

Nine Mile Point 2

Initiating Events



Significance: Nov 10, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Violation of TS 5.4.1 for inadequate surveillance procedure which resulted in inadvertent closure of main steam isolation valves and a reactor scram

The inspector identified a Non-cited Violation for an inadequate surveillance procedure, which resulted in the inadvertent closure of the main steam isolation valves and a reactor scram. This finding was of very low safety significance based on the change in core damage frequency associated with a reactor trip. (Section 1R22 and 1R14)

Inspection Report# : [2001008\(pdf\)](#)

Mitigating Systems



Significance: Dec 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT CORRECTIVE ACTIONS ASSOCIATED WITH THE RHS HEAT EXCHANGER.

A non-cited violation of 10CFR50, Appendix B, Criterion XVI, Corrective Actions, for inadequate corrective actions related to a deviation and event report (DER), which adversely affected the licensee's ability to assess and trend the operability of the residual heat removal system (RHS) heat exchangers. The inspector determined that the corrective actions documented as completed in the DER, had not been performed. This issue was greater than minor because the licensee's ability to accurately assess the RHS heat exchangers performance and to conservatively identify their potentially degrading performance was negatively impacted and never actually resolved. The issue was of very low safety significance based on the actual results of the performance testing indicating the RHS heat exchangers had always remained operable. (Section 1R07)

Inspection Report# : [2001010\(pdf\)](#)



Significance: Dec 29, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ESTABLISH PROCEDURES ASSOCIATED WITH REACTOR BUILDING EQUIPMENT COOLING.

A non-cited violation of 10CFR50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, was identified for the failure to incorporate and implement specific operator actions documented in approved engineering support analysis 2M01-03 to monitor, control, and maintain reactor building temperature; specifically the emergency core cooling system, reactor core isolation cooling system and motor control center room temperatures within a specified temperature range when normal reactor building ventilation is isolated during a loss of coolant accident. This finding was determined to be of very low safety significance based on a Phase 1 Significance Determination Process (SDP) review because severe winter temperature conditions had not occurred since October, 2001, when it was identified that procedural changes were required to support operability of equipment. Therefore, the safety function of mitigating equipment and the secondary containment was not impacted. (Section 1R17)

Inspection Report# : [2001010\(pdf\)](#)



Significance: Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Missed response time testing of the high pressure core spray initiation signals and the main steam flow channels. LER 2000-001

On January 12, 2000, the licensee identified that the response time testing for the high pressure core spray initiation signals and the main steam flow channels were not being tested within the frequency required by technical specifications surveillance requirements 4.3.2.3 and 4.3.3.3. The cause was improper maintenance of the surveillance test database. The licensee's risk assessment and inspector evaluation of this issue identified this as very low safety significance (Green) as the required channels were subsequently tested satisfactorily. Accordingly this violation of TS 4.3.2.3 and 4.3.3.3 is being treated as a Non-Cited Violation (NCV), consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

TS requirement not performed for RCIC due to an inadequate work package. LER 2000-010

During the refueling outage, maintenance was performed on both divisions of the RCIC high steam flow instruments which inadvertently rendered them inoperable by introducing air into the lines. The cause was that a previous work order did not include steps for refilling and venting instrument lines that were drained during maintenance. From April 18 to April 25, the licensee failed to implement Technical Specification 3.3.2.c which requires the RCIC system to be isolated from the steam supply within one hour with both high steam flow instruments inoperable. On April 25, the licensee declared the reactor core isolation cooling system high steam flow instrumentation inoperable due to erratic indication and implemented TS 3.3.2.c. This issue was of very low risk significance (Green) in that a redundant high pressure injection system was available, and the duration was less than the TS allowed outage time. This violation of TS 3.3.2.c is being treated as an NCV consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Missed TS for primary containment integrity. LER 2000-011

On May 12, 2000, the licensee identified that the Primary Containment Isolation Valve 2RHS*V192 was not being verified closed every 31 days as required by Technical Specification Surveillance Requirement 4.6.1.1.b. In 1986 an engineering change notice changed the valve from a normally open valve to a normally locked valve. This change made the valve a containment isolation valve subject to position verification in accordance with TS. The valve position was subsequently checked and found to be closed. This issue was of very low risk significance (Green), in that, the valve was determined to be in the correct position. The licensee attributed this omission to failure to properly revise all affected documents when the engineering change request was issued. In addition the licensee failed to correct the deficiency sooner after the discrepancy was identified by an audit of the containment penetrations. This violation of TS 4.6.1.1.b is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Reactor coolant recirculation system primary containment isolation valves no tested. LER 2000-013

On August 29, 2000, the licensee identified that the inservice testing requirements of TS 4.6.3.3 were not being met for 16 reactor coolant recirculation system primary containment isolation valves. Specifically, the valves were not timed individually but were timed in groups of four. On August 30, 2000 the licensee received Staff approval for the previous test methodology until the valves could be tested during the next scheduled outage. The test method was subsequently changed and proper testing was conducted with satisfactory results. This issue was of very low risk significance (Green), in that, the valve functioned properly when subjected to an appropriate timing test. The licensee attributed this failure to properly inservice test the reactor coolant recirculation system primary containment isolation valves to misapplication or misinterpretation of the American Society of Mechanical Engineers Boiler and Pressure Vessel Code. This violation of TS 4.0.5 is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

Failure to enter TS action statement at the correct point in the electrical breaker switching sequence. LER 2000-015

The licensee identified this TS violation and determined the cause for the oversight as poor work practices, in that, both the specific work order (WO No. 99-16586-02) and governing operating procedure (N2-OP-72) Precautions/Limitations Sections were not adhered to. The failure to take action in accordance with TS 3.8.1.1. is a violation of very low risk significance (Green), in that, the oversight was identified within 16 minutes of the one-hour time limit and the remaining offsite power sources were available and fully functional during this time interval. This issue is being treated as an NCV consistent with Section VI.A.1 of the NRC Enforcement Policy,

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Primary containment purge supply isolation valves failed their leak rate test. LER 2000-016

As documented in the LER, the causes for this event included equipment problems (corrosion products on the valve seating surfaces) and personnel performance deficiencies (including operator failure to properly close 2CPS*AOV107 and poor management decision-making with respect to timely corrective actions to address identified equipment problems). The licensee's failure to take appropriate and timely corrective actions to address identified containment isolation valve leakage problems resulted in violating the primary containment isolation valve allowed leakage limits per TS 3.6.1.1 and 3.6.1.2. Licensee analysis and inspector review confirmed that this event was of very low safety significance (Green). Confirmatory leak rate testing of the non-credited downstream purge system piping isolation valves identified leakage values of 7.1 and 5.8 standard cubic feet per hour (scfh) in the normal and vented configurations, respectively. The sum of these leakage values and the total known primary containment leakage rate of 140 scfh, is still significantly less than the regulatory acceptance criteria of 0.6 La (494 scfh). The failure to take appropriate corrective action is contrary to 10 CFR 50, Appendix B, Criterion XVI, and is a violation. This issue is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Mar 31, 2001

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate test methodology used for reverse flow testing of check valve in low pressure core spray system. LER 2000-017

On November 22, 2000, the licensee identified that the inservice testing requirements of TS 4.0.5 were not being met for valve 2CSL*V9. Specifically, the test pressure used was insufficient to seat the check valve and verify the cessation of flow. The test method was changed and proper reverse flow testing was conducted with satisfactory results. This issue was of very low risk significance (Green), in that, the valve functioned properly when subjected to an appropriate reverse flow test. The licensee attributed this failure to properly inservice test 2CSL*V9 to poor testing program management and improper validation of the test methodology. This violation of TS 4.0.5 is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy.

Inspection Report# : [2001002\(pdf\)](#)

G

Significance: Feb 10, 2001

Identified By: NRC

Item Type: FIN Finding

EMERGENCY DIESEL GENERATOR VENTILATION OPERABILITY DETERMINATION NOT CONSISTENT WITH POSTULATED EVENTS.

The inspector identified that the initial operability determination was not adequate to conclude that the emergency diesel generator (EDG) ventilation system would remain operable if the motor-operated dampers failed to open, coincident with cold ambient temperatures. This finding was of very low safety significance, in that operating procedures provide sufficient guidance to monitor and control EDG room temperature and the dampers have demonstrated sufficient reliability.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Feb 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO MAINTAIN THE EXPANSION JOINT TIE ROD GAPS IN ACCORDANCE WITH ESTABLISHED DESIGN SPECIFICATIONS.

The inspector identified a non-cited violation (NCV) involving the failure to maintain the tie rod gaps for the reactor building closed loop cooling system expansion joints within design specifications. This finding was of very low safety significance, in that, the system remained operable and engineering analysis determined that the added loading was well within the allowed stress values.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Feb 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CORRECTIVE ACTIONS ASSOCIATED WITH FIRE DAMPERS.

The inspector identified an NCV associated with ineffective corrective action for previous damper failures which contributed to the December 21, 2000, release of carbon dioxide into the reactor building through a fire damper that failed to function. Another NCV was identified involving the failure to follow general administrative procedure GAP-PSH-02 which resulted in a missed surveillance test that would have detected the faulted damper prior to it being required to function. The fire damper failure to close was determined to be of very low safety significance because of the

small percentage of carbon dioxide released from the switchgear room into the reactor building and because of the plant staff's actions and available procedures to mitigate this type of event.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Feb 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE ASSOCIATED WITH FIRE DAMPER SURVEILLANCE TEST.

The inspector identified an NCV associated with ineffective corrective action for previous damper failures which contributed to the December 21, 2000, release of carbon dioxide into the reactor building through a fire damper that failed to function. Another NCV was identified involving the failure to follow general administrative procedure GAP-PSH-02 which resulted in a missed surveillance test that would have detected the faulted damper prior to it being required to function. The fire damper failure to close was determined to be of very low safety significance because of the small percentage of carbon dioxide released from the switchgear room into the reactor building and because of the plant staff's actions and available procedures to mitigate this type of event.

Inspection Report# : [2000011\(pdf\)](#)

G

Significance: Dec 30, 2000

Identified By: NRC

Item Type: FIN Finding

SHUTDOWN COOLING INSIDE CONTAINMENT ISOLATION CHECK VALVE WAS OPERABLE BUT NOT ADEQUATE.

The inspectors determined that the initial technical basis to conclude that the shutdown cooling inside containment isolation check valve, 2RHS*MOV39B, was operable, but not adequate. This finding was of very low safety significance, in that, the outside containment isolation valve is normally shut during power operations and a subsequent alternate Appendix J leak rate test determined that the valve would perform its intended containment isolation function.

Inspection Report# : [2000010\(pdf\)](#)

G

Significance: Dec 30, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ADEQUATELY TEST THE HPCS PUMP DISCHARGE CHECK VALVE.

The inspector determined that the high pressure core spray (HPCS) inservice test was not adequately testing the reverse flow safety function of the HPCS pump discharge check valve. This finding was of very low safety significance due to the very low probability of a loss of offsite power (LOOP) coincident with a small break loss of coolant accident (SBLOCA) which would rely upon the HPCS system independent electrical power and coolant injection design functions. This issue was treated as a Non-Cited Violation of 10 CFR50, Appendix B, Criterion XI, "Test Control."

Inspection Report# : [2000010\(pdf\)](#)

G

Significance: Nov 11, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

UNIT 2, VIOLATION OF 10CFR50, APPENDIX B, CRITERION III (FLOOD PROTECTION MEASURES)

The inspectors identified that degraded flood protection equipment at Unit 2, involving the watertight doors of the reactor building auxiliary bays, potentially compromised the emergency core cooling systems located in these rooms in the event of internal flooding. This finding was of very low safety significance because the watertight doors were determined to be degraded, but functional. The inspectors identified this as a Non-Cited Violation for failure to maintain the design configuration of the water tight doors per 10CFR50, Appendix B, Criterion III. (Section 1R06)

Inspection Report# : [2000008\(pdf\)](#)

G

Significance: Nov 11, 2000

Identified By: NRC

Item Type: URI Unresolved item

UNIT 2 UNRESOLVED ITEM INVOLVING THE MAINTENANCE OF THE FWS-L10 VALVES PER THE LICENSEE'S MAINTENANCE RULE PROGRAM.

The inspectors identified that the licensee did not recognize that the valve seat leakage of the Unit 2 feedwater control valves (FWS-L10A, B, and C) adversely impacted the ATSW mitigation function of the redundant reactivity control system, as discussed in the UFSAR. This finding was of very low safety significance because, although the valves have a documented history of excessive leak-by, this leakage was not significant enough to compromise their ATWS mitigation function. (Section 1R04)

Inspection Report# : [2000008\(pdf\)](#)



Sep 29, 2000

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate design inputs and failure to translate design into specifications and procedures (six examples)

Green. The team identified that NMPC reclassified the safety function of the containment spray raw water system inter-tie check valves from active to passive components with only a pressure boundary safety function. This reclassification was used to provide the bases for removing the valves from the in-service test (IST) program. The team also found that several safety evaluations and calculations credited the valves with closing to prevent reverse flow from the containment spray and core spray systems into the containment spray raw water system. The failure to properly classify these valves was determined to be of very low risk significance (Green) by the SDP phase 1 screening. This conclusion was based on the finding that although the safety classification determination allowed removal of the valves from the IST program, the valves had not yet been removed from the test procedure and continued to receive a reverse flow closure test. Therefore, there were no actual consequences caused by this error. The failure to identify and translate the design basis requirements of the inter-tie check valves into the IST program is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.1, Design-Mechanical, Electrical and Instrumentation and Control) Green. The team identified that the pump developed head acceptance criteria in the Unit 1 containment spray pump surveillance tests was non-conservative with respect to the design bases. The team determined this issue to be of very low risk significance (Green) by the SDP phase 1 screening. This conclusion was based the team's review of current surveillance test results which found the pumps had adequate margin between the measured values and the test acceptance criteria to account for the error introduced by the calculation. The failure to translate design basis assumptions into test procedure acceptance criteria is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.1, Design-Mechanical, Electrical and Instrumentation and Control) Green. The team identified that NMPC did not consider the most limiting scenario when evaluating the adequacy of the net positive suction head (NPSH) for the containment spray system pumps. As a result, operating procedures were not consistent with the design bases. This issue was evaluated using the SDP phase 1 screening and was determined to be an issue of very low risk significance (Green). This conclusion was based on a consideration that system functionality would not be affected since pressure in the containment peaks, and then decreases to below 3.5 psig within approximately 12.5 minutes of a LOCA, resulting in the short term operation of two pumps on one suction strainer. Also, until containment pressure is reduced to 0 psig, at which time the pumps would be secured, the existing containment pressure serves to counteract the adverse effects of elevated torus water temperature and pressure drop across the strainer on NPSH. Additionally, if pump cavitation were to result from two pump operation on one strainer, it would be recognized by the operators and, once a cavitating pump was secured, additional NPSH would be available for the remaining operating pump. The failure to validate design assumptions is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.1, Design-Mechanical, Electrical and Instrumentation and Control) Green. The team identified that, due to improper design assumptions, assumed margins in the Unit 2 service water system hydraulic performance analysis were incorrect. The analysis concluded that there was 20% margin to account for pump degradation and instrument uncertainty. However, as a result of the incorrect assumption the margin was not 20% and, if the pumps were assumed to be degraded by 10%, there would be no margin to account for instrument uncertainty. The team determined this issue was of very low safety significance (Green) by the SDP phase 1 screening. This conclusion was based on the team's review of the most recent surveillance procedure test results which were found to be acceptable and did not indicate significant loss of margin due to pump degradation. Therefore, the service water system was functional and the service water pumps remained operable. The failure to validate the design assumption is considered a non-cited violation of 10 CFR 50 Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.1, Design-Mechanical, Electrical and Instrumentation and Control) Green. The team identified that plant procedures did not include directions to start a containment spray raw water pump within 15 minutes following a loss-of-coolant accident (LOCA). This issue was evaluated using the SDP phase 1 screening and was determined to be of very low risk significance (Green). This conclusion was based on a consideration that system functionality would not be impaired. Following an accident, the operators monitor key parameters that include containment and torus temperature. In the event of an adverse trend, and/or actuation of the torus high temperature annunciator, plant procedures would result in the starting of a CSRW pump. However, the failure to translate design basis information into operating procedures is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.2, Operations, Maintenance and Testing) Green. The team reviewed Unit 2 Nuclear Engineering Report NER-2M-037, which provides the requirements for taking reactor building unit coolers out of service for testing. The team identified that these requirements had not been incorporated in the service water operating procedure. The team determined this issue was of very low risk significance (Green) based on SDP phase 1 screening. This conclusion was based on the observation that, while not specified in the procedure, the current practice was to route all work orders that take a reactor building unit coolers out of service to engineering for approval. Also, the team did not identify any instances where the reactor building coolers were removed from service without the engineering requirements being met. The failure to properly translate design basis information into the operating procedure is considered a non-cited violation of 10 CFR 50 Appendix B, Criterion III, Design Control. The issue was entered in the NMPC corrective action program. (Section 1R21.2, Operations, Maintenance and Testing)

Inspection Report# : [2000007\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance: N/A Feb 10, 2001

Identified By: NRC

Item Type: NCV NonCited Violation

LICENSEE FAILED TO ANNOUNCE AN EGRESS ROUTE WHEN EVACUATING THE REACTOR BUILDING DURING THE DECEMBER 21, 2000, CARBON DIOXIDE DISCHARGE EVENT.

Control room personnel did not complete the procedure for evacuating the reactor building as specified in EPIP-EPP-05A, Local Area/Building Evacuation, Attachment 1, Emergency Announcement, in that they did not provide an egress route, as directed in step 3.f, for personnel in the reactor building to avoid areas potentially affected by the CO2 discharge.

Inspection Report# : [2000011\(pdf\)](#)

Occupational Radiation Safety

Significance: N/A Nov 10, 2001

Identified By: Licensee

Item Type: NCV NonCited Violation

The licensee did not properly maintain a high radiation area locked as required by TS 5.7.2.

The licensee did not properly maintain a high radiation monitor locked as required by TS 5.7.2.

Inspection Report# : [2001008\(pdf\)](#)

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Jun 09, 2000

Identified By: NRC

Item Type: FIN Finding

Corrective actions for DERS reviewed appeared appropriate.

The prescribed C/As for DERS reviewed appeared appropriate to correct the problems. The backlog of C/As was being managed well and the team did not identify any backlogged action that represented an adverse effect on plant risk. (Section 40A2.3)

Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Jun 09, 2000

Identified By: NRC

Item Type: FIN Finding

Licensee's resolution of problems was adequate.

Based on the sample reviewed, the licensee's resolution of problems was adequate. Items entered into the C/A program were properly classified and prioritized for resolution. The evaluations and root causes analyses reviewed were of good depth and quality. Although the team found a few instances where the evaluation of some DERs had not been completed within the specified time, the team did not identify any instance that represented a significant concern. The licensee was already aware of these delays and was taking action to correct the problem. (Section 40A2.2)

Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Jun 09, 2000

Identified By: NRC

Item Type: FIN Finding

QA, Self-assessments, and oversight review committee actions were appropriate.

Issues identified in the QA Audits and self assessment reports reviewed had been properly entered into the DER process. Some assessment findings resulted in recommendations and identification of issues not previously included in the DER process. Based upon a review of a sample of meeting minutes of the SORC and CARB, and observation of some CARB meetings, the team found that the committees provided good oversight

of the C/A Program. (Section 40A2.4)
 Inspection Report# : [2000003\(pdf\)](#)

Significance: N/A Jun 09, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Seven examples of equipment problems/failures which were not entered into the DER process for operability assessments or trending.
 NO COLOR. The licensee was effective at identifying and tracking problems. The team did not identify any issues that were not already being tracked. However, the team identified seven examples where issues involving equipment failures documented in the Problem Identification process had work orders to conduct the repairs, but no DERs were written as required. This failure to initiate DERs is a violation of TS, but being treated as a non-cited violation. (Section 40A2.1)
 Inspection Report# : [2000003\(pdf\)](#)



Significance: Sep 29, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Failure to properly implement corrective actions.

Green. The team identified that NMPC had determined that the containment spray raw water system radiation monitors could alarm due to background radiation levels following a LOCA. However, the associated alarm response procedures had not been revised to alert operators to this potential and to provide appropriate response actions. The team determined this issue to be of very low risk significance (Green) by the SDP phase 1 screening. The team determined this issue to be of very low risk significance (Green) by the SDP phase 1 screening. This conclusion was based on a recognition that the simultaneous actuation of all four alarms following a LOCA, without a corresponding indication on the downstream service water system radiation monitor, would be sufficient information for the operators to recognize the alarms as spurious due to background radiation. The failure to implement corrective actions to correct the affected procedure is considered a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI, Corrective Action. This item was entered into the NMPC corrective action program. (Section 40A1, Identification and Resolution of Problems)
 Green. The team identified that an Emergency Operating Procedure (EOP) attachment, intended to be a standalone procedure, did not contain all the directions necessary to perform the procedure without referring to other operations procedures. The team determined this issue to be of very low risk significance (Green) by the SDP phase 1 screening. This conclusion was based on the fact that the system operating procedure included the appropriate guidance, as did operator training, and the issue did not affect the operability of the service water system. The failure of NMPC to implement appropriate corrective actions to ensure adequacy of operating procedures is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action. This item was entered into the NMPC corrective action program. (Section 40A1, Identification and Resolution of Problems)
 Inspection Report# : [2000007\(pdf\)](#)

Significance: N/A Jul 01, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Failure to implement the SAT process for the licensed operator training program.

NO COLOR. NMPC failed to consistently implement the systems approach to training (SAT) process for the licensed operator training program as required by 10 CFR 55.59(c). Specifically, training programs were not evaluated and revised based on observed performance deficiencies of licensed operators in the job setting. Corrective actions to the self-revealing deficiencies addressed the apparent symptoms, but corrective actions to prevent recurrence were missing or erratic. There was reasonable assurance that licensed operators have received adequate training to perform acceptably in the job setting, based on immediate corrective actions taken. This failure to implement the SAT process is being treated as a Non-Cited Violation, consistent with Section VI.A of the Enforcement Policy, issued on May 1, 2000 (65 FR 25368). (Section 40A4b1)
 Inspection Report# : [2000004\(pdf\)](#)

Significance: N/A Jul 01, 2000
 Identified By: NRC
 Item Type: NCV NonCited Violation

Failure to implement the SAT process for the non-licensed operator training program.

NO COLOR. NMPC failed to consistently implement the systems approach to training (SAT) process for the non-licensed operator (shift technical advisors, auxiliary operators, licensed operator candidates) training program as required by 10 CFR 50.120. Specifically, training programs were not evaluated and revised based on observed performance deficiencies of non-licensed personnel in the job setting. Corrective actions to the self-revealing deficiencies addressed the apparent symptoms, but long term corrective actions to prevent recurrence were missing or erratic. There was reasonable assurance that non-licensed operators have received adequate training to perform acceptably in the job setting, based on immediate corrective actions taken. This failure to implement the SAT process is being treated as a Non-Cited Violation, consistent with Section VI.A of the Enforcement Policy, issued on May 1, 2000 (65 FR 25368). (Section 40A4b2)
 Inspection Report# : [2000004\(pdf\)](#)

Last modified : April 01, 2002