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U. S. NUCLEAR REGULATORY COMMISSION

REGION I

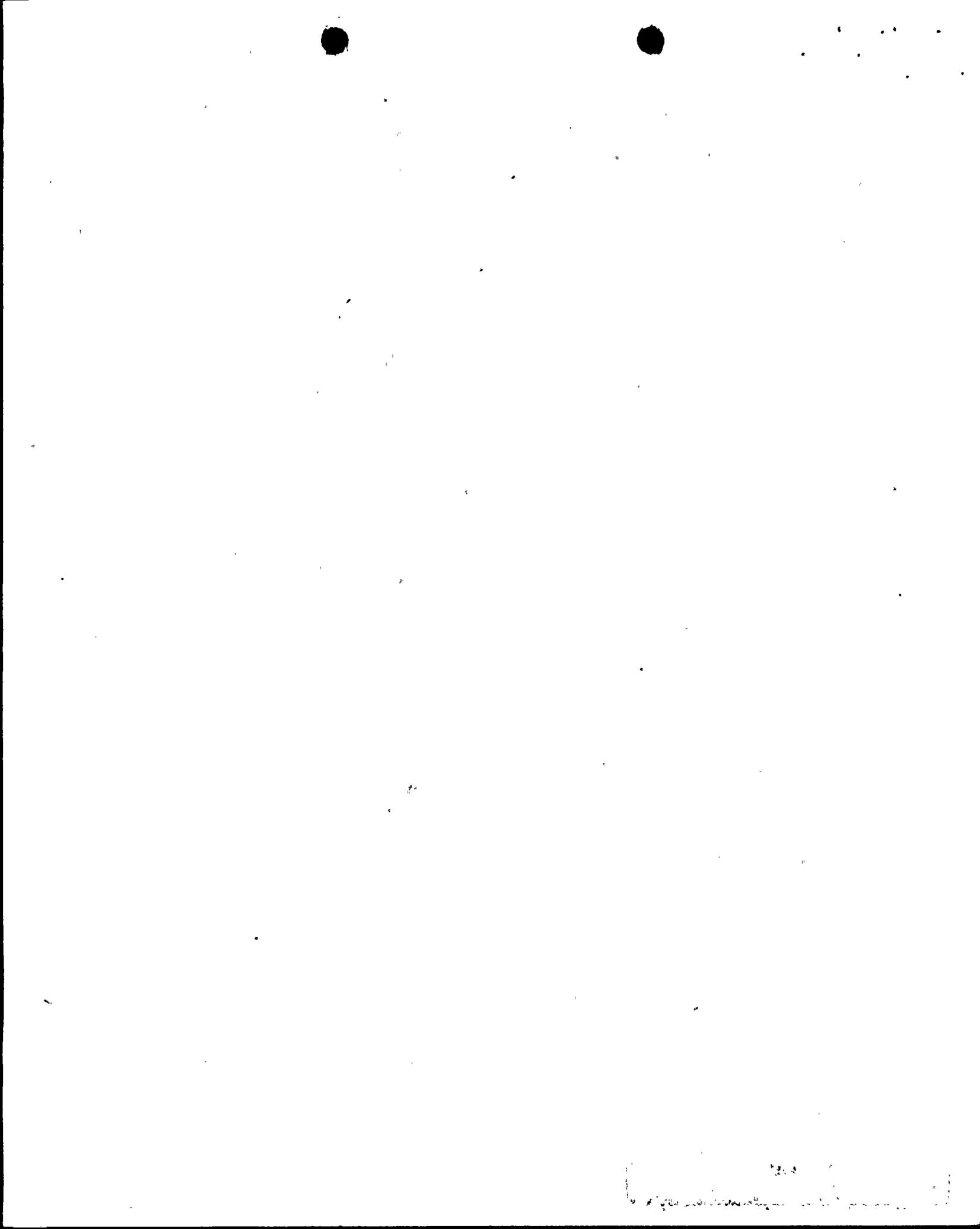
SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE

NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT NUCLEAR STATION, UNIT I

June 22, 1982

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I. INTRODUCTION

a. Purpose and Overview

The Systematic Assessment of Licensee Performance (SALP) is an integrated NRC Staff effort to collect the available observations on an annual basis and evaluate licensee performance based on those observations with the objectives of improving the NRC Regulatory Program and licensee performance. The assessment period is May 1, 1981 through April 30, 1982.

The prior SALP assessment period was February 1, 1980 through January 31, 1981.

Significant findings of that assessment were provided in the applicable Performance Analysis Functional Areas (Section IV).

Evaluation criteria used during this assessment are discussed in Section III below. Each criterion was applied using the "Attributes for Assessment of Licensee Performance" contained in NRC Manual Chapter 0516.

b. SALP Attendees:

R. W. Starostecki, Director, Division of Project and Resident Programs
T. T. Martin, Director, Division of Engineering & Technical Programs
G. Snyder, Acting for Director, Division of Emergency Preparedness & Operational Support
E. J. Brunner, Chief, Reactor Projects Branch No. 1, Division of Project and Resident Programs
H. B. Kister, Chief, Reactor Projects Section No. 1C, Division of Project and Resident Programs
P. J. Polk, Licensing Project Manager, Operating Reactors Branch No. 2, NRR
S. D. Hudson, Senior Resident Inspector, Nine Mile Point Nuclear Station, Unit 1

c. Background

(1) Licensee Activities

The facility was out of service from March to July 1981 for its biannual refueling outage. From July 5, 1981 to March 19, 1982 the plant operated at nearly full power.

On March 19, 1982, the plant was shutdown for replacement of two reactor recirc pump seals. During this outage, leakage was detected from two reactor vessel recirc system safe ends. The plant remains out of service for the replacement of all affected recirculation system safe ends.

(2) Inspection Activities

One NRC resident inspector was assigned on a full time basis during the assessment period. Another resident inspector, whose duties are split between this and another facility, was onsite about 30% of the time.

Total NRC Inspection Hours: 3046 (Resident and region based)

Distribution of Inspection Manhours is shown on Table 3.

Emergency Plan appraisal team conducted an inspection on August 17 to 28, 1981.

A tabulation of Inspection Activities is attached as Table 4.
A tabulation of violations is attached as Table 5.

II. SUMMARY OF RESULTS

NINE MILE POINT NUCLEAR STATION, UNIT 1

| <u>FUNCTIONAL AREAS</u> | <u>CATEGORY 1</u> | <u>CATEGORY 2</u> | <u>CATEGORY 3</u> |
|--|-----------------------|-----------------------|-----------------------|
| 1. <u>Plant Operations</u> | | X | |
| 2. <u>Radiological Controls</u> Radiation Protection Radioactive Waste Management Transportation Effluent control and Monitoring | | | X |
| 3. <u>Maintenance</u> | | X | |
| 4. <u>Surveillance (Including Inservice and Preopera- tional Testing)</u> | | X | |
| 5. <u>Fire Protection</u> | | X | |
| 6. <u>Emergency Preparedness</u> | | X | |
| 7. <u>Security & Safeguards</u> | X | | |
| 8. <u>Refueling</u> | X | | |
| 9. <u>Licensing Activities</u> | X | | |

III. CRITERIA

The following evaluation criteria were applied to each functional area:

1. Management involvement in assuring quality.
2. Approach to resolution of technical issues from a safety standpoint.
3. Responsiveness to NRC initiatives.
4. Enforcement history.
5. Reporting and analysis of reportable events.
6. Staffing (including management).
7. Training effectiveness and qualification.

To provide consistent evaluation of licensee performance, attributes associated with each criterion and describing the characteristics applicable to Category 1, 2, and 3 performance were applied as discussed in NRC Manual Chapter 0516, Part II and Table 1.

The SALP Board conclusions were categorized as follows:

Category 1: Reduced NRC attention may be appropriate. Licensee management attention and involvement are aggressive and oriented toward nuclear safety; licensee resources are ample and effectively used such that a high level of performance with respect to operational safety or construction is being achieved.

Category 2: NRC attention should be maintained at normal levels. Licensee management attention and involvement are evident and are concerned with nuclear safety; licensee resources are adequate and are reasonably effective such that satisfactory performance with respect to operational safety or construction is being achieved.

Category 3: Both NRC and licensee attention should be increased. Licensee management attention or involvement is acceptable and considers nuclear safety, but weaknesses are evident; licensee resources appeared strained or not effectively used such that minimally satisfactory performance with respect to operational safety and construction is being achieved.

IV. PERFORMANCE ANALYSIS

1. Plant Operations

During the previous assessment period (February 1, 1980 to January 31, 1981), four violations were identified. Two involved the failure to maintain valves locked as required and another involved the failure to maintain the reactor building track bay door sealed. Random inspections by the resident inspectors in these areas showed no further problems. The fourth item involved the violation of a Limiting Condition for Operation for the simultaneous removal from service of an emergency diesel generator and a containment spray pump.

This functional area was under continuing review by the resident inspectors during the current assessment (May 1, 1981 to April 30, 1982). A civil penalty was assessed on September 2, 1982 for the violation of a Technical Specification Limiting Condition for Operation when all automatic isolation protection for both Emergency Condensers was bypassed. The NRC increased the amount of the civil penalty above the base amount normally imposed to stress the importance of this event. This was the third event of the improper removal of equipment from service in a nine month period. The licensee actions since this most recent event appear to have been effective in preventing further similar violations.

Three other violations involved the failure to follow administrative procedures for equipment tagging and maintaining the Control Room Log Book and the failure to revise drawings and procedures. Thirteen Licensee Event Reports reported operational problems. These include a radioactive spill while backwashing a reactor water clean-up filter, exceeding core thermal limits for average planar linear heat generation rate, exceeding reactor water chloride limit due to improper flushing of a heat exchanger, and a modification of the Emergency Condenser steam line vents which allowed a potential leakage path to the atmosphere in the event of a tube failure in either Emergency Condenser. This modification of the Emergency Condenser steam line vents had been improperly approved by the Site Operations Review Committee as being not safety-related when in fact it was. After the error was discovered by the licensee, he promptly notified the NRC and took immediate corrective action to reduce the potential for leakage to the atmosphere.

During the period both Emergency Diesel Generators were found to be inoperable. The licensee promptly reported the event to the NRC and took immediate corrective action. The NRC conducted an investigation and established that aside from the violation of limiting conditions for operation, a failure to establish procedures for monitoring emergency equipment to ensure it is maintained in the proper state of readiness was apparent. Additional management attention in this area appears to be needed.

In response to a violation for failure to update procedures and drawings following plant modifications, the licensee has initiated a review of all safety related modifications performed from 1974 to 1979 to ensure proper "close-out" of plant modifications. To date, over 80 modifications have been reviewed by the licensee. Additionally, the licensee is revising the procedure for administrative control of modifications to prevent future problems from developing. This demonstrates the responsiveness of the licensee to NRC concerns to ensure that they are thoroughly reviewed. In response to a violation regarding valve line-ups, the licensee has also committed to field check all valve lineups to ensure accuracy.

Evidence of the licensee's commitment to ensure adequate staffing and training is displayed by the licensee maintaining a third licensed reactor operator on each shift. This exceeded the minimum Technical Specification requirements of two licensed reactor operators per shift. A second Assistant Operations Supervisor was also assigned during the period to further strengthen the Operations Department staffing. Four Shift Technical Advisors (STA's) received senior reactor operator licenses and another STA received a reactor operator's license during the period.

Conclusion

Category 2

2. RADIOLOGICAL CONTROLS

ANALYSIS

During the previous assessment period the Health Physics Appraisal identified major problems in all Radiological Controls areas. An Immediate Action Letter (IAL) was issued in October 1980 and an Action Plan established to upgrade the Health Physics Program. Eleven violations were identified in Health Physics and one violation was identified in Rad Waste Management. Followup inspections by region based inspectors found the Action Plan schedule acceptable and on course. Monthly status reports have been submitted by the licensee for November 1980 through November 1981 and quarterly thereafter. Extensive review of status has identified no major new issues. HPA followup in May 1982 (outside assessment period) resulted in additional commitments.

During this assessment period there was one inspection of Rad Waste Management (28 hours) conducted by a region based Inspector. A burial site inspection was also conducted by a State of South Carolina Inspector. The Resident Inspector has supplemented regional inspection by conducting monthly reviews of selected radiological controls areas.

Although no region-based inspections of the Radiation Protection Program were conducted, the resident inspector monitored the status of the program during the appraisal period.

A Severity Level III violation (free-standing liquid in excess of allowable limits) was reported by the State of South Carolina. This violation involved a generic problem with the use of urea formaldehyde solidification processes. The licensee immediately stopped usage of urea formaldehyde, obtained a temporary system, and is completing a permanent accepted system which was already under construction. No further burial site violations have been identified since September 1981.

Radiation Protection

Four violations involved procedure adherence in the areas of frisking, personnel dosimetry, and radiation work permits were identified. In addition, the licensee failed to fulfill commitments to the NRC in the areas of internal exposure control, radiation and contamination surveillance, respiratory protection and ALARA. Region I management involvement was necessary to resolve these issues. (HPA Followup)

The licensee has augmented the professional and technician staff, conducted training courses, purchased equipment and scheduled improvements to the entire Radiation Protection Program. Periodically, the licensee has reported the status of action items to Region I. The responses have been generally adequate, with slippage of commitment dates due to high priority items such as Emergency Planning, which also required management attention and oversight. Corporate level professional support is still

lacking. Only one corporate H.P. provides oversight which requires planning and implementation by the plant staff. Communication with station management is ongoing, regarding commitment dates.

The ALARA Program Staff still lacks two Radiological Engineers, and has only been partially successful in tracking job performance. Gaps still exist as noted in the resident inspector's reports. Current ALARA Commitments (out of the assessment period) relating to the safe end replacement now underway have been substantial and key requirements have been included as part of the license amendment which approved the safe end replacement.

The licensee has achieved all-shift Health Physics coverage and is trying to delineate technician job descriptions, to assure they reflect the specific abilities required. Five clerks from the department's administrative staff support these efforts on a dedicated basis, rather than as a temporary assignments as existed in the past.

The licensee has tended to delay resolution in response to violations concerning high radiation area access. A one year time frame lapsed before corrective action was fully implemented. Other isolated violations were identified but were not indicative of any programmatic breakdowns. The licensee is currently upgrading the general training program.

Rad Waste Management

One violation for inadequate audits was identified. Rad Waste now has dedicated technicians rather than obtaining personnel as needed from operations, which was being done in the past. The program is now more responsive since the Rad Waste Coordinator supervises these activities. Audits of the Rad Waste area early in the assessment period were fragmented, without adequate followup of deficiencies identified. The resident inspector's reports indicate some improvements are being made in this area.

Transportation

A violation for excess free standing liquid in a cask delivered to a burial site and a violation for failure to establish a procedure for receipt of radioactive materials were identified.

Corrective action in connection with delivery of Rad Waste in an unacceptable form to a burial ground site was prompt and effective. The issue involved free standing liquid in excess of allowable limits and the use of urea formaldehyde, which was immediately terminated by the licensee.

Effluent Control and Monitoring

A violation for failure to establish a procedure for effluent tank discharge and a violation for failure to establish a calibration frequency for an effluent flow meter were identified.

A 5 curie liquid effluent release to the lake was promptly and completely reported to the NRC as required during this assessment period per Technical Specifications. This normal release was also included in the annual report.

Conclusion for RADIOLOGICAL CONTROLS:

Category 3

Board Recommendations

Increased health physics inspection effort in accordance with a revised basic inspection program commensurate with the license amendment SER dated June 18, 1982 and the nature of the safe end repair.

3. Maintenance

During the previous assessment period, (February 1, 1980 to January 31, 1981) the resident inspectors identified two violations. These involved the failure to follow administrative requirements for the lifting of leads. No further violation of these requirements were identified during the current assessment period.

During this assessment period, maintenance activities were under continuing review by the resident inspectors. One violation, for which a civil penalty was imposed, resulted from the removal from service of safety related components to perform corrective maintenance. This violation is discussed more fully in area #1, Plant Operations.

One regional based inspection of the administration and documentation of the maintenance program was conducted. One violation was identified for failure to take effective corrective action to a licensee's Quality Assurance audit of the maintenance program. Several items of failure to complete required documentation of maintenance activities, identified in the licensee's December 1980 QA audit were still evident during the March 1982 inspection.

The licensee has a sound maintenance program despite the identified problems concerning the adequacy of maintenance procedures and the proper documentation of work requests. This was evident by 254 days of continuous operation during this assessment period. With the exception of the two short outages to correct turbine vibration problems encountered during startup from the 1981 refueling outage there were no forced outages for maintenance during this period. The licensee adequately assigns priorities for corrective maintenance and there are no long outstanding inoperable safety related equipment or components. The licensee also firmly believes in a preventative maintenance program which he had formally established in some areas such as electrical breakers and plans to expand his program to include other areas such as air operated valves.

In March 1982, during a hydrostatic test of the reactor vessel, cracks were discovered in two reactor vessel safe ends. Since these safe ends were furnace sensitized during manufacturing, the licensee has been conducting additional testing to prove early detection of possible cracks. This augmented in service inspection program began in 1979. Plans for replacing the safe ends, in the event that cracks were found, were prepared at that time.

A great deal of management attention has been devoted to the repair of these safe ends. An April 21, 1982 letter from the NRC to the licensee requested that the licensee submit its plans for reactor decontamination, mitigation of worker radiation doses, removal and replacement of the safe ends, and justification for resuming operations. The licensee's submittals to date appear to be timely.

As a result of the cracks discovered in the recirculation (recirc) system safe ends, the licensee performed additional ultrasonic testing (UT) on the suction and discharge piping near the recirc system pumps. The licensee is in the process of performing a metallurgical analysis of the UT indications found near the suction and discharge of the pump casing to piping welds. The licensee also plans to examine additional welds in the recirc system piping, after the piping is decontaminated, to ensure that all possible defects in the recirc system are found and corrected prior to start-up.

Conclusion

Category 2

4. Surveillance

During the previous assessment period (February 1, 1980 to January 31, 1981), two violations were identified. Increased supervisory review by the licensee of completed surveillance records appears to have corrected this problem in the affected department.

This area was under continuous review by the resident inspectors for the current assessment period (May 1, 1981 to April 30, 1982). One regional inspection was also conducted on the Containment Integrated Leak Rate Test (CILRT). Two violations were identified in this area. Only one Licensee Event Report involved the failure to complete a surveillance test within the required frequency.

During the CILRT, the inspector noted that the main feedwater check valves and motor operated isolation valves were not scheduled to be tested locally and added to the results of the CILRT. This could have resulted in a nonconservative measurement for the primary containment leak rate in the event of a loss of feedwater during a loss of coolant accident. There appeared to be a reluctance on the part of the licensee to conduct a local leak rate test on these valves. At the insistence of NRC, the licensee ultimately performed an air test on each of the feedwater check valves and a water leakage test of the motor operated feedwater isolation valves. The licensee also committed to install the necessary modification to allow air testing of the motor operated feedwater isolation valves.

Instrument and Control Departmental supervision appears to be aggressively involved in correcting any personnel errors. During a surveillance test, the inspector noticed that a technician had inadvertently caused a main steam isolation valve isolation signal. When this event was brought to the attention of the departmental supervisor, he ensured that the test procedure was adequate and promptly stressed the importance of procedural compliance to all his technicians.

Conclusion

Category 2

5. Fire Protection

During the previous assessment period no region based programmatic inspection of the fire protection program was conducted. The resident inspector identified two violations for failure to maintain fire doors closed.

During this assessment period, one inspection was performed by a region based inspector. In addition, the Senior Resident Inspector reviewed fire prevention/protection activities on a routine basis. One Severity Level V violation was identified by the Senior Resident Inspector involving an open penetration in a fire barrier without a fire watch.

The fire protection system modifications required by 10 CFR 50, Appendix R and Amendment 33 to Technical Specifications were completed. The licensee established a well equipped full time, professional fire brigade well in excess of NRC requirements and is upgrading the training program in accordance with 10 CFR 50, Appendix R. The fire prevention/protection program is administered on a full time basis by an engineer. In process inspection of these activities found acceptable licensee implementation and substantial management dedication of resources. The licensee was responsive to prior inspection findings and licensing issues related to fire protection.

An inspection after the assessment period (June 15-18, 1982) found weaknesses in several program areas; procedures for control of combustibles do not include important provisions of Branch Technical Position (BTP) 9.5-1 or 10 CFR 50, Appendix R; fire brigade training procedures do not specify training frequencies consistent with the above; preplanned fire strategies do not contain all information specified by BTP 9.5-1 or 10 CFR 50, Appendix R; and, other miscellaneous procedure deficiencies were identified with respect to License Amendment 33, BTP 9.5-1; and 10 CFR 50, Appendix R. Enforcement actions for these findings were pending at the time of the SALP Board Meeting on June 22, 1982.

Although the licensee has made substantial progress and improvements in the level of fire prevention and protection, additional management attention to program content and implementation appear warranted.

Conclusion

Category 2

6. Emergency Preparedness

During the current assessment period, an Emergency Preparedness Implementation Appraisal (EPIA) was conducted on August 17-28, 1981. During this appraisal 24 significant findings and 35 improvement items were identified. A Confirmatory Action Letter was sent to the licensee on September 8, 1981 which described actions the licensee agreed to complete by October 28, 1981 on the four most significant findings. On February 22, 1982, a letter was sent to the licensee which included the following: Appendix A, Significant Emergency Preparedness Findings; Appendix B, Emergency Preparedness Improvement Items; Appendix C, Emergency Preparedness Evaluation Report; and NRC Region I Inspection Report 50-220/81-18.

The deficiencies identified during the EPIA indicated that the emergency organization described in the Emergency Plan did not provide for all emergency functions required during initial, intermediate and final phases of augmentation. There did not appear to be a formally assigned corporate emergency planning coordinator or other qualified individual to assist the site emergency planning coordinator so that all aspects of the site and corporate emergency response were developed and maintained. Emergency organization positions were not clearly defined nor were authorities and responsibilities unambiguously defined. The command hierarchy structure as well as reporting chains and inter-relationships at any phase of augmentation were not clearly defined. The licensee did not appear to have a method to ensure that a sufficient number of professionals and technicians would be available to support extended operations beyond 24 hours.

Letters from the licensee during the period of September 14, 1981 to October 28, 1981 and March 29, 1982 described the licensee's corrective actions on the identified findings. A follow-up inspection is scheduled for July, 1982 to verify the licensee's corrective actions.

A full-scale exercise was also evaluated on September 15, 1981. This evaluation determined that the licensee demonstrated the capability to implement their Emergency Preparedness Program in a manner to adequately protect the health and safety of the public. The findings of FEMA-Region II concerning this exercise were that the objectives of the exercise were generally achieved by the State and local agency responses.

The licensee, as indicated above, has been responsive to NRC initiatives, and has provided acceptable resolution in a timely, viable and sound manner.

Conclusion

Category 2

7. Security and Safeguards

Two regional based inspections were conducted during the previous assessment period. One violation was identified related to access control to a vital area.

During this assessment period, there was one routine physical protection inspection performed by a region-based inspector. Routine resident inspection continued throughout the assessment period. No violations were identified. Certain recommendations for improvements in security monitoring were provided as a result of the NRC investigation into the inoperability of the Emergency Diesel Generators which was discussed in the plant operations functional area.

Security program improvements included: (1) the completion of a new security facility containing added space for management, training, kitchen, lockers, conference rooms, and secondary site access control; (2) an increase in Security organization personnel authorizations of 33% i.e., three Security Training/Investigators, one Security Area Investigator, one Systems Technician, three additional Security Shift Supervisors (the Site Security Supervisor has also been provided with an assistant); (3) the licensee procured two new computers for the security computerized access control system. The computers are currently being data loaded and are scheduled to be installed and operational in November 1982.

Performance findings demonstrated a significant relationship between site and corporate management representatives in directing the Security Program. Safety and Security issues were technically addressed and decisions were timely and appropriate. Cooperation was evident in response to NRC recommendations. Management controls assured compliance with NRC requirements.

Conclusion

Category 1

8. Refueling

During the previous assessment period, (February 1, 1980 to January 31, 1981) no refueling operations were conducted. During the current assessment period (May 1, 1981 to April 30, 1982), the resident inspectors witnessed portions of a full core off load and reload and removal of the control rod blades from the reactor vessel to the spent fuel pool. There were no violations and no licensee event reports associated with these refueling activities.

During the removal of the control rod blades, two fuel support castings were accidentally dropped. Representatives of the licensee's operations and quality control departments conducted a visual inspection, in accordance with a written procedure, to determine the integrity of each fuel support casting and the appropriate control rod guide tubes. Although one casting was rejected, this event demonstrates a technically sound resolution of a potential safety problem.

The inspector reviewed the licensee procedure for verification of core loading to detect a possible fuel loading error. The procedure was found to meet the NRC recommended use of an independent examiner to visually verify proper fuel bundle orientation and a separate underwater TV scan to check each fuel bundle serial number. The step is video taped and also independently checked by a second Reactor Analyst technician.

Current staffing was adequate to meet the requirements for a dedicated Senior Reactor Operator to directly supervise fuel handling operators. This requirement became effective for the full core off load beginning in March 1982. During this off load, the inspectors observed non-licensed operators from Unit 2 receiving on-the-job training in fuel handling operations. Although fuel loading at Unit 2 is not scheduled for several years, this demonstrates the licensee's efforts to give its operators as much training as possible.

The licensee currently has a permanently assigned outage coordinator and an assistant. The licensee management of outages appears adequate, however, effort regarding ALARA appeared minimal during the 1981 outage. During the current outage the planning has been realistic and ALARA efforts regarding safe end replacement has been substantial. Even though the outage was unexpected, the critical path work is running on schedule.

Conclusion

Category 1

9. Licensing Activities

Evaluation

Most of the Nine Mile Point (Unit 1) engineering work is done inhouse. Due to many years of nuclear experience and a stable work force, Niagara Mohawk's licensing staff demonstrates well above average managerial capability and superior technical competence. As a result the licensee is quick to become involved in licensing issues, usually remains abreast of NRC needs, and on occasion anticipates requirements.

With respect to specific license amendment requests, Niagara Mohawk provides timely and accurate information. In addition to normal amendment submittals, requests often are unique and result in first of a kind approval which serve as a precedent for other BWR's. While amendment work is in progress the licensee takes schedules seriously, makes a best effort to be responsive, and is prompt in identifying schedular problems. In this perspective, meetings are held frequently, and the licensee keeps the NRC well informed. Usually, these meetings are well organized and factual in nature. As a result very few items are outstanding for significant periods of time, and the Nine Mile Point license was amended seven times over the evaluation period.

In contrast to the above, one major licensing issue has remained unresolved for a significant period. In December 1976, the staff initiated work regarding non-jet pump plant Core Spray performance. Subsequently, in 1979, cracks were discovered in the Nine Mile Point Core Spray spargers. Although the licensee has indicated an intention to provide a submittal on this subject, none has been received to date. Since the Core Spray System is the only low pressure ECCS at Nine Mile and since ALARA consideration would dictate a sparger/nozzle changeout during the current fuel/internals offload, corrective action should be pursued in a timely fashion.

During the evaluation period -- SRO tests were administered resulting in passing grades for individuals.

Conclusion

Category 1

V. SUPPORTING DATA AND SUMMARIES

1. Licensee Event Reports

Tabular Listing

Type of Events:

| | | |
|----|------------------------------|-----------|
| A. | Personnel Error | 7 |
| B. | Design/Man./Constr./Install. | 2 |
| C. | External Cause | 2 |
| D. | Defective Procedures | 2 |
| E. | Component Failure | 27 |
| X. | Other | 11 |
| | Total | <u>51</u> |

Licensee Event Reports Reviewed

Report No. 81-11 to 81-54, 82-02 to 82-10, (81-25 and 82-01 - void)

Causal Analysis

Four sets of common mode events were identified.

- *a. LERs 81-12, 81-13, 81-16, 81-18, 81-19, 81-20, 81-22, 81-23, 81-24, and 81-27 involved failure to containment isolation valves to meet the requirements for local leak rate testing.
- b. LERs 81-11, 81-14, 81-15, 81-17, 81-26, 81-28, and 81-30 involved instrument drift.
- c. LERs 81-21, 81-35, and 81-45 involved failure to properly approve a temporary change to a procedure.
- d. LERs 81-37, 81-38, and 81-46 involved poultry, fish and algae samples in which the radionuclide concentrations were greater than 10 times the control value.

2. Investigation Activities

An investigation into the inoperability of the Emergency Diesel Generators was conducted from August 18-25 and September 1-3, 1981.

- * The unusually large number of LERs in this area is primarily due to the licensee's custom technical specifications for Reporting Requirements which require an LER for each valve that fails to meet a specified leak rate. GE STS does not require an LER unless the combined total of all valves exceeds a specified limit.

3. Escalated Enforcement Actions

a. Civil Penalties

A Civil Penalty in the amount of \$50,000 was assessed on September 2, 1981 for the bypassing of all automatic isolation protection for both Emergency Condenser Systems on July 29, 1981.

b. Orders

None

c. Immediate Action/Confirmatory Action Letters

An Immediate Action Letter was issued on August 18, 1981 regarding additional security measures to be taken relative to both Emergency Diesel Generators being found inoperable.

A Confirmatory Action Letter was issued September 8, 1981 as a result of the Emergency Preparedness Appraisal inspection.

4. Management Conference Held During The Assessment Period

An Enforcement Conference was held at the Region I Office on August 5, 1981 regarding the bypassing of all automatic isolation protection from both Emergency Condensers.

On September 29, 1981, a management meeting was held at the Region I Office to discuss findings of the licensee and the NRC's investigations concerning the defeating of the automatic start capability of both Emergency Diesel Generators.

TABLE 1

TABULAR LISTING OF LERS BY FUNCTIONAL AREA
NINE MILE POINT NUCLEAR STATION, UNIT 1

| <u>Area</u> | <u>Number/Cause Code</u> | <u>Total</u> |
|---|--------------------------|--------------|
| 1. Plant Operations | 5/A, 2/B, 2/D, 3/E, 1/X | 13 |
| 2. Radiological Controls | 1/A, 1/C, 2/E, 5/X | 9 |
| 3. Maintenance | 3/E, 2/X | 5 |
| 4. Surveillance | 1/A, 18/E, 2/X | 21 |
| 5. Fire Protection | 1/E | 1 |
| 6. Emergency Preparedness | None | |
| 7. Security and Safeguards | 1/X | 1 |
| 8. Refueling | None | |
| 9. Licensing Activities | None | |
| Other (Original Design Errors And Equipment Failures Not Classifiable Into Areas 1-9 | 1/C | 1 |
| | TOTAL | 51 |

Cause Codes: A - Personnel Error
B - Design, Manufacturing, Construction or Installation Error
C - External Cause
D - Defective Procedures
E - Component Failure
X - Other

TABLE 2

VIOLATIONS (5/1/81 - 4/30/82)

NINE MILE POINT NUCLEAR STATION, UNIT 1

A. Number and Severity Level of Violations

1. Severity Level

| | |
|--------------------|-----------|
| Deviation | 0 |
| Severity Level I | 0 |
| Severity Level II | 0 |
| Severity Level III | 2 |
| Severity Level IV | 2 |
| Severity Level V | 11 |
| Severity Level VI | <u>1</u> |
| Total | <u>16</u> |

B. Violations Vs. Functional Area

| FUNCTIONAL AREAS | <u>Severity Levels</u> | | | | | | DEV |
|---------------------------|------------------------|----|-----|----|----|----|-----|
| | I | II | III | IV | V | VI | |
| 1. Plant Operations | | | 1 | 2 | 2 | 1 | |
| 2. Radiological Controls | | | 1 | | 5 | | |
| 3. Maintenance | | | | | 1 | | |
| 4. Surveillance | | | | | 2 | | |
| 5. Fire Protection | | | | | 1 | | |
| 6. Emergency Preparedness | | | | | | | |
| 7. Security & Safeguards | | | | | | | |
| 8. Refueling | | | | | | | |
| 9. Licensing Activities | | | | | | | |
| 10. Others | | | | | | | |
| Totals | | | 2 | 2 | 11 | 1 | |

Total Violations = 16

TABLE 3

INSPECTION HOURS SUMMARY (5/1/81 - 4/30/82)

NINE MILE POINT NUCLEAR STATION, UNIT 1

| | <u>HOURS</u> | <u>% OF TIME</u> |
|---------------------------|-------------------|------------------|
| 1. Plant Operations | 943 | 31 |
| 2. Radiological Controls | 153 | 5 |
| 3. Maintenance | 123 | 4 |
| 4. Surveillance | 163 | 5.5 |
| 5. Fire Protection | 103 | 3 |
| 6. Emergency Preparedness | (1)939 | 31 |
| 7. Security & Safeguards | (2)600 | 19.5 |
| 8. Refueling | 22 | 1 |
| 9. Licensing Activities | No Data Available | |
| Total | <u>3046</u> | <u>100%</u> |

(1) The large number of hours expended were a result of the two week emergency preparedness appraisal and observation of the first full scale emergency preparedness drill.

(2) The large number of hours expended were a result of the NRC investigation into the inoperability of the emergency diesel generators.

TABLE 4

INSPECTION REPORT ACTIVITIES (5/1/81 - 4/30/82)

NINE MILE POINT NUCLEAR STATION, UNIT 1

| <u>Inspection Report No.</u> | <u>Inspection Hours</u> | <u>Areas Inspected</u> |
|------------------------------|-------------------------|---|
| 81-10 | 28 | Radioactive Waste Management |
| 81-13 | 76 | Routine Resident Inspection |
| 81-14 | 60 | Region Based Containment Integrated Leak Rate Testing Inspection |
| 81-15 | 32 | Region Based Fire Protection Inspection |
| 81-16 | 105 | Routine Resident Inspection |
| 81-17 | 103 | Routine Resident Inspection |
| 81-18 | 610 | Emergency Preparedness Appraisal |
| 81-19 | 12 | Special Enforcement Conference regarding the bypassing of all automatic isolation protection for both Emergency Condenser Systems |
| 81-20 | 69 | Region Based Security Inspection |
| 81-21 | 101 | Routine Resident Inspection |
| 81-22 | 501 | Region Based Investigation of the loss of both Emergency Diesel Generators |
| 81-23 | 268 | Region Based Emergency Exercise Inspection |
| 81-24 | 113 | Routine Resident Inspection |
| 81-25 | 2 | Inspection of radioactive waste Shipment by South Carolina Department of Environmental Control |

TABLE 4
(Continued)

INSPECTION REPORT ACTIVITIES (5/1/81 - 4/30/82)

NINE MILE POINT NUCLEAR STATION, UNIT 1

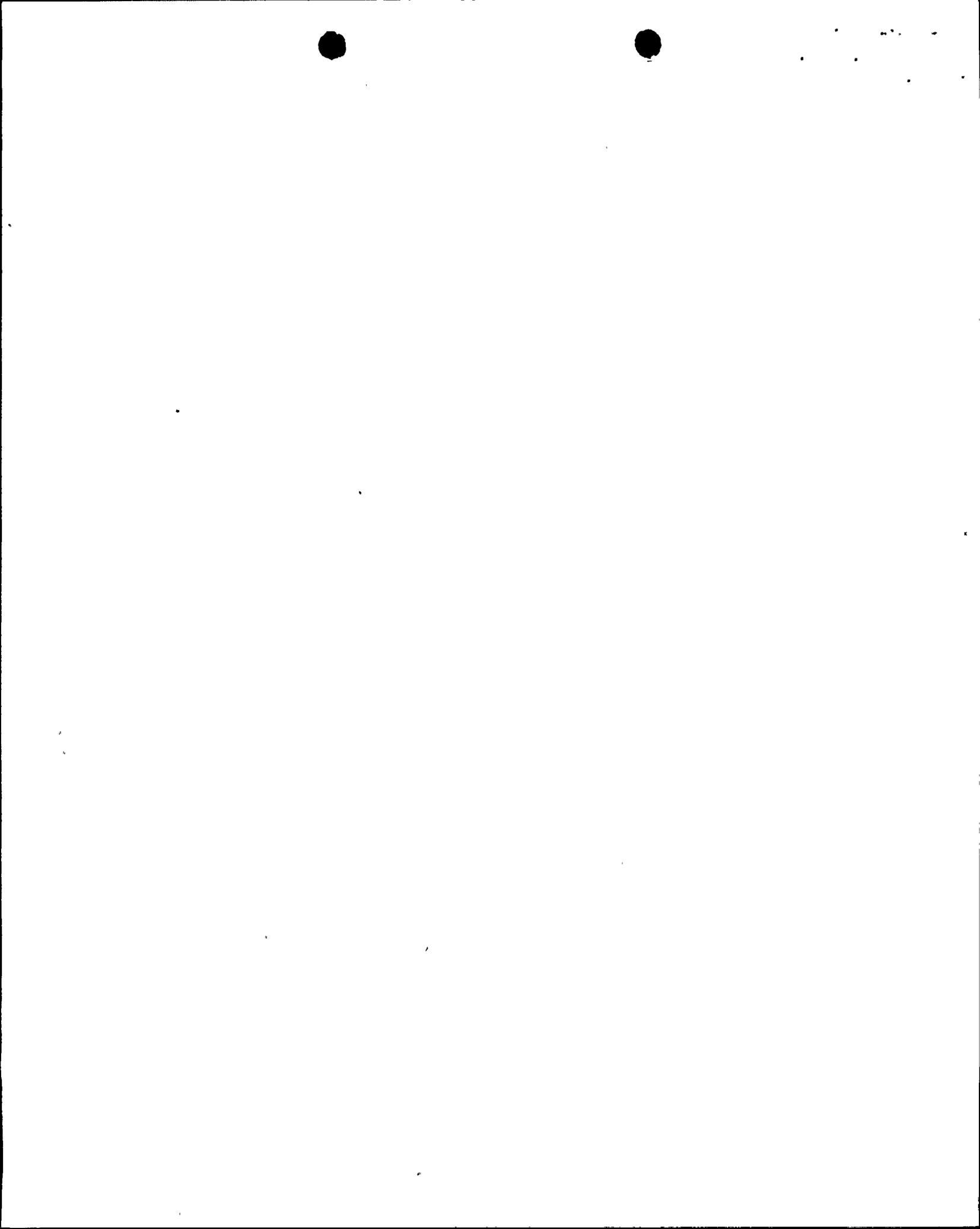
| <u>Inspection Report No.</u> | <u>Inspection Hours</u> | <u>Areas Inspected</u> |
|------------------------------|-------------------------|---|
| 81-26 | | Special Enforcement Conference regarding the loss of both Emergency Diesel Generators |
| 81-27 | 145 | Routine Resident Inspection |
| 81-28 | 91 | Routine Resident Inspection |
| 81-29 | 128 | Routine Resident Inspection |
| 82-01 | 177 | Routine Resident Inspection |
| 82-02 | 91 | Routine Resident Inspection |
| 82-03 | 44 | Region Based Maintenance Program Inspection |
| 82-04 | 160 | Routine Resident Inspection |
| 82-05 | 94 | Routine Resident Inspection |

TABLE 5

NINE MILE POINT NUCLEAR STATION, UNIT 1

ENFORCEMENT DATA (5/1/81 - 4/30/82)

| <u>Inspection Report No.</u> | <u>Inspection Date</u> | <u>Violation</u> | <u>Severity Level</u> | <u>Functional Area</u> |
|------------------------------|---------------------------------|---|-----------------------|------------------------|
| 81-10 | April 28 - May 1, 1981 | Failure to completely audit rad waste program | V | 5 |
| | | Failure to establish procedures for receipt of radioactive material | V | 2 |
| 81-13 | May 2-31, 1981 | Failure to maintain a fire barrier sealed | V | 4 |
| 81-16 | June 1-30, 1981 | Failure to properly approve a temporary change to a procedure | V | 4 |
| 81-17 | July 1-31, 1981 | Bypassing all automatic isolation protection on both Emergency Condensers | III | 1 |
| 81-21 | August 1-31, 1981 | Failure to follow procedure for control of contamination | V | 2 |
| 81-24 | September 1-30, 1981 | Failure to follow procedures for use of the Extended Radiation Work Permit | V | 2 |
| 81-25 | September 23, 1981 | Shipping of solidified radioactive waste containing detectable free standing liquid | III | 2 |
| 81-27 | October 1-31, 1981 | Failure to follow procedures for maintaining the Control Room Log Book | IV | 1 |
| 82-01 | January 1 - February 7, 1982 | Failure to revise drawings and procedures | V | 1 |
| 82-03 | March 1-5, 1982 | Failure to ensure effective corrective action to a QA audit | V | 3 |





Enclosure 3



Resolution