October 27, 2000

Mr. William O'Connor, Jr.
Vice President
Nuclear Generation
Detroit Edison Company
6400 North Dixie Highway
Newport, MI 48166

SUBJECT: FERMI 2 NUCLEAR POWER PLANT - NRC INSPECTION REPORT 50-341/00-12

Dear Mr. O'Connor:

On September 29, 2000, the NRC completed the baseline problem identification and resolution inspection at the Fermi 2 Nuclear Power Plant. The enclosed report presents the results of that inspection. The results were discussed on September 29, 2000, with you and members of your staff.

The inspection was an examination of activities conducted under your license as they relate to identification and resolution of problems and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection consisted of a selected examination of procedures and representative records, observation of activities, and interviews with personnel.

Based on the results of the inspection, the inspectors concluded that, in general, problems were properly identified, evaluated, and corrected. However, some meaningful issues had been identified at Fermi where the corrective actions were not vigorously implemented to address the issues. Inspectors identified two findings where corrective actions were inadequate and which were determined to be violations of NRC requirements. In both cases repeated problems were identified. One problem was with use of an out-of-date procedure revision and the other involved not meeting storage requirements for safety-related battery cells. These findings were of very low safety significance (GREEN) and are being treated as Non-Cited Violations (NCVs), consistent with Section VI.A of the Enforcement Policy. If you deny these NCVs, you should provide a response, with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-001; and the NRC Resident Inspector at the Fermi facility.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available **electronically** for public inspection in the NRC Public Document Room **or** from the *Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from* the NRC Web site at http://www.nrc.gov/NRC/ADAMS/index.html (the Public Electronic Reading Room).

Sincerely,

/RA/

Mark Ring, Chief
Reactor Projects Branch 1

Docket No. 50-341
License No. NPF-43

Enclosure: Inspection Report 50-341/00-012

cc w/encl: N. Peterson, Director, Nuclear Licensing
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Compliance Supervisor
R. Whale, Michigan Public Service Commission
Michigan Department of Environmental Quality
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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-341
License No:	NPF-43
Report No:	50-341/00-12
Licensee:	Detroit Edison Company
Facility:	Enrico Fermi, Unit 2
Location:	6400 N. Dixie Highway Newport, MI 48166
Dates:	September 18 through September 29, 2000
Inspectors:	R. Lerch, Lead Inspector J. Larizza, Resident Inspector, Fermi W. Scott, Reactor Engineer
Approved by:	Mark Ring, Chief Reactor Projects Branch 1 Division of Reactor Projects

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety	Radiation Safety	Safeguards
● Initiating Events ● Mitigating Systems ● Barrier Integrity ● Emergency Preparedness	● Occupational ● Public	● Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: http://www.nrc.gov/NRR/OVERSIGHT/index.html.

SUMMARY OF FINDINGS

IR 05000341-00-12, on 9/18 to 9/29/00; Detroit Edison Company, Fermi 2; annual baseline inspection of the identification and resolution of problems; two Non-Cited Violations were identified in effectiveness of corrective actions.

The inspection was conducted by two region-based inspectors and one resident inspector. This inspection identified two issues of ineffective corrective actions which had very low safety significance (GREEN) and were classified as non-cited violations. The significance of issues was determined by the significance determination process.

Identification and Resolution of Problems

Miscellaneous

The inspectors concluded that the corrective action program was functional and typically identified and corrected conditions adverse to quality. The inspectors found that station personnel effectively identified and entered problems on Condition Assessment Resolution Documents (CARDs) into the corrective action program. The CARDs were used for problem identification and were tracked through problem evaluation and corrective action completion. The inspectors were concerned however, that some meaningful issues had been identified at Fermi where the corrective actions were not vigorously implemented to address the issues. This was evident in the CARDS identifying repeat issues and inspection findings over the past year. The issues identified however, had very low risk significance.

Cornerstone: Mitigating Systems

- Green. In two instances, the licensee quality assurance organization staff identified that maintenance work planners were not using the latest revision of a pre-job walk-down checklist. On February 7, 2000, it was documented that Revision 5 of the walk-down checklist from Maintenance Department Instruction (MDI) 012 was being used. Revision 6 to this checklist had been issued in November of 1999. The walk-down checklist was used on all jobs including safety-related work. On August 25, 2000, the quality assurance organization identified again that Revision 5 of MDI-012 was still in use. This demonstrated that the corrective actions taken for the first CARD were ineffective.

  This violation was assessed for risk using the Significance Determination Process. The issue was concluded as having very low safety significance because no equipment was directly affected, and is being treated as a Non-Cited Violation (NCV 50-341/00-12-01) of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action.”

- Green. Inadequate storage conditions for replacement safety-related battery cells were identified with CARDs on two occasions. Condition Assessment Resolution Document 99-13152 was written on March 26, 1999 to document a condition of “Inadequate storage of the spare Q1 station batteries”. These are replacement safety-related battery cells. On February 22, 2000, CARD 00-11754 was written questioning the adequacy of

the Fermi-1 storage location, and shelf life of the Q1 batteries, based on storage requirements. As of September 27, 2000, no action had been taken to resolve the storage requirements.

This issue was evaluated using the significance determination process as having very low safety significance because the batteries were not installed and is being treated as a Non-Cited Violation (NCV 50-341/00-12-02) of 10 CFR 50, Appendix B, Criterion XVI, “Corrective Action.”

Report Details

4. OTHER ACTIVITIES (OA)

4OA2 Problem Identification and Resolution

.1 Corrective Action Program Review

a. Inspection Scope

The inspectors conducted a review of the Fermi process for identifying and correcting problems at the plant. The problem identification program and its effectiveness was evaluated by reviewing issues identified in previous NRC inspections, selected corrective action program documents and records, and discussing the program with licensee personnel, which included management and supervision as well as engineers and craftsmen. The inspection also included a review of applicable procedures and records for indication of corrective action effectiveness. The reviews evaluated the effectiveness of the program at each stage in the process for identifying issues, documenting and evaluating the issues, and assigning appropriate corrective actions and tracking them to completion.

b. Issues and Findings

The inspectors concluded that the corrective action program was functional and typically identified and corrected conditions adverse to quality. The inspectors found that station personnel effectively identified and entered problems on Condition Assessment Resolution Documents (CARDs) into the corrective action program. The significance threshold for entering issues into the program was purposely set low to identify issues well below the requirements of 10 CFR 50 Appendix B, “Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants.” The CARDs were used for problem identification and were tracked through problem evaluation and corrective action completion. The inspectors were concerned however, that some significant issues had been identified at Fermi where the corrective actions were not vigorously implemented to address the issues. This was evident in the CARDS identifying repeat issues and inspection findings over the past year. The issues identified however, had very low risk significance.

.2 Effectiveness of Problem Identification

a. Inspection Scope

The inspectors reviewed inspection reports issued over the last year, various Condition Assessment Resolution Documents (CARDs) and corrective action procedures, audits, and self-assessments, in order to determine if problems were being identified at the proper threshold and entered into the corrective action process. The documents listed in Attachment 1 were used during the review.

While onsite, the inspectors attended the daily management screening meeting and observed the corrective action review meeting conducted by managers to review the resolution of top priority issues including the review of root cause analyses and corrective actions.

b. Issues and Findings

There were no findings in this inspection area. Plant problems were generally recognized at a low threshold. The CARD process was central to the licensee's corrective action program as CARDs and associated corrective actions were tracked and trended, and reviewed for operability, reportability and maintenance rule applications. In addition, CARDs received significance classification levels 1 through 4 which determined the appropriate level of cause and extent-of-condition investigation. Level 1 CARDs were the highest priority and received root cause evaluation.

.3 Prioritization and Evaluation of Issues

a. Inspection Scope

The inspectors reviewed the prioritization and evaluation of a selected sample of CARDs. The assessment included a review of the category assigned, operability and reportability determinations, extent of condition evaluations, cause investigations, and the appropriateness of the assigned corrective actions. The documents listed in Attachment 1 were used during the review.

The inspectors attended some daily management meetings and one corrective action review board to observe the assignment of condition report categories for current issues and the review of root cause analyses and corrective actions.

b. Issues and Findings

The inspectors determined that licensee personnel generally evaluated and categorized issues appropriately. Cause evaluations and corrective actions were of sufficient depth for the problem identified. The inspectors noted several other issues related to prioritization and evaluation effectiveness which were discussed and provided insight into the licensee's corrective action process but did not constitute an inspection finding. Issues regarding prioritization and evaluation of CARDs included:

- The documented evaluation or corrective action did not stand alone. Inspectors had to interview the evaluators to determine the full extent of evaluation and corrective actions for several CARDs.
- Several CARDs were closed to other CARDs which were subsequently closed without referencing the original CARD. Although there were no issues lost due to transfers. The transfer of issues was not proceduralized.
- The backlog of open CARDs was at 4800. The number of level 4 CARDs had increased with each of the last two refueling outages then leveled off. The numbers for the level 1 though 3 CARDs had stayed approximately level.
- In several examples of level 1 through 3 CARDs, due dates had been extended more than once.

The inspectors discussed these issues with licensee staff. The licensee was aware of the issues and had a draft procedure revision under review to improve the corrective action process. The backlog was due, in part, to new categories of items added to the program. The revised program backlog, which lowered the threshold for initiating CARDs significantly 3 years ago, is being trended by managers to find what a "normal" number of open CARDs should be.

.4 Effectiveness of Corrective Action

a. Inspection Scope

The inspectors reviewed selected condition reports and associated corrective actions to evaluate the effectiveness of corrective actions. The documents listed in Attachment 1 were used during the review.

b. Issues and Findings

With the exception of several meaningful issues, the majority of corrective actions reviewed were timely, complete, and effective in preventing recurrence of the problem. The inspectors identified two issues with ineffective corrective action which were determined to be violations of NRC requirements. Other additional examples of ineffective or untimely corrective actions resulted in recurrence of problems. Examples of recurring problems included use of wrong lubricants in an emergency diesel generator and the diesel fire pump, and applying too much torque to packing nuts on motor-operated valves. The two violations identified in this inspection area are discussed below:

- In two instances, the licensee quality assurance organization staff identified that maintenance work planners were not using the latest revision of a pre-job walk-down checklist. On CARD 00-10731 dated February 7, 2000, it was documented that Revision 5 of the walk-down checklist from Maintenance Department Instruction (MDI) 012 was being used. Revision 6 to this checklist had been issued in November of 1999. The walk-down checklist was used on all jobs including safety-related work. This CARD, 00-10731, was closed on March 23, 2000. On August 25, 2000, the quality assurance organization identified again that Revision 5 of MDI-012 was still in use. This demonstrated that the corrective actions taken for the first CARD were ineffective.

  Criterion XVI of 10 CFR 50, Appendix B, "Corrective Action," requires that measures shall be established to assure that conditions adverse to quality, such as deviations and nonconformances are promptly identified and corrected. The failure to promptly correct the use of the wrong revision of a procedure was considered a violation of Criterion XVI. This violation was assessed for risk using the Significance Determination Process. The issue was concluded as having very low safety significance (GREEN) because no equipment was directly

affected, and is being treated as a **Non-Cited Violation (NCV 50-341/00-12-01)**, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CARD 00-19342.

- Inadequate storage conditions for replacement safety-related battery cells were identified with CARDs on two occasions. Condition Assessment Resolution Document 99-13152 was written on March 26, 1999, to document a condition of "Inadequate storage of the spare Q1 station batteries". The CARD investigation identified numerous inadequacies associated with the storage of the batteries located at the Equipment Supply Organization (ESO) facility. The corrective action for this CARD was to re-located the batteries to a storage room within Fermi-1. This action was taken in July 1999, however, this CARD did not address safety-related battery storage requirements.

  On February 22, 2000, CARD 00-11754 was written questioning the adequacy of the Fermi-1 storage location, and shelf life of the Q1 batteries, based on the Level B Material Storage requirements. As of September 27, 2000, when this issue was identified by the inspection team, no action had been taken to resolve this CARD. A subsequent investigation by the licensee revealed that the batteries did require special storage requirements, and a plan was developed to satisfy the storage requirements.

  Criterion XVI of 10 CFR 50, Appendix B, "Corrective Action," requires that measures shall be established to assure that conditions adverse to quality, such as deviations and nonconformances are promptly identified and corrected. The failure to promptly correct the improper storage of the Q1 batteries was considered a violation of Criterion XVI. The issue was evaluated as having very low safety significance (GREEN) because only spare equipment was affected and is being treated as a **Non-Cited Violation (NCV 50-341/00-12-02)**, consistent with Section VI.A of the NRC Enforcement Policy. This violation is in the licensee's corrective action program as CARD 00-11754.

.5 Effectiveness of Licensee Audits and Assessments

a. Inspection Scope

The inspectors reviewed audits and self-assessments related to operations, maintenance, and the corrective action process to evaluate the effectiveness of these activities in assessing licensee performance and identifying problems. The selected audits and assessments are listed in Attachment 1.

b. Issues and Findings

There were no findings in this inspection area. The audits and assessments reviewed were of generally good quality and identified issues for the licensee to resolve.

.5 Assessment of Safety Conscious Work Environment

a. Inspection Scope

During inspectors discussions with plant staff, inspectors attempted to assess whether there were impediments to the establishment of a safety conscious work environment. There were no indications in the corrective action process or in discussions with plant staff of any reluctance to identify issues.

a. Issues and Findings

There were no findings associated with this inspection area.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. William O'Conner and other members of licensee management in an exit meeting on September 30, 2000. Licensee management acknowledged the findings presented and indicated that no proprietary information was provided to the inspectors.

PARTIAL LIST OF PERSONS CONTACTED

Detroit Edison Company

W. O'Connor, Vice President, Nuclear Operations
P. Fessler, Assistant Vice President, Nuclear Operations
R. DeLong, Director, System Engineering
J. Moyers, Director, Nuclear Quality Assurance
L. Sanders, Director, Nuclear Training
S. Stasek, Manager, Nuclear Assessment
A. Kowalczuk, Manager, Nuclear Support
R. Libra, Manager, Technical
K. Hlavaty, Superintendent, Operations
E. Kokosky, Superintendent, Radiation Protection
J. Davis, Superintendent, Outage Management
S. Booker, Superintendent, Work Control
T. Stack, Supervisor, Security, Operations Support
R. Johnson, Supervisor, Licensing
J. Davis, General Supervisor, Operations
J. Conen, Assistant to Manager, Nuclear Assessment
T. Haberland, Maintenance

NRC

S. Reynolds, Deputy Director, Division of Reactor Safety, RIII
M. Ring, Chief, Reactor Projects Branch 1, Division of Reactor Projects
S. Campbell, Senior Resident Inspector, Fermi 2

ITEMS OPENED, CLOSED, AND DISCUSSED

OPENED

50-341/00-012-01	NCV	Failure to use the latest procedure revision
50-341/00-012-02	NCV	Failure to correct safety-related battery storage conditions which were not meeting requirements.

CLOSED

50-341/00-012-01	NCV	Failure to use the latest procedure revision
50-341/00-012-02	NCV	Failure to correct safety-related battery storage conditions which were not meeting requirements.

DISCUSSED

None

LIST OF ACRONYMS USED

CARD	Condition Assessment Resolution Document
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
IR	Inspection Report
LER	Licensee Event Report
MOV	Motor Operated Valves
NCV	Non-cited Violation
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
SDP	Significance Determination Process
SRI	Senior Resident Inspector
TS	Technical Specifications

ATTACHMENT 1

LIST OF DOCUMENTS REVIEWED

The following is a list of licensee documents reviewed during the inspection. Inclusion of a document on this list does not imply that NRC inspectors reviewed the entire document, but, rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. In addition, inclusion of a document on this list does not imply NRC acceptance of the document, unless specifically stated in the body of the inspection report.

Procedures

FBP-26	Rev-0	Self-Assessment Guidelines
MQA11	Rev-4	Condition Assessment Resolution Document
MQA12	Rev-2	Cause Analysis and Corrective Action Determination
MQA13	Rev-0	Quality Trending
		CARD Review Board Charter (Draft Copy)
MQA11	Rev-5	Condition Assessment Resolution Document (Draft Copy)
MQA12	Rev-3	Cause Analysis and Corrective Action Determination (Draft Copy)
MQA13	Rev-1	Quality Trending (Draft Copy)
FBP-26	Rev-1	Self-Assessment Guidelines (Draft Copy)

Corrective Action Resolution Documents

00-01419	Diesel Fire Pump leak from oil pressure line
00-10538	Incorrect labeling of control wires to position 11A and 11B
00-10730	Perform an Effectiveness Review for Card 98-16656
00-11016	E2150F004A Failed To Open. 72C-3A Pos. 8A Overloads Tripped
00-11017	Loss of Power to E1150-F015A; MCC 72CF- Position 2C Open
00-11152	HPCI Aux. Oil Pump did not start during shutdown of HPCI
00-11418	Level 8 Trip on HPCI while Performing 44.030.254
00-11435	RCIC Inverter is unusually hot
00-11498	Loss of MCC 72F-4A
00-12129	Mixed oil in D/G Fire Pump
00-12178	Improper Packing Torque Applied to E2150F015A
00-12219	Mixed oil in Diesel Fire Pump Engine and Diesel Fire Pump angle drive
00-12246	Broken Terminal Strip
00-12273	Fermi 1 Key Issued To Unauthorized Individual
00-12427	Follow-up on CARD Program Effectiveness Review (Self-assessment results)
00-12432	Problems found during licensing self-assessment on closed CARD's
00-12491	Ineffective Corrective Actions for CARD 98-12207
00-12534	Protective covers for MCC Bucket switched

00-12810	Corrective Actions for Level 1 CARD 98-10035 were not completed in accordance with Action Plan
00-13063	CARD Processed as Level-4 with potential Tech. Spec. Compliance concern
00-13182	Damaged equipment / parts have been discarded before inspection by CARD Solution Team
00-13868	LLRT Failure on B2103F022C & B2103F028C
00-13869	LLRT Failure on Inboard MSIV "D" steam line
00-13873	E1100F050A Failed LLRT (Pressure Isolation Test) SR 3.4.5.1
00-13927	Audit finding: CARD's 98-17625 and 98-16521 were closed prior to all corrective actions being completed
00-14305	Abnormal odor coming from EDG 12 Control Panel
00-14320	Failure to initiate CARD when PMT fails
00-14336	First Quarter operations human performance review indicates rule-based errors as emerging trend
00-14497	Evidence for the Root Cause Investigation Lost
00-14509	Oil not staged for safety system outage
00-14541	Missing nut and lock washer from RCIC coupling
00-15051	Low viscosity oil in EDG 11 Generator
00-15122	Fuses not in Compliance with EJ Spec.
00-15360	Effectiveness Review for CARD 99-10074 reveals one corrective action that was not effectively implemented by one supervisor
00-15567	Not meeting QA requirements
00-15597	Inadequate supervision or inadequate work control practices that could lead to equipment damage
00-16505	Packing worn badly on startup
00-16539	QA witness of bolt torquing
00-16713	Failure to initiate CARD when PMT fails
00-16867	Declining trend in revised oversight process EDG safety system unavailability performance indicator
00-16928	Security Drills Safeguards
00-16946	PM Program Deficiencies
00-16950	EECW Div-1 Pump performance unexplained change
00-17280	North TBCCW Pump failed to start
00-17349	SRV "B" re-opened after close PB Pressed.
00-17674	ISEG Recommendation
00-18087	Relay Room - Reactor FW Pump turbine controls are obsolete with virtually no spare parts
00-18581	CARD 98-11351 Closed without resolving the identified condition
00-18582	CARD 98-01743 Closed without completing the corrective action
00-18583	CARD 98-12761 closed without all corrective actions completed
00-18586	CARD 98-13006 closed without all corrective actions completed/ addressed
00-18703	Unacceptable PMT results
00-18771	Procedure violation, Failure to remove CARD Tag per MWC-02
00-18774	CARD Tag not removed when work request canceled
00-18776	CARD Tag not properly removed after closure per NQA-11
00-18825	NMA-11 Procedure Revision

00-18963	Blown Fuse in Turbine Trip Circuitry caused closure of LPIV's 4 & 5
00-18983	Increase Equipment deficiencies in the fire protection system.
00-19342	Audit Finding: Recurring problem with work control and maintenance using incorrect revision of work package walkdown checklist.
00-19364	3 Level-4 CARD's written in the last 3 months on control room computer room HVAC
00-19376	CARD Tag not removed when work complete
00-19377	CARD Tag not removed when work complete
98-12808	Wrong fuse per EJ Spec. and different fuse required for same type motor
98-14314	Maintenance Rule classification of MCC's as (a) (10 (transfer of Get Well Plan for MCC's from DER 97-0421 to CARD)
98-16903	Evaluate Y2K Mission-Critical, Suspect, Embedded, System or Component
99-02412	RCIC Control Valve not going Full Open
99-11152	Please address the RF06 Critique Items on Attached List that concern I&C Team
99-12658	Potential Adverse Trend Associated with Human Performance In Maintenance
99-12749	Effectiveness Review For CARD 98-10675, Trip Of Div 2 CCHVAC Chiller On High Motor Temperature
99-13054	Mixed oil in #6 GSW Pump lower bearing
99-13068	Radioactive Material Not Tracked I.A.W. MRP 15
99-13152	Inadequate Storage of the Q1 Station Batteries
99-13197	Crossed Cables On Scram Solenoid Pilot Valves
99-13280	Potential Violation Of MGA07 Requirements For Record Retention And Storage
99-13434	Post Maintenance Testing Failure of Pass
99-13490	Mixed oil in Circ. Water Decant Pump upper motor bearing
99-13518	Failure to Enter T.S. Action 3.8.1.1C
99-13713	MSR warm-up Valves Sustained Damage Due to Suspected Waterhammer
99-13775	Exposed Rotating Equipment (Safety)
99-13894	Problems during PMT on WR 000Z973674
99-14080	Audit Finding - Ongoing long-term Training Issues Are Not Driven to Completion
99-14098	Inadequate Work Package Led To Potentially Turning Over EDG During Restoration, Causing Possible Damage and/or Injury
99-14207	RHRSW Cross-Tie Valve Failed in Mid Position
99-14321	Concerns identified during CARD Review Board member's effectiveness review for level 2 CARD 98-11409
99-14662	Incorrect Fuse Installed
99-15185	Repetitive Component Failure
99-15345	Possible Installation Of Restricted GE HFA Relay
99-15812	Incorrect Fuse Installed, Also Not Fully Installed
99-15825	CARD 99-14711 Closed out without completing corrective actions
99-15864	Audit Finding - Procedure Use And Adherence Problems
99-15903	Potential CARD System Inadequacies
99-15939	Wrong Fuses Installed

99-15968	Fuse listed in 3071-128-EJ (EJ Spec.) does not match fuse found in panel
99-16383	On-Line Testing of Excess Flow Check Valves
99-16492	Audit Finding: Preventive Maintenance (PM) Program Transition Project Concerns
99-16537	CW Pump Cooling System Regulators miss-adjusted
99-16562	Lack Of Adequate Information To Ensure Timely And Effective Review Of PMT Impacts
99-16676	Tracking Card - Resolution of INPO Evaluation SG1 EN.1-2 "Process/ Decision Making Improvements".
99-16706	Audit finding: Configuration Control Issues Associated with the Removal Of Fermi 1250V DC Power Batteries
99-16718	Possible trend in failing to obtain NSS Authorization prior to performing work
99-16853	Recent Failures of Riley Temperature Switches
99-16963	Failure Of Temperature Monitor E41N602A
99-17132	INPO Area for Improvement (HU 1-1) Human Performance
99-17134	INPO Area for Improvement (MA.2-2) Errors Made during Maintenance Work
99-17148	INPO Area for Improvement (EQ.1-3) Weakness In Preventive Maintenance
99-17395	Discrepancy in fuse size
99-17434	Rilley temperature failure
99-17643	Acrid Smell from EDG #14 Control Panel
99-17802	Non Safety Related fuses are installed in Safety Related Control Circuit of 480V Unit Substation Voltage Regulator
99-17962	HPCI Operating Time For Mitigation of the Small Break LOCA; possible discrepancy between EQ and UFSAR
99-18309	MCC has control power fuses other than EJ Spec. required, also the main line fuses differ from EJ Spec
99-18377	Incorrect Valve opening spring found installed on RCIC Turbine Governor Valve
99-18870	Inadequate Design for Maintenance and Operation
99-18972	Untimely Corrective Action
99-19289	Acceptance Criteria Revised Using a TCN: Surveillance Procedure 42.610.01
99-19377	NRC disposition of SLC's / EDG violation

Assessments

NANL-00-0064	March 31, 2000	Correspondence to Safval M. Berg, INPO
SAI 00-0031	March 6, 2000	CARD 97-12152 Program Effectiveness Assessment
NSIP-00-0006	March 10, 2000	Self-assessment of corrective actions for CARD 97-12152
NPSC-00-0017	March 6, 2000	Work Control's self-assessment of the Closed CARD's
NPRC-00-0067	March 3, 2000	RP Organization CARD Assessment
NPMA-00-0012	February 2, 2000	Maintenance Department Self-assessment of the effectiveness of the corrective actions associated with CARD 98-10094
NPNA-00-0031	March 7, 2000	Maintenance CARD Self-Assessment
TMPR-00-0065	March 16, 2000	RF07 EECW Related CARD's
TMIS-00-0031	March 7, 2000	CARD 97-12152 CARD Program Effectiveness Review (Reference NPOP-00-0101)
TMPR-00-0069	June 13, 2000	EECW Assessment results of RF-07 CARD's w/QCIRs
TMPR-00-0031	March 7, 2000	CARD 97-12152 Engineering Projects CARD Program Effectiveness Self-Assessment Results.
	March 7, 2000	Correspondence to Kevin Hlavaty from William E. Miller, CARD 97-12152 Owner CARD 97-12152, CARD Program Effectiveness - Self-Assessment Results
NAQA-00-0007	February 21, 2000	Self-Assessment Report NQA CARD's
	March 1, 2000	Training Self-Assessment for CARD Program Effectiveness
	February 29, 2000	Plant Support Engineering CARD Program Self-Assessment
TMPE-00-0252	June 21, 2000	NQA "RF07" Trend Wall of Configuration Control Related CARD's
	March 1, 2000	Correspondence to NQA from Lynette Dowler CARD Effectiveness Self-Assessment