

# Plant Performance Review - Millstone



[Plant Performance Review Index](#) | [News and Information](#) | [NRC Home](#) | [E-mail](#)

September 30, 1999

Mr. R. P. Necci, Vice President  
Nuclear Oversight and Regulatory Affairs  
C/O Mr. D. A. Smith, Manager - Regulatory Affairs  
Northeast Nuclear Energy Company  
PO Box 128  
Waterford, CT 06385

**SUBJECT: MID-CYCLE PLANT PERFORMANCE REVIEW (PPR) - MILLSTONE STATION**

Dear Mr. Necci:

On September 16, 1999, the NRC staff completed the mid-cycle Plant Performance Review (PPR) of Millstone. The staff conducted these reviews for all operating nuclear power plants to integrate performance information and to plan inspection activities at your facility through March 2000. The focus of this performance review was to identify changes in performance over the past six months, and to allocate inspection resources accordingly. The results of the Millstone full PPR were provided to you in a letter dated April 9, 1999. In our May 3, 1999 letter following the April 1999 Senior Management Meeting, we indicated that the Millstone Units 2 and 3 require enhanced monitoring as agency and regional focus plants respectively. A Millstone Assessment Panel was established to guide the enhanced NRC oversight of the Millstone units as described in our August 20, 1999 letter.

Our mid-cycle PPR review of Millstone determined that your performance was generally consistent with that described in our April 9 and May 3, 1999 letters, but operational performance of both units has improved. In July 1999, we completed a team inspection which concluded that the safety conscious work environment at Millstone was generally healthy and that your staff was effective in identifying, resolving and preventing equipment problems and personnel performance issues. However, the NRC identified several recent instances in which condition reports were not initiated, resulting in untimely or inadequate corrective actions. Examples included water intrusion into the bearing oil of a Unit 2 auxiliary feedwater pump, air entrapment in the Unit 2 emergency core cooling system sump recirculation piping, and inoperable Unit 3 recirculation spray system room sump pumps. Based on these observations, we are planning to examine problem identification and corrective action program implementation as part of previously planned inspections of the safety conscious work environment, work control process improvements and backlog reduction efforts. Further, ongoing issues concerning the ability to adequately use the post accident sampling system will be the subject of an NRC initiative inspection. In addition, as is the case with all pressurized water reactors, we plan to follow up on your response to Generic Letter 98-02, "Loss of Coolant Inventory and Associated Potential for Loss of Emergency Mitigation Functions While in a Shutdown Condition."

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated review of licensee performance trends. The PIM includes items summarized from inspection reports or other docketed correspondence between

the NRC and Northeast Nuclear Energy Company from October 1998 through September 1999. As noted above, greater emphasis was placed on those issues identified in the past six months during this performance review. The NRC does not attempt to document all aspects of licensee programs and performance that may be functioning appropriately. Rather, the NRC only documents issues that the NRC believes 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 the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our plans for future inspection activities at your facility so that you will have an opportunity to prepare for these inspections and to provide us with feedback on any planned inspections that may conflict with your plant activities. Enclosure 2 details our inspection plan from September 1999 through March 2000 to coincide with the scheduled implementation of the revised reactor oversight process in April 2000. The rationale or basis for each regional initiative inspection added since the last PPR is discussed above so that you are aware of the reason for emphasis in these program areas. Resident inspections are not listed due to their ongoing and continuous nature.

If circumstances arise that cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at 610-337-5129 with any questions you may have.

Sincerely,

**Original Signed By:**

James C. Linville, Director  
Millstone Inspection Directorate

Docket Nos. 50-336; 50-423  
License No. DPR-65; NPR-49

Enclosures: [Not included in web document]

1. Plant Issues Matrix
2. Inspection Plan

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/15/1999	1999007	Pri: OPS	NRC	POS	Pri: 5C	<b>Unit 3 Problem Reporting System - Condition Report</b>
Record ID: 78705		Sec:		Sec: 5A		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.
Dockets Discussed: 05000423 MILLSTONE 3		Ter:		Ter:		
06/14/1999	1999006	Pri: OPS	NRC	NEG	Pri: 1A	<b>Unit 2 Poor Operator Communication with other Work Groups</b>
Record ID: 78729		Sec:		Sec:		Although communications between operators was a strength, examples of poor communication between operators and other work groups led to plant configuration changes without operator knowledge.
Dockets Discussed: 05000336 MILLSTONE 2		Ter:		Ter:		
06/14/1999	1999006	Pri: OPS	NRC	NEG	Pri: 1C	<b>Unit 2 Operating Procedure Inadequacy</b>
Record ID: 78730		Sec:		Sec:		During a pre-job brief an operator identified an inadequate surveillance for the atmospheric dump valves which if performed as written could have resulted in a reactor trip. Although it is good that operators are properly addressing these procedural issues as they arise, reliance on individuals performing the procedures to identify procedural deficiencies presents an unnecessary challenge to plant personnel.
Dockets Discussed: 05000336 MILLSTONE 2		Ter:		Ter:		
06/14/1999	1999006	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 2 Startup and Power Ascension</b>
Record ID: 78687		Sec:		Sec:		Unit 2 startup and power ascension was performed in a controlled and conservative manner following a shutdown which lasted in excess of three years. Operators performed evolutions slowly and deliberately and executed the power ascension without any significant events. Line management and nuclear oversight maintained a strong presence in the control room and provided a positive influence on the conduct of operations.
Dockets Discussed: 05000336 MILLSTONE 2		Ter:		Ter:		
06/14/1999	1999006	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 3 Operational Evolutions in Support of Refueling Outage 6</b>
Record ID: 78690		Sec:		Sec:		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.
Dockets Discussed: 05000423 MILLSTONE 3		Ter:		Ter:		
06/14/1999	1999006	Pri: OPS	Licensee	POS	Pri: 1B	<b>Unit 3 Main Board Annunciator Loss</b>
Record ID: 78691		Sec:		Sec:		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.
Dockets Discussed: 05000423 MILLSTONE 3		Ter:		Ter:		

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/14/1999	1999006-01	Pri: OPS	NRC	NCV	Pri: 1C	<b>Unit 2 (Closure of URI 96-09-09) Failure to Provide Procedural Guidance for Bypassing Automatic Actuation o</b> At Unit 2, the failure of the licensee to establish adequate procedural guidance for intentionally bypassing the automatic actuation of the engineered safeguards actuation system is a violation of Technical Specification 6.8.1. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This failure occurred following issuance of a related NRC Information Notice.
Record ID: 78731		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/19/1999	1999005	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 3 Response to Operational Challenges, Operability Concerns and Equipment Problems</b> 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.
Record ID: 78633		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000423 MILLSTONE 3						
04/19/1999	1999005	Pri: OPS	NRC	POS	Pri: 4C	<b>Unit 2 Operating Procedure Agreement with Final Safety Analysis Report</b> Following the licensee's Configuration Management Plan (CMP) effort, which was intended to identify discrepancies related to the Final Safety Analysis Report (FSAR), 1998 NRC Inspection Reports and a Northeast Utilities (NU) self-assessment documented additional examples of operating procedures that were not consistent with the FSAR. Based on these findings, NU conducted an expanded review of approximately 50 systems to identify instances where operating procedures did not reflect final safety analysis report requirements. This expanded review was acceptable and the few identified deficiencies were appropriately dispositioned.
Record ID: 78632		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/19/1999	1999005-09	Pri: OPS	Licensee	NCV	Pri: 1A	<b>Unit 3 Failure to Perform Steam Generator Drain Down Sampling</b> 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)
Record ID: 78635		Sec:		Sec: 5C		
Dockets Discussed:				Ter:		
05000423 MILLSTONE 3						
04/19/1999	1999005-10	Pri: OPS	Licensee	NCV	Pri: 1A	<b>Unit 3 Failure to Perform a Daily RM Check</b> 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)
Record ID: 78634		Sec:		Sec: 5C		
Dockets Discussed:				Ter:		
05000423 MILLSTONE 3						
04/19/1999	1999005-11	Pri: OPS	Licensee	NCV	Pri: 1A	<b>Unit 3 Failure to Perform Hydrogen Recombiner Channel Calibration</b> 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)
Record ID: 78636		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000423 MILLSTONE 3						

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005-12	Pri: OPS	Licensee	NCV	Pri: 1A	<b>Unit 3 Failure to Perform Fuel Handling Crane Limit Switch Surveillance</b> 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)
Record ID: 78637		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000423 MILLSTONE 3						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 2 Operational Safety Team Inspection - Conduct of Operations</b> Unit 2 operations department had sufficient personnel to provide coverage throughout the restart period without excessive use of overtime. The shift turnovers observed were of high quality with active participation from groups supporting operations. Pre-job briefings were generally good with a few minor communications weaknesses. Significant Item List No. 13 is closed.
Record ID: 78661		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 2 Operational Safety Team Inspection - Operator Knowledge, Performance and Training</b> Unit 2 operator performance was generally good and control room demeanor was observed as appropriate. Both licensed and non-licensed operators were aware of plant conditions and maintenance activities in progress. The operators conducted plant evolutions in a safe and controlled manner, and exhibited a conservative approach to equipment manipulation. Generally, control room operators expeditiously identified plant equipment malfunctions or changes in plant conditions. Generally, operator control board awareness and annunciator response were good.
Record ID: 78663		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1A	<b>Unit 2 Operational Safety Team Inspection - Quality Assurance in Operations</b> Nuclear oversight observations provided accurate accounts of activities involving the conduct of operations. Self-assessments were critical and the licensee's corrective action plans for improvement were appropriate.
Record ID: 78666		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Management (SIL 1)</b> Unit 2 Management Processes - Appropriate standards and expectations for safety were established by senior management and were understood by subordinate managers and staff. The team concluded that management expectations for safe plant operations were communicated, understood and followed by the plant staff. Senior plant management used a variety of communication methods to reinforce expectations. Management expectations regarding employee concerns were understood by the staff.  Planning and direction for the restart and recovery of Unit 2 were effective. The application of probabilistic risk assessment insights to design and operation of the plant were adequate. Effective leadership was provided and management involvement in routine activities and emerging issues was appropriate. The Nuclear Oversight Verification Plan and "windows" assessment tools were effective mechanisms for management to assess restart readiness. Significant Item List (SIL) item No. 1, Management Oversight and Effectiveness; Licensee Staff Safety Culture, and the associated NRC Restart Assessment Plan items are closed.
Record ID: 78657		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Corrective Action Program</b> Unit 2 Corrective Action Program is adequate to support plant restart. Plant deficiencies are being included in the corrective action program and recent root cause evaluations are thorough. The licensee's backlog management plan was adequate and the licensee's process for deferral contained appropriate methodology for the identification of items acceptable for deferral and completion after the Unit 2 restart. Significant Item List No. 12 is closed.
Record ID: 78658		Sec:		Sec:		
Dockets Discussed:				Ter:		
05000336 MILLSTONE 2						

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

Region 1  
MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Independent Oversight (Nuclear Oversight Verification Plan)</b>  The Nuclear Oversight Verification Plan provides effective independent assessment of performance for resolution of "key issues". The Nuclear Oversight Organization's involvement in operations, maintenance, surveillance and engineering has been satisfactory. Line organization cooperation and support for oversight activities was apparent. The team concluded that the various reporting mechanisms employed by the nuclear oversight organization provided an effective means of capturing conditions adverse to quality and ensuring that those conditions were corrected. The reports were critical assessments and provided senior management with a useful "snapshot" of plant performance and areas requiring additional attention. Nuclear oversight audit findings with restart implications are being properly addressed.
Record ID: 78659		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Quality Review Committees</b>  The Millstone quality review committees, including the plant operations review committee (PORC), station operations review committee (SORC) and nuclear safety assessment board (NSAB) all meet the technical specification (TS) requirements. The team concluded that the NSAB was providing effective independent oversight.
Record ID: 78660		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: OPS	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Operations Training, Organization, and Administration</b>  Unit 2 licensed operators had satisfactorily completed requalification training. A review of the lesson plans, discussions with licensed operators, and observation of plant and simulator performance indicated that the training provided to the operators was sufficient to ensure that they could safely restart the unit. Modification training for the operators was appropriate to effectively communicate plant changes completed during the outage. Operations department staffing levels were adequate to support the safe operation of the plant. Communications within the operations department and with other site organizations were good. Operators generally initiated operability determinations in response to degraded equipment conditions. The team observed good command and control of shift activities.
Record ID: 78665		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004-01	Pri: OPS	NRC	NCV	Pri: 1A	<b>Unit 2 Operational Safety Team Inspection - Operator Performance</b>  Unit 2 operators, in one case, failed to monitor, in a timely manner, steam generator temperatures in accordance with a technical specification surveillance test requirement. There were no safety consequences as a result of not conducting this surveillance because the required plant parameters were always satisfied. The failure to conduct this technical specification required surveillance 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. On several occasions operators failed to appropriately communicate unexpected alarms to the Unit Supervisor.
Record ID: 78664		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
03/05/1999	1998219-04	Pri: OPS	NRC	NCV	Pri: 1C	<b>Unit 2 Inadequate Procedure Controls Closure of Steam Supply Valve to Turbine-Driven Auxiliary Feed Pump</b>  In URI 98-203-10, the NRC noted that Operating Procedure (OP) 2322, "Auxiliary Feedwater System," provided instructions and allowed continued power operations of the reactor with one of the two steam supplies to the turbine-driven auxiliary feedwater (TDAFW) pump (2-MS-201 or 2-MS-202) closed. The procedure required that the operator take specific manual actions in areas outside the control room before starting the TDAFW pump. The licensing and design bases for Millstone Unit 2 require that the TDAFW pump be started from the control room within 10 minutes after a loss-of-feedwater event. The licensee determined that the operator actions required to place the TDAFW pump on line would take longer than 10 minutes, which was inconsistent with the design bases of the plant. The failure of OP 2322 to provide adequate instructions for operation with 2-MS-201 or 2-MS-202 closed was identified as a violation of TS 6.8.1.
Record ID: 78748		Sec: ENG		Sec: 4A		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/01/1999	1999002-01	Pri: OPS	Self	NCV	Pri: 1A Sec: 3A Ter: 3C	<b>Unit 2 Inadvertent Reactor Coolant System Water Level Increase</b>  At Unit 2, while in Mode 5, an inadvertent increase in reactor coolant system (RCS) level of approximately 25 inches occurred when the safety injection tank (SIT) outlet motor operated valves (MOVs) were opened to perform testing because operators failed to recognize the potential for a significant quantity of water in the SIT lower head and its injection piping to be present and drain to the RCS. Consequently, the operators did not request a procedure change to provide specific instructions and precautions for opening the valves while in this plant condition. The water that was added had approximately the same boron concentration as the RCS and water level remained several feet below the lowest open penetration in the reactor vessel head. The NRC concluded that the failure to establish adequate procedural controls for operation of the SIT outlet MOVs constituted a violation of Technical Specification 6.8.1.a.
Record ID: 78617		Sec:				
Dockets Discussed:						
05000336 MILLSTONE 2						
03/01/1999	1999002-02	Pri: OPS	Self	NCV	Pri: 3A Sec: 1A Ter: 3C	<b>Unit 2 Inadvertent Transfer of Water from the Spent Fuel Pool</b>  At Unit 2, the operating procedure that provides instructions for draining the refueling cavity was inadequate in that, at the completion of the draining evolution, the procedure failed to direct the isolation of the flow path to the liquid radioactive waste system. Subsequently, the configuration established through use of this procedure led to the inadvertent loss of approximately 2 inches of spent fuel pool water level when about 2730 gallons of spent fuel pool water was transferred to the liquid radioactive waste system. However, performance of the plant equipment operator was good in promptly identifying and terminating the spent fuel pool water loss.
Record ID: 78618		Sec:				
Dockets Discussed:						
05000336 MILLSTONE 2						
03/01/1999	1999002-06	Pri: OPS	NRC	NCV	Pri: 1A Sec: 1B Ter: 4C	<b>Unit 3 Control Room Filtration System - Entry into TS 3.0.3</b>  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.
Record ID: 78622		Sec:				
Dockets Discussed:						
05000423 MILLSTONE 3						
03/01/1999	1999002-03	Pri: OPS	Self	NCV	Pri: 1A Sec: 1C Ter:	<b>Unit 2 Inadvertent Charging Pump Injection</b>  At Unit 2, although the testing portion of the integrated test of the Facility 1 engineered safety features components was well executed, the procedure instructions for restoration from the test were inadequately implemented. Steps to restore the "A" charging pump were performed in an inappropriate sequence, which resulted in the inadvertent start of the "A" charging pump. The subsequent injection of approximately 100 gallons of water from the volume control tank to the reactor coolant system (RCS) did not result in a reduction in RCS boron concentration. The NRC concluded that the surveillance procedure was weak in that, it allowed restoration steps to be performed out of sequence when the shift manager determined that the sequence of performance was unimportant and the procedure did not clearly identify restoration steps where the sequence of performance was important. The failure to adequately implement the surveillance procedure constituted a violation of Technical Specification 6.8.1.c.
Record ID: 78619		Sec: MAINT				
Dockets Discussed:						
05000336 MILLSTONE 2						
02/17/1999	1999001-01	Pri: OPS	NRC	NCV	Pri: 5A Sec: 4B Ter:	<b>Unit 2 Failure to Initiate a Condition Report for Two Control Room Deficiencies</b>  Unit 2 personnel failed to initiate Condition Reports in accordance with station procedure RP 4, "Corrective Action Program," for the proper evaluation of conditions adverse to quality involving the charging pump hand switches and reactor building closed cooling water system valve 2-RB-210 leakage. This Severity Level IV violation of procedural requirements is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. Other tracking systems were used to ensure final resolution of these control room deficiencies, but these tracking mechanisms lacked appropriate operability reviews to assess system or plant impact.
Record ID: 78616		Sec:				
Dockets Discussed:						
05000336 MILLSTONE 2						

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/11/1999	1998006	Pri: OPS	NRC	NEG	Pri: 1A	U/2 - Use of Valve Lineup Form to realign In-Service Systems
	Record ID: 78605	Sec:			Sec: 1C	U/2 - During restoration following integrated testing of ESF components, the inspector discussed with operators the propriety of using a valve lineup form to restore the shutdown cooling system valve alignment rather than an approved procedure that controlled the sequence of valve manipulations. The NRC concluded that operator acceptance of using valve lineup forms to realign in-service systems was a general weakness in operations. This is a concern because a valve lineup form does not control the sequence of valve manipulations, which is often important for in-service systems.
	Dockets Discussed:				Ter:	
	05000336 MILLSTONE 2					
01/11/1999	1998006	Pri: OPS	NRC	NEG	Pri: 1B	U/3 - Dissemination of Transient Information to Licensed Operators
	Record ID: 78602	Sec:			Sec:	U/3 - While the lifting and reseating of two main steam safety valves (MSSVs) was identified in a timely manner and reviewed for adequate system response, this information was not initially disseminated to all operators involved in recovery operations.
	Dockets Discussed:				Ter:	
	05000423 MILLSTONE 3					
01/11/1999	1998006	Pri: OPS	NRC	POS	Pri: 1A	U/3 - Operator Actions Following the Failure of a Potential Transformer Fuse
	Record ID: 78607	Sec:			Sec:	U/3 - Following the failure of a potential transformer fuse in the "A" train 34D, 4KV bus, operators took appropriate actions to declare the affected instrumentation inoperable and entered technical specification 3.3.2.
	Dockets Discussed:				Ter:	
	05000423 MILLSTONE 3					
01/11/1999	1998006	Pri: OPS	NRC	POS	Pri: 1B	U/3 - Licensed Operator Actions in Response to MSIV Closure and Reactor Trip
	Record ID: 78601	Sec:			Sec: 2A	U/3 - Licensed operator recovery actions, and overall control room activities, in response to the unexpected main steam isolation valve (MSIV) closure and resultant automatic reactor trip were deliberate and well controlled.
	Dockets Discussed:				Ter:	
	05000423 MILLSTONE 3					
01/11/1999	1998006	Pri: OPS	NRC	NEG	Pri: 3A	U/2 - Fuel Handling Operations
	Record ID: 78604	Sec: ENG			Sec: 5A	U/2 - Although fuel handling operations were generally well controlled, one incident occurred where the spent fuel pool area hoist operator raised a fuel assembly approximately 2 inches above the prescribed height and when recovering from this, the operator did not immediately stop when the fuel hoist did not respond as expected. Similarly, when two pieces of tape were found on top of fuel assemblies in the spent fuel pool, the licensee did not initially plan to assess the impact of undetected tape on the fuel and core components during power operations.
	Dockets Discussed:				Ter: 4B	
	05000336 MILLSTONE 2					
11/23/1998	1998005	Pri: OPS	NRC	NEG	Pri: 1A	U/3 - Several Downpowers and Trips
	Record ID: 78580	Sec:			Sec: 1B	U/3 - When feedwater heater control level control problems were identified on October 9, operators reduced power to 84 percent to facilitate troubleshooting. On October 15, another downpower was conducted to perform additional repairs to secondary side thermowell and level controller. On October 28, operators tripped the reactor from 100 percent when high conductivity at the discharge of the condensate pumps was detected. Operators again tripped the reactor from 90 percent power on November 11, due to an anticipated turbine trip/reactor trip due to degradation of condenser vacuum.
	Dockets Discussed:				Ter:	
	05000423 MILLSTONE 3					

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/23/1998	1998005	Pri: OPS	NRC	NEG	Pri: 1A	<b>U/3 - Two Manual Trips Due to Equipment Problems</b>
Record ID: 78579		Sec:			Sec: 2A	U/3 - During the next inspection period, the operators initiated two manual trips of the reactor. Continued management attention must be directed to a reduction in the backlogged list of equipment problems and other issues that have the potential to create future operational challenges.
Dockets Discussed: 05000423 MILLSTONE 3					Ter:	
11/23/1998	1998005	Pri: OPS	NRC	NEG	Pri: 1A	<b>U/2 - RBCCW Design Information Translation into Operating Procedure</b>
Record ID: 78595		Sec:			Sec: 4A	U/2 - The licensee failed to adequately translate design information regarding reactor building closed cooling water (RBCCW) flow to the shutdown cooling heat exchanger to the operating procedure used to control RBCCW system configuration. This negative finding is of minor safety significance because operation at power in an improper RBCCW system configuration was found to be unlikely and because the effect of operation in an improper configuration on post-accident containment pressure was found to be minimal. Therefore, this failure constitutes a violation of minor significance and is not subject to formal enforcement action.
Dockets Discussed: 05000336 MILLSTONE 2					Ter:	
11/23/1998	1998005	Pri: OPS	NRC	NEG	Pri: 1C	<b>U/3 - Need for Operational Focus for Continued Improvement</b>
Record ID: 78582		Sec:			Sec:	U/3 - Review of independent and third party evaluation documents of Unit 3 performance provide conclusions consistent with the NRC view of the need for a strong operational focus for continued improvement. The Unit 3 theme for a renewed "operational focus" is well served, but must be directed toward all areas and departments affecting plant operations, in order to be fully effective.
Dockets Discussed: 05000423 MILLSTONE 3					Ter:	
11/23/1998	1998005	Pri: OPS	NRC	POS	Pri: 1B	<b>U/3 - Operator Response to High Conductivity Levels with Subsequent Manual Reactor Trip</b>
Record ID: 78569		Sec:			Sec: 2A	U/3 - Operators properly responded to high conductivity levels in the secondary system and manually tripped the reactor. Operators took appropriate command and control of the plant to place it in a safe condition in accordance with procedures. Close coordination and communication was observed among the operations, chemistry, engineering and maintenance departments during the shut down and methodical troubleshooting activities. Although the plant was designed to operate with more than one waterbox out of service, the licensee conservatively maintained the plant shut down until the leaking condenser was identified, based on chemistry results. The specific, leaking "C" condenser tube was identified and plugged shortly after restart.
Dockets Discussed: 05000423 MILLSTONE 3					Ter:	
11/23/1998	1998005	Pri: OPS	NRC	POS	Pri: 1B	<b>U/3 - Manual Trip Prior to Low Condenser Vacuum</b>
Record ID: 78575		Sec:			Sec: 5C	U/3 - Operators manually tripped the plant during a rain storm on November 11 in accordance with procedures when imminent loss of condenser vacuum was anticipated. The licensee promptly convened an event review team and implemented appropriate corrective actions prior to restarting the reactor.
Dockets Discussed: 05000423 MILLSTONE 3					Ter: 5B	
11/23/1998	1998005	Pri: OPS	NRC	POS	Pri: 1C	<b>U/3 - Acceptable Corrective Actions in Response to OSTI Enforcement Issues</b>
Record ID: 78581		Sec:			Sec: 5C	U/3 - NRC review of the corrective actions to the enforcement items issued as a result of the operational safety team inspection of Unit 3 found acceptable responses on the part of the licensee's staff, particularly in the operations area.
Dockets Discussed: 05000423 MILLSTONE 3					Ter:	

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/23/1998	1998005	Pri: OPS	NRC	POS	Pri: 3B	<b>U/2 - Licensed Operator Requal Training Program</b>  Record ID: 78596 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter: U/2 - The Licensed Operator Requalification Training (LORT) program at Unit 2 met regulatory requirements with no significant weaknesses identified. The LORT program content was balanced and met the needs of the operators. The simulator scenarios and written examinations administered during the first three weeks of the cycle were independent with no overlap. This was considered to be a strength. The evaluations of the simulator scenarios and job performance measures (JPMs) were objective and thorough. Minor problems on evaluation consistency were identified. The feedback process as part of the systems approach to training (SAT) program was found to be effective. The licensee was found to be meeting the regulatory requirements associated with licensed operators that were reviewed. Based upon current staffing levels, the inspectors determined that Millstone 2 was meeting licensed operator staffing requirements. Planned licensed operator increases will supplement the licensed operator pool.
10/05/1998	1998216	Pri: OPS	Licensee	NEG	Pri: 1A	<b>U/3 - Numerous Shutdowns and Downpowers</b>  Record ID: 78577 Dockets Discussed: 05000423 MILLSTONE 3  Sec: 1B  Ter: U/3 - Unit 3 began the inspection period in cold standby, commencing a reactor startup following repair of a leaking auxiliary feedwater valve. On August 27, power was reduced to 47 percent to facilitate a main condenser tube leak. On September 10, operators began a TS required shutdown when check valves in the service water-hypochlorite injection system failed their surveillance tests. On September 15, operators manually tripped the reactor when high conductivity in the condensate system was detected. On September 18, operators again entered TS 3.0.3, conducting a shutdown to 27 percent power when the same hypochlorite injection system components again failed the surveillance tests. On October 1, operators again entered TS 3.0.3, reducing power to 54 percent, following a blown fuse on a safety-related inverter.
10/05/1998	1998216	Pri: OPS	NRC	NEG	Pri: 1A	<b>U/3 - Procedurally Mandated Trip Due to Plant Conditions was Preventable</b>  Record ID: 78576 Dockets Discussed: 05000423 MILLSTONE 3  Sec: 1B  Ter: U/3 - A manual reactor trip was procedurally mandated by plant conditions that were preventable; several downpowers and operating evolutions, required to comply with the technical specifications, were caused by either component malfunctions or surveillance test failures that were not isolated in occurrence.
10/05/1998	1998216	Pri: OPS	NRC	NEG	Pri: 1A	<b>U/3 - Need for Additional Training to Prevent Future Challenges to Plant Operation</b>  Record ID: 78578 Dockets Discussed: 05000423 MILLSTONE 3  Sec: 1C  Ter: U/3 - The inspector discussed with the responsible plant managers, including the unit director, the need for additional training and an enhanced approach to prevent problem recurrence to reduce, where possible, the number of future challenges to plant operation.
10/05/1998	1998216	Pri: OPS	NRC	POS	Pri: 1A	<b>U/3 - Licensee Management, Operators and Support Personnel Responded Well to Challenges</b>  Record ID: 78554 Dockets Discussed: 05000423 MILLSTONE 3  Sec: 1B  Ter: U/3 - Licensee management, operators, and support personnel responded well to the challenges encountered by Unit 3 personnel during this inspection period. Conservative decision-making, deliberate planning, event response and analysis, and appropriate corrective action review were in evidence.
10/05/1998	1998216	Pri: OPS	NRC	POS	Pri: 1A	<b>U/3 - Diligent and Deliberate Storm Preparations</b>  Record ID: 78572 Dockets Discussed: 05000423 MILLSTONE 3  Sec: 1C  Ter: U/3 - With regard to the storm preparations on August 26, 1998, the licensee was deliberate and diligent in its planning activities.

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/05/1998	1998218	Pri: OPS	NRC	POS	Pri: 1A	<b>U/3 - Conservative, Prudent Downpower</b>
	Record ID: 78574	Sec:			Sec: 2A	U/3 - A power reduction on October 1 caused by an inverter failure, was the result of a collaborative decision between operations shift management and unit licensing personnel. The inspector concurred that the entry into TS 3.0.3, while conservative, was both prudent and properly reached given the guidance provided by a Regulatory Guidance Position.
	Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
10/05/1998	1998216	Pri: OPS	NRC	POS	Pri: 1B	<b>U/3 - Deliberate and Controlled Operator Response to a Trip</b>
	Record ID: 78573	Sec:			Sec:	U/3 - Regarding the reactor trip on September 15, crew activities were deliberate and controlled, communications and briefings were clear, and shift management responded to equipment questions appropriately.
	Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
10/05/1998	1998216	Pri: OPS	NRC	POS	Pri: 3B	<b>U/2 - Preparations for Fuel Load</b>
	Record ID: 78594	Sec:			Sec: 3C	U/2 - Both Operations and Reactor Engineering Departments are making progress for fuel load. Operating procedures, Modes 6 and 5 surveillance tests, and the fuel movement operator training program are comprehensive and acceptable. Nuclear Oversight has been effective in identifying deficiencies in the process and providing their own input to plant readiness. The process for ensuring plant readiness also appears to be comprehensive. Emergent work has delayed fuel load on a number of occasions and at the end of the inspection period, the fuel load date was still being evaluated by the licensee.
	Dockets Discussed: 05000336 MILLSTONE 2				Ter:	
10/05/1998	1998216-01	Pri: OPS	NRC	VIO IV	Pri: 1A	<b>U/2 - MISPOSITIONING OF THROTTLE VALVE IN THE RBCCW SYSTEM</b>
	Record ID: 78520	Sec:			Sec: 5A	U/2 - After the NRC identified that the indicated reactor building closed cooling water (RBCCW) flow to the "A" engineered safeguards room cooler was off-scale high, the cause of the condition was determined to be that the associated throttle valve, 2-RB-68.1A, was in a fully open rather than throttled position. The NRC determined that the RBCCW valve lineup procedure was inadequate in that instructions contained in a note did not specify that this throttled position be verified. As a result, the valve lineup was performed on two occasions without identifying this mispositioned valve. The failure to establish an adequate valve lineup procedure is considered a violation of Technical Specification 6.8.1.c. Although the safety significance of this event in the current defueled condition was minimal, the mispositioning is a concern because the licensee's corrective actions for this inspector identified issue did not address the inadequate valve lineup procedure. It also raises concerns about how the positions of other throttle valves are being verified. The NRC also considered operator performance to be weak in not investigating the high RBCCW flow to the "A" engineered safeguards room cooler.
	Dockets Discussed: 05000336 MILLSTONE 2				Ter: 5B	
10/05/1998	1998216-07	Pri: OPS	Licensee	NCV	Pri: 1A	<b>U/3 - Improper RHR Testing During Transition to Mode 4</b>
	Record ID: 78526	Sec:			Sec:	U/3 - During a review of procedures, the licensee identified a historical violation of the Unit 3 TS with the plant in Mode 5. The licensee performed residual heat removal system testing during the transition to Mode 4 incorrectly using a one hour out of service allowance for leak testing. This licensee identified TS violation is considered a non-cited violation. (See LER 97-37)
	Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
10/05/1998	1998216-08	Pri: OPS	Licensee	NCV	Pri: 1A	<b>U/3 - Missed TS Surveillance of ESFAS Isolation Instrumentation</b>
	Record ID: 78527	Sec:			Sec:	U/3 - Licensee corrective actions to address this LER, relating to a missed surveillance, appeared appropriately directed to the specific TS violations. Collectively, the incorporation of triggering mechanisms into operating procedures for TS required surveillances was an effective program enhancement. Operator compliance with procedure requirements, as well as cognizance of system configuration and plant status, have improved since restart. The issue was properly analyzed and reported by the licensee and is considered a non-cited violation. (See LER 97-44)
	Dockets Discussed: 05000423 MILLSTONE 3				Ter:	

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/05/1998	1998216-09	Pri: OPS	Licensee	NCV	Pri: 1A	<b>U/3 - Inadvertent RCS Positive Reactivity Addition While in a TS LCO</b>
Record ID: 78528		Sec:	Sec:			U/3 - Licensee corrective actions to address an LER, relating to operator cognizance of plant conditions during surveillance activities, appeared appropriately directed to the specific TS violation. Collectively, the incorporation of triggering mechanisms into operating procedures for TS required surveillances was an effective program enhancement. Operator compliance with procedure requirements, as well as cognizance of system configuration and plant status, have improved since restart. The issue was properly analyzed and reported by the licensee and is considered a non-cited violation. (See LER 97-49)
Dockets Discussed: 05000423 MILLSTONE 3		Ter:				
10/05/1998	1998216-10	Pri: OPS	Licensee	NCV	Pri: 2B	<b>U/3 - Deficiencies Identified in the Performance of Surveillance for PORV Instrumentation</b>
Record ID: 78529		Sec:	Sec:			U/3 - Licensee corrective actions to address an LER, relating to deficiencies in the performance of a surveillance, appeared appropriately directed to the specific TS violations. Collectively, the incorporation of triggering mechanisms into operating procedures for TS required surveillances was an effective program enhancement. Operator compliance with procedure requirements, as well as cognizance of system configuration and plant status, have improved since restart. The issue was properly analyzed and reported by the licensee and is considered a non-cited violation. (See LER 97-52)
Dockets Discussed: 05000423 MILLSTONE 3		Ter:				
10/05/1998	1998216-11	Pri: OPS	Licensee	NCV	Pri: 1C	<b>U/3 - Channel Check Surveillance Requirements not in Compliance with TS</b>
Record ID: 78530		Sec:	Sec: 3C			U/3 - Licensee corrective actions to address an LER, relating to a failed surveillance, appeared appropriately directed to the specific TS violation. Collectively, the incorporation of triggering mechanisms into operating procedures for TS required surveillances was an effective program enhancement. Operator compliance with procedure requirements, as well as cognizance of system configuration and plant status, have improved since restart. The issue was properly analyzed and reported by the licensee and is considered a non-cited violation. (See LER 97-53)
Dockets Discussed: 05000423 MILLSTONE 3		Ter:				
08/09/1999	1999008	Pri: MAINT	NRC	POS	Pri: 2B	<b>Unit 3 Maintenance Activities</b>
Record ID: 78715		Sec:	Sec:			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.
Dockets Discussed: 05000423 MILLSTONE 3		Ter:				
08/09/1999	1999008	Pri: MAINT	NRC	POS	Pri: 2B	<b>Unit 3 Surveillance Observation</b>
Record ID: 78716		Sec:	Sec:			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.
Dockets Discussed: 05000336 MILLSTONE 2		Ter:				
08/09/1999	1999008	Pri: MAINT	NRC	POS	Pri: 2B	<b>Unit 3 Maintenance Rule Application</b>
Record ID: 78717		Sec:	Sec:			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.
Dockets Discussed: 05000423 MILLSTONE 3		Ter:				

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/09/1999	1999008-03	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec:	<b>INADEQUATE TROUBLESHOOTING PROCEDURE FOR THE "A" EMERGENCY DIESEL GENERATOR RELATE</b> In August 1997, the Unit 2 "A" emergency diesel generator (EDG) inadvertently started during troubleshooting activities. The root cause of the event was a failure to establish enough detail in a maintenance troubleshooting procedure to prevent an inadvertent EDG start. The licensee's corrective actions included establishing adequate procedural controls over troubleshooting activities on safety-related equipment. The root cause evaluation was thorough, and the immediate and long term corrective actions were adequate. The failure to establish and implement adequate procedures in accordance with Technical Specification 6.8.1 is a violation of NRC requirements. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV 50-336/99-08-03). Licensee Event Report 50-336/97-027-00 is closed.
	Record ID: 78829 Dockets Discussed: 05000336 MILLSTONE 2				Ter:	
08/09/1999	1999008-04	Pri: MAINT Sec:	NRC	NCV	Pri: 4B Sec:	<b>FAILURE TO MEET ASME SECTION XI SURVEILLANCE REQUIREMENTS RELATED TO LER 50-336/97-024-00</b> At Unit 2, the licensee identified in 1997 that they failed to meet certain portions of ASME Section XI surveillance requirements, as required by Unit 2 Technical Specifications (TS). The licensee's corrective actions included procedural changes, implementation of additional testing, and gaining approval to use specific code cases. The licensee properly reported, and corrected the deficiency. The root cause evaluation was thorough, and the immediate and long term corrective actions were adequate. The failure to meet the ASME Section XI testing requirements, as required by Unit 2 TS, is a violation of NRC requirements. This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-04) Licensee Event Report 50-336/97-024-00 & 01 is closed.
	Record ID: 78830 Dockets Discussed: 05000336 MILLSTONE 2				Ter:	
07/15/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec:	<b>Unit 3 Maintenance Related Corrective Actions</b> 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 property developed and effectively implemented.
	Record ID: 78707 Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec:	<b>Unit 3 Surveillance Testing of Main Steam Code Safety Valve and Safety Injection System Functions</b> 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.
	Record ID: 78692 Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec:	<b>Unit 3 Inservice Inspection</b> 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.
	Record ID: 78693 Dockets Discussed: 05000423 MILLSTONE 3				Ter:	
06/14/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec:	<b>Unit 3 Eddy Current Testing</b> 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
	Record ID: 78694 Dockets Discussed: 05000423 MILLSTONE 3				Ter:	

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/14/1999	1999006-03	Pri: MAINT	Licensee	NCV	Pri: <del>C</del>	<b>Unit 3 Failure to Test Unit 1 Main Stack Nobel Gas Monitor to Meet Unit 3 Technical Specifications</b> Record ID: 78695 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: 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.
06/14/1999	1999006-04	Pri: MAINT	Licensee	NCV	Pri: <del>C</del>	<b>Unit 3 Failure to Test Low Pressure Safety Injection Check Valve in 1995</b> Record ID: 78696 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: 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	Licensee	NCV	Pri: <del>C</del>	<b>Unit 3 Failure to Properly Calibrate the Meteorologica Monitoring Wind Speed Channel</b> Record ID: 78697 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: 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	Licensee	NCV	Pri: <del>C</del>	<b>Unit 3 Failure to Properly Test Residual Heat Removal Valve 3RHS-MV8702B</b> Record ID: 78698 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: 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	Licensee	NCV	Pri: <del>C</del>	<b>Unit 3 Failure to Properly Test the P-4 Logic Prior to 1996</b> Record ID: 78699 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: 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	NRC	POS	Pri: <del>C</del>	<b>Unit 3 Observed Maintenance Activities</b> Record ID: 78640 Dockets Discussed: 05000423 MILLSTONE 3 Sec: Ter: Unit 3 observed maintenance and surveillance activities were appropriately controlled and performed in accordance with approved procedures or work orders and technical specification requirements.

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005	Pri: MAINT	NRC	POS	Pri: 1C	<b>Unit 2 Repair Associated with a Leaking Shutdown Cooling Suction Valve</b>
Record ID: 78638		Sec:	Sec:			At Unit 2, the NRC conducted extensive inspections of the repair activities associated with a leaking shutdown cooling suction valve, which was unisolable from the reactor coolant system (RCS) and was required to remain operable for RCS pressure boundary integrity and for decay heat removal in Operational Mode 5, cold shutdown. The NRC found that there were no regulatory requirements that would prohibit this repair and that the repair could be accomplished safely, without undue risk. The licensee implemented the repair in a controlled manner that maintained operability of the valve throughout the repair activities. The repair stopped the pressure seal leakage. The NRC found that the modification to weld a seal ring between the valve body and bonnet satisfied the American Society of Mechanical Engineers Boiler and Pressure Vessel Code requirements.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/19/1999	1999005-01	Pri: MAINT	Licensee	NCV	Pri: 1A	<b>Unit 2 (Closure of LER 96-24 &amp; URI 96-08-09) Failure to Perform Response Time Testing of the Foxboro SPEC</b>
Record ID: 78639		Sec:	Sec:			Northeast Utilities' review of the failure to perform response time testing of the Foxboro SPEC 200 instrumentation used for the Reactor Protection and Engineered Safeguards Actuation Systems was comprehensive and resulted in the revision and/or development of several surveillance procedures. Subsequent testing verified that the response time of the affected safety-related loops was within the Technical Specification limits. This failure is a violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. Furthermore, the above evaluation and resolution of the issue acceptably addressed the NRC concerns regarding root cause and scope of testing.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: MAINT	NRC	POS	Pri: 1A	<b>Unit 2 Operational Safety Team Inspection - Conduct of Maintenance</b>
Record ID: 78667		Sec:	Sec:			Unit 2 maintenance activities observed were generally of good quality. Maintenance technicians conducted good pre-job briefings in the maintenance shops and briefed operators on job scope prior to beginning work. Procedure adherence by the maintenance staff was generally good. The team observed instances where work was stopped to clarify or revise maintenance procedures. The maintenance workers were knowledgeable of assigned maintenance tasks and had received appropriate training. The team concluded that the maintenance rework rate was at an acceptable level, and that the licensee had adequately resolved maintenance rework issues through the corrective action system. Appropriate maintenance supervisory oversight of field activities was observed.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: MAINT	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Maintenance Organization and Procedures</b>
Record ID: 78669		Sec:	Sec:			Unit 2 maintenance were generally adequate for the intended tasks. Performance in the area of planning and scheduling was mixed. Planning was thorough, with detailed work packages prepared to support most AWO activities. Schedule adherence did not meet licensee's goals primarily due to emergent issues. The team did not observe any instances where schedule pressures or changes adversely affected plant safety. The licensee's performance in assessing the safety/risk of planned maintenance was acceptable. Safety assessments for maintenance activities were addressed by appropriate procedures and the risk significance of planned activities was discussed at planning meetings. Significant Item List No. 6 is closed.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
04/07/1999	1999004	Pri: MAINT	NRC	POS	Pri: 2A	<b>Unit 2 Operational Safety Team Inspection - Material Condition of Facilities</b>
Record ID: 78668		Sec:	Sec:			Unit 2 necessary equipment repairs were either completed or scheduled for completion prior to plant restart. Maintenance backlogs were being appropriately managed and routinely assessed for impact on operations. The control of operator work-arounds and control room deficiencies was also found to be adequate to support plant restart. The plant material condition and housekeeping were acceptable. The Backlog Reduction and Work-It-Now (WIN) Teams had a positive impact on addressing emergent work and reducing the automated work order (AWO) backlog. Significant Items List No. 7 is closed.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description	
03/26/1999	1999003	Pri: MAINT	NRC	POS	Pri: 2A	<b>Unit 2 Fire Protection - Maintenance and Plant Equipment</b>	
Record ID: 78679		Sec:				Sec:	Unit 2 plant equipment being used for post-fire safe shutdown was in good material condition and alternative shutdown capability could be operationally implemented in a timely manner with the current staffing level of operating shift. The licensee effectively implemented the fire barrier inspection of the group 9 seals. Additionally, the licensee identified deficiencies because of the increased training of the Site Fire Protection personnel, greater awareness of fire boundaries integrity on the site, and an improved inspection procedure. The corrective actions for the deficiencies appeared to be reasonable.
Dockets Discussed: 05000336 MILLSTONE 2						Ter:	
03/01/1999	1999002	Pri: MAINT	NRC	POS	Pri: 2B	<b>Unit 3 Consideration for Potential Adverse Impact Upon Safety-Related Components and Functions</b>	
Record ID: 78631		Sec:				Sec:	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.
Dockets Discussed: 05000423 MILLSTONE 3						Ter:	
01/11/1999	1998006	Pri: MAINT	NRC	POS	Pri: 2A	<b>U/3 - Material Reconciliation Effort for New MSIV Solenoid Valves</b>	
Record ID: 78606		Sec:				Sec: 5B	U/3 - The preliminary failure mechanism of stress corrosion cracking for the main steam isolation solenoid valves appears reasonable, although a formal root cause remains to be determined. The licensee's material reconciliation effort was thorough and of sufficient depth to provide a basis for the installation of new MSIV solenoid valves.
Dockets Discussed: 05000423 MILLSTONE 3						Ter:	
01/11/1999	1998006	Pri: MAINT	NRC	POS	Pri: 2B	<b>U/3 - Surveillance and Troubleshooting Activities for 34D, 4KV Bus</b>	
Record ID: 78609		Sec:				Sec: 3B	U/3 - Following the failure of a potential transformer fuse in the "A" train 34D, 4KV bus, thorough licensee discussion of the plant design and options for troubleshooting were observed. The normally scheduled monthly operability surveillance, performed at power, and troubleshooting on the affected instrumentation, performed in cold shutdown, were well controlled and completed without affecting operable plant equipment.
Dockets Discussed: 05000423 MILLSTONE 3						Ter: 5C	
11/23/1998	1998005	Pri: MAINT	NRC	NEG	Pri: 2A	<b>U/3 - Backlogged List of Equipment Problems</b>	
Record ID: 78591		Sec:				Sec: 2B	U/3 - A reduction in the backlogged list of equipment problems and other issues that have the potential to create operational challenges to the plant is an issue that merits continued licensee management attention.
Dockets Discussed: 05000423 MILLSTONE 3						Ter:	
11/23/1998	1998005	Pri: MAINT	NRC	POS	Pri: 2A	<b>U/3 - Proper Use of Temp Mod and SE During Maintenance</b>	
Record ID: 78587		Sec:				Sec:	U/3 - The proper use of a temporary modification, including a safety evaluation considering the seismic design, material specifications and independent calculations, was verified for a maintenance activity on a feedwater system containment isolation valve.
Dockets Discussed: 05000423 MILLSTONE 3						Ter:	

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/23/1998	1998005	Pri: MAINT	NRC	POS	Pri: 2A Sec: 1C Ter:	<b>U/3 - Adequate Controls for Troubleshooting, Failure Analysis and Repair</b> U/3 - Review of inspected troubleshooting, failure analysis, and maintenance repair activities revealed the implementation of adequate controls by the licensee.
Record ID: 78585 Dockets Discussed: 05000423 MILLSTONE 3						
11/23/1998	1998005	Pri: MAINT	NRC	POS	Pri: 2B Sec: 3A Ter:	<b>U/2 - Medium Voltage Breaker Maintenance</b> U/2 - The NRC concluded that the maintenance on the medium voltage breaker located in Unit 2 Cubicle A410 was performed in an acceptable manner using approved procedures. Also, the licensee had acceptable justification for the level of maintenance performed on individual breakers. (Section U2.M1.2)
Record ID: 78597 Dockets Discussed: 05000336 MILLSTONE 2						
11/23/1998	1998005	Pri: MAINT	NRC	POS	Pri: 3A Sec: Ter:	<b>U/3 - Controlled and Professional Performance of Surveillance Activities</b> U/3 - Knowledgeable operators and maintenance and instrumentation and control technicians performed the observed Unit 3 surveillance activities in a controlled and professional manner.
Record ID: 78584 Dockets Discussed: 05000423 MILLSTONE 3						
11/23/1998	1998005-05	Pri: MAINT	Licensee	NCV	Pri: 2B Sec: Ter:	<b>U/3 - Inadequate Testing of Logic Circuits</b> U/3 - Licensee corrective action for an LER that involved inadequate testing of logic circuits was determined to be acceptable. The corrective measures were commensurate with the safety significance of the self-identified problem and included consideration of long term programmatic initiatives to preclude problem recurrence. Reportability, timeliness, event analysis requirements have been met. (See LER 97-17-02)
Record ID: 78563 Dockets Discussed: 05000423 MILLSTONE 3						
11/23/1998	1998005-06	Pri: MAINT	Licensee	NCV	Pri: 2B Sec: Ter:	<b>U/3 - Non-EQ Parts Installed in Safety Related Components</b> U/3 - Licensee corrective actions an LER that involved non-EQ parts installed in safety related components was determined to be acceptable. The corrective measures were commensurate with the safety significance of the self-identified problem and included consideration of long term programmatic initiatives to preclude problem recurrence. Reportability, timeliness, event analysis requirements have been met. (See LER 97-50)
Record ID: 78564 Dockets Discussed: 05000423 MILLSTONE 3						
10/05/1998	1998216	Pri: MAINT	NRC	NEG	Pri: 2B Sec: Ter:	<b>U/3 - Progress Needed to Improve the 12 Week Schedule</b> U/3 - Continued progress is required for several improvements to the twelve-week on-line work schedule process, including the prioritization of backlogged work with operator impact, proper operator work control staffing, and review of the methods for changing or adding to the existing work scope.
Record ID: 78590 Dockets Discussed: 05000423 MILLSTONE 3						

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/05/1998	1998216	Pri: MAINT	NRC	POS	Pri: 2B	<b>U/3 - On-Line Maintenance Process Use of PRA</b>  U/3 - The Unit 3 on-line maintenance process has been structured to use probabilistic safety assessment insights and operator judgement to achieve a balance between plant safety, schedule duration, and required work completion. A sample review of the implementation of this process determined that PRA information is effectively used and schedule adjustments routinely made to address the changing plant system configuration and risk profile. For the areas inspected, the Maintenance Rule (10 CFR 50.65) objectives, in relation to the risk perspectives of work control and overall plant safety, were effectively met.
Record ID: 78556		Sec:				
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/05/1998	1998216-04	Pri: MAINT	NRC	NCV	Pri: 2B	<b>U/2 - Channel Functional Test of Facility 2 SIAS Manual Push Button</b>  U/2 - Operators performed the pre-brief and surveillance test of manual safety injection actuation signal initiation well, and the test results satisfied the relevant technical specification acceptance criteria. However, the NRC noted that operators referred to an operating procedure to determine which components would actuate rather than referring to a drawing specified by the surveillance procedure. A subsequent comparison of the operating procedure and the drawing revealed four errors in the operating procedure attachment that lists the actuated components. However, the concerns with the operating procedure adequacy had previously been identified by the licensee and the NRC considers the corrective action plan to be acceptable. Accordingly, this concern was characterized as a non-cited violation.
Record ID: 78523		Sec:		Sec: 3A		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
10/05/1998	1998216-12	Pri: MAINT	Licensee	NCV	Pri: 2B	<b>U/3 - Corrective Actions Not Met for Trending Valve Leakage</b>  U/3 - Licensee corrective actions for an LER documenting an IST program problem were determined to be acceptable. The licensee implemented the corrective actions in a timely manner after problem identification and before taking the unit to a higher mode of operation. No adverse safety consequences actually developed as a result of this IST problem, which is considered a licensee identified, non-cited violation. (See LER 97-27)
Record ID: 78531		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/05/1998	1998216-13	Pri: MAINT	NRC	NCV	Pri: 2B	<b>U/3 - Quarterly IST Closure Testing of SWS Check Valves Not Performed</b>  U/3 - Licensee corrective actions for an LER documenting an IST program problem was determined to be acceptable. The licensee implemented the corrective actions in a timely manner after problem identification and before taking the unit to a higher mode of operation. No adverse safety consequences actually developed as a result of this IST program omission, which is considered a licensee identified, non-cited violation. (See LER 97-40)
Record ID: 78532		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/05/1998	1998216-14	Pri: MAINT	Licensee	NCV	Pri: 2B	<b>U/3 - Failure to Include Three Valves in the IST Program</b>  U/3 - Licensee corrective actions for an LER documenting an IST program problem was determined to be acceptable. The licensee implemented the corrective actions in a timely manner after problem identification and before taking the unit to a higher mode of operation. No adverse safety consequences actually developed as a result of this IST program omission, which is considered a licensee identified, non-cited violation. (See LER 97-42)
Record ID: 78533		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/05/1998	1998216-16	Pri: MAINT	Licensee	NCV	Pri: 2B	<b>U/3 - Inadequate TS surveillance of SSPS</b>  U/3 - The licensee's corrective actions for inadequate technical specification surveillances of the solid state protection system were appropriate. The required procedural revisions were completed before the unit was allowed to change mode. This is considered a non-cited violation. (See LER 97-58)
Record ID: 78535		Sec:		Sec:		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/09/1999	1999008	Pri: ENG	NRC	POS	Pri: 4A	<b>Unit 3 Engineering Activities</b>
Record ID: 78720		Sec:	Sec: 5C			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.
Dockets Discussed: 05000423 MILLSTONE 3			Ter:			
08/09/1999	1999008-05	Pri: ENG	NRC	NCV	Pri: 5A	<b>FAILURE TO PROMPTLY ADDRESS WATER INTRUSION INTO "B" AUXILIARY FEEDWATER PUMP BEARING</b>
Record ID: 78831		Sec:	Sec: 5B			At Unit 2, the licensee failed to initiate a condition report and implement effective corrective actions when a significant amount of water was identified in the oil removed from the outboard bearing of the "B" auxiliary feed water pump during a scheduled oil change on April 12, 1999. As a result, the condition recurred during continuous operation of the pump from May 25 through 29, 1999, and the degraded condition was not identified and corrected until June 1, 1999. In addition, the licensee's assessment of operability during the period prior to June 1, 1999, was not well founded in that it was based on the ability of the system, rather than the component, to perform its design function. Finally, the licensee inappropriately used the conclusion that the pump had been operable as a basis to reduce the degree of thoroughness in identifying and implementing corrective actions to address the recurrent problems with water intrusion. The failure of the licensee to implement adequate corrective actions to address the water intrusion problems on April 12, 1999, is a violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-05)
Dockets Discussed: 05000336 MILLSTONE 2			Ter: 5C			
08/09/1999	1999008-06	Pri: ENG	NRC	NCV	Pri: 5B	<b>FAILURE TO WRITE A CONDITION REPORT FOR AN UNANALYSED FLOW DISTRIBUTION IN THE RBCCW SYSTEM</b>
Record ID: 78832		Sec:	Sec: 1A			At Unit 2, following the repair of a reactor building closed cooling water (RBCCW) throttle valve, the licensee failed to initiate a condition report when RBCCW flow to the "B" containment air recirculation cooler significantly exceeded the post-maintenance acceptance criteria. Because this higher flow rate could have resulted in insufficient RBCCW flow to other safety-related components, a condition report was necessary to initiate an operability assessment of the "B" RBCCW train, which was in service. Although a subsequent evaluation showed that the RBCCW flow to other safety-related components would have remained within established margins, the failure to initiate a condition report, as required by the licensee's administrative procedure governing their corrective action program, is a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-06) In addition, rather than using an approved procedure, an engineering disposition was inappropriately used to provide instructions to manipulate the in-service RBCCW system to establish a new throttle position for the repaired valve.
Dockets Discussed: 05000336 MILLSTONE 2			Ter: 1C			
08/09/1999	1999008-07	Pri: ENG	NRC	NCV	Pri: 4A	<b>FAILURE TO CONTROL PARTS USED IN THE REACTOR PROTECTION SYSTEM RELATED TO LER 50-336/97</b>
Record ID: 78833		Sec:	Sec:			At Unit 2, the licensee identified in 1997 that a failed, non-quality assurance (non-QA) lamp was installed in a QA circuit and had to the potential to affect the performance of safety-related circuits. The failure of the licensee to implement appropriate quality standards and measures for the selection and review of suitability of application of material, parts, equipment, and processes that are essential to the safety-related functions of systems and components is a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-07) Licensee Event Report 50-336/97-021-00 is closed.
Dockets Discussed: 05000336 MILLSTONE 2			Ter:			
08/09/1999	1999008-08	Pri: ENG	NRC	NCV	Pri: 4A	<b>FAILURE TO IDENTIFY SINGLE FAILURE VULNERABILITY IN THE AUXILIARY FEEDWATER SYSTEM WATER</b>
Record ID: 78834		Sec:	Sec:			At Unit 2, the licensee identified in 1997 that a postulated single failure of a condenser hotwell makeup valve would cause a diversion of water from the condensate storage tank and impact the availability of sufficient water for the auxiliary feedwater system to perform its safety function. The licensee adequately determined the root cause of the single failure vulnerability and took appropriate corrective actions. The failure to establish appropriate design controls to ensure that safety-related equipment would function as assumed in the Unit 2 Final Safety Analysis Report is a violation of 10 CFR 50, Appendix B, Criteria III, "Design Control." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-08) Licensee Event Report 50-336/97-025-00 is closed
Dockets Discussed: 05000336 MILLSTONE 2			Ter:			

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

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
08/09/1999	1999008-09	Pri: ENG	NRC	NCV	Pri: 4A	<b>INADEQUATE DESIGN OF THE 120 VOLT AC DISTRIBUTION SYSTEM RELATED TO LER 50-336/98-001-00</b>  Record ID: 78835 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter: At Unit 2, the licensee identified in 1998 that, under some postulated high energy line break or seismic design basis accident conditions, the isolation of 120 volt vital AC electrical faults could not be ensured. The licensee appropriately reported and corrected the deficiency. The root cause evaluation was thorough, and the corrective actions were adequate. The failure to ensure that safety-related 120 volt vital AC equipment was designed in accordance with 10 CFR 50, Appendix B, Criterion III, "Design Control," to adequately respond to design basis accidents, is a violation of NRC requirements. This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-09) Licensee Event Report 50-336/98-001-00 is closed.
08/09/1999	1999008-10	Pri: ENG	NRC	NCV	Pri: 4A	<b>INADEQUATE MAIN STEAM LINE BREAK ANALYSIS RELATED TO LER 50-336/98-007 &amp; 01</b>  Record ID: 78836 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter: At Unit 2, the licensee identified in 1998 that inadequate calculations of limiting power distributions had been performed for the Main Steam Line Break Analysis for cycle 13. As part of the corrective action, the licensee adequately reported the deficiency, requested a technical specification change and received a license amendment to resolve the deficiency. The failure to perform an adequate main steam line break analysis is a violation of 10 CFR 50 Appendix B, Criterion III, "Design Control." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-10) Licensee Event Report 50-336/98-007-00 & 01 is closed.
07/15/1999	1999007	Pri: ENG	NRC	POS	Pri: 2B	<b>Unit 3 Recovery Backlog</b>  Record ID: 78706 Dockets Discussed: 05000423 MILLSTONE 3  Sec:  Ter: 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	NRC	POS	Pri: 4B	<b>Unit 3 Operability Determination Process</b>  Record ID: 78708 Dockets Discussed: 05000423 MILLSTONE 3  Sec:  Ter: 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.
07/15/1999	1999007-01	Pri: ENG	NRC	NCV	Pri: 4A	<b>Unit 3 Examples of Corrective Action and Design Control NCVs</b>  Record ID: 78704 Dockets Discussed: 05000423 MILLSTONE 3  Sec:  Ter: 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	NRC	NCV	Pri: 5A	<b>Unit 3 Inadequate Corrective Actions for RSS Sump Pump Issues</b>  Record ID: 78779 Dockets Discussed: 05000423 MILLSTONE 3  Sec:  Ter: The licensee failed to identify and correct the cause of a failure of a pump during post-modification testing.

# United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/14/1999	1999006-02	Pri: ENG	NRC	NCV	Pri: 4A	<b>Unit 2 (Closure of URI 98-208-02) Failure to Perform Design Reviews of Temporary Modifications</b>  Unit 2 failed to perform design reviews of temporary modifications that were installed through plant procedures, which was a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control." 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 the corrective action program. The licensee's plan to complete the required design reviews prior to installation and as part of the biannual review of procedures was acceptable.
Record ID: 78732		Sec:				Sec:
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2						
06/14/1999	1999006-08	Pri: ENG	Licensee	NCV	Pri: 1C	<b>Unit 3 Failure to Perform Inservice Inspection Tests Earlier in the First 10 Year Interval</b>  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
Record ID: 78701		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
06/14/1999	1999006-09	Pri: ENG	Licensee	NCV	Pri: 1C	<b>Unit 3 Failure to Perform the Certain Required ASME Section XI Examinations Between 1989 and 1995</b>  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.
Record ID: 78702		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
06/14/1999	1999006	Pri: ENG	NRC	NEG	Pri: 2A	<b>Unit 2 Manual Reactor Trip on May 25, 1999</b>  On May 25, 1999, Unit 2 operators initiated a manual reactor trip, when a steam leak developed in the turbine building as a result of a transient in the feedwater heaters. Operator performance in isolating the steam leak and placing the plant in a stable condition was good. The feedwater heater transient was caused by improper setup of the feedwater heater level control valves. Inadequate procedural control was identified as the root cause, with inadequate initial design and inadequate corrective actions to address recurring level control problems identified as contributing causes. The transient developed into a steam leak because generic engineering guidance for selecting torque values was improperly applied in the selection of torque values for the feedwater heater relief valve flange fasteners. The NRC found that the corrective actions implemented prior to restart were adequate to address the direct causes of the feedwater heater level control problems and the subsequent steam leak. Longer term corrective actions described in LER 50-336/99-009-00 to address the root causes were also acceptable. Therefore, LER 50-336/99-009-00 is closed. No violation of NRC regulatory requirements occurred. (Section U2.01.3)
Record ID: 78688		Sec: OPS				Sec: 1B
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2						
04/19/1999	1999005	Pri: ENG	NRC	POS	Pri: 1A	<b>Unit 3 Fuel Receipt Activities</b>  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.
Record ID: 78649		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
04/19/1999	1999005	Pri: ENG	NRC	POS	Pri: 2A	<b>Unit 2 Service Water Spool Pin Hole Leak</b>  Unit 2 design, evaluation, and implementation of the temporary repair of a "pin-hole" leak of the "A" emergency diesel generator service water supply header spool No. SK4253 was acceptable and in accordance with NRC Generic Letter (GL) 90-05. The piping containing the flaw was operable with Temporary Modification No.2-99-008 until a replacement spool was installed. The licensee installed a fully qualified replacement spool prior to Unit 2 restart.
Record ID: 78641		Sec:				Sec:
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2						

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005-02	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of URI 93-19-02 &amp; LER 97-31) Failure to Meet Requirements for Protection From Pipe Whip</b>
Record ID: 78642		Sec:		Sec:		Unit 2 Final Safety Analysis Report (FSAR), Section 6.1.4.1.1, "Damage Protection Criteria," specifies the requirements to protect systems and structures from the results of pipe whip or pipe rupture. The failure of the equipment and structures discussed in LER 50-336/97-031-00 to meet the FSAR requirements is a violation of 10 CFR 50, Appendix B, Criterion III, Design Control. However, this violation is identified as a Non-Cited violation (NCV 50-336/99-05-02) in accordance with Section VII.B.1 of the NRC Enforcement Policy because the licensee identified the design deficiencies and took appropriate actions to correct the discrepancies.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/19/1999	1999005-03	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 Station Blackout Issues Identified in the Vectra Assessment</b>
Record ID: 78643		Sec:		Sec:		Unit 2, acceptably addressed the Station Blackout issues identified in the Vectra assessment. Therefore, EEI 50-336/96-201-28, Violation 50-336/02092, and Unit 2 SIL item number 31 are closed. The prepared analyses were reasonable; the calculations detailed, conservative, and in accordance with industry standards. However, the inspector found that dc voltage drop calculations were inadequate in that two incorrect assumptions were identified in shutdown voltage of the safety-related inverters and voltage drop in control cables. This is a violation of 10 CFR 50, Appendix B, Criterion III, "Design Control." This concern had limited safety impact because the battery currently has sufficient spare capacity to compensate for the potential deficiency. The licensee initiated action to evaluate the issues. Therefore, this Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/19/1999	1999005-04	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of LER 97-06) Main Steam Line Break Analysis Did Not Include Auxiliary Feedwater Flow</b>
Record ID: 78644		Sec:		Sec:		Unit 2, final safety analysis report, Chapter 14, accident analysis for a main steam line break (MSLB) event initiated from low power was inadequate in that it did not consider the effects of auxiliary feedwater flow at the start of the accident which created the potential for peak containment pressure to exceed containment design pressure. The failure to establish an adequate MSLB analysis is a violation of 10CFR50, Appendix B, Criterion III, Design Control. However, the licensee identified this inadequacy and took adequate corrective actions to ensure containment pressure would remain below containment design pressure following a MSLB event. Therefore, this non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/19/1999	1999005-05	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of LER 97-15) Water Hammer and Thermally Induced Over Pressurization of Isolated Piping S</b>
Record ID: 78645		Sec:		Sec:		Unit 2 effectively addressed the potential for water hammer and thermally induced overpressurization of isolated piping segments during postulated accident conditions. The failure of the licensee to consider the potential failure modes of isolated piping segments during the initial system design is a violation of 10CFR50, Appendix B, Criterion III, Design Control. This non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/19/1999	1999005-06	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of LER 97-19) Inadequate Design Review and Testing of the 1992 Upgrade to the Engineered S</b>
Record ID: 78646		Sec:		Sec:		Unit 2 adequately addressed the potential for unexpected electro-magnetic interference (EMI) between the Automatic Test Initiation feature of the Engineered Safeguards Actuation System (ESAS) and the timing circuit for the shedding and sequencing of the emergency bus loads. The existence of the EMI signal which, under degraded voltage conditions, could have delayed the shedding and sequencing of the emergency loads on the electrical buses by as much as ten seconds, was the result of inadequate design reviews and/or testing during the 1992 upgrading of the ESAS. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV 50-336/99-05-06), consistent with Appendix C of the NRC Enforcement Policy, which permits closure of most Severity Level IV violations which have been entered into their corrective action program.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005-07	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of LER 97-29) Failure to Maintain Main Steam and Feedwater Systems Within the Design Basis</b>
Record ID: 78647		Sec:		Sec:		Unit 2, failed to maintain the main steam and the feedwater systems within the design basis by failing to include required loads in pipe stress and pipe support calculations was a violation of 10CFR50, Appendix B, Criterion III, Design Control. However, the licensee identified these discrepancies with the design basis, and took adequate corrective actions to bring these two systems within the allowable established values in the code of record. Therefore, this licensee identified and corrected violation is being treated as a Non-Cited Violation.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/19/1999	1999005-08	Pri: ENG	Licensee	NCV	Pri: 4A	<b>Unit 2 (Closure of LER 98-12) Inadequate Loss of Normal Feedwater Event Analysis</b>
Record ID: 78648		Sec:		Sec:		Unit 2, accident analysis for a loss of normal feedwater (LONF) event was found by the licensee to be inadequate in that inaccurate and non-conservative assumptions were used for the initial steam generator water level and other parameters. This condition was a violation of 10CFR50, Appendix B, Criterion III, Design Control. However, the licensee identified the discrepancies, and took adequate corrective actions which provided an adequate margin to steam generator dryout following a LONF event. Therefore, this non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation, (NCV 50-336/99-05-08) consistent with Section VII.B.1 of the NRC Enforcement Policy. Significant Items List No. 55.5 is closed.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/07/1999	1999004	Pri: ENG	NRC	POS	Pri: 1C	<b>Unit 2 Operational Safety Team Inspection - Design Changes</b>
Record ID: 78673		Sec:		Sec:		Unit 2 design changes resolved the emergency core cooling system (ECCS) single failure vulnerabilities. Additionally, the aspects of the design changes reviewed, with the exception of the emergency operating procedures (EOP) changes, had been properly implemented. The licensee demonstrated that appropriate administrative controls were in place to ensure that the EOPs would be corrected prior to becoming effective. Significant Item List No. 53.1 is closed.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/07/1999	1999004	Pri: ENG	NRC	POS	Pri: 4B	<b>Unit 2 Operational Safety Team Inspection - Conduct of Engineering</b>
Record ID: 78670		Sec:		Sec:		Unit 2 planned and emergent engineering activities were managed well. Daily planning of issues at the morning meeting set the priorities of both the system and design engineering departments. Communication with and support to other departments were good. The identification, documentation and control of issues within the condition report (CR) system were good. Corrective actions associated with CRs and other open items were properly tracked within the action item tracking and trending system (AITTS).
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		
04/07/1999	1999004	Pri: ENG	NRC	POS	Pri: 4B	<b>Unit 2 Operational Safety Team Inspection - Engineering Procedures and Documentation</b>
Record ID: 78672		Sec:		Sec:		Unit 2's operability (OD) process was comprehensive, with ODs that were technically sound and documented an adequate basis for establishing operability of a degraded component or system. The licensee's program to maintain the accuracy of vendor manual information was being properly implemented. An adequate Unit 2 setpoint process was implemented and the Unit 2 Instrumentation and Control (I&C) setpoint specifications provided a clear definition of the program for the generation and documentation of safety-related, instrument and control setpoints. The commercial grade dedication and item equivalency evaluation programs were affective and performed appropriate evaluations to support plant restart. The team concluded that the operating experience program was functioning adequately to support restart. The backlog of reviews had been evaluated by the licensee to identify those issues requiring review before restart and appropriate priorities had been assigned to these issues. The majority of recently identified drawing issues have had minor safety significance. Current procedures and processes for updating operational critical drawings in the control room had been followed.
Dockets Discussed: 05000336 MILLSTONE 2				Ter:		

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/07/1999	1999004	Pri: ENG	NRC	POS	Pri: 4C	<b>Unit 2 Operational Safety Team Inspection - Engineering Support Facilities and Equipment</b>  Record ID: 78671 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter:  Unit 2's design control process was being properly implemented. The technical quality of changes was good and modification package content, including the 10CFR50.59 screening and safety reviews, are comprehensive. Post-modification testing accomplished the verification of important design change attributes. The use of a Quality Review Board has contributed to improvements in the quality of the engineering products. Engineering has been effective in resolving issues. As a result, the use of temporary modifications was minimal. The number of installed temporary modifications (TMs) was low and below the plant goal. The team concluded that the evaluation and control of temporary modifications was good and that the installed TMs had no adverse impact on safe plant operation. The licensee had adequate controls in place to ensure deferred work was properly evaluated. No deferred modifications were identified that would affect safe plant operation.  The licensee had substantially improved the design and licensing basis of the control room heating ventilation and air conditioning (HVAC) system. Inconsistencies between the system design criteria contained in the final safety analysis report (FSAR), TS and the operating and surveillance procedures were eliminated. Single failure design errors were corrected. The system readiness review was thorough. The control room HVAC surveillance testing program was a strength.
03/26/1999	1999003	Pri: ENG	NRC	NEG	Pri: 1C	<b>Unit 2 Fire Protection - Timed Analysis for Alternate Shutdown</b>  Record ID: 78676 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter:  Unit 2 timeline analysis performed for alternate shutdown did not accurately reflect the conditions which could exist in that eventuality. Specifically, the analysis did not reflect the potential for the power operated relief valves, head vents, and letdown valves to remain open for up to five minutes after control room evacuation, due to bottle up panel cables being unprotected in fire area R-1.
03/26/1999	1999003	Pri: ENG	NRC	NEG	Pri: 1C	<b>Unit 2 Fire Protection - Procedures</b>  Record ID: 78680 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter:  Unit 2 post-fire shutdown procedures, in some instances, contained problems related to sequencing of DC control power actions, and some actions were not well coordinated between the Unit 1 and Unit 2 procedures.
03/26/1999	1999003	Pri: ENG	NRC	POS	Pri: 1C	<b>Unit 2 Fire Protection - Safe Shutdown Methodology and Program</b>  Record ID: 78674 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter:  Unit 2 safe shutdown methodology was found to be acceptable and the safe shutdown capability portion of the licensee's program was found to be adequate. The level of protection provided for redundant trains of post-fire shutdown systems satisfied the technical requirements of Appendix R to 10 CFR 50. The licensee's administrative controls with respect to configuration control/Appendix R compliance in the modification process were acceptable.
03/26/1999	1999003	Pri: ENG	NRC	POS	Pri: 1C	<b>Unit 2 Fire Protection - Configuration Control and Maintenance</b>  Record ID: 78675 Dockets Discussed: 05000336 MILLSTONE 2  Sec:  Ter:  Unit 2 administrative controls with respect to configuration control/Appendix R compliance in the modification process were acceptable. The required maintenance and testing of the equipment supporting the Unit 1 electrical backfeed to Unit 2 is up to date and is being tracked.

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/26/1999	1999003	Pri: ENG	NRC	POS	Pri: 1C	<b>Unit 2 Fire Protection - Fire Barrier and Quality Control</b> Record ID: 78678 Dockets Discussed: 05000336 MILLSTONE 2 Sec: Unit 2 - A fire barrier penetration seal was installed and inspected in accordance with the installation procedure, and the manufacturer's installation instructions. The installers and quality control (QC) inspector were knowledgeable of the procedural requirements and were properly trained. Ter:
03/26/1999	1999003	Pri: ENG	NRC	POS	Pri: 1C	<b>Unit 2 Fire Protection - Audits</b> Record ID: 78682 Dockets Discussed: 05000336 MILLSTONE 2 Sec: Unit 2 - Audits and assessments of the Fire Protection Program conducted since the autumn of 1996 have been effective in identifying deficiencies and areas for improvement. In addition, they have included followup of audit findings through the use of the corrective action program. Ter:
03/26/1999	1999003	Pri: ENG	NRC	POS	Pri: 2A	<b>Unit 2 Fire Protection - Penetration Seals</b> Record ID: 78677 Dockets Discussed: 05000336 MILLSTONE 2 Sec: Unit 2 has adequately implemented the commitment to perform inspections of silicone foam fire penetration seals for voids and material problems when the seals were repaired or replaced. The seal inspection conducted by the Fire Protection Engineer was professionally performed and no seal deficiencies were identified. Ter:
03/05/1999	1998219-01	Pri: ENG	NRC	NCV	Pri: 4A	<b>Unit 2 Number of Post-Accident Monitoring Channels was Inconsistent with FSAR</b> Record ID: 78735 Dockets Discussed: 05000336 MILLSTONE 2 Sec: The NRC (URI 98-201-13) noted that the licensee's reduction of Regulatory Guide (RG) 1.97, Category 1 (safety-related and seismically qualified) post-accident monitoring indicators, from four channels to two channels, was technically adequate but inconsistent with the licensing basis reflected in FSAR Table 7.5-3. Table 7.5-3 identified four channels of Category 1 indication, meaning that the indication channels would be designed and qualified as safety-related from sensor to panel display. The licensee had two Category 1 channels and two nonsafety-related channels for a total of four channels. The licensee's failure to properly update FSAR Table 7.5-3 to reflect the reduction from four to two redundant RG 1.97 indication channels is a violation of 10 CFR 50.71(e), which requires, in part, that the licensee periodically update the FSAR. Ter:
03/05/1999	1998219-03	Pri: ENG	NRC	NCV	Pri: 5C	<b>Unit 2 Failed to Implement Adequate Corrective Actions for CCW System Water Hammer Scenario</b> Record ID: 78741 Dockets Discussed: 05000336 MILLSTONE 2 Sec: The NRC (URI 98-202-09) noted that LER 97-015-00 had identified a LOCA scenario that might result in severe voiding and water hammer of RBCCW piping to the containment air recirculation (CAR) coolers. The scenario involved a delayed manual start of the RBCCW pump if the automatic start somehow failed. The licensee had failed to study and address the delayed-start scenario. Later, the licensee determined that the piping would be overstressed if the manual restart scenario were to occur, but that the scenario would not result in catastrophic failure of RBCCW piping and containment penetrations. The failure to take appropriate corrective action for the delayed pump start scenario is considered to be a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action." Ter:
03/05/1999	1998219-02	Pri: ENG	NRC	NCV	Pri: 5C	<b>Unit 2 Failed to Implement Adequate Corrective Actions in Revising RBCCW Rad Monitor Setpoint Calc</b> Record ID: 78738 Dockets Discussed: 05000336 MILLSTONE 2 Sec: PLTSUP Ter: The NRC (Violation 98-202-05) noted that the flow rate assumed in the setpoint analysis for the RBCCW radiation monitor, RM-6038, was not assured by operating procedures and practice. In its response to the violation, the licensee stated that a calculation would be developed to determine new RM-6038 alarm setpoints. This revised calculation was inadequate because it did not consider the transport time of contamination from the contaminated train of RBCCW to the noncontaminated train of RBCCW. The transport time of contamination between the two trains was required to be considered in determining whether offsite release limits in 10 CFR Part 20 could be exceeded before RM-6038 would alarm. Ter:

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/01/1999	1999002-04	Pri: ENG	Licensee	NCV	Pri:	<b>Unit 2 Failure to Maintain Design Configuration</b>
Record ID: 78728		Sec:		Failure to maintain the design configuration of the safety-related piping systems is a violation of 10 CFR 50, Appendix B, Criterion III, Design Control. Problems were self-identified, corrected, and the risk was minimal.		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
03/01/1999	1999002-08	Pri: ENG	Self	NCV	Pri: 1C	<b>Unit 3 Control Room Habitability</b>
Record ID: 78624		Sec:		The licensee's event review team for an inadvertent Unit 3 carbon dioxide actuation, identified that the review in response to NUREG 0737, Item IID.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.		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
01/11/1999	1998006	Pri: ENG	NRC	NEG	Pri: 1A	<b>U/3 - Troubleshooting and Repair of the 34D 4KV Bus While in TS 3.3.2</b>
Record ID: 78608		Sec:		U/3 - The licensee initially determined that troubleshooting and repair could be performed on the affected instrumentation ("A" train, 34D, 4 KV bus) while in TS 3.3.2. In order for the licensee to restore the inoperable channel, another channel would need to be removed from service. The licensee initially determined that this action was allowed per the TS under Action 20b, which allows the licensee to bypass the inoperable channel for up to four hours to perform surveillance testing on the other channels. The inspector discussed the appropriateness of this interpretation of the TS with plant management. The inspector, licensee, and NRC personnel from the office of NRR held a conference call to discuss the licensee's plan. After the discussion, the TS branch in NRR determined that this would be an inappropriate use of the licensee's specific TS. The licensee subsequently decided not to pursue the repair using this TS.		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
01/11/1999	1998006	Pri: ENG	NRC	POS	Pri: 5C	<b>U/3 - Licensee Corrective Actions/Investigation of MSIV Closure</b>
Record ID: 78603		Sec:		U/3 - Licensee activities to investigate the cause of an MSIV closure during partial stroke testing, and to implement corrective actions in the form of a design modification to the MSIVs, were well detailed, planned, and executed		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
11/23/1998	1998005-08	Pri: ENG	Licensee	NCV	Pri: 4A	<b>U/3 - Defective Design of RSS Expansion Joint Tie Rod Assembly</b>
Record ID: 78566		Sec:		U/3 - The licensee's corrective actions in response to a design deficiency in the tie rod assemblies for eight Unit 3 RSS expansion joints are acceptable. This licensee-identified and corrected violation is being treated as a non-cited violation. (See LER 97-21)		
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/26/1998	1998203-15	Pri: ENG	NRC	VIO III	Pri: 4C	<b>Unit 2 Failure to Perform Required 50.59 Evaluation</b>
Record ID: 78628		Sec:		The licensee made a change to the facility as described in FSAR Section 10.4.5, Condensate and Feedwater System, that created an unreviewed safety question (USQ). Prior to the change, the licensee did not perform a safety evaluation to determine if the change created a USQ. Specifically, Technical Specification clarification 3.7.1.2(1) was issued which would have allowed Unit 2 to operate for up to 72 hours following isolation of one of the two flow paths from the three AFW pumps to the two steam generators (SGs). With the flow path to one SG isolated, a main steam line break on the other SG would result in no AFW flow being supplied to an intact SG. As a result, the clarification had the potential to increase the overall consequences of an accident described in the FSAR		
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/05/1998	1998216	Pri: ENG	Licensee	NEG	Pri: 4A	<b>U/3 - Modification to Service Water Hypochlorite Injection System Installed Incompatible Valve Materials</b>
Record ID: 78555		Sec:		Sec: 2A		U/3 - Through observations of corrective actions and review of documentation related to the inoperability of the Unit 3 service water system, appropriate licensee response was observed to the Technical Specification (TS) 3.0.3 entry caused by the failure of the check valves in the service water hypochlorite injection system. However, the recent modification installed valve materials which were incompatible with the hypochlorite system. This inadequate design led to the inoperability of both trains of service water and subsequently required two entries into TS 3.0.3 and two downpowers.
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						
10/05/1998	1998216-05	Pri: ENG	NRC	NCV	Pri: 4B	<b>U/2 - Translation of Design Information into Surveillance Procedure</b>
Record ID: 78524		Sec:		Sec:		U/2 - System readiness reviews for the service water system and the control room air conditioning system, which support the transition to operational mode 6, refueling, from a defueled condition, were implemented well. The dispositioning of a licensee identified slow closure of a control room boundary isolation damper revealed a historical concern with the translation of design information into surveillance procedures. However, the licensee implemented effective corrective actions to address this concern and therefore, it was characterized as a non-cited violation.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
08/09/1999	1999008	Pri: PLTSUP	NRC	NEG	Pri: 1C	<b>Security Personnel Turnover</b>
Record ID: 78722		Sec:		Sec:		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.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
05000423 MILLSTONE 3						
08/09/1999	1999008	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Fitness for Duty Programs</b>
Record ID: 78723		Sec:		Sec:		The fitness-for-duty program was being implemented in accordance with the licensee's procedures and regulatory requirements.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
05000423 MILLSTONE 3						
08/09/1999	1999008	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Unit 3 External Radiological Controls</b>
Record ID: 78721		Sec:		Sec: 5B		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.
Dockets Discussed:		Ter:				
05000336 MILLSTONE 2						
05000423 MILLSTONE 3						
06/14/1999	1999006-10	Pri: PLTSUP	Licensee	NCV	Pri: 1C	<b>Unit 3 Failure to Meet Technical Specification 6.12.1 Requirements for High Radiation Entry Requirements</b>
Record ID: 78703		Sec:		Sec:		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.
Dockets Discussed:		Ter:				
05000423 MILLSTONE 3						

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

Region I  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005	Pri: PLTSUP	NRC	NEG	Pri: 1C	<b>Unit 3 Contamination Control</b>  Sec: 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.  Ter:
Record ID: 78653		Sec:		Sec:		
Dockets Discussed:		Sec:		Ter:		
05000423 MILLSTONE 3		Sec:		Ter:		
04/19/1999	1999005	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Offsite Dose Calculation Manual Requirements for Reporting Effluent Releases</b>  Sec: 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.  Ter:
Record ID: 78650		Sec:		Sec:		
Dockets Discussed:		Sec:		Ter:		
05000336 MILLSTONE 2		Sec:		Ter:		
05000423 MILLSTONE 3		Sec:		Ter:		
04/19/1999	1999005	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Radiological Environmental Monitoring Program</b>  Sec: 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.  Ter: 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.
Record ID: 78651		Sec:		Sec:		
Dockets Discussed:		Sec:		Ter:		
05000336 MILLSTONE 2		Sec:		Ter:		
05000423 MILLSTONE 3		Sec:		Ter:		
04/19/1999	1999005	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Radiation Monitor System - Calibrations and Reliability</b>  Sec: 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.  Ter:
Record ID: 78654		Sec:		Sec:		
Dockets Discussed:		Sec:		Ter:		
05000336 MILLSTONE 2		Sec:		Ter:		
05000423 MILLSTONE 3		Sec:		Ter:		
04/19/1999	1999005	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Ventilation System Radiological Monitoring</b>  Sec: 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.  Ter:
Record ID: 78655		Sec:		Sec:		
Dockets Discussed:		Sec:		Ter:		
05000336 MILLSTONE 2		Sec:		Ter:		
05000423 MILLSTONE 3		Sec:		Ter:		

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005	Pri: PLTSUP	NRC	POS	Pri: 2B	<b>Meteorological Monitoring Program Was Effective</b> Record ID: 78652 Dockets Discussed: 05000336 MILLSTONE 2 05000423 MILLSTONE 3 Sec: 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. Ter:
04/19/1999	1999005-13	Pri: PLTSUP	NRC	URI	Pri: 5C	<b>Unit 2 (Closure of URI 90-18-05) Post Accident Sampling System</b> Record ID: 78734 Dockets Discussed: 05000336 MILLSTONE 2 Sec: 4B At Unit 2, the licensee adequately demonstrated the operation of the PASS. Sample results met the appropriate acceptance criteria and, although the licensee could not consistently meet the total dissolved gas (TDG) acceptance criteria, TDG concentration results were marginally outside the acceptable value. The licensee is continuing to assess the method for retrieving and analyzing a TDG sample for better accuracy. Revised/approved PASS procedures were found to be detailed, technicians were retrained, equipment deficiencies were corrected and the system was repeatedly tested. The licensee adequately demonstrated an Emergency PASS drill and met the time requirement for obtaining post-accident sample results within 3 hours. An unresolved item is being opened to allow further NRC evaluation of the licensee's method for assessing core damage without the use of a TDG analysis and to review the 10CFR50.54(q) evaluation for determining whether or not the procedure change decreased the effectiveness of the E-Plan. Ter:
03/26/1999	1999003	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Unit 2 Fire Protection -Training, Shift Manning and Augmented Coverage</b> Record ID: 78681 Dockets Discussed: 05000336 MILLSTONE 2 Sec: OPS Unit 2 post-fire safe shutdown operator training and qualification tasks were comprehensive, and reflected the current approved revision of the safe shutdown procedures. The tasks covered major steps in the procedures in sufficient detail to ensure the adequacy of the operators' level of understanding. Augmented shift manning in place was adequate for the performance of post-fire shutdown activities. The CONVEX procedure and manning appeared to provide adequate controls for deenergizing the offsite feeds to the electrical distribution system. Ter:
03/01/1999	1999002	Pri: PLTSUP	NRC	POS	Pri: 1B	<b>Unit 3 Actions Taken in Response to an Inadvertent Carbon Dioxide Discharge</b> Record ID: 78630 Dockets Discussed: 05000423 MILLSTONE 3 Sec: 5B 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. Ter:
03/01/1999	1999002	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Licensee's Efforts in the Health Physics Area</b> Record ID: 78629 Dockets Discussed: 05000423 MILLSTONE 3 Sec: 2B 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. Ter:
01/11/1999	1998006	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Common - Security Program</b> Record ID: 78611 Dockets Discussed: 05000245 MILLSTONE 1 05000336 MILLSTONE 2 05000423 MILLSTONE 3 Sec: Common - The security program was inspected during this period. The inspection consisted of selective reviews of procedures and records, inspector observations, and interviews with security personnel. No safety concerns or violations were identified. The inspector determined that the security program was effectively implemented to protect against acts of radiological sabotage. Ter:

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/11/1999	1998006	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Common - Radioactive Material Shipments</b>
Record ID: 78610		Sec:			Sec: 3B	Common - All radioactive material shipments reviewed were determined to be in compliance with the applicable provisions of Titles 10 and 49 CFR. The technical training program for personnel involved in the transportation of radioactive materials was effective. The licensee provided an independent review of all radioactive material shipments from Millstone Station utilizing detailed checklists, which was effective.
Dockets Discussed:					Ter:	
05000245 MILLSTONE 1 05000336 MILLSTONE 2 05000423 MILLSTONE 3						
01/11/1999	1998006	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Common - Security Audit Program</b>
Record ID: 78612		Sec:			Sec: 5A	Common - The review of the licensee's audit program for security indicated that audits were comprehensive in scope and depth, that the audit findings were reported to the appropriate level of management, and that the program was being properly administered.
Dockets Discussed:					Ter:	
05000245 MILLSTONE 1 05000336 MILLSTONE 2 05000423 MILLSTONE 3						
01/11/1999	1998006	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Common - Security Self-Assessment Program</b>
Record ID: 78613		Sec:			Sec: 5A	Common - A review of the self-assessment program documentation in conjunction with the key performance indicators program indicated that the programs were being effectively implemented to identify and resolve potential weaknesses.
Dockets Discussed:					Ter:	
05000245 MILLSTONE 1 05000336 MILLSTONE 2 05000423 MILLSTONE 3						
11/23/1998	1998005-07	Pri: PLTSUP	Licensee	NCV	Pri: 1C	<b>U/3 - Vital Area Barrier Gratings in Main Steam Valve Building Floor Not Secured</b>
Record ID: 78565		Sec:			Sec:	U/3 - Licensee corrective actions for an LER that involved vital area barrier maintenance was determined to be acceptable. The corrective measures were commensurate with the safety significance of the self-identified problem and included consideration of long term programmatic initiatives to preclude problem recurrence. Reportability, timeliness, event analysis requirements have been met. (See LER 97-S001)
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
11/23/1998	1998005-10	Pri: PLTSUP	NRC	VIO IV	Pri: 2B	<b>U/2 - Failure to Satisfy Penetration Seal Testing and Configuration Requirements</b>
Record ID: 78568		Sec:			Sec: 3A	U/2 - The fire penetration seals that were sampled in Unit 2 were satisfactory with regards to physical damage, presence of required permanent damming material, shrinkage and separation. The quality and consistency of the work orders improved with the implementation of subsequent revisions to the procedure MP 2721N. An issue involving indeterminate seal fill depths remains unresolved. Additionally, the inspector identified a violation in which several penetration seals were not installed or repaired to a test 1 configuration, which resulted in a violation of the Millstone 2 fire protection requirement.
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2						
10/05/1998	1998216	Pri: PLTSUP	NRC	POS	Pri: 1C	<b>Common - Effective Radiation Protection Program</b>
Record ID: 78557		Sec:			Sec:	Common - An effective radiation protection program for activities being conducted at all three units is being implemented. The changing work scope at Units 1 and 2 has led to a review of the annual exposure goals for these units.
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2 05000423 MILLSTONE 3						

## United States Nuclear Regulatory Commission

### PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
 MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/05/1998	1998216	Pri: PLTSUP	NRC	POS	Pri: 3B	<b>Common - Effective Technical Training Program for Radiation Protection Workers</b>  Common - An effective technical training program has been established for the continuing education of licensee radiation protection technicians.
Record ID: 78558		Sec:				Sec:
Dockets Discussed:					Ter:	
05000336 MILLSTONE 2						
05000423 MILLSTONE 3						
07/15/1999	1999007	Pri: OTHER	NRC	MISC	Pri: 5C	<b>Safety Conscious Work Environment</b>  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.
Record ID: 78713		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
07/15/1999	1999007	Pri: OTHER	NRC	POS	Pri: 5A	<b>Self Assessment</b>  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.
Record ID: 78710		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
07/15/1999	1999007	Pri: OTHER	NRC	POS	Pri: 5A	<b>Nuclear Oversight Audit of the Corrective Action Process</b>  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.
Record ID: 78711		Sec:				Sec: 5C
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						
07/15/1999	1999007	Pri: OTHER	NRC	POS	Pri: 5C	<b>Employee Concern Program</b>  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.
Record ID: 78712		Sec:				Sec:
Dockets Discussed:					Ter:	
05000423 MILLSTONE 3						

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

Region 1  
MILLSTONE

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
07/15/1999	1999007-03	Pri: OTHER	NRC	NCV	Pri: 5C	Unit 3 Inadequate Corrective Actions for Organizational Changes
	Record ID: 78781	Sec:			Sec:	Team assessed the effectiveness of NU implementation of the corrective actions in CR M3-00-0542. However, the initial corrective actions were not effective.
	Dockets Discussed:				Ter:	
	05000423 MILLSTONE 3					

# United States Nuclear Regulatory Commission

## PLANT ISSUE MATRIX

By Primary Functional Area

### Legend

#### Type Codes:

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

#### Template Codes:

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

#### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

#### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

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

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

**MILLSTONE**  
**Inspection / Activity Plan**  
**10/01/1999 - 03/31/2000**

Units	Inspection Activity	Title	Number of NRC Inspectors / Individuals	Planned Dates		Inspection Type
				Start	End	
2,3	IP 40001	Resolution Of Employee Concerns	3	10/04/1999	10/08/1999	Regional Initiative
2,3	IP 81700	Physical Security Program For Power Reactors	1	12/06/1999	12/10/1999	Core
2,3	IP 92904	Followup - Plant Support	1	12/09/1999	12/10/1999	Regional Initiative
2,3	IP 40500	Effectiveness Of Licensee Process to Identify, Resolve, And Prevent Problems	1	01/03/2000	01/07/2000	Regional Initiative
2,3	IP 2515/142	Draindown During Shutdown and Common-Mode Failure (NRC GL 98-02)	1	01/10/2000	01/14/2000	Safety Issues
2,3	IP 40001	Resolution Of Employee Concerns	2	01/24/2000	01/28/2000	Regional Initiative
2,3	IP 40500	Effectiveness Of Licensee Process to Identify, Resolve, And Prevent Problems	2	01/24/2000	01/28/2000	Regional Initiative
2,3	IP 62700	Maintenance Program Implementation	1	01/24/2000	01/28/2000	Regional Initiative
2,3	IP 62706	Maintenance Rule Inspection Procedure	1	01/24/2000	01/28/2000	Other Routine
2,3	IP 82301	Evaluation Of Exercises For Power Reactors	2	03/13/2000	03/17/2000	Core
3	IP 84750	Radioactive Waste Treatment, And Effluent And Environmental Monitoring	1	03/20/2000	03/24/2000	Core

