

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

05000336 - Millstone 2

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
11/22/1999	1999012-01	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: Ter:	FAILURE TO ADEQUATELY IMPLEMENT THE OPERATING PROCEDURE TO MAINTAIN THE AXIAL POWER DIST Operators did not adequately anticipate the effect of xenon during a planned power increase from 84 to 100 percent power. Consequently, this routine power increase was performed in a manner that resulted in the reactor's axial power distribution value exceeding the limit specified in the operating procedure, the receipt of multiple reactor protection system pre-trip alarms for local power density, and the unplanned need to add multiple batches of concentrated boric acid to restore axial power distribution within the specified limit. The failure to adequately implement the operating procedure to maintain the axial power distribution value within the specified limit, as required by Technical Specification 6.8.1, is being treated as a Non-Cited Violation.
10/04/1999	1999009	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	WEAK CIRCULATING WATER SYSTEM OPERATING PROCEDURE At Unit 2, the circulating water system operating procedure was weak in that it did not specify the reactor power level to allow securing a circulating water pump. As a result when a circulating water pump was secured at 85% power, numerous main condenser alarms and reduced main condenser vacuum occurred, which unnecessarily challenged plant operators.
10/04/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	REACTOR STARTUP FROM FORCED OUTAGE At Unit 2, during the forced outage that occurred due to a dropped control rod, the licensee's corrective actions were found acceptable in addressing an electrical ground in the wire to the lower gripper coil which caused the rod to drop. The pre-evolution briefing of operators prior to reactor startup was thorough with a good discussion of industry operating experience and extra operator staffing was provided during the startup.
10/04/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	GOOD OPERATOR RESPONSE TO DROPPED CONTROL ROD At Unit 2, on September 17, 1999, operators appropriately implemented the required actions for a dropped control rod and performed a reactor shutdown in a controlled and deliberate manner. Operator performance was particularly good in that the dropped rod occurred at a time they were responding to numerous main condenser alarms that resulted when the "D" circulating water pump was secured.
10/04/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: 3A Ter:	GOOD OPERATOR RESPONSE TO FEEDWATER SYSTEM At Unit 2, when a control circuit card failed for the main feedwater regulating bypass valve, reactor operator performance was good in immediately recognizing, before any alarms were received, that the bypass valve had closed. Due to prompt action by the reactor operator to restore main feedwater flow, a plant transient was averted.
10/04/1999	1999009-02	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	FAILURE TO ADEQUATELY ESTABLISH AND MAINTAIN PLANT COOLDOWN PROCEDURE TO REFLECT A CHA At Unit 2, the licensee failed to revise the plant cooldown procedure to reflect a change in reactor protection system (RPS) setpoints in April 1999. As a result, an unplanned RPS actuation on low steam generator level occurred while the plant was shut down. The failure to adequately maintain the plant cooldown procedure is being treated as a Non-Cited Violation

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10/04/1999	1999009-03	Pri: OPS Sec:	NRC	NCV	Pri: 4C Sec: Ter:	FAILURE TO REPORT AN UNPLANNED ACTUATION OF RPS The licensee incorrectly retracted their initial notification of an unplanned RPS actuation. This retraction constitutes a failure to report a condition as required by 10 CFR 50.72 and is being treated as a Non-Cited Violation
10/04/1999	1999009-04	Pri: OPS Sec:	NRC	NCV	Pri: 5A Sec: Ter:	FAILURE TO INITIATE A CONDITION REPORT TO DOCUMENT THAT CRITICAL DATA WAS NOT TAKEN AT THE At Unit 2, the NRC identified that the licensee failed to initiate a condition report to document that, during the reactor startup, reactor criticality occurred at a higher power level than expected which resulted in the recording of critical data at power level that was higher than power level specified in the procedure. A condition report is necessary to ensure that the cause of the higher power level is evaluated and that corrective actions are taken to prevent recurrence during future reactor startups. The failure to initiate a condition report as required by the corrective action procedure is being treated as a Non-Cited Violation
08/09/1999	1999008-01	Pri: OPS Sec:	NRC	NCV	Pri: 5A Sec: 1A Ter: 1C	FAILURE TO PROMPTLY ADDRESS POTENTIAL AIR ENTRAPMENT IN THE EMERGENCY CORE COOLING SYSTEM At Unit 2, operators failed to initiate a condition report and take timely corrective actions when they suspected that the piping between the "B" train containment sump isolation valve and the downstream check valve was not full of water. Trapped air in the piping had the potential to render the "B" train high pressure safety injection (HPSI) and containment spray pumps inoperable. However, operators inappropriately determined that it was acceptable to wait up to four weeks to determine whether the piping contained air. Prompt actions, including the confirmation of trapped air in the containment sump suction piping, were not taken until concerns were raised by the NRC inspector about three weeks later. Although the amount of trapped air was small and would not have prevented the "B" HPSI and containment spray pumps from performing the intended function, the failure to address this deficient condition in a timely manner 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 50-336/99-08-01)
08/09/1999	1999008-02	Pri: OPS Sec:	NRC	NCV	Pri: 5A Sec: 1A Ter: 1C	FAILURE TO INITIATE A CONDITION REPORT WHEN A LEAKING SAFETY INJECTION ACCUMULATOR ISOLATION VALVE WAS Prior to Unit 2 plant startup, the licensee failed to initiate a condition report when a five-day trend showed the No. 3 safety injection tank (SIT) was leaking by the closed isolation valve to the reactor coolant system (RCS). A condition report was necessary to initiate an assessment of SIT operability with the leaking isolation valve. Following an NRC inquiry, a condition report was initiated and the licensee's operability determination found the SIT to be operable. The NRC found that the operability determination was adequately supported and an acceptable corrective action plan was developed. The failure to initiate a condition report is a violation of 10 CFR Part 50, Appendix B, Criterion V, "Instruction, Procedures and Drawings." This Severity Level IV violation is being treated as a Non-Cited Violation. (NCV 50-336/99-08-02)
06/14/1999	1999006	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: Ter:	Unit 2 Poor Operator Communication with other Work Groups 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.

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06/14/1999	1999006	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Unit 2 Operating Procedure Inadequacy 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.
06/14/1999	1999006	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 2 Startup and Power Ascension 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.
06/14/1999	1999006-01	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Unit 2 (Closure of URI 96-09-09) Failure to Provide Procedural Guidance for Bypassing Automatic Actuation of 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.
03/05/1999	1998219-04	Pri: OPS Sec: ENG	NRC	NCV	Pri: 1C Sec: 4A Ter:	Unit 2 Inadequate Procedure Controls Closure of Steam Supply Valve to Turbine-Driven Auxiliary Feed Pump 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 basis 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.
04/19/1999	1999005	Pri: OPS Sec:	NRC	POS	Pri: 4C Sec: Ter:	Unit 2 Operating Procedure Agreement with Final Safety Analysis Report 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Conduct of Operations 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.

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04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Operator Knowledge, Performance and Training 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Quality Assurance in Operations 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Management (SIL 1) 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Corrective Action Program 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Independent Oversight (Nuclear Oversight Verification Plan) 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.

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04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Quality Review Committees 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.
04/07/1999	1999004	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Operations Training, Organization, and Administration 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.
04/07/1999	1999004-01	Pri: OPS Sec:	NRC	NCV	Pri: 1A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Operator Performance 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.
03/01/1999	1999002-01	Pri: OPS Sec:	Self	NCV	Pri: 1A Sec: 3A Ter: 3C	Unit 2 Inadvertent Reactor Coolant System Water Level Increase 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.
03/01/1999	1999002-02	Pri: OPS Sec:	Self	NCV	Pri: 3A Sec: 1A Ter: 3C	Unit 2 Inadvertent Transfer of Water from the Spent Fuel Pool 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.

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03/01/1999	1999002-03	Pri: OPS Sec: MAINT	Self	NCV	Pri: 1A Sec: 1C Ter:	Unit 2 Inadvertent Charging Pump Injection 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.
02/17/1999	1999001-01	Pri: OPS Sec:	NRC	NCV	Pri: 5A Sec: 4B Ter:	Unit 2 Failure to Initiate a Condition Report for Two Control Room Deficiencies 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.
01/05/2000	1999014	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	INCOMPLETE IMPLEMENTATION OF ON-LINE MAINTENANCE PROCEDURE At Unit 2, the NRC identified that although the on-line maintenance procedure specified that Operations Manager approval was needed when the planned removal of equipment from service placed the plant in an "Orange" risk condition, the plant staff had not been documenting his approval. Because the Operations Manager was aware of the "Orange" conditions, he had approved the conditions. Therefore, no violation occurred. The licensee's corrective action, which involved changing the on-line maintenance procedure to remove the statement regarding Operations Manager approval, was found acceptable.
01/05/2000	1999014-01	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: 4B Ter:	FAILURE TO PLACE RPS INTO A MAINTENANCE RULE (a)(1) STATUS The licensee failed to recognize that the established performance criteria of no repetitive functional failures for the reactor protection system was exceeded on May 28, 1999, and again exceeded in October and November 1999, when another three functional failures occurred. The licensee failed to place the system into an (a) (1) status and establish goals commensurate with safety in violation of 10 CFR 50.65(a)(1). As a result, the licensee was untimely in developing a plan to address recurrent instances where an RPS channel was rendered inoperable due to a drifting thermal margin/low pressure setpoint. This violation is being treated as a Non-Cited Violation, consistent with section VII.B.1.a of the NRC Enforcement Policy.
01/05/2000	1999014-02	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	FAILURE TO ESTABLISH AND IMPLEMENT ADEQUATE TESTING OF THE SAFETY INJECTION RECIRCULATION I The licensee identified in 1998 that the technical specification (TS) required, ASME code visual tests, had not been performed on portions of safety injection recirculation header piping. This is a violation of Unit 2 TS 4.0.5. The licensee's corrective actions were found acceptable. This violation of TS 4.0.5, is being treated as a Non-Cited Violation.

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01/05/2000	1999014-03	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	FAILURE TO ESTABLISH AND IMPLEMENT ADEQUATE CAR FAN TESTING The licensee identified in 1998 that the technical specification (TS) required containment air recirculation fan start testing, had historically not been performed. This is a violation of TS 4.6.2.1.2. The licensee's corrective actions were found acceptable. This violation of TS 4.6.2.1.2, is being treated as a Non-Cited Violation.
01/05/2000	1999014-04	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	FAILURE TO ESTABLISH AND IMPLEMENT ADEQUATE TESTING OF CERTAIN CHECK VALVES The licensee identified in 1998 that the technical specification (TS) required check valve full flow tests had not been performed in accordance with ASME Section XI requirements, on specific check valves. This is a violation of TS 4.0.5. The licensee's corrective actions were found acceptable. This violation of TS 4.0.5, is being treated as a Non-Cited Violation.
11/22/1999	1999012-02	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: 2B Ter:	FAILURE TO ADEQUATELY IMPLEMENT THE SURVEILLANCE PROCEDURE TO ADJUST "B" EDG OUTPUT VOL Following surveillance testing and operation of the "B" emergency diesel generator (EDG) on July 7, 1999, the licensee failed to restore the automatic voltage regulator to the position specified in the associated surveillance procedure. As a result, the "B" EDG output voltage was well below normal at its next start and was close to rendering the "B" EDG inoperable. The failure to adequately implement the surveillance procedure is being treated as a Non-Cited Violation.
10/04/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	FEEDWATER MAINTENANCE COORDINATED WITH OPERATIONS At Unit 2, the replacement of a control circuit card for the main feedwater regulating bypass valve was well coordinated with operations and appropriate contingency measures were in place in the event an unexpected feedwater transient occurred during the card replacement.
08/09/1999	1999008-03	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	INADEQUATE TROUBLESHOOTING PROCEDURE FOR THE "A" EMERGENCY DIESEL GENERATOR RELATED TO 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.
08/09/1999	1999008-04	Pri: MAINT Sec:	NRC	NCV	Pri: 4B Sec: Ter:	FAILURE TO MEET ASME SECTION XI SURVEILLANCE REQUIREMENTS RELATED TO LER 50-336/97-024-00 & 0' 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.

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04/19/1999	1999005	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Repair Associated with a Leaking Shutdown Cooling Suction Valve 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.
04/19/1999	1999005-01	Pri: MAINT Sec:	Licensee	NCV	Pri: 1A Sec: Ter:	Unit 2 (Closure of LER 96-24 & URI 96-08-09) Failure to Perform Response Time Testing of the Foxboro SPEC 200 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.
03/26/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	Unit 2 Fire Protection - Maintenance and Plant Equipment 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.
04/07/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 1A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Conduct of Maintenance 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.
04/07/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Maintenance Organization and Procedures 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.

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04/07/1999	1999004	Pri: MAINT Sec:	NRC	POS	Pri: 2A Sec: Ter:	Unit 2 Operational Safety Team Inspection - Material Condition of Facilities 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.
01/05/2000	1999014	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	DEGRADED CONDITIONS AFFECTING THE REACTOR PROTECTION SYSTEM HAVE BEEN ADEQUATELY ADDRE At Unit 2, the NRC concluded that the licensee's determination of continued operability of the reactor protection system, despite some degradation, was adequately founded. The majority of issues pose only a minimal increase in the probability of an inadvertent reactor trip or a distraction to the control operators and have no effect on the system's safety function. The licensee has implemented or scheduled appropriate measures to address the degraded conditions consistent with their importance to safety.
01/05/2000	1999014-05	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO ADEQUATELY ESTABLISH AND IMPLEMENT DESIGN CONTROLS ASSOCIATED WITH SAFETY-REL The licensee identified in 1998 that certain safety-related cable trays and cables did not meet design basis requirements for separation and/or placement. The licensee's corrective actions were found acceptable. This violation of 10 CFR 50, Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation.
01/05/2000	1999014-06	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO ADEQUATELY ESTABLISH AND IMPLEMENT DESIGN CONTROLS TO ENSURE THAT THE SAFETY- The licensee identified in 1998 that certain containment pressure instruments did not meet design basis requirements for post loss of coolant accident pressure retention. The licensee's corrective actions were found acceptable. This violation of 10 CFR 50, Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation.
01/05/2000	1999014-07	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: Ter:	FAILURE TO ADEQUATELY ESTABLISH AND IMPLEMENT DESIGN CONTROLS FOR THE PRESSURIZER SPRAY The licensee identified in 1998 that pressurizer spray line operating procedures and practices did not meet the design basis requirements for reheating, maximum spray flow and other parameters affecting thermal fatigue parameters for the pressurizer spray line. The licensee's corrective actions were found acceptable. This violation of 10 CFR 50, Appendix B, Criterion III, Design Control is being treated as a Non-Cited Violation.
11/22/1999	1999012-03	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	INADEQUATE DESIGN CONTROLS TO ENSURE THAT REQUIRED CHILLED WATER FLOW IN THE VITAL SWITC The licensee reported on January 30, 1997, that the actual vital chilled water flow to the east and west DC switchgear room coolers was lower than the indicated flow and that the reduced flow would have resulted in room temperatures exceeding final safety analysis report post-accident design temperatures. This condition resulted from a failure to adequately implement design controls to ensure that required chilled water flow in the vital switchgear room coolers was correctly translated into specifications, drawings and procedures. This violation of 10 CFR 50, Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation. The licensee's corrective actions were found acceptable. Licensee Event Report 50-336/96-43-00 is closed.

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11/22/1999	1999012-04	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	FAILURE TO ESTABLISH AN ADEQUATE PROCEDURE FOR DAMPER TRACK INSPECTIONS AND FOR THE INSP The NRC inspected a 1997 unresolved item (URI) and identified two instances where the licensee failed to establish and implement adequate fire protection program procedures. One instance was a failure to establish an adequate procedure for damper track inspections and a second instance was a failure to provide a method for the inspection of fire rated assemblies, fire barriers, and fire penetration seals. These two procedural inadequacies constitute a violation of Technical Specification 6.8.1 and are being treated as a Non-Cited Violation. Corrective Actions were found to be adequate. URI 50-336/97-84-02 is closed.
11/22/1999	1999012-05	Pri: ENG Sec:	NRC	NCV	Pri: 2B Sec: 4B Ter:	FAILURE TO ADEQUATELY TEST TO ENSURE THAT AFW PUMP WAS CAPABLE OF OPERATING WITHIN THE R The licensee identified in 1998 that the "A" AFW pump was not capable of meeting its design basis flow rate following a modification performed on its impeller. The licensee's corrective actions were found acceptable. This violation of 10 CFR 50, Appendix B, Criterion XI, Test Control, is being treated as a Non-Cited Violation. Licensee Event Reports 50-336/98-04-00, 01, & 02 are closed.
11/22/1999	1999012-06	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	INADEQUATE DESIGN CONTROLS REGARDING RBCCW DESIGN CRITERIA UPON A LOSS OF SERVICE WATER The licensee identified in 1998 that a postulated loss of a Unit 2 service water pump without operator action to trip the associated reactor building closed cooling water (RBCCW) pump could cause RBCCW system temperatures to exceed the design basis values established in the Unit 2 Final Safety Analysis Report. The resulting reduction in room cooling capability could have impacted equipment operability in the other train. This violation of 10 CFR 50, Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation. The licensee's corrective actions were found acceptable. Licensee Event Report 50-336/98-06-00 is closed.
11/22/1999	1999012-07	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	INADEQUATE DESIGN CONTROLS REGARDING AN AFW SINGLE FAILURE VULNERABILITY ON LOSS OF A DC The licensee reported in 1998 that the auxiliary feedwater (AFW) system did not meet the revised loss of normal feedwater (LONF) safety analysis for the most limiting single failure. The postulated most limiting single failure could have resulted in less AFW flow to the steam generators than was credited in the Final Safety Analysis Report for a LONF event. This violation of 10 CFR 50 Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation. The licensee's corrective actions were found acceptable. Licensee Event Reports 50-336/98-22-00, 01, & 02 are closed.
10/22/1999	1999010-02	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: Ter:	FAILURE TO CORRECT IDENTIFIED CONDITIONS ADVERSE TO QUALITY The licensee's Independent Safety Engineering Group determined that corrective actions for some prior deficiencies were ineffective or untimely. A specific example was the identified deficiency associated with the training documentation of engineering personnel that was not corrected in a timely manner to prevent a recurrence of the problem. The failure to correct conditions adverse to quality in a manner to prevent recurrence was a non-cited violation.
10/04/1999	1999009-05	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: 1C Ter:	INADEQUATE DESIGN CONTROL MEASURES TO ASSURE THAT THE 4160 VOLT SWITCHGEAR ROOM COOLER At Unit 2, the NRC found that design control measures were inadequate to assure that the 4160 volt switchgear room coolers were capable of maintaining a suitable environment for the vital switchgear under post-accident conditions. This Severity Level IV violation of design control requirements is being treated as a Non-Cited Violation (NCV 50-336/99-09-05). The licensee's determination that the "A" train 4160 volt switchgear remained operable when the switchgear room cooler was removed from service for corrective maintenance was found acceptable.

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10/04/1999	1999009-06	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	(CLOSURE OF LER 97-35) SHUTDOWN COOLING ISOLATION VALVE DOES NOT COMPLY WITH APPENDIX R At Unit 2, the licensee identified in 1997 that a valve that isolates the shutdown cooling system from the reactor coolant system was vulnerable to a fire-induced hot short. The licensee's corrective actions were found acceptable. This violation of 10 CFR 50, Appendix R, Fire Protection, is being treated as a Non-Cited Violation. Licensee Event Report 50-336/97-35-00 is closed.
10/04/1999	1999009-07	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	(CLOSURE OF LER 98-03) INADEQUATE DESIGN CONTROLS TO EVALUATE INTERACTION BETWEEN THE REA At Unit 2, the licensee identified in 1998 that the design analysis of the interaction between the reactor vessel internals and the reactor vessel did not properly address dynamic loading associated with a loss of coolant accident or a design bases earthquake. This violation of 10 CFR 50 Appendix B, Criterion III, Design Control, is being treated as a Non-Cited Violation. The licensee's corrective actions were found acceptable. Licensee Event Report 50-336/98-03-00 is closed.
08/09/1999	1999008-05	Pri: ENG Sec:	NRC	NCV	Pri: 5A Sec: 5B Ter: 5C	FAILURE TO PROMPTLY ADDRESS WATER INTRUSION INTO "B" AUXILIARY FEEDWATER PUMP BEARING 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)
08/09/1999	1999008-06	Pri: ENG Sec:	NRC	NCV	Pri: 5B Sec: 1A Ter: 1C	FAILURE TO WRITE A CONDITION REPORT FOR AN UNANALYSED FLOW DISTRIBUTION IN THE RBCCW SYST 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.

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08/09/1999	1999008-07	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO CONTROL PARTS USED IN THE REACTOR PROTECTION SYSTEM RELATED TO LER 50-336/97-021- 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.
08/09/1999	1999008-08	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	FAILURE TO IDENTIFY SINGLE FAILURE VULNERABILITY IN THE AUXILIARY FEEDWATER SYSTEM WATER SU 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.
08/09/1999	1999008-09	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	INADEQUATE DESIGN OF THE 120 VOLT AC DISTRIBUTION SYSTEM RELATED TO LER 50-336/98-001-00 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 Sec:	NRC	NCV	Pri: 4A Sec: Ter:	INADEQUATE MAIN STEAM LINE BREAK ANALYSIS RELATED TO LER 50-336/98-007 & 01 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.

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06/14/1999	1999006	Pri: ENG Sec: OPS	NRC	NEG	Pri: 2A Sec: 1B Ter:	Unit 2 Manual Reactor Trip on May 25, 1999 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.O1.3)
06/14/1999	1999006-02	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of URI 98-208-02) Failure to Perform Design Reviews of Temporary Modifications 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.
03/05/1999	1998219-01	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Unit 2 Number of Post-Accident Monitoring Channels was Inconsistent with FSAR 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.
03/05/1999	1998219-02	Pri: ENG Sec: PLTSUP	NRC	NCV	Pri: 5C Sec: 4A Ter:	Unit 2 Failed to Implement Adequate Corrective Actions in Revising RBCCW Rad Monitor Setpoint Calc 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.

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03/05/1999	1998219-03	Pri: ENG Sec:	NRC	NCV	Pri: 5C Sec: Ter:	Unit 2 Failed to Implement Adequate Corrective Actions for CCW System Water Hammer Scenario 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."
04/19/1999	1999005	Pri: ENG Sec:	NRC	POS	Pri: 2A Sec: Ter:	Unit 2 Service Water Spool Pin Hole Leak 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.
04/19/1999	1999005-02	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of URI 93-19-02 & LER 97-31) Failure to Meet Requirements for Protection From Pipe Whip 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.
04/19/1999	1999005-03	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 Station Blackout Issues Identified in the Vectra Assessment 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.
04/19/1999	1999005-04	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of LER 97-06) Main Steam Line Break Analysis Did Not Include Auxiliary Feedwater Flow 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.

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04/19/1999	1999005-05	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of LER 97-15) Water Hammer and Thermally Induced Over Pressurization of isolated Piping Se 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.
04/19/1999	1999005-06	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of LER 97-19) Inadequate Design Review and Testing of the 1992 Upgrade to the Engineered S 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.
04/19/1999	1999005-07	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of LER 97-29) Failure to Maintain Main Steam and Feedwater Systems Within the Design Basis 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.
04/19/1999	1999005-08	Pri: ENG Sec:	Licensee	NCV	Pri: 4A Sec: Ter:	Unit 2 (Closure of LER 98-12) Inadequate Loss of Normal Feedwater Event Analysis 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.
03/26/1999	1999003	Pri: ENG Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Timed Analysis for Alternate Shutdown 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.

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03/26/1999	1999003	Pri: ENG Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Procedures 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 Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Safe Shutdown Methodology and Program 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 Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Configuration Control and Maintenance 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.
03/26/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Fire Barrier and Quality Control 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.
03/26/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Fire Protection - Audits 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.
03/26/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 2A Sec: Ter:	Unit 2 Fire Protection - Penetration Seals 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.

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04/07/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Design Changes 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.
04/07/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Unit 2 Operational Safety Team Inspection - Conduct of Engineering 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).
04/07/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Unit 2 Operational Safety Team Inspection - Engineering Procedures and Documentation 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.
04/07/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	Unit 2 Operational Safety Team Inspection - Engineering Support Facilities and Equipment 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.

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Region I

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/01/1999	1999002-04	Pri: ENG Sec:	Licensee	NCV	Pri: Sec: Ter:	Unit 2 Failure to Maintain Design Configuration 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.
01/05/2000	1999014	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	EVENT LOGS WERE PROPERLY MAINTAINED AND USED TO ANALYZE, TRACK, AND ADDRESS SAFEGUARDS I Event logs were properly maintained and used to analyze, track, and address safeguards events. The logs indicated that there have been several breakdowns, involving the control of Safeguards information. This issue has been entered into the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 2A Sec: Ter:	WEAKNESS WAS IDENTIFIED IN THE EFFECTIVENESS OF THE SECURITY COMMUNICATIONS SYSTEM A weakness was identified in the effectiveness of the security communications system. This weakness has been entered in the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3B Sec: Ter:	WEAKNESSES IN THE DOCUMENTATION OF TRAINING WERE IDENTIFIED Weaknesses in the documentation of training were identified. These weaknesses have been entered into the licensee's corrective action program.
01/05/2000	1999014	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: Ter:	SECURITY PROGRAM AUDITS AND SELF-ASSESSMENTS EFFECTIVE IN RESOLVING POTENTIAL WEAKNESSE Security Program audits were comprehensive in scope and depth, the audit findings were reported to the appropriate level of management, and the program was being properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weaknesses.
10/04/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: Ter:	EFFECTIVE IMPLEMENTATION OF RADIOLOGICAL CONTROLS Radiological controls were effectively implemented during a Unit 2 forced outage in late September 1999.

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10/04/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 3A Sec: 1C Ter:	DOSE ASSESSMENT PROGRAM The internal exposure measurement and dose assessment program at Millstone is effective.
10/04/1999	1999009	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5B Ter: 5C	SELF ASSESSMENT OF RADIATION PROTECTION The RP program has an active oversight and self-assessment program that engages problems in an effective manner.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE HUMAN SERVICES ORGANIZATION'S "PEOPLE TEAM" EFFECTIVELY FOCUSED ON EMERGING ISSUES AT MILLSTONE The Human Services Organization's "People Team" effectively focused on emerging issues and coordinated follow-up actions. Action was taken in a timely manner to evaluate and address potential safety conscious work environment issues. The "People Team" made improvements in establishing accountability for and tracking of actions. The Core Group and the targeted workplace surveys were effective tools for monitoring the safety conscious work environment at Millstone. The survey reports provided a thorough evaluation of the survey results. However, the recommendations did not always result in timely, proactive corrective actions. Team interviews found that site employees were familiar with programs and processes for handling concerns, and they would be willing to raise nuclear safety concerns. The Safety Conscious Work Environment (SCWE) department used the SCWE Case Process appropriately to address significant concerns based on established criteria. Action plans were well developed, and planned actions and assessment activities appeared to have been implemented in a timely manner. The team identified discrepancies in the documentation and tracking of actions and assessment activities, most notably in older case files. The Executive Review Board process was thorough and functioned as designed to ensure upcoming personnel actions were appropriate, and not the result of harassment, intimidation, discrimination, or retaliation.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE ECOP WAS EFFECTIVE IN PROVIDING OVERSIGHT OF THE SCWE AT MILLSTONE The Employee Concerns Oversight Panel (ECOP) was effective in providing oversight of the safety conscious work environment at Millstone. The team determined that the ECOP quarterly report was comprehensive and provided detailed information that site management could use to assess the safety conscious work environment at Millstone.

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	THE ECP DEPARTMENT WAS ADEQUATELY STAFFED AND WAS EFFECTIVE IN HANDLING EMPLOYEE CONCERNS. The Employee Concerns Program (ECP) department was adequately staffed and was effective in handling employee concerns. Generally, key performance indicators (KPIs) showed positive or steady trends and performance in the ECP area. However, two KPIs, the backlog of cases under investigation and the backlog of open ECP corrective actions, showed negative trends. To help reduce the backlog of cases under investigation, the licensee was training an individual to become an ECP investigator. However, site management attention is warranted to address the increasing backlog of ECP corrective actions. The ECP department continued to perform thorough investigations. The quality of the ECP case files was high, with good investigative work noted. In all but one ECP case file, the investigations properly supported the conclusions. The ECP department reopened this investigation. The ECP department did not begin an investigation into a potential harassment, intimidation, retaliation, and discrimination (HIRD) issue until eight weeks after they had received the concern. The licensee is considering enhancing their process to prevent recurrence.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	LHC OBSERVED THAT THERE HAS BEEN IMPROVEMENT IN MOST AREAS SINCE JUNE 1999 Little Harbor Consultants (LHC) observed that there has been improvement in most areas since June 1999. All programs and policies put in place to enhance site performance with respect to a safety conscious work environment are functioning reasonably well.
10/08/1999	1999011	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	OVERALL IMPROVEMENT IN THE SAFETY CONSCIOUS WORK ENVIRONMENT The team observed a generally healthy safety conscious work environment at Millstone. We noted overall improvement in most areas since the NRC's previous assessment in June 1999. Although the team found some minor deficiencies, these deficiencies did not detract from the overall effectiveness of the programs.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Security Personnel Turnover There has been an increase in the turnover rate in the security force sergeant ranks causing a shortage of sergeants to man regulatory required posts. The inspection determined that all required posts have been properly manned, overtime being worked by the sergeants was within prescribed guidelines and management was taking action to train and qualify additional sergeants to increase staffing levels.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Fitness for Duty Programs The fitness-for-duty program was being implemented in accordance with the licensee's procedures and regulatory requirements.
08/09/1999	1999008	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: 5B Ter:	Unit 3 External Radiological Controls The licensee is continuing to conduct an aggressive and comprehensive event review of a 7.04 rem exposure, involving an individual's personnel TLD device, to determine if the exposure represents an actual exposure to an individual or was the result of tampering with the individual's TLD, or other deliberate misconduct. The licensee's event review effort was conducted by knowledgeable personnel, and was comprehensive in scope and depth.

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

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/19/1999	1999005-13	Pri: PLTSUP Sec:	NRC	URI	Pri: 5C Sec: 4B Ter:	Unit 2 (Closure of URI 90-18-05) Post Accident Sampling System 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.
03/26/1999	1999003	Pri: PLTSUP Sec: OPS	NRC	POS	Pri: 1C Sec: Ter:	Unit 2 Fire Protection -Training, Shift Manning and Augemented Coverage 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.

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Legend

Type Codes:

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

Template Codes:

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

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

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

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