

Plant Performance Review - Millstone Unit 3

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March 31, 2000

Mr. Stephen E. Scace, Director Nuclear Oversight and Regulatory Affairs
Northeast Nuclear Energy Company
P.O. Box 128
Waterford, Connecticut 06385

Subject: Plant Performance Review - Millstone Unit 3

The purpose of this letter is to communicate our assessment of your performance and to inform you of our planned inspections at your facility. On February 24, 2000, we completed a Plant Performance Review (PPR) of Millstone Unit 3. We conduct these reviews to develop an integrated overview of the safety performance of each operating nuclear power plant. We use the results of the PPR in planning and allocating inspection resources and as inputs to our senior management meeting (SMM) process. This PPR evaluated inspection results and safety performance information for the period from January 16, 1999, through January 31, 2000, but emphasized the last six months to ensure that our assessment reflected your current performance. Our last full and mid-cycle PPR reviews of Millstone Unit 3 were provided to you in letters dated April 9, 1999, and September 30, 1999, respectively.

The NRC has been developing a revised reactor oversight process that will replace our existing inspection and assessment processes, including the PPR, the SMM, and the Systematic Assessment of Licensee Performance (SALP). We recently completed a pilot program for the revised reactor oversight process at nine participating sites and are making necessary adjustments based on feedback and lessons learned. We plan to begin initial implementation of the revised reactor oversight process industry-wide on April 2, 2000.

This PPR reflects continued NRC process improvements as we make the transition into the revised reactor oversight process. You will notice that the following summary of plant performance is organized differently from our previous performance summaries. Instead of characterizing our assessment results by SALP functional area, we are organizing the results into the strategic performance areas embodied in the revised reactor oversight process. In addition, we have considered the historical performance indicator data that you submitted in January 2000, in conjunction with the inspection results, in assessing your performance. The results of this PPR were used to establish the inspection plan in accordance with the new risk-informed inspection program (consisting of baseline and supplemental inspections). Although this letter incorporates some terms and concepts associated with the new oversight process, it does not reflect the much broader changes in inspection and assessment that will be evident after we have fully implemented our revised reactor oversight process.

During the last six months of this assessment period, Millstone Unit 3 remained at full power most of the time. We have not identified any significant performance issues during this assessment period in any of the three strategic performance areas (reactor safety, radiation safety and safeguards) and note that Millstone

Unit 3 continues to operate in a safe manner. Therefore, we currently plan to conduct only our normal baseline inspections at your facility as noted in the attached inspection plan.

The corrective action program and engineering controls demonstrated improvements from the previous cycle. However, recurrent design control problems with the recirculation spray system (RSS) cubicle sump pumps represented ineffective corrective actions and inadequate design controls relating to previous sump pump modifications. NRC team inspections of both the corrective action and engineering programs found effective controls for identifying, resolving, and preventing equipment problems and personnel performance issues; and good engineering support of Millstone Unit 3 operations and maintenance.

A generally healthy safety conscious work environment existed at Millstone. The station had appropriate programs and processes established to address employee concerns and to monitor and evaluate the safety conscious work environment. Site employees were familiar with programs and processes for handling concerns, and they were willing to raise nuclear safety concerns. Challenges to a safety conscious work environment remained due to the impending sale of the plant and planned reductions in contractor and staff positions. The NRC will continue to monitor the safety conscious work environment at Millstone, including the review of the findings from the future Little Harbor Consultant reports, to determine if further NRC inspection in this area is warranted.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), used during this PPR process to arrive at our integrated view of your performance trends. The PIM for this assessment is grouped by the prior SALP functional areas of operations, maintenance, engineering and plant support, although the future PIM will be organized along the cornerstones of safety as described in the revised reactor oversight process. The attached PIM includes items summarized from inspection reports or other docketed correspondence between the NRC and Northeast Nuclear Energy Company regarding Millstone Unit 3. We did not document all aspects of your programs and performance that may be functioning appropriately. Rather, we only documented issues that we believe warrant management attention or represent noteworthy aspects of performance. In addition, the PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since our last inspection report was issued, but had not yet received full review and consideration. We will make this material publicly available as part of the normal issuance of our inspection reports and other correspondence.

Enclosure 2 lists our planned inspections for the period April 2000 through March 2001 at Millstone Unit 3 to allow you to resolve scheduling conflicts and personnel availability in advance of our inspector arrival onsite. Since many of our inspections at Millstone Unit 3 and at other Region I facilities during this period involve a team of inspectors, our ability to reschedule inspections is limited. Therefore we request you inform us as soon as possible of any scheduling conflicts. The inspection schedule for the latter half of the period is more tentative and may be adjusted in the future due to emerging performance issues at Millstone Unit 3 or other Region I facilities. Routine resident inspections are not listed due to their ongoing and continuous nature.

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (610) 337-5129.

Sincerely,

/RA/

James C. Linville, Director
Millstone Inspection Directorate

Docket Nos. 50-423

License Nos. NPF-49

Enclosures: [Not Included in the Web-Posted Version]

1. Plant Issues Matrix
2. Inspection Plan

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PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I
05000423 - Millstone 3

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/05/2000	1999014	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: 2A Ter:	ISSUES INVOLVING OPERABILITY/REPORTABILITY APPROPRIATELY HANDLED The established Unit 3 operational and radiological controls were adequate to provide for the safe implementation of plant evolutions and control room activities, as well as for the effective handling and tracking of plant equipment status. Issues involving component operability, availability, reportability, and regulatory compliance were appropriately addressed by the licensee staff.
11/22/1999	1999012-08	Pri: OPS Sec:	NRC	NCV	Pri: 2B Sec: 4C Ter:	FAILURE TO ADEQUATELY ESTABLISH AND IMPLEMENT TESTING IN ACCORDANCE WITH TS 4.0.5. The licensee reported on February 18, 1998, that testing of the Unit 3 Turbine Driven Auxiliary Feedwater Pump (TDAFWP) had not fully met specific American Society of Mechanical Engineers (ASME) Section XI in-service testing requirements. This condition resulted from a failure to perform biennial position indication verification tests of certain TDAFWP solenoid operated valves and TDAFWP performance testing outside an accepted two percent band for rotational speed. This violation of Millstone Unit 3 Technical Specification 4.0.5 is being treated as a Non-Cited Violation.
11/22/1999	1999012-09	Pri: OPS Sec:	NRC	NCV	Pri: 4A Sec: 2A Ter:	FAILURE TO ENSURE THAT DESIGN CRITERIA ARE CORRECTLY TRANSLATED INTO SPECIFICATIONS, DRAWING On February 20, 1998, the licensee reported that they had identified historical failures to provide weep holes and other modifications to some safety related conduit and junction boxes located within the containment and auxiliary buildings. Without these modifications the equipment was potentially degraded and unable to meet the post Loss of Coolant Accident (LOCA) design basis described in the Unit 3 Final Safety Analysis Report (FSAR). This condition resulted from a failure to establish and implement an adequate 10 CFR 50.49 analysis to ensure that the Unit 3 FSAR design basis was maintained. This violation of 10 CFR 50 Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation.
11/22/1999	1999012-10	Pri: OPS Sec:	NRC	NCV	Pri: 2B Sec: 4C Ter: 4A	FAILURE TO ADEQUATELY IMPLEMENT DESIGN CONTROLS TO ENSURE THAT DESIGN BASIS DATA WERE CC On March 18, 1998, the licensee reported that they had identified certain manual valves with an active safety function and several check valves that were historically not adequately tested in accordance with American Society of Mechanical Engineers (ASME) Section XI. ASME Section XI testing requirements are implemented through Unit 3 Technical Specification (TS) 4.0.5, to ensure that equipment performance criteria assumed in the Final Safety Analysis Report are met. This violation of TS 4.0.5 is being treated as a Non-Cited Violation.
11/22/1999	1999012-11	Pri: OPS Sec:	NRC	NCV	Pri: 2A Sec: 1A Ter:	OPERATING WITH A FAILED STEAM GENERATOR LEVEL CHANNEL WITHOUT PLACING IT IN THE TRIPPED CO The licensee reported on October 13, 1998, that it had operated for a period of approximately three days with an inoperable Engineered Safety Function (ESF) channel (steam generator level) not in the tripped condition as required by Unit 3 Technical Specification (TS) 3.3.2. The cause of the condition was a failure of a P-14 bistable input power supply. Upon discovery, the failure was corrected. Failing to place the inoperable ESF instrument channel in a tripped condition is a violation of Unit 3 TS 3.3.2 and is being treated as a Non-Cited Violation.
11/22/1999	1999012-12	Pri: OPS Sec:	NRC	NCV	Pri: 4C Sec: 2B Ter:	FAILURE TO ESTABLISH ADEQUATE MONTHLY OPERATIONAL AND CHANNEL CALIBRATION SURVEILLANCES The licensee reported on October 20, 1998, that historical surveillance testing of the Unit 3 Loose Parts Monitoring (LPM) system had not met Technical Specification (TS) requirements for range and accuracy. This violation of TS 3.3.3.8 is being treated as a Non-Cited Violation.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/04/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	RESPONSE TO LEAK IN CONDENSATE DEMINERALIZER SYSTEM The licensee responded well to a leak in the Unit 3 condensate demineralizer system. Operators isolated the leak and stabilized power at 80 percent to control the transient which followed. Effective operations command and control and appropriate licensee cleanup efforts were observed during and after the transient. The licensee demonstrated thorough followup to determine why a damaged demineralizer drain valve did not fail closed, as expected.
10/04/1999	1999009-08	Pri: OPS Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO ADEQUATELY IMPLEMENT DESIGN CONTROLS TO ENSURE THAT THE SW DESIGN BASIS WAS C On September 10, 1998, with Unit 3 in Mode 1, both trains of the service water (SW) system were declared inoperable when check valves associated with sodium hypochlorite injection failed to reseal following a surveillance test. The valve failures resulted from internal valve corrosion, caused by the placement of hypochlorite-susceptible materials in portions of the system subjected to relatively high concentrations of hypochlorite. The failure to adequately implement design controls to ensure that the SW design basis was correctly translated into specifications, drawings and procedures was a violation and was appropriately identified, documented, and corrected. Associated LER 50-423/98-37 is closed. This violation is being treated as non-cited.
10/04/1999	1999009-09	Pri: OPS Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO ENSURE THAT THE SI ACCUMULATOR VALVE DESIGN BASIS WAS CORRECTLY TRANSLATED IN At Unit 3, the licensee reported on January 6, 1998, that the motor pinion gear keys in three out of four SI accumulator isolation valves were sheared. The condition was adequately responded to and resolved by the licensee. The root cause was a failure to adequately translate the valve design criteria into appropriate design specifications for the pinion keys. This failure is a violation and is being treated as non-cited (NCV 50-423/99-09-09). LER 50-423/98-01 is closed.
10/04/1999	1999009-10	Pri: OPS Sec:	NRC	NCV	Pri: 2B Sec: 4C Ter: 4A	FAILURE TO ADEQUATELY IMPLEMENT DESIGN CONTROLS TO ENSURE THAT THE EDG DESIGN BASIS WAS I The licensee reported on September 9, 1997, that the Unit 3 Emergency Diesel Generator (EDG) coolers would not have met their design criteria for thermal performance due to fouling that resulted from historical fuel oil leaks into the EDG fresh water cooling water system from the fuel oil injectors. The fouling was not identified because of inadequate thermal performance testing. The condition was adequately responded to and resolved by the licensee. The failure to adequately implement design controls to ensure that the EDG design basis was correctly translated into specifications, drawings and procedures is a violation and is being treated as non-cited. (NCV 50-423/99-09-10) LER 50-423/98-01 is closed.
10/04/1999	1999009-11	Pri: OPS Sec:	NRC	NCV	Pri: 4A Sec: 2B Ter:	FAILURE TO ADEQUATELY IMPLEMENT DESIGN CONTROLS TO ENSURE THAT THE CAM DESIGN BASIS WAS I On February 6, 1998, the licensee reported that the Unit 3 Containment Air Monitor (CAM) alarm and alert setpoints were set above those indicated in the Millstone Unit 3 Final Safety Analysis Report (FSAR). The condition was adequately responded to and resolved by the licensee. Failing to adequately implement design controls to ensure that the CAM design basis was correctly translated into specifications, drawings and procedures is a violation and is being treated at non-cited. LER 50-423/98-09 is closed.
08/09/1999	1999008	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 3 Operations Overall, Unit 3 plant operations and specific operational evolutions were well controlled during this inspection period. While the plant challenges requiring the unplanned entry into TS action statements were few, the plant operators and management responded to these events in a deliberate, yet timely, and conservative manner. Since the completion of RFO 6 activities and the return of the plant to power operations, Unit 3 operated safely on line for 42 days, as of the end of this inspection period.

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08/09/1999	1999008-11	Pri: OPS Sec:	NRC	NCV	Pri: 4B Sec: Ter:	INADEQUATE 18 MONTH SURVEILLANCE TEST ON THE EMERGENCY DIESEL GENERATORS The licensee had failed to verify that each Unit 3 diesel started from standby conditions since May of 1995, and this is considered a violation of NRC requirements. Based upon the licensee's promptly initiated corrective actions upon problem discovery, this Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-423/99-08-11) LER 50-423/99-003-00 is closed.
07/15/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: 5C Ter: 5A	Unit 3 Operator Work Around Process The operator workaround process is effectively implemented, such that the burden on operators is minimized, and an adequate interface exists with the corrective action program for resolution. The licensee has the capability to identify Condition Reports at Millstone 1 that would impact the operation of Millstone 2 and Millstone 3 through an effective use of the system readiness report that identified common systems, the operation manual on system interaction, and the technical requirement manual.
07/15/1999	1999007	Pri: OPS Sec:	NRC	POS	Pri: 5C Sec: 5A Ter:	Unit 3 Problem Reporting System - Condition Report The licensee continued to implement a high volume, low threshold problem reporting system. Problem identification was enhanced by lowering the condition report (CR) threshold. Opportunities for improvement were noted in initiating CRs for ineffective corrective actions. Management set clear expectations on corrective action program performance goals. The quality of the root cause investigations was acceptable; however, some investigations did not identify all causes for the event. Consequently, corrective actions were not always comprehensive. In general, corrective actions were effectively implemented.
06/14/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 3 Operational Evolutions in Support of Refueling Outage 6 Unit 3, operational evolutions in support of refueling outage 6 were generally well controlled, with "defense in depth" considerations and departmental support of operational activities in evidence. Communications and shift turnover controls were adequate; although, as discussed by the inspectors with the responsible shift managers, not always consistent with the expectations set by the conduct of operations protocol.
06/14/1999	1999006	Pri: OPS Sec:	Licensee	POS	Pri: 1B Sec: Ter:	Unit 3 Main Board Annunciator Loss At Unit 3, the licensee responded appropriately to the loss of main board annunciators, identified the cause and recovered from event in a timely manner, and appropriately restored the electrical alignment to normal prior to the continuation of testing.
04/19/1999	1999005	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 3 Response to Operational Challenges, Operability Concerns and Equipment Problems Overall, Unit 3 staff response to the operational challenges, operability concerns, and equipment problems that emerged during this inspection period was adequate; with evidence of conservative decision making by plant management, and appropriate actions and timely corrective measures taken by the operators on shift.

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04/19/1999	1999005-09	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: 5C Ter:	Unit 3 Failure to Perform Steam Generator Drain Down Sampling Unit 3 failed to perform the required sampling during steam generator drain down which is a violation of TS. The licensee's corrective actions were timely and acceptable. Therefore, this licensee-identified and corrected violation is being treated as a non-cited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. (See LER 50-423/98-013)
04/19/1999	1999005-10	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: 5C Ter:	Unit 3 Failure to Perform a Daily RM Check Unit 3 failed to perform a daily check of a radiation monitor which is a violation of technical specifications. The licensee's corrective actions were timely and acceptable. Therefore, this licensee-identified and corrected violation is being treated as a non-cited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. (See LER 50-423/98-20)
04/19/1999	1999005-11	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: Ter:	Unit 3 Failure to Perform Hydrogen Recombiner Channel Calibration Unit 3 historical failure to perform a channel calibration of the hydrogen recombiners is a violation of technical specifications. The licensee's corrective actions were timely and acceptable. Therefore, this licensee-identified and corrected violation is being treated as a non-cited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. (See LER 50-423/98-30)
04/19/1999	1999005-12	Pri: OPS Sec:	Licensee	NCV	Pri: 1A Sec: Ter:	Unit 3 Failure to Perform Fuel Handling Crane Limit Switch Surveillance Unit 3 failure to perform the fuel handling crane limit switch surveillance is a violation of technical specifications. The licensee's corrective actions were timely and acceptable. Therefore, this licensee-identified and corrected violation is being treated as a non-cited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. (See LER 50-423/98-32)
03/01/1999	1999002-06	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: 1B Ter: 4C	Unit 3 Control Room Filtration System - Entry into TS 3.0.3 The Unit 3 control room envelope was breached following an inadvertent carbon dioxide suppression system actuation when the nonsafety-related control building purge system was placed in service. When the control room envelope was breached, Technical Specification (T.S.) 3.7.7 required declaring both trains of control room filtration inoperable. T.S. 3.0.3 required the plant to be placed in hot standby within 7 hours. Operators failed to enter and comply with either T.S. due to an ambiguous statement in the bases section of T.S. 3.7.7.
01/05/2000	1999014-08	Pri: MAINT Sec:	NRC	NCV	Pri: 4B Sec: 4C Ter:	FAILURE TO ADEQUATELY DOCUMENT SUPPLEMENTARY INSTRUCTIONS FOR POTENTIAL SEISMIC INTERAC Review of the licensee's work control procedures governing the erection of scaffolding identified adequate controls and engineering directions. However, some Unit 3 scaffolding was identified by NRC field inspection to be in violation of procedural provisions for ensuring that seismic interactions would not impact the operability of nearby safety-related equipment. This failure to follow procedures is being treated as a Non-Cited Violation.

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01/05/2000	1999014-09	Pri: MAINT Sec:	NRC	URI	Pri: 2B Sec: 2A Ter:	ADEQUACY OF PERFORMANCE MEASURES FOR HIGH RISK SIGNIFICANT SSCS An unresolved item is being opened to allow further NRC evaluation of whether a violation of 10 CFR 50.65(a)(1) and (a)(2) occurred with respect to: (1) the licensee's methods for establishing performance measures for high risk significant structures, systems and components; (2) failure of the licensee to place the station blackout (SBO) diesel in an (a)(1) status and to establish appropriate goals in the general time frame of April 13, 1999, following the second functional failure; (3) the licensee's method of establishing performance measures for the emergency diesel generators and SBO diesel.
10/04/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: 5C Ter:	SURVEILLANCE ACTIVITIES WERE PERFORMED IN A CONTROLLED MANNER Observed Unit 3 surveillance activities were performed in a controlled manner, in accordance with approved procedures. Where testing problems arose or failures occurred, the licensee developed action plans to evaluate and correct the identified concerns. To address any generic questions of component or system operability, the licensee prudently scheduled additional testing on an expedited basis, as permitted by the overall plant conditions.
10/04/1999	1999009-12	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 5A Ter:	INEFFECTIVE IMPLEMENTATION OF SAFETY-RELATED DESIGN CONTROL MEASURES FOR THE RELOCATION Inspection-tours of Unit 3, including observation of ongoing maintenance and modification activities, identified some issues that required follow-up, for which the licensee appropriately issued condition reports. While most of these items were minor, one finding involving the ineffective implementation of safety-related design control measures for the relocation of an emergency lighting box resulted in the identification of a Non-Cited Violation.
08/09/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Maintenance Activities Overall, the inspection of selected Unit 3 maintenance activities, including field observations, document reviews, and work controls and priorities identified acceptable practices and good coordination across the unit departments. The prioritization and authorization for off-shift work hours to complete safety-related and risk significant equipment and LCO repair activities was well controlled; and good coordination of the daily work scope to preclude an increase in the plant risk posture because of the equipment removed from service for preventive maintenance was in evidence. Preventive maintenance inspections and other work were well planned, procedurally controlled, and trended by the system engineer, in the case of reviewed service water system activities.
08/09/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Surveillance Observation Observed Unit 3 surveillance activities were generally performed in a controlled manner in accordance with approved procedures. One instance of inattention to detail was observed by the inspector regarding improper independent verification. The error was corrected and did not recur through the rest of the surveillance.
08/09/1999	1999008	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Maintenance Rule Application The maintenance rule was properly implemented on the Unit 3 risk significant service water, auxiliary feedwater, and containment recirculation spray systems. Scoping information, performance criteria and unreliability data were maintained in accordance with approved procedures. Maintenance rule action plans were in place for the applicable systems and their status and system unavailability were monitored by licensee management.

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07/15/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Maintenance Related Corrective Actions The corrective action program was implemented effectively in the maintenance area. Maintenance rule corrective actions plans for the auxiliary feedwater, service water, and high pressure injection systems were properly developed and effectively implemented.
06/14/1999	1999006	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: 2B Ter:	OUTAGE CONFIGURATION AND WORK CONTROL PROBLEMS We also noted that a number of problems in configuration and work control were either self-identified or self-revealed during this period. Your increased management focus on such concerns addressed the need for more rigorous process controls on certain tagging and system restoration activities. We understand that your staff is developing longer-term corrective actions to reinforce station management's configuration control expectations and ensure that such events are not repetitive and do not result in more severe consequences.
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Unit 3 Surveillance Testing of Main Steam Code Safety Valve and Safety Injection System Functions Unit 3 Surveillance testing was conducted in accordance with established procedures. Good coordination was observed between control room operators and the responsible engineering personnel in support of the testing activities, system lineups, and disposition of test results. Where appropriate, technical expertise was obtained to confirm that the surveillance test data was consistent with the acceptance criteria.
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Unit 3 Inservice Inspection Unit 3 inservice inspection was performed acceptably and included appropriate ASME program coverage, qualified personnel, approved procedures, proper implementation, acceptable examination documentation, and NU oversight. The inspections performed were thorough and of sufficient extent to determine the integrity of the components inspected.
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Unit 3 Eddy Current Testing Unit 3 - Eddy current testing of steam generator tubes included acceptable procedures, qualified personnel, proper implementation, appropriate examination documentation and adequate NU oversight. The inspections performed were thorough and of sufficient extent to determine the integrity of the tubes inspected. When identified, nonconforming conditions were verified by use of alternate probe types, characterized, sized and properly dispositioned in accordance with established requirements
06/14/1999	1999006-03	Pri: MAINT Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Test Unit 1 Main Stack Noble Gas Monitor to Meet Unit 3 Technical Specifications Unit 3 - The failure to properly test the Unit 1 main stack noble gas monitor is a violation of Unit 3 TS Table 4.3-9 This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy.

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Region 1
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/14/1999	1999006-04	Pri: MAINT Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Test Low Pressure Safety Injection Check Valve in 1995 Unit 3 - The failure to properly test low pressure safety injection check valve 3SIL-V15 in 1995 is a violation of NRC requirements. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy.
06/14/1999	1999006-05	Pri: MAINT Sec:	Licensee	NCV	Pri: 2B Sec: Ter:	Unit 3 Failure to Properly Calibrate the Meteorologica Monitoring Wind Speed Channel Unit 3 failed to properly calibrate the meteorological monitoring wind speed channel which is a violation of technical specifications (TS) 4.3.3.4. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy.
06/14/1999	1999006-06	Pri: MAINT Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Properly Test Residual Heat Removal Valve 3RHS-MV8702B Unit 3 - The failure to properly test Residual Heat Removal suction valve 3RHS*MV8702B as followup testing to the 1989 test results is a violation of Technical Specifications (TS) 4.4.6.2.2.e. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy.
06/14/1999	1999006-07	Pri: MAINT Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Properly Test the P-4 Logic Prior to 1996 Unit 3 failed to properly test the P-4 logic prior to 1996 which is a violation of TS 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.
04/19/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 3 Observed Maintenance Activities Unit 3 observed maintenance and surveillance activities were appropriately controlled and performed in accordance with approved procedures or work orders and technical specification requirements.
03/01/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Consideration for Potential Adverse Impact Upon Safety-Related Components and Functions During the licensee planning and conduct of corrective maintenance activities, the inspector observed appropriate consideration for potential adverse impact upon safety related components and functions. Questions raised by the inspector were satisfactorily resolved. Licensee conduct of the required maintenance was adequately controlled. Where necessary, followup reviews of the maintenance activities were instituted by the licensee to validate effectiveness, ensure operability, or improve the approach to the conduct of such needed work in the future.

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01/05/2000	1999014	Pri: ENG Sec:	NRC	POS	Pri: 2A Sec: 4B Ter:	GOOD ENGINEERING REVIEW OF COMPONENT CORROSION The licensee system engineer appropriately conducted follow-up of observed corrosion on some safety-related Unit 3 valves. Material engineers evaluated the as-found conditions in the plant, determined that the immediate, adverse safety impact was minimal, and recommended a solution to eliminate further corrosion as a longer term corrective action. Overall licensee response to this issue was good.
11/22/1999	1999012-13	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: 2B Ter: 5C	FAILURE TO ASSURE THAT THE QUALIFICATION TESTING FOR USE OF THE SUBJECT AIR-DRIVEN SUMP PUM The licensee's failure to assure that the qualification testing for use of the air-driven sump pumps in a safety related application met all design control requirements was a violation of 10 CFR 50, Appendix B, Criterion III, Design Control. However, based upon the licensee's subsequent corrective actions, promptly and deliberately implemented after the pump failure identified on September 23, 1999, and consistent with the NRC Enforcement Policy, this failure is being treated as a non-cited violation. Unresolved Item 50-423/99-09-13 is closed.
10/22/1999	1999010-02	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: Ter:	FAILURE TO CORRECT IDENTIFIED CONDITIONS ADVERSE TO QUALITY The licensee's Independent Safety Engineering Group determined that corrective actions for some prior deficiencies were ineffective or untimely. A specific example was the identified deficiency associated with the training documentation of engineering personnel that was not corrected in a timely manner to prevent a recurrence of the problem. The failure to correct conditions adverse to quality in a manner to prevent recurrence was a non-cited violation.
08/09/1999	1999008	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 5C Ter:	Unit 3 Engineering Activities The review of ongoing Unit 3 engineering activities, conducted as follow-up to known system or equipment problems, revealed adequate design implementation, within the assumed accident analysis and other design-basis considerations. Where commitments had been made by the licensee to address specific design concerns (e.g., component EEQ for steam line breaks; piping configuration analyses to review gas accumulation; HELB assumptions), the inspector verified that the licensee implemented the appropriate actions to further evaluate the identified issues.
07/15/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 2B Sec: Ter:	Unit 3 Recovery Backlog The licensee has an excellent system to track the recovery backlog through an effective use of key performance indicators (KPI). The licensee proposal for backlog management plan commitment change is rationally supported by a screening process. NNECO is effectively implementing a new 12-week rolling maintenance planning and scheduling program. The backlog of risk-significant corrective maintenance was being reduced. The licensee had developed tools to track the completion of corrective actions and assignments, which were effectively used to trend performance. One area for improvement was to assure the KPI for maintenance adequately shows progress in reducing the backlog.
07/15/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Unit 3 Operability Determination Process The implementation of the operability determination process, as well as the corrective actions for items important to safety, was effective. One area for improvement was the licensee's failure to evaluate all relevant safety-related breakers for continued operability.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/15/1999	1999007-01	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: 5C Ter:	Unit 3 Examples of Corrective Action and Design Control NCVs Unit 3 opportunities for improvement in the corrective action program were noted in examples where corrective actions were ineffective, such as those related to organizational changes. The implementation of the design change for the 3DAS*P15A and B sump pumps was poor and corrective actions were ineffective on several occasions. Several examples of violations of the requirements of 10 CFR 50 Appendix B Criteria III, "Design Control," and Criteria XVI, "Corrective Action," were identified. The violations are being treated as non-cited Violations, consistent with Appendix C of the NRC Enforcement Policy.
07/15/1999	1999007-02	Pri: ENG Sec:	NRC	NCV	Pri: 5A Sec: 5C Ter:	Unit 3 Inadequate Corrective Actions for RSS Sump Pump Issues The licensee failed to identify and correct the cause of a failure of a pump during post-modification testing.
06/14/1999	1999006-08	Pri: ENG Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Perform Inservice Inspection Tests Earlier in the First 10 Year Interval Unit 3 failed to perform Inservice Inspection pressure tests earlier in the first 10 year inspection interval for 2 ASME systems and 17 containment isolation valves which is a violation of technical specification (TS) 4.0.5. This Severity Level IV violation is being treated as a Non-Cited Violation consistent with Appendix C of the NRC Enforcement Policy.
06/14/1999	1999006-09	Pri: ENG Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Perform the Certain Required ASME Section XI Examinations Between 1989 and 1995 Unit 3 failed to perform the required American Society of Mechanical Engineers (ASME) Section XI examinations in 10 separate ASME systems in 1989 and 1995 which is a violation of TS 4.0.5. This Severity Level IV violation is being treated as a Non-cited Violation consistent with Appendix C of the NRC Enforcement Policy.
04/19/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 3 Fuel Receipt Activities Unit 3 new fuel receipt activities were well controlled and performed by knowledgeable reactor engineering, maintenance, and health physics personnel. Fuel inspections were thorough and nonconformances were appropriately dispositioned.
03/01/1999	1999002-08	Pri: ENG Sec:	Self	NCV	Pri: 1C Sec: Ter:	Unit 3 Control Room Habitability The licensee's event review team for an inadvertent Unit 3 carbon dioxide actuation, identified that the review in response to NUREG 0737, Item IIID.3.4 requirements and Regulatory Guide 1.78, was inadequate. The licensee had failed to consider carbon dioxide as a design input in the toxic chemical analysis for control room habitability. A subsequent operability determination concluded that with the cable spreading room carbon dioxide system locked out, the control room ventilation system remained operable and the fire safe shutdown analysis remained valid.

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01/05/2000	1999014	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	EVENT LOGS WERE PROPERLY MAINTAINED AND USED TO ANALYZE, TRACK, AND ADDRESS SAFEGUARDS E Event logs were properly maintained and used to analyze, track, and address safeguards events. The logs indicated that there have been several breakdowns, involving the control of Safeguards information. This issue has been entered into the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 2A Sec: Ter:	WEAKNESS WAS IDENTIFIED IN THE EFFECTIVENESS OF THE SECURITY COMMUNICATIONS SYSTEM A weakness was identified in the effectiveness of the security communications system. This weakness has been entered in the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3B Sec: Ter:	WEAKNESSES IN THE DOCUMENTATION OF TRAINING WERE IDENTIFIED Weaknesses in the documentation of training were identified. These weaknesses have been entered into the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: Ter:	SECURITY PROGRAM AUDITS AND SELF-ASSESSMENTS EFFECTIVE IN RESOLVING POTENTIAL WEAKNESSE Security Program audits were comprehensive in scope and depth, the audit findings were reported to the appropriate level of management, and the program was being properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weaknesses.
10/04/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 1C Ter:	DOSE ASSESSMENT PROGRAM The internal exposure measurement and dose assessment program at Millstone is effective.
10/04/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	SELF ASSESSMENT OF RADIATION PROTECTION The RP program has an active oversight and self-assessment program that engages problems in an effective manner.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE HUMAN SERVICES ORGANIZATION'S "PEOPLE TEAM" EFFECTIVELY FOCUSED ON EMERGING ISSUES AND COORDINATED FOLLOW-UP ACTIONS. The Human Services Organization's "People Team" effectively focused on emerging issues and coordinated follow-up actions. Action was taken in a timely manner to evaluate and address potential safety conscious work environment issues. The "People Team" made improvements in establishing accountability for and tracking of actions. The Core Group and the targeted workplace surveys were effective tools for monitoring the safety conscious work environment at Millstone. The survey reports provided a thorough evaluation of the survey results. However, the recommendations did not always result in timely, proactive corrective actions. Team interviews found that site employees were familiar with programs and processes for handling concerns, and they would be willing to raise nuclear safety concerns. The Safety Conscious Work Environment (SCWE) department used the SCWE Case Process appropriately to address significant concerns based on established criteria. Action plans were well developed, and planned actions and assessment activities appeared to have been implemented in a timely manner. The team identified discrepancies in the documentation and tracking of actions and assessment activities, most notably in older case files. The Executive Review Board process was thorough and functioned as designed to ensure upcoming personnel actions were appropriate, and not the result of harassment, intimidation, discrimination, or retaliation.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE ECOP WAS EFFECTIVE IN PROVIDING OVERSIGHT OF THE SCWE AT MILLSTONE The Employee Concerns Oversight Panel (ECOP) was effective in providing oversight of the safety conscious work environment at Millstone. The team determined that the ECOP quarterly report was comprehensive and provided detailed information that site management could use to assess the safety conscious work environment at Millstone.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE ECP DEPARTMENT WAS ADEQUATELY STAFFED AND WAS EFFECTIVE IN HANDLING EMPLOYEE CONCERNS. The Employee Concerns Program (ECP) department was adequately staffed and was effective in handling employee concerns. Generally, key performance indicators (KPIs) showed positive or steady trends and performance in the ECP area. However, two KPIs, the backlog of cases under investigation and the backlog of open ECP corrective actions, showed negative trends. To help reduce the backlog of cases under investigation, the licensee was training an individual to become an ECP investigator. However, site management attention is warranted to address the increasing backlog of ECP corrective actions. The ECP department continued to perform thorough investigations. The quality of the ECP case files was high, with good investigative work noted. In all but one ECP case file, the investigations properly supported the conclusions. The ECP department reopened this investigation. The ECP department did not begin an investigation into a potential harassment, intimidation, retaliation, and discrimination (HIRD) issue until eight weeks after they had received the concern. The licensee is considering enhancing their process to prevent recurrence.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	LHC OBSERVED THAT THERE HAS BEEN IMPROVEMENT IN MOST AREAS SINCE JUNE 1999 Little Harbor Consultants (LHC) observed that there has been improvement in most areas since June 1999. All programs and policies put in place to enhance site performance with respect to a safety conscious work environment are functioning reasonably well.

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10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	OVERALL IMPROVEMENT IN THE SAFETY CONSCIOUS WORK ENVIRONMENT The team observed a generally healthy safety conscious work environment at Millstone. We noted overall improvement in most areas since the NRC's previous assessment in June 1999. Although the team found some minor deficiencies, these deficiencies did not detract from the overall effectiveness of the programs.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Security Personnel Turnover There has been an increase in the turnover rate in the security force sergeant ranks causing a shortage of sergeants to man regulatory required posts. The inspection determined that all required posts have been properly manned, overtime being worked by the sergeants was within prescribed guidelines and management was taking action to train and qualify additional sergeants to increase staffing levels.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Fitness for Duty Programs The fitness-for-duty program was being implemented in accordance with the licensee's procedures and regulatory requirements.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5B Ter:	Unit 3 External Radiological Controls The licensee is continuing to conduct an aggressive and comprehensive event review of a 7.04 rem exposure, involving an individual's personnel TLD device, to determine if the exposure represents an actual exposure to an individual or was the result of tampering with the individual's TLD, or other deliberate misconduct. The licensee's event review effort was conducted by knowledgeable personnel, and was comprehensive in scope and depth.
06/14/1999	1999006-10	Pri: PLTSUP Sec:	Licensee	NCV	Pri: 1C Sec: Ter:	Unit 3 Failure to Meet Technical Specification 6.12.1 Requirements for High Radiation Entry Requirements Two Unit 3 condition reports, written during refueling outage 6, documented violations of Technical Specification 6.12.1 high radiation area entry requirements. Both instances involved the use of alarming dosimeters that alarmed after reaching the preset integrated dose value, but were not audible to the worker and resulted in additional exposure to personnel. Both instances were identified by the licensee. Effective short term corrective actions were taken, and long term actions were initiated to evaluate other instrumentation options. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy, which permits closure of most Severity Level IV violations based on their having been entered into their corrective action program.
04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Unit 3 Contamination Control Unit 3 experienced instances of poor contamination control during preparations for its 6th refueling outage. These observations, coupled with similar, recent nuclear oversight observations, indicate a need for management attention in this area.

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04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Offsite Dose Calculation Manual Requirements for Reporting Effluent Releases Offsite Dose Calculation Manual (ODCM) requirements for reporting effluent releases and projected doses to the public were effectively implemented. The ODCM contained sufficient specification, information, and instruction to acceptably implement and maintain the radioactive liquid and gaseous effluent control programs.
04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Radiological Environmental Monitoring Program The radiological environmental monitoring program (REMP) was effectively implemented in accordance with regulatory requirements. The licensee effectively performed sample collection activities, conducted the land use census, and maintained and calibrated the automatic sampling equipment and analysis equipment according to the appropriate procedures. The procedures were technically correct, but needed some administrative revision to reflect program oversight and implementation responsibilities. The most recent audit of the REMP was detailed and thorough and covered every aspect of the REMP. The audit was sufficient to effectively evaluate implementation and effectiveness of the REMP. The recommendations for improvement were appropriate and corrective actions for areas for improvements were appropriate. The REMP quality assurance program was effectively maintained and implemented in accordance with regulatory requirements. The environmental laboratory continued to implement excellent QA/QC programs for the REMP, provide effective validation of analytical results, and conduct the QA/QC programs in accordance with procedures that reflect industry standards and methods. The programs were capable of ensuring independent checks on precision and accuracy of the measurements of radioactive material in environmental media.
04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Radiation Monitor System - Calibrations and Reliability The licensee established, implemented, and maintained an effective Radiation Monitoring System program with respect to electronic calibrations, radiological calibrations, system reliability and tracking and trending.
04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Ventilation System Radiological Monitoring The licensee established, implemented, and maintained an effective ventilation system surveillance program with respect to charcoal adsorption surveillance tests, high efficiency particulate filter mechanical efficiency tests, and air flow rate tests.
04/19/1999	1999005	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Meteorological Monitoring Program Was Effective The meteorological monitoring program was effectively maintained and implemented in accordance with regulatory requirements. The licensee's performance with regard to maintaining the meteorological monitoring instrumentation reliability was also effective. The licensee improved meteorological monitoring instrumentation through program ownership and better communication, tracking areas for improvement, and correcting previous problems.

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03/01/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 1B Sec: 5B Ter:	Unit 3 Actions Taken in Response to an Inadvertent Carbon Dioxide Discharge Operator actions taken in response to an inadvertent carbon dioxide discharge into the cable spreading room were good. The licensee's Event Response Team (ERT) was generally thorough. The ERT identified several deficiencies and recommended appropriate corrective actions.
03/01/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 2B Ter:	Licensee's Efforts in the Health Physics Area The licensee's efforts in the health physics area, specifically in dose minimization to address the packing leak on the "D" steam generator wide range level isolation valve in containment, was both appropriate and well planned.
07/15/1999	1999007	Pri: OTHER Sec:	NRC	MISC	Pri: 5C Sec: Ter:	Safety Conscious Work Environment The ongoing supervisor cascade, the recent contracting of Entergy to manage the decommissioning of Unit 1, planned reductions in contractor and licensee positions, and consideration for broadbanding, represent significant personnel impacts and a potential challenge to the safety conscious work environment. With these major activities, the site's ability to maintain and monitor the safety conscious work environment will be significantly tested. The Human Services organization, in coordination with other organizations, has recognized these challenges. Taking advantage of the Safety Conscious Work Environment (SCWE) organization and its processes, the licensee has initiated actions to mitigate the impact of these changes. The licensee needs to remain vigilant in monitoring the impact of these events, which places increased importance on the efforts to coordinate the evolving processes used to monitor the safety conscious work environment.
07/15/1999	1999007	Pri: OTHER Sec:	NRC	POS	Pri: 5A Sec: Ter:	Self Assessment Self Assessments - The operations work observation program has the elements to be an effective tool to improve performance. The Millstone 3 maintenance organization performed well-planned and self-critical assessments of several programs. The employee concerns program (ECP) self-assessments were generally good and usually critical of the subject areas audited. The self-assessment schedule is an appropriate tool to track initiation of self-assessments. Engineering self-assessments were generally acceptable; however, the corrective actions associated with some assessment findings were narrowly focused. The team concluded that the self-assessment process was critical, and effectively contributed to problem resolution.
07/15/1999	1999007	Pri: OTHER Sec:	NRC	POS	Pri: 5A Sec: 5C Ter:	Nuclear Oversight Audit of the Corrective Action Process The Nuclear Oversight's audit of corrective actions was effective. The PORC has been effective in fulfilling the requirements of technical specifications, and had appropriately identified, tracked and closed out issues raised during the meetings. The Independent Safety Engineering Group (ISEG) performed the functions required by Unit 3 technical specifications. Evaluations were performed in appropriate areas, detailed recommendations are provided and good follow-up of corrective actions is performed. The industry operating experience program is being implemented effectively. The Nuclear Safety Assessment Board (NSAB) was providing effective oversight of Millstone activities, including a thorough assessment and oversight of the recently completed refueling outage at Unit 3.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/15/1999	1999007	Pri: OTHER Sec:	NRC	POS	Pri: 5C Sec: Ter:	Employee Concern Program The Employee Concerns Program (ECP) organization continues to possess the independence, resources and management support to perform thorough, unbiased investigations of employee concerns. Employee surveys, assessments and team interviews indicate that the overwhelming majority of employees are willing to raise concerns. Generally, the team observed a healthy safety conscious work environment at Millstone. As part of the review of corrective actions, the team queried employees regarding their willingness to raise concerns to management. Based on this limited survey, employees indicated no reluctance to raise safety concerns. In particular, employees indicated that they felt comfortable raising issues through the corrective action processes. However, there was an indication that some workers did not want to be obstacles to meeting schedules and deadlines, and another indication that the supervisory cascade might have some influence on the ease for potential supervisors to raise issues.
07/15/1999	1999007-03	Pri: OTHER Sec:	NRC	NCV	Pri: 5C Sec: Ter:	Unit 3 Inadequate Corrective Actions for Organizational Changes Team assessed the effectiveness of NU implementaiton of the corrective actions in CR M3-00-0542. However, the initial corrective actions were not effective.

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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.

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates		Inspection Type
					Start	End	
	71121.01 - OCC RAD		1				
3	IP 7112101	Access Control to Radiologically Significant Areas		1	04/10/2000	04/14/2000	Baseline Inspections
	4/17 EXM - OPER LIC EXAM		3				
3	U01251	MILLSTONE 3 INITIAL EXAM		3	04/17/2000	04/21/2000	Not Applicable
	71130 - SECURITY		1				
3	IP 7113001	Access Authorization Program (Behavior Observation Only)		1	06/05/2000	06/09/2000	Baseline Inspections
3	IP 7113002	Access Control (Search of Personnel, Packages, and Vehicles: Identification and		1	06/05/2000	06/09/2000	Baseline Inspections
	711117B - PERMANENT MODIFICATIONS - UNIT 3		3				
3	IP 7111102	Evaluation of Changes, Tests, or Experiments		3	06/12/2000	06/16/2000	Baseline Inspections
3	IP 711117B	Permanent Plant Modifications		3	06/12/2000	06/16/2000	Baseline Inspections
	71121.03 - OCCUPATIONAL RAD SAFETY - INSTRUMENTATIO		1				
3	IP 7112103	Radiation Monitoring Instrumentation		1	08/21/2000	08/25/2000	Baseline Inspections
	71122.03 - PUBLIC RAD SAFETY - REMP		1				
3	IP 7112203	Radiological Environmental Monitoring Program		1	10/02/2000	10/06/2000	Baseline Inspections
	71122.02 - PUBLIC RAD SAFETY - RADWASTE		1				
3	IP 7112202	Radioactive Material Processing and Transportation		1	11/13/2000	11/17/2000	Baseline Inspections
	71111.11 - LIC OPER RQ INSP		3				
3	IP 7111111Q			3	12/04/2000	12/08/2000	Baseline Inspections
	71152 - PROBLEM IDENTIFICATION & RESOLUTION		6				
3	IP 71152	Identification and Resolution of Problems		1	01/29/2001	02/02/2001	Baseline Inspections
3	IP 71152	Identification and Resolution of Problems		1	02/12/2001	02/16/2001	Baseline Inspections
	71130.03 - SECURITY - RESPONSE		3				
3	IP 7113003	Response to Contingency Events (Protective Strategy and Implementation of Prot		3	02/12/2001	02/16/2001	Baseline Inspections
	71121.02 - OCCUPATIONAL RAD SAFETY		1				
3	IP 7112102	ALARA Planning and Controls		1	02/26/2001	03/02/2001	Baseline Inspections

