Reference 9.3

DCS No: N/A
Date: 12/11/81

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-81-130

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by IE staff on this date.

Facility: Nine Mile Point, Unit 1 (Niagara Mohawk Power Corp.) and J. A. Fitzpatrick (Power Authority of the State of New York), Scriba, New York (Docket Nos. 50-220; 50-333)

Licensee Emergency Classification:
_____ Notification of Unusual Event
_____ Alert
_____ Site Area Emergency
_____ General Emergency
__X__ Not Applicable

Subject: ANOMALOUS ENVIRONMENTAL WATER SAMPLE MEASUREMENTS

On December 2, 1981, the licensees reported to the NRC anomalous results of water samples collected at several farms located in the prevailing downwind area, in the vicinity of the two plants. Sampling was conducted three times from June through October, 1981 from farms from which milk is regularly sampled. One June sample, one July sample, and two August samples showed positive results. All four samples contained very similar levels of Cs-134 (about 15 pCi/l), Cs-137 (about 20 pCi/l), Mn-54 (about 6 pCi/l), and Co-60 (about 9 pCi/l). Three of the samples had very similar levels of Co-58 (about 4 pCi/l). The licensees had previously determined that the June-July samples had been slightly contaminated (1-2 pCi/l of Cs-134 and Cs-137) through reagents and supplies used in the sampling, and made efforts to eliminate any sources of contamination from future samples. Soil and grass collected at each farm contained only expected naturally occurring activity. None of the above sample results were of a level which would have required reporting by the licensee's technical specifications.

Because of the very similar levels of activity, it seems unlikely that the detected activity actually existed in the sampled water sources in that the four samples were collected at different times, the water sources are at various distances from the plant, and all sources have various volumes and rates of dilution. These factors would be expected to result in different levels of activity in each location if the source of contamination were airborne plant releases. There appears to be no waterborne contamination pathway from the plants to the water sources sampled. Irrespective of the source of the contamination, the measured activity would not produce a critical organ (liver) dose in excess of the 10 CFR 50, Appendix I, Part C limit of 15 mrem/yr if the sampled water were used for drinking over the course of one year. The licensees have stated, however, that none of the four water sources are used for drinking water. The licensees plan to collect additional samples in December, including sediment samples

CONTACT: T. Jackson, 488-1207; R. Bores, 488-1213

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and more complete water samples (up and downstream of farms as appropriate). The licensees consider it a possibility that there will be media interest and attention associated with this round of sampling.

The licensees plan to continue to investigate and to publish the results in the Annual Environmental Program Reports covering 1981. The licensees will continue to keep Region I apprised of any developments.

This PN is issued for information only. The State of New York is being informed. NRC will not issue a press release, and the licensees do not plan to issue one at this time.

MAR 17 1992

Docket No. 50-220 License No. DPR-63

Niagara Mohawk Power Corporation
ATTN: Mr. John Endries
President
300 Erie Boulevard West
Syracuse, New York 13212

Dear Mr. Endries:

Subject: NRC Region I Augmented Inspection Team (AIT) Review of the February 21, 1992, Nine Mile Point Unit 1 Inadvertent Isolation of the Ultimate Heat Sink

This letter transmits the AIT report for the inspection led by Dr. P. K. Eapen between February 22 and March 4, 1992. This inspection assessed the circumstances, causes, personnel actions, and the safety implications of the inadvertent isolation of Unit 1 from Lake Ontario, the unit's ultimate heat sink. At the conclusion of this inspection, a public exit meeting was held on March 4, 1992, with you and other members of your organization to discuss the preliminary findings of the AIT.

The areas examined during the inspection, including matters important to protect the health and safety of the public, are identified in the enclosed inspection report. Within these areas, the AIT conducted detailed examinations of the gates and the pumps in the screen house bay and related indications in the control room; held discussions and formal interviews with personnel involved in this event; reviewed relevant records including computer printouts before, during, and after the event, and trends of pertinent plant parameters; and evaluated the adequacy of established procedures, management oversight, and personnel training.

The AIT concluded that the causes for this event were: (1) Failure to follow the established work control process by various levels of personnel in multiple groups of your organization; (2) Inadequate management attention to assure that the workers understood and followed established procedures; (3) Inadequate communications within and among organizations participating in work activities; and (4) Failure to adequately consider the risks associated with test activities that affected multiple systems during shutdown conditions.