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LEMPGES, T. E. Niagara Mohawk Power Corp.
RECIP. NAME RECIPIENT AFFILIATION
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SUBJECT: Responds to violations noted in Insp Rept 50-410/87-08. Corrective actions: changes to Procedures N2-OP-31 & N2-OP-61B initiated, memo discussing events will be issued & Administrative Procedure AP-2 will be revised.

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NIAGARA MOHAWK

NINE MILE POINT NUCLEAR STATION / P.O. BOX 32 LYCOMING, NEW YORK 13093 / TELEPHONE (315) 343-2110

September 8, 1987
(NMP27146)

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Re: Nine Mile Point Unit 2
Docket No. 50-410
NPF-69

Gentlemen:

Attacned is Niagara Mohawk's response to the Notice of Violation contained in Inspection Report No. 50-410/87-08 dated July 30, 1987. A week extension was granted as discussed in our letter to you dated August 31, 1987, (Letter Number NMP2L-1071).

Very truly yours,

NIAGARA MOHAWK POWER CORPORATION

T. E. Lempges
Vice President
Nuclear Generation

GAG/pns
3623G
Attachment

cc: Regional Administrator, Region I
Mr. W. A. Cook, Resident Inspector

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NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT UNIT 2

DOCKET NO. 50-410

RESPONSE TO NOTICE OF VIOLATION 50-410/87-08-02

Violation 50-410/87-08-02

As a result of the inspection conducted on April 20, 1987 to June 7, 1987, and in accordance with NRC Enforcement Policy (10 CFR Part 2, Appendix C), the following violation was identified:

> Nine Mile Point Unit 2 Technical Specification 6.8 requires that the licensee implement procedures for normal operation and response to alarm conditions for the Residual Heat Removal (RHR) and Standby Gas Treatment (SBGT) systems.
>
> -- Operating Procedure N2-OP-31 for the RHR system specifies that while operating the heat exchanger in the Shutdown Cooling Mode, the reactor coolant side outlet valve and the service water side inlet valves be open.
>
> Contrary to the above, on May 8 and June 1, 1987, the RHR system was operating in the Shutdown Cooling Mode, but the heat exchanger reactor coolant side outlet and the service water side inlet valves were shut.
>
> -- Operating Procedure N2-OP-61B for the SBGT system specifies that operator response to a low heater differential temperature alarm is to secure the train and investigate the cause of the alarm condition.
>
> Contrary to the above, on May 29, June 1 and June 5, 1987, alarms for low heater differential temperatures were locked in while the SBGT system trains were in operation and operators did not secure the trains to investigate and correct the cause of the alarm condition.

Response

CASE-1 - Residual Heat Removal System Valve Alignment

Niagara Mohawk admits that Case-1 cited in the Notice of Violation constitutes a violation of regulatory requirements in that plant operating procedures were not followed properly. After evaluating the facts of this case, we conclude that the operators performed the proper actions with respect to control of the plant, but did not adhere to the existing procedure or properly modify the procedure in accordance with the provisions for temporary procedure changes. The following paragraphs further describe Niagara Mohawk's position on this case.

The operators had followed the steps of Section 8.0 of Operating Procedure N2-OP-31 to place the Residual Heat Removal system in the shutdown cooling mode. Steps 8.10 and 8.11 of this procedure require opening the service water inlet and outlet valves. Subsequent steps 8.17 a through c direct methods for decreasing the cooldown rate, and include the direction to shut the heat exchanger service water outlet valve when the heat exchanger bypass valve RHS*MOV8A(B) is fully open. Since there was minimal core heat present, full heat exchanger bypass flow was required. In accordance with precautions 5.0 and 6.0 of the procedure, under these conditions the operators left the service water valve closed and shut the Residual Heat Removal system discharge valve to prevent flow through the heat exchanger. The procedure did not, however, specifically allow the Residual Heat Removal discharge valve to be shut in the shutdown cooling mode. Subsequent to discussions with the Resident Inspector, Niagara Mohawk, on June 1, 1987, issued a Temporary Change Notice to this procedure to specifically allow these valves to be closed. The apparent root cause of this event is a procedural deficiency in that the steps of the procedure did not specifically allow the valve line-up to accomplish the direction given in the precautions.

CASE-2 - Response to Alarm Annunciator in Standby Gas Treatment System

Niagara Mohawk admits that Case-2 cited in the Notice of Violation constitutes a violation of regulatory requirements in that plant operating procedures were not properly followed. After evaluating the facts of this case, we conclude that the operators performed the proper actions with respect to control of the plant and followed the corrective actions as intended by the writer of the procedure. The following paragraphs further describe the specifics of this case.

This case addresses the proper application of the corrective actions in Operating Procedure N2-OP-61B. The specific event involved the activation of alarm annunciator 870102 resulting from low air delta temperature conditions. The operator did not stop the associated fan as required by procedure step 2.3.d. The operator did not take this action since it would preclude his ability to identify and correct the problem as required by step 2.3.g of the procedure. In this case, the operator properly considered that the corrective actions were not intended to be performed in sequence, as two of the steps were mutually exclusive, but provided options of several corrective actions. After discussion with the Resident Inspector, Niagara Mohawk, on June 5, 1987, issued a Temporary Change Notice to this procedure to increase clarity to prevent future misunderstandings. The apparent root cause of this event is a procedural deficiency in that the operating procedure did not provide the operator with the latitude to take only those investigative measures necessary to evaluate the annunciator condition and take corrective actions as required.

Corrective Action

Changes to both procedures involved (N2-OP-31 and N2-OP-61B) were initiated prior to the end of the inspection period. In addition to the procedure changes, the Station Superintendent will issue a memorandum discussing these events and the lessons learned.

This memorandum will be placed in the Operations Lessons Learned Book for immediate review by on-shift Operations personnel, and will be incorporated into the operator requalification training program.

In addition, Administrative Procedure AP-2 will be revised to indicate that corrective actions specified in operating procedures provide guidance to the operator on acceptable actions to take. These actions taken by the operator should be consistent with his evaluation of the conditions and the procedures. The Administrative Procedure will be revised so that sequential implementation of corrective actions is not required unless specifically stated in the procedure. This policy will be incorporated as a training objective in the operator training program.

Date When Full Compliance Will Be Achieved

The procedure changes discussed above have been implemented. The memorandum will be issued by September 11, 1987. Administrative Procedure AP-2 will be revised by November 1, 1987, and the training program will be revised within 6 weeks of release of the Revised AP-2 Procedure.