation of NRC requirements. **Dockets Discussed:** 05000220 Nine Mile Point 1
03/27/1999	1999003-05	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** **Ter:**	**Inability to achieve safe shutdown due to Unit 2 service water bay unit coolers being out-of-service** On February 12, NMPC identified that Unit 2 service water bay unit coolers credited in the Updated Final Safety Analysis Report to be available during a control room fire and evacuation were routinely taken out of service without recognizing the impact on safe shutdown capability. The identification of this concern indicated a good questioning attitude. Nonetheless, the failure to ensure safe shutdown capability is a violation of the NMPC's license requirement regarding the fire protection program. This licensee identified and corrected non-compliance is a Non-Cited Violation. (NCV 50-410/99-03-05) Reference LER 99-01 and LER 99-01 suppl 001. **Dockets Discussed:** 05000410 Nine Mile Point 2
03/27/1999	1999003-06	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** 4B **Sec:** **Ter:**	**Inadequate corrective actions regarding Unit 2 safe shutdown capability** The corrective actions for a previous Licensee Event Report and deviation/event report were inadequate in that the actions were narrowly focused which contributed to the delayed identification of the concern with the service water bay unit coolers. This licensee identified and corrected non-compliance is a Non-Cited Violation. (NCV 50-410/99-03-06). **Dockets Discussed:** 05000410 Nine Mile Point 2
03/12/1999	1999002	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Good OE Program** NMPC had a defined OE program and was using the operating experience and industry information as an integral part of its corrective action program at both units. In general, OE items were properly reviewed for applicability and assignment to station branches for disposition. The issues were being handled in an effective and timely manner, and corrective actions were adequate. Notwithstanding, several examples were identified where older OE items and isolated examples of recent OE items were not properly reviewed for applicability and assigned for disposition. NMPC was implementing corrective actions for this matter, including consolidation of OE reviews under a new organization to improve review of OE items for applicability and assignment disposition. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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03/12/1999	1999002	**Pri:** ENG **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Good engineering self-assessment program.** NMPC had a good engineering self-assessment program. The engineering self-assessments were thorough and broad in scope, resulting in many good findings and recommendations. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
03/12/1999	1999002-01	**Pri:** ENG **Sec:**	Licensee	NCV	**Pri:** **Sec:** **Ter:**	**Failure to implement appropriate acceptance criteria.** NMPC implemented generally good identification and resolution of engineering problems. The corrective and preventive actions implemented or planned were generally appropriate for the issues identified in the DERs. Engineering problems identified were generally resolved appropriately and the root cause evaluations (RCE) for engineering DERs were thorough and appropriate. A Non-cited violation of 10 CFR 50, Appendix B, Criterion V was identified and included in the licensee's corrective action program. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
12/18/1999	1999010	**Pri:** PLTSUP **Sec:**	Licensee	NEG	**Pri:** 3A **Sec:** **Ter:**	**Security department slow to respond to a potential tampering issue.** On November 11, 1999, during routine maintenance at Unit 1, technicians found a pen cap lodged in the internals of a turbine building seal water pressure switch. The pen cap was positioned to prevent the alarm function from working. The security department was not initially made aware of the potential tampering issue and, as such did not become involved with the investigation until November 15. NMPC determined that the cause was most likely due to improper maintenance conducted in the past. The inspector concluded that the licensee's investigation was thorough. However, the security department was slow to investigate a potential tampering issue. (S1.1) **Dockets Discussed:** 05000220 Nine Mile Point 1
12/18/1999	1999010	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:**	**With a few minor exceptions, the Fire Protection Program was being adequately implemented.** With some exceptions, NMPC was implementing an adequate Fire Protection Program. Fire detection and suppression systems located in safety-related areas were tested in accordance with requirements, fire brigade personnel were adequately trained, and fire barriers were maintained and inspected. Appropriate administrative requirements were in place to control the position of valves and components in the fire main system. (F2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 2B **Ter:**	**Effective implementation of the REMP.** The licensee effectively maintained and implemented the Radiological Environmental Monitoring Program, including the monitoring, land use census, and inter-laboratory comparison programs, in accordance with regulatory requirements. The monitoring program was implemented using the appropriate procedures, the annual reports accurately reflected the analysis and quality assurance results, and the contractor laboratory continued to implement effective QA/QC programs for the REMP and continued to provide effective validation of analytical results. The environmental monitoring program was capable of ensuring independent verification validation of the integrity of the effluent release program. (R1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 2B **Ter:**	**Meteorological monitoring program effectively implemented.** The meteorological monitoring program was effectively implemented in accordance with regulatory requirements. Overall, the licensee effectively maintained system operability and properly performed channel calibrations and channel functional tests for the meteorological instrumentation. (R1.3) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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10/30/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1A **Sec:** 2B **Ter:**	**Corrective action program effective in identifying and resolving radcon deficiencies.** The corrective action program was effectively used to identify, evaluate, and resolve radiological deficiencies as evidenced by corrective action associated with an August 25, 1999 event at Unit 2 where a radiation protection technician received a dose higher than anticipated during a spent resin transfer evolution. The documentation of the event provided an accurate assessment of root causes and corrective and preventive actions were comprehensive. (R7.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**QA audits of REMP and MMP were thorough and effective.** The licensee met the QA audit requirements. The audits were thorough and of sufficient depth to assess the radiological environmental monitoring program (REMP) and meteorological monitoring program (MMP). Performance of audits and assessments were appropriate in that specific REMP and MMP activities were directly observed, timely feedback regarding the activity observed was provided, and identified findings were appropriately categorized. (R7.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** PLTSUP **Sec:** MAINT	NRC	POS	**Pri:** 1A **Sec:** 2B **Ter:** 3A	**Housekeeping conditions at both units were effective.** Housekeeping conditions at Unit 1 and Unit 2 were effectively maintained as evidenced by clear aisles and walkways, labeled storage areas, and well illuminated work areas. Radiological boundaries were effectively maintained as evidenced by well delineated boundaries, and appropriately posted and barricaded high radiation areas. (R2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009	**Pri:** PLTSUP **Sec:** OPS	NRC	POS	**Pri:** 3A **Sec:** 2B **Ter:**	**Licensee performance during an EP exercise was good.** The emergency response organization demonstrated the ability to properly implement the Emergency Plan during an exercise on October 27, 1999. Overall, performance during the exercise was good. (P1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
10/30/1999	1999009-07	**Pri:** PLTSUP **Sec:** MAINT	Licensee	NCV	**Pri:** 1A **Sec:** 3A **Ter:**	**Failure to follow radiation protection procedures to promptly leave a work area and report an abnormal dosi** The implementation of the radiological controls program was mixed. At Unit 2, a radiation protection technician failed to promptly leave a work area and report that his electronic dosimeter had exceeded an administrative alarm set-point during support of a spent resin disposal project. This was determined to be a non-cited violation. In contrast, radiological controls for the Unit 1 spent fuel pool re-rack job and a Unit 1 traverse in-core probe replacement were thoroughly planned and effectively implemented. (R1.1) **Dockets Discussed:** 05000410 Nine Mile Point 2
06/19/1999	1999005	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2B **Sec:** 3A **Ter:**	**Radcon controls good during the Unit 1 outage.** Radiological controls during the Unit 1 outage were good. Protective clothing, dosimetry and radiological posting requirements and radiation protection technician oversight were effective in minimizing personnel exposure. (R1.1) **Dockets Discussed:** 05000220 Nine Mile Point 1

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05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** **Ter:**	**Radwaste material/waste management and transportation programs effective.** Radioactive material/waste management and transportation programs were effectively implemented as evidenced by use of up-to-date regulations and facility licenses, appropriately trained personnel, proper procedural guidance and adequate maintenance of procedures, appropriate use of scaling factors to estimate isotopic content of radioactive material/waste packages, and proper shipping records. (R1.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**Radiological controls for Unit 1 outage were effective.** Radiological controls for the Unit 1 refuel outage were effectively planned and implemented and focused on jobs with elevated exposure estimates, high dose rates, and radiologically complex work. (R1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1
05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**RP practices were effective.** Radiological posting practices for access to radiation areas, high radiation areas, and airborne radioactivity areas were effective as evidenced by well defined boundaries and clear radiological postings. Some opportunities to enhance informational postings on the refuel floor that required "health physics notification prior to entry" beneath the drywell dome and reactor head insulation were identified. (R1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**Comtamination control practices were acceptable for the "Green Area."** Contamination monitoring requirements for access to the Turbine Building 305' Green Area (clean area within the radiologically controlled area [RCA]) did not include an entire whole body frisk similar to the requirements for RCA exit. However, they were adequate to minimize the risk for the spread and ingestion of significant amounts of radioactive contamination based on use of detailed procedures, restrictions on personnel that could use the facility, and close health physics oversight. (R1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:**	**Effective high radiation area controls.** Effective high radiation area controls were implemented as evidenced by clear radiological postings, use of locked doors when required, use of "Alarming" dosimetry, use of radiation work permits (RWPs), use of remote door alarms, requirements for a minimum available exposure for access, and increased health physics oversight and monitoring for high radiation area entry. (R1.2) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
05/08/1999	1999004	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 1C **Sec:** 3A **Ter:** 2A	**Material conditions were good with good housekeeping practices.** Material conditions were good and housekeeping practices were effective as evidenced by clear aisles and walkways, neatly stored tools and equipment, and painted floor and wall surfaces. (R2.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

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05/08/1999	1999004	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2	NRC	POS	**Pri:** 5A **Sec:** 5C **Ter:**	**Self-assessments, audits, and DER system use were effective.** Self-assessments, audits, and the deficiency/event reporting system were effectively used to identify, evaluate, and resolve radiological control issues as evidenced by the conduct of multiple self-assessments and audits to satisfy the radiation protection program review requirements in 10CFR20.1101(c) and use of the DER system to implement appropriate corrective actions and controls to prevent unplanned exposures. (R7.1)
05/08/1999	1999004-07	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	NCV	**Pri:** 1C **Sec:** 3A **Ter:**	**Radiological controls program corrective actions.** One non-cited violation was identified associated with the failure to maintain access restrictions in the upper elevation of the drywell during movement of an irradiated core component on March 15, 1997. (R7.1)
03/27/1999	1999003	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2	NRC	POS	**Pri:** 5B **Sec:** **Ter:**	**Emergency preparedness for hydrogen fire** A site emergency preparedness exercise which was conducted on February 25, demonstrated acceptable performance by emergency response personnel. The post exercise drill critique provided good insight into performance and constructive criticism. (Section P4.1)
03/27/1999	1999003-07	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1	NRC	NCV	**Pri:** 1C **Sec:** 5A **Ter:**	**Failure to update satellite copies of the Unit 1 pre-fire plan for commitments associate with "Criticality Accide** The NRC identified that copies of the pre-fire plans for the refuel floor were not changed to reflect NMPC commitments made for an exemption to 10CFR70.24, "Criticality Accident Requirements." The cause was attributed, in part, to poor administrative control and supervision processes for ensuring that fire protection procedures are updated. (NCV 50-220-99-03-07). Reference LER 99-01.
03/12/1999	1999002	**Pri:** PLTSUP **Sec:** **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2	NRC	POS	**Pri:** **Sec:** **Ter:**	**Plant support groups shown improved performance in DER implementation.** Overall, the plant support groups have shown improved performance in implementing the DER program. NMPC's radiation protection branches implemented reasonable closure actions to address root causes of identified problems. The Security group appropriately issued DERs for identified findings including adverse trend DERs. However, some inconsistency in categorizing Security DERs was apparent and specific management initiated corrective actions were not fully implemented for repetitive issues.

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03/12/1999	1999002	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** **Sec:** **Ter:**	**Plant support area self assessments were good.** The radiation protection groups at NMP had a good self-assessment program. DERs were written for findings meeting the thresholds for DERs. The chemistry groups at NMP did not have a well defined departmental self-assessment program, but had recently taken the initiative to develop a self-assessment program with defined areas for self-assessment including a long term proposed schedule. Security self-assessments provided a good review of program conformance to applicable Security Plan requirements. However, the self-assessments did not examine previous DERs concerning Security personnel, procedures, or practices to evaluate the effectiveness of corrective actions. The EP organization implemented a defined self-assessment program with established performance indicators for use in evaluation of EP program elements. Self-assessment within the fire protection group was limited resulting in many critical program findings being identified during quality assurance audits. Since quality assurance audits occur relatively infrequently, undetected fire protection concerns persisted.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
03/12/1999	1999002-02	**Pri:** PLTSUP **Sec:**	NRC	NCV	**Pri:** **Sec:** **Ter:**	**Failure to submit special reports in accordance with TS 6.9.3.f.** Overall, licensing processing of DERs was adequate. An example was identified where the length of time taken to resolve one Category 1 DER, along with additional confusion caused by the use of a non-endorsed TS interpretation, resulted in the licensee not meeting the spirit of its procedural requirement for prompt attention to a Category 1 DER. Licensing has improved in closing old DERs, but additional attention and emphasis on timely disposition appears warranted. A Non-Cited Violation of Technical Specification 6.9.3.f was identified and included in the licensee's corrective action program.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 2A **Sec:** **Ter:**	**Security facilities and equipment** NMPC security facilities and equipment were well maintained and reliable and were able to meet the license commitments and NRC requirements.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3A **Sec:** **Ter:**	**Housekeeping and radiological controls** Housekeeping and radiological controls for the reactor water cleanup system areas were acceptable.
Dockets Discussed: 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2						

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

NINE MILE POINT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 3B **Sec:** **Ter:**	**Security force knowledge** The security force members adequately demonstrated that they had the requisite knowledge necessary to effectively implement the duties and responsibilities associated with their position. (Section S4) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Hydrogen Fire emergency Preparedness** On January 14, NMPC declared an Unusual Event due to the plant's proximity to a hydrogen fire at the adjacent FitzPatrick Nuclear Power Plant. The site Emergency Preparedness Program requirements were effectively implemented for a fire at an adjacent facility. NMPC held a post-event critique to review their performance and used the UE as a training opportunity. Several recommendations were made to improve the specific response capabilities. (Section P4.1) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Security and safeguards activities** NMPC conducted their security and safeguards activities in a manner that protected public health and safety, and in accordance with their license commitments and NRC requirements. **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Security and safeguards procedures and documentation** Security and safeguards procedures and documentation were properly implemented. Event Logs were being properly maintained and effectively used to analyze, track, and resolve safeguards events. (Section S3) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4C **Sec:** **Ter:**	**Management support of security** The level of management support was adequate to ensure effective implementation of the Security Plan, and was evidenced by adequate staffing levels and the allocation of resources to support programmatic needs. (Section S6) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 4C **Sec:** 3B **Ter:**	**Security force training** Security force personnel were trained in accordance with the requirements of the Training and Qualification Plan. Training documentation was properly maintained and accurate, and the training staff provided effective training. (Section S5) **Dockets Discussed:** 05000220 Nine Mile Point 1 05000410 Nine Mile Point 2

United States Nuclear Regulatory Commission
PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

NINE MILE POINT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/13/1999	1999001	**Pri:** PLTSUP **Sec:**	NRC	POS	**Pri:** 5B **Sec:** **Ter:**	**Security audits** Security audits were comprehensive in scope and depth, audit findings were reported to an appropriate level of management, and the audit program was found to have been properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that self-assessments were effective in identifying and resolving potential performance weaknesses. (Section S7)

Dockets Discussed:
05000220 Nine Mile Point 1
05000410 Nine Mile Point 2

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

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.