

ENCLOSURE 1

FINAL SALP REPORT

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

SYSTEMATIC ASSESSMENT OF LICENSEE PERFORMANCE

INSPECTION REPORT NO. 88-99

NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT UNITS 1 AND 2

DOCKET NOS. 50-220 and 50-410

ASSESSMENT PERIOD: March 1, 1988 to February 28, 1989

BOARD MEETING - April 13, 1989

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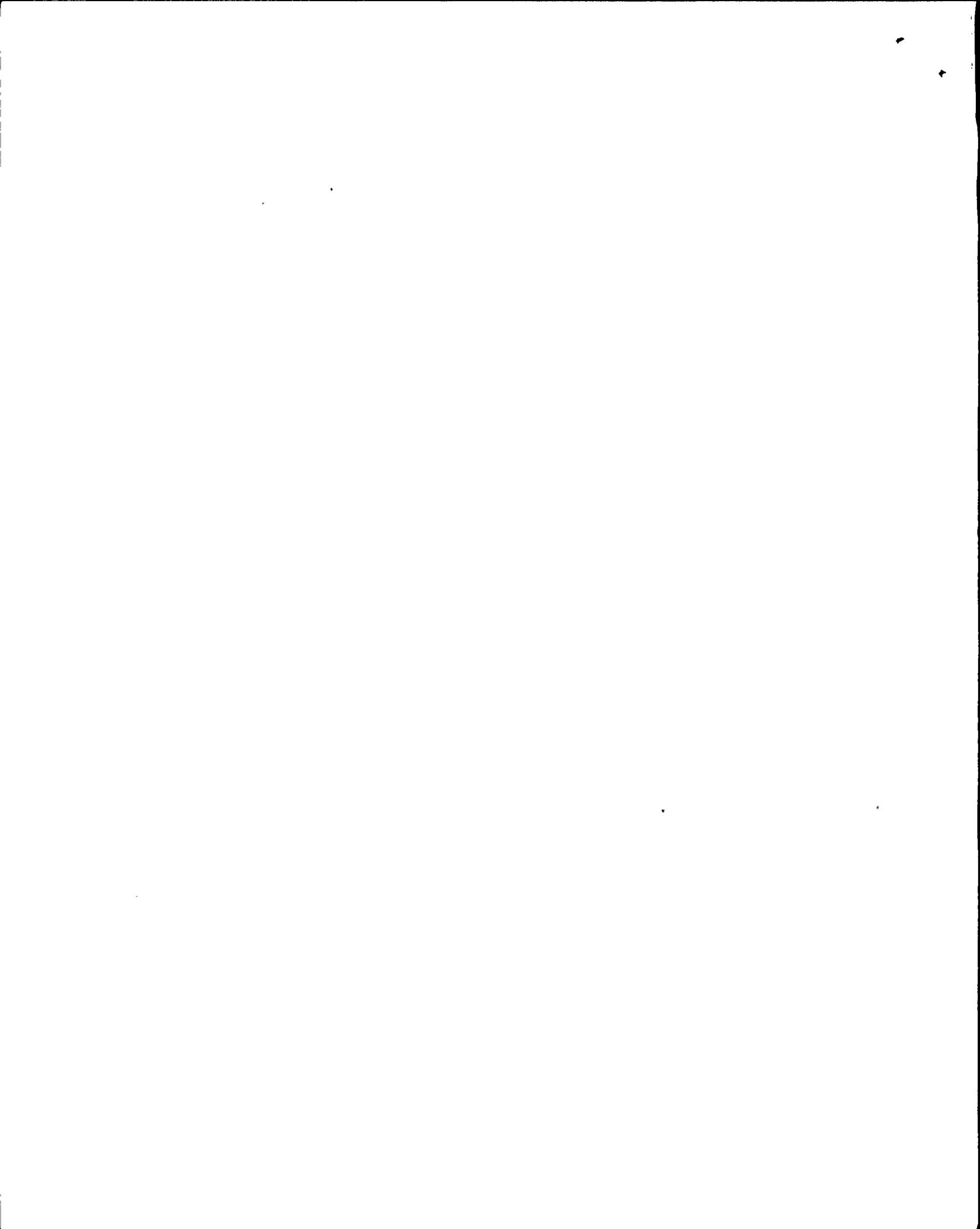
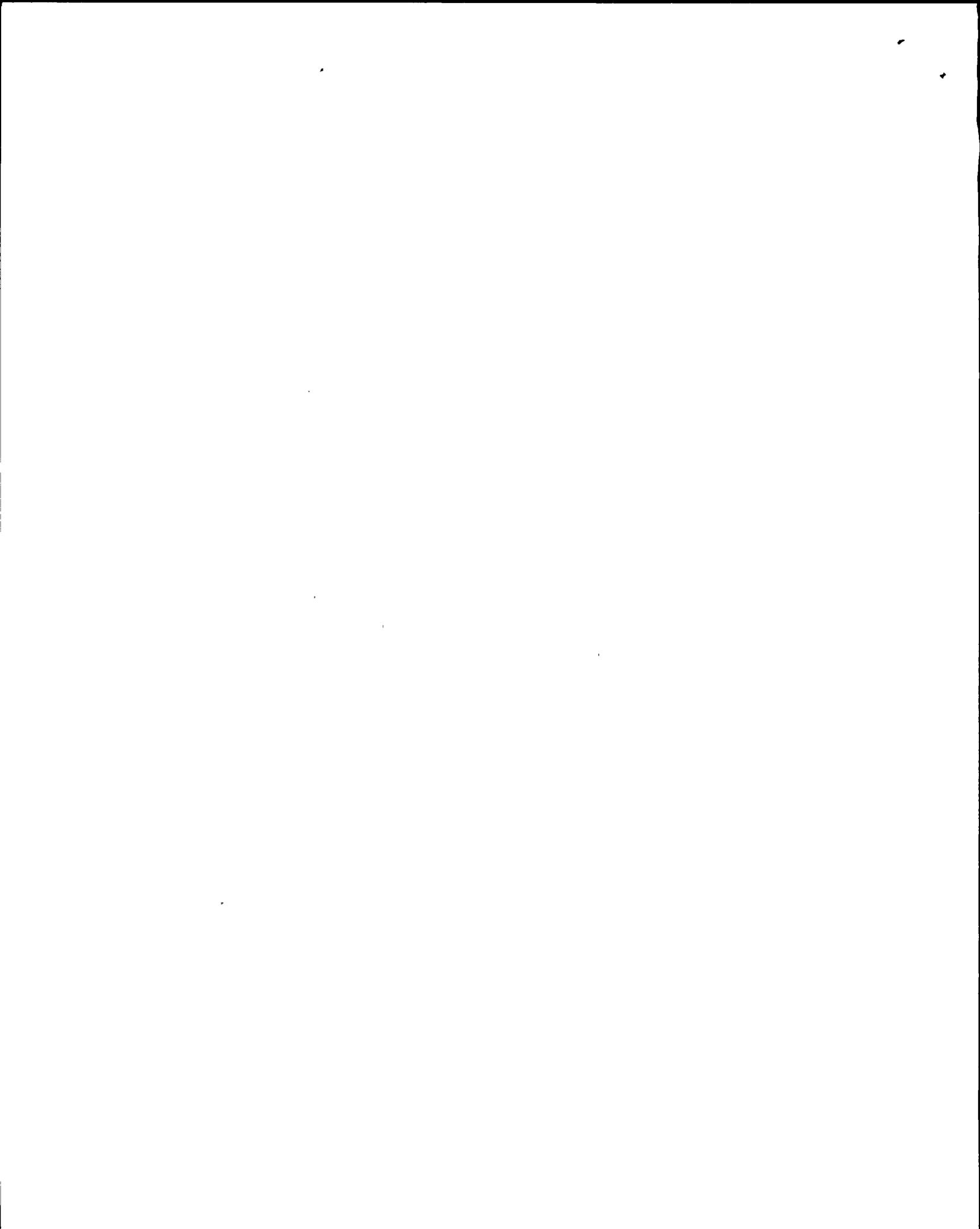


TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION	1
A. Licensee Activities	1
B. Direct Inspection and Review Activities	3
II. SUMMARY OF RESULTS	5
A. Overview	5
B. Facility Performance Analysis Summary	6
C. Unplanned Shutdowns, Plant Trips, and Forced Outages .	7
III. CRITERIA	9
IV. PERFORMANCE ANALYSIS	10
A. Operations	10
B. Radiological and Chemistry Controls	15
C. Maintenance and Surveillance	19
D. Emergency Preparedness	25
E. Security and Safeguards	27
F. Engineering and Technical Support	29
G. Safety Assessment/Quality Verification	32
V. SUPPORTING DATA AND SUMMARIES	36
A. Enforcement Activity	36
B. Confirmatory Action Letter	39
C. Inspection Hour Summary	40
D. Licensee Event Report Causal Analysis and Summary	41
E. Other	44



I. INTRODUCTION

The Systematic Assessment of Licensee Performance (SALP) program is an integrated NRC staff effort to collect the available observations and data on a periodic basis and to evaluate licensee performance based upon this information. The SALP program is supplemental to normal regulatory processes used to ensure compliance with NRC rules and regulations. The SALP program is intended to be sufficiently diagnostic to provide a rational basis for allocating NRC resources and to provide meaningful guidance to the licensee's management to promote quality and safety of plant construction and operation.

An NRC SALP Board, composed of the staff members listed below, met on April 13, 1989, to review the collection of performance observations and data on performance, and to assess licensee performance in accordance with the guidance in Chapter NRC-0516, "Systematic Assessment of Licensee Performance." A summary of the guidance and evaluation criteria is provided in Section III of this report. The Board's findings and recommendations were forwarded to the NRC Regional Administrator for approval and issuance.

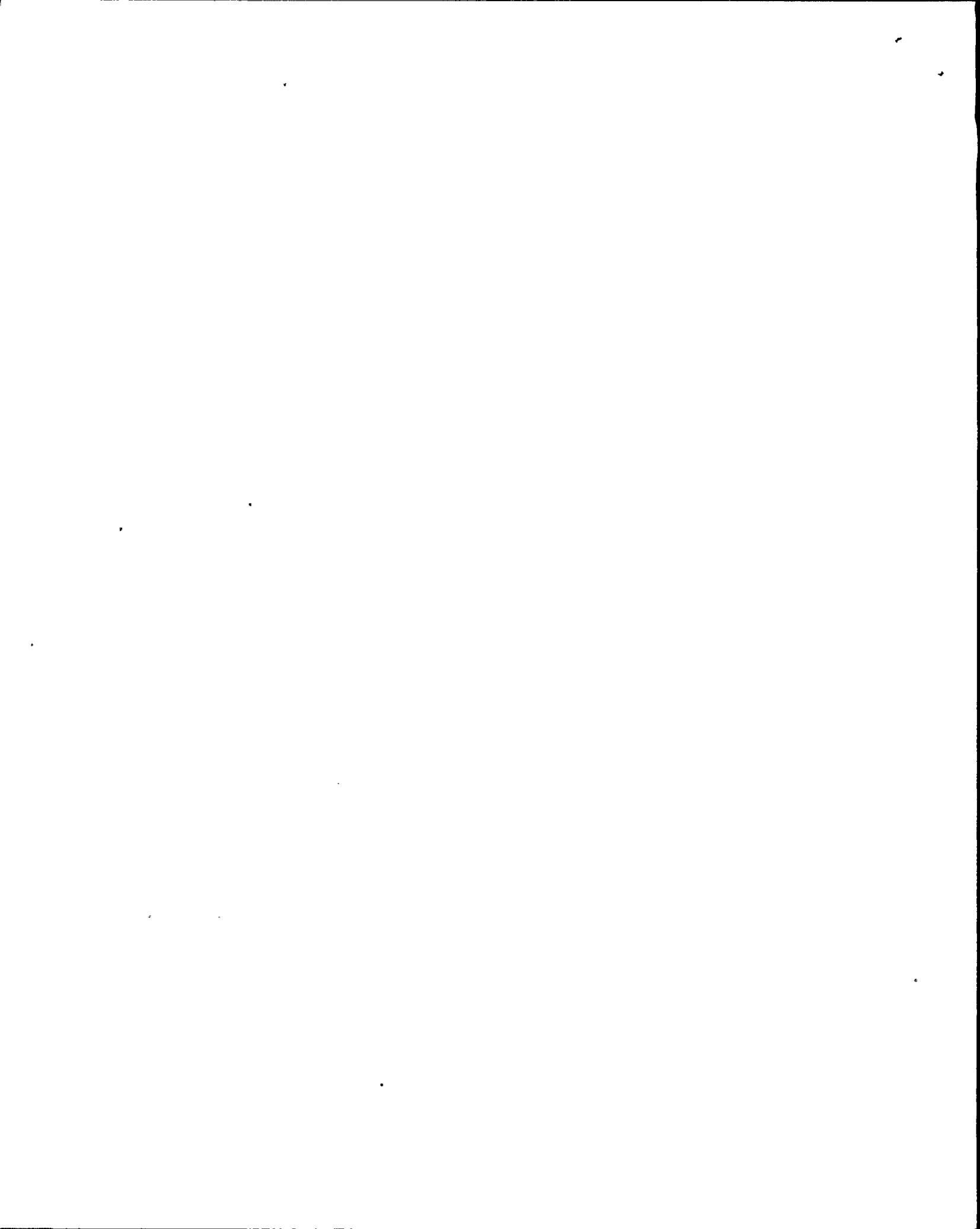
A. Licensee Activities

Unit 1

The assessment period began with Unit 1 shut down and defueled. The reactor was shut down in December 1987 as a result of a feedwater system induced transient. Following the shutdown, significant deficiencies in the licensee's Inservice Inspection (ISI) and Fire Protection Programs were identified, thus requiring the unit to remain shut down pending resolution.

Throughout the assessment period, the majority of the activities at Unit 1 involved resolution of the ISI and Inservice Testing (IST) Program concerns, fire barrier penetration concerns, operator requalification and Emergency Operating Procedures (EOP) training issues, and resolution of additional specific issues outlined in the Restart Action Plan. These issues are discussed in further detail elsewhere in this assessment. NRC Confirmatory Action Letter (CAL) No. 88-17 was issued to summarize the NRC's overall concerns with Unit 1 performance and to formalize the licensee's corrective action commitments prior to Unit 1 restart.

The CAL was issued on July 24, 1988 and confirmed three requirements which the licensee has committed to meet before restart authorization will be granted by the NRC. Item one of the CAL called for Niagara Mohawk management to determine the root causes of their problems. Item two called for



the licensee to develop short-term and long-term corrective actions to prevent recurrence of these problems. To address these elements of the CAL the licensee developed and provided to the NRC on December 22, their Restart Action Plan (RAP). The RAP was submitted to the NRC for review and approval and delineates short-term corrective actions which the licensee must take prior to Unit 1 restart. The NIP was made available for review on site and contains long-term corrective actions and additional programmatic changes needed. At the end of the assessment period. The RAP was still undergoing NRC review. The third item requires the licensee to conduct and document, for NRC staff review, a self-assessment of their readiness to restart Unit 1.

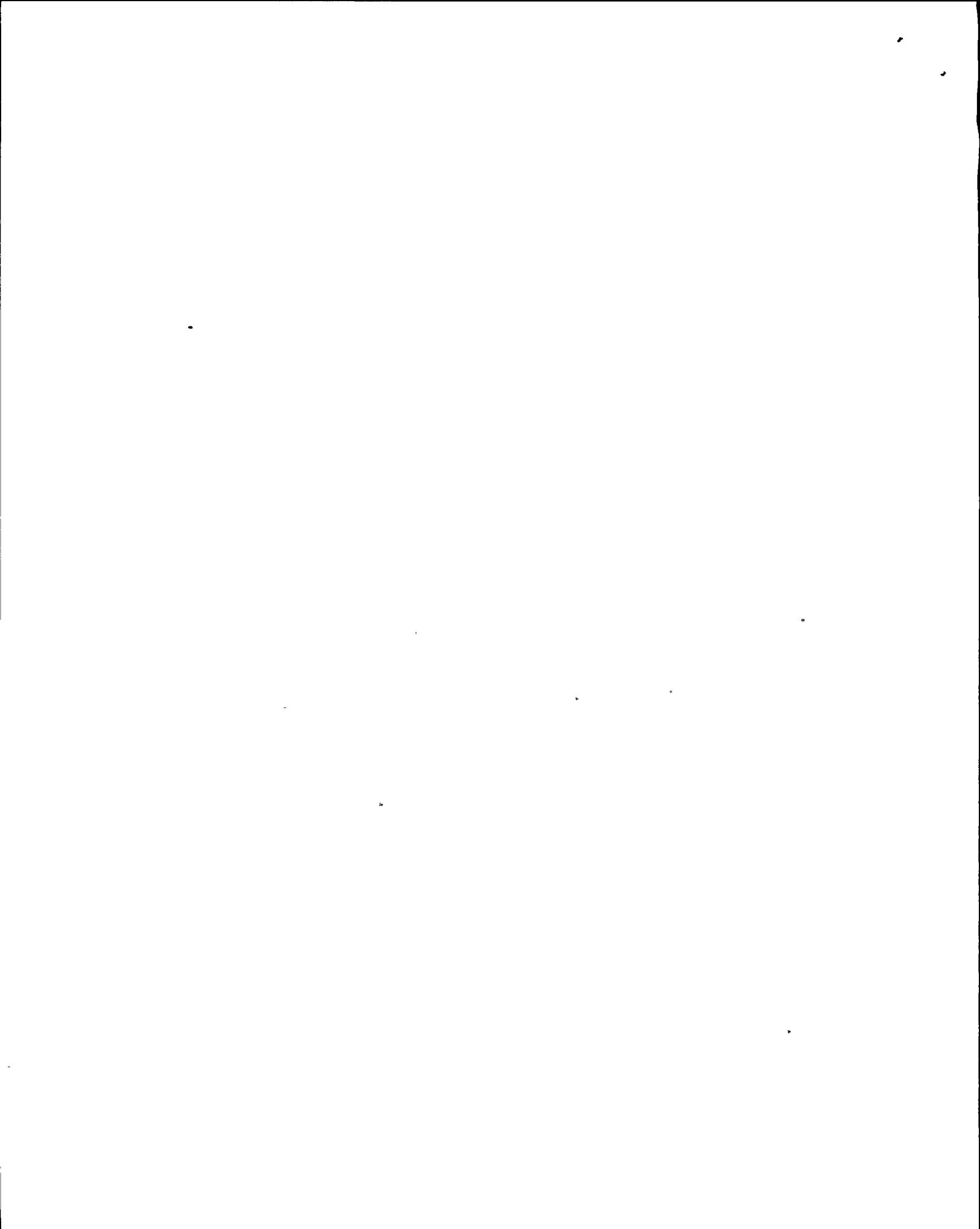
During the assessment period, major changes in the licensee's station organizational structure were made, as well as several key personnel changes. Additionally, the new position of Executive Vice President-Nuclear was created towards the end of the assessment period. The majority of the other changes were at the site staff level and took place throughout the assessment period.

Unit 2

Early in the assessment period, the licensee completed the last phase of the Power Ascension Test Program and declared the unit available for commercial operation on March 11, 1988. The unit operated at power until April 29, 1988, when it was shutdown to support a three week planned outage. During power operations prior to the outage, the unit experienced two scrams, one of which was caused by personnel error. The three week outage was completed and the unit was returned to power on May 22, 1988.

On May 23, 1988, a recirculation pump seal leak caused a forced plant shutdown. The seal was repaired and the unit was returned to power on May 30, 1988. During power operations through September 2, 1988, the reactor scrambled five times. Two scrams were the result of problems with the Feedwater Control System, two were caused by deficiencies in the Electrohydraulic Control (EHC) system, and personnel error resulted in one additional scram. On September 2, 1988, the licensee shut the plant down due to missed snubber surveillance testing and a leak in the cooling coils of the main generator.

The unit was returned to power on September 15, 1988 on single recirculation loop operation due to binding of the "B" loop recirculation pump discharge valve. The unit operated at power until September 22, 1988, when a reactor scram resulted from a loss of Reactor Building Closed Loop Cooling due to an inadequate plant impact assessment for surveillance testing. The unit was returned to power and operated at power until the start of a planned mid-cycle outage which commenced on October 1, 1988.



The mid-cycle maintenance and surveillance outage was scheduled to be completed by December 1, 1988. Outage activities continued through the end of this assessment period on February 28, 1989. The outage was extended primarily due to containment isolation valves failing Appendix J leakage testing criteria and also due to problems with the service water system cross-connect valve actuation logic not meeting the single failure criterion.

B. Direct Inspection and Review Activities

Units 1 and 2

An NRC Senior Resident Inspector was assigned for the entire assessment period. Previously assigned Resident Inspectors were reassigned and replaced in June and November 1988.

During the 12 month assessment period, the NRC expended a total of 7756 inspection hours; 5250 hours at Unit 1 and 2506 hours at Unit 2. Functional area distribution of inspection hours is documented at the beginning of each individual functional area and tabulated in Table 2 in Section V.C.

During the period, several major NRC team inspections were conducted, most focusing on Unit 1 as noted below:

- During the month of March, 1988, an inspection of outage activities at both units was conducted. The inspection involved a comprehensive look at plant maintenance, modifications and surveillance at Unit 1, observation of a 100% load rejection startup test for Unit 2, and the procurement program for both units with emphasis on purchase and dedication of commercial grade items.
- In June, 1988, an in-depth review of the implementation and use of Emergency Operating Procedures (EOPs) was conducted by NRC license examiners and by NRC contractors. The inspection focused mainly on Unit 1 EOPs, but as a result of significant deficiencies identified in Unit 1 EOPs, the inspection was expanded to include Unit 2, as well.
- For three weeks in September and October, 1988, a Safety System Functional Inspection (SSFI) was conducted by NRC inspectors and contractors. The inspection involved an in-depth examination of the Core Spray System and High Pressure Coolant Injection (HPCI) mode of the feedwater system.



- In November, 1988, a one week inspection was conducted to determine the status of implementation of Regulatory Guide 1.97 "Instrumentation for Light Water Cooled Nuclear Power Plants to Assess Plant and Environmental Conditions during and following an Accident", at both units.
- In December, 1988, a two week Maintenance Team Inspection was conducted at both units by NRC inspectors. The inspection focused on all aspects of maintenance activities ranging from engineering support to observation of activities in the field.

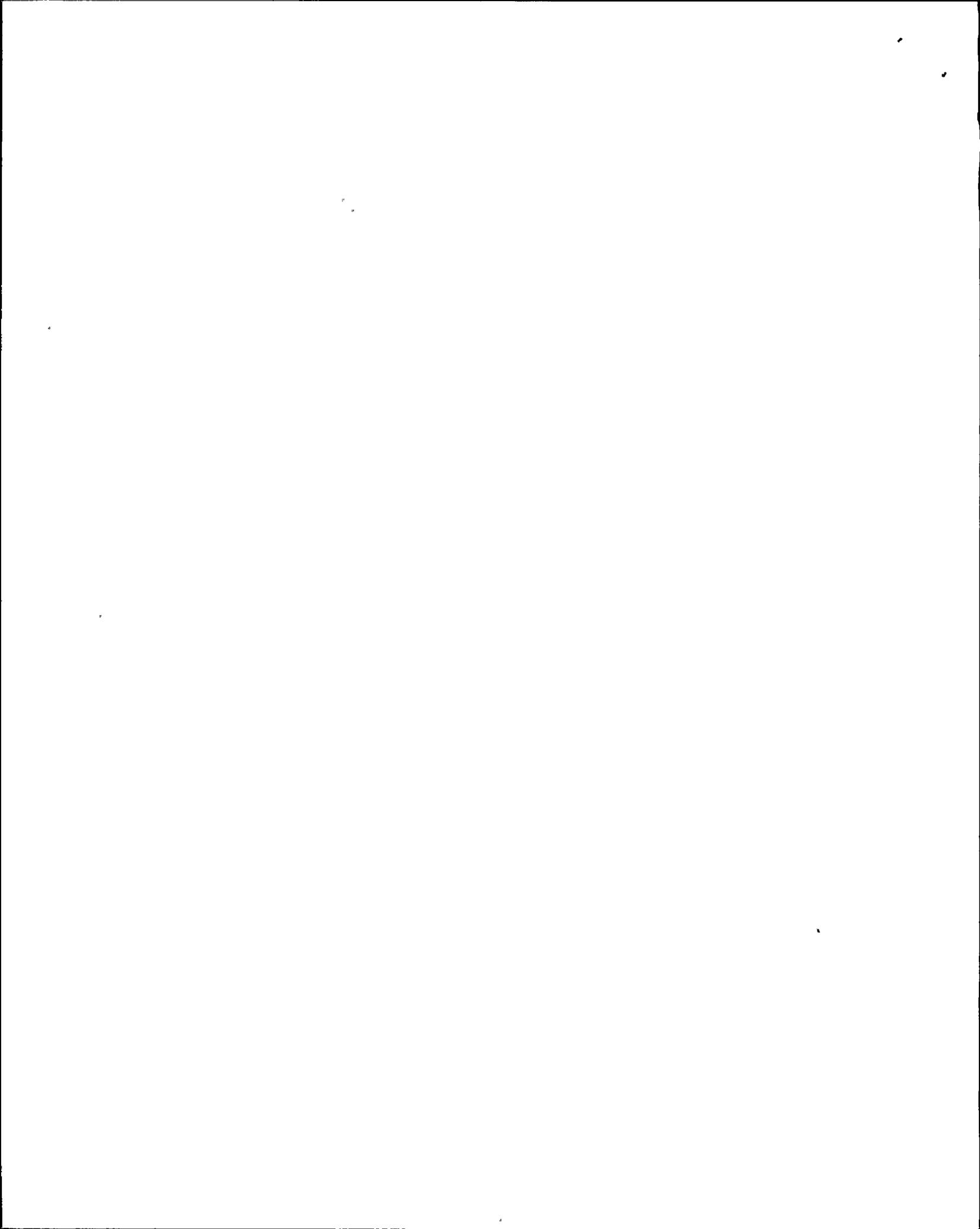
In December, 1988, a team inspection was performed to examine the status of the licensee's Inservice Inspection (ISI) program at Unit 1 to determine if corrective actions were satisfactory in response to previously identified deficiencies.

- At the end of the assessment period, a Special Team Inspection (STI) comprising NRC personnel and contractors was conducted on site and at the corporate engineering office. Overall focus of the inspection was to assess the effectiveness of management controls and oversight mechanisms in various key functional areas.
- Various other inspections were conducted throughout the assessment period by NRC resident inspectors, Region I and Headquarters personnel and by NRC contractors. Most of these were combined inspections of a more routine nature as opposed to the comprehensive team inspections. An exception to this was a special inspection by the resident inspectors of wiring problems associated with the Automatic Depressurization System (ADS) at Unit 2.

This report is the NRC's assessment of the licensee's safety performance at Nine Mile Point Units 1 and 2 for the period of March 1, 1988 through February 28, 1989.

The SALP Board for Nine Mile Point Units 1 & 2:

<u>NAME</u>	<u>TITLE</u>
W. Kane (Chairman)	Director, Division of Reactor Projects (DRP)
R. Capra	Director, Project Directorate No. I-1, NRR
R. Conte	Chief, Boiling Water Reactor Section, Division of Reactor Safety (DRS)
W. Cook	Senior Resident Inspector, Nine Mile Point 1 and 2, DRP
J. Johnson	Chief, Projects Section 2C, DRP
W. Johnston	Deputy Director, DRS
M. Knapp	Director, Division of Radiation Safety and Safeguards (DRSS)
M. Slosson	Project Manager, Nine Mile Point 1 and 2, NRR
E. Wenzinger	Chief, Projects Branch 2, DRP



Attendees (non-voting)

M. Banerjee	Project Engineer, Projects Section 2C, DRP
R. Barkley	Reactor Engineer, Projects Section 2C, DRP
R. Bellamy	Chief, FRSS Branch, DRSS
A. Finkel	Senior Reactor Engineer, DRS
D. Florek	Senior Operations Engineer, DRS
J. Furia	Radiation Specialist, DRSS
M. Hunemiller	Project Engineer, NRR
W. Lancaster	Physical Security Inspector, DRS
R. Laura	Resident Inspector, Nine Mile Point 1 and 2, DRP
R. Loesch	Radiation Specialist, DRSS
V. McCree	Project Engineer, NRR
W. Pasciak	Chief, ERPS, DRSS
M. Shanbaky	Chief, FRPS, DRSS
R. Temps	Resident Inspector, Nine Mile Point 1 and 2, DRP

II. SUMMARY OF RESULTSA. Overview

Overall licensee performance during this assessment period has not shown significant improvement. Even though the functional areas of Security Safeguards and Emergency Preparedness continue to be rated highly, the remainder of the functional areas have shown marginal, if any, improvement, or have declined.

In the area of Unit 1 Operations, early in the assessment period the poor performance by licensed operators as reflected in their understanding and ability to implement the new Emergency Operating Procedures indicated both poor training and a complacency with respect to the adequacy of the training received. Evidence of a strained relationship between the Operations and Training Departments also was acknowledged during the previous assessment period. Actions taken during this assessment period to remedy the situation were not successful. This lack of effective change in operator attitudes toward training and the ineffective station management initiatives to deal with this situation continue to be significant concerns to the NRC.

In the areas of Unit 2 Operations, and Maintenance and Surveillance, the high rate of personnel errors by both the licensed and unlicensed staff and maintenance and testing personnel continued during this assessment period. Station and corporate management efforts to reduce or minimize the frequent safety system challenges and plant transients have not been effective. Likewise, the direct support to the station provided by the Engineering Department staff has been inconsistent and not reflective of an overall goal to improve performance and enhance long term station



reliability and safety. This appears to be reflective of low performance expectations in that it is a newly licensed facility. Corporate and station management should assure that the current level of performance for Unit 2 is not acceptable in light of the large number of unplanned trips and shutdowns.

The NRC acknowledges the licensee's commitment to a comprehensive Nuclear Improvement Program which addresses the root causes and provides the essential elements to effect overall performance improvements. The NRC also acknowledges the licensee's recent management changes made to provide the necessary leadership to the Nuclear Division to ensure a thorough and successful implementation of this Program. These changes are viewed as significant, however, because they were made late in the assessment period their effectiveness has not been reflected in this assessment.

B. Facility Performance Analysis Summary

Last Period Dates

Unit 1 11/1/86 - 2/29/88

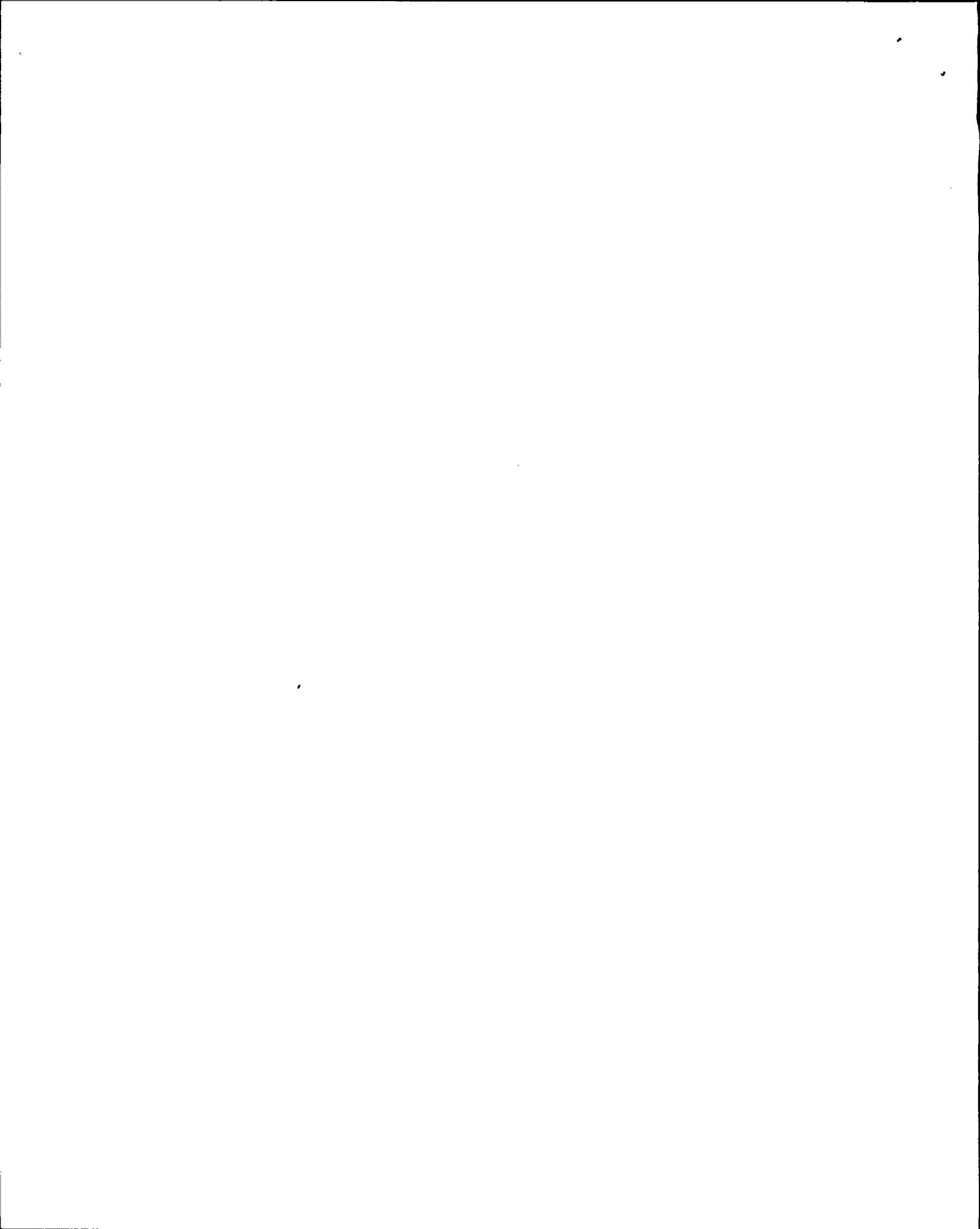
Unit 2 2/1/87 - 2/29/88

Present Period Dates

Unit 1 3/1/88 - 2/28/89

Unit 2 3/1/88 - 2/28/89

	<u>Functional Area</u>	<u>Category Last Period</u>	<u>Trend</u>	<u>Category This Period</u>	<u>Trend</u>
1.	Operations				
1.	Unit 1	2		3	
2.	Unit 2	2 improving	3	
2.	Radiological Controls and Chemistry	2 declining	2	
3.	Maintenance and Surveillance	(2/2)		3	
4.	Emergency Preparedness	1		1	
5.	Security and Safeguards	1		1	
6.	Engineering and Technical Support	2		3	
7.	Safety Assessment/Quality Verification	*		3 improving



8.	Licensing	2	declining	N/A
9.	Training and Qualification Effectiveness	2		N/A
10.	Assurance of Quality	3		N/A

N/A -- Indicates that the category was not rated this period.

* This functional area was not assessed

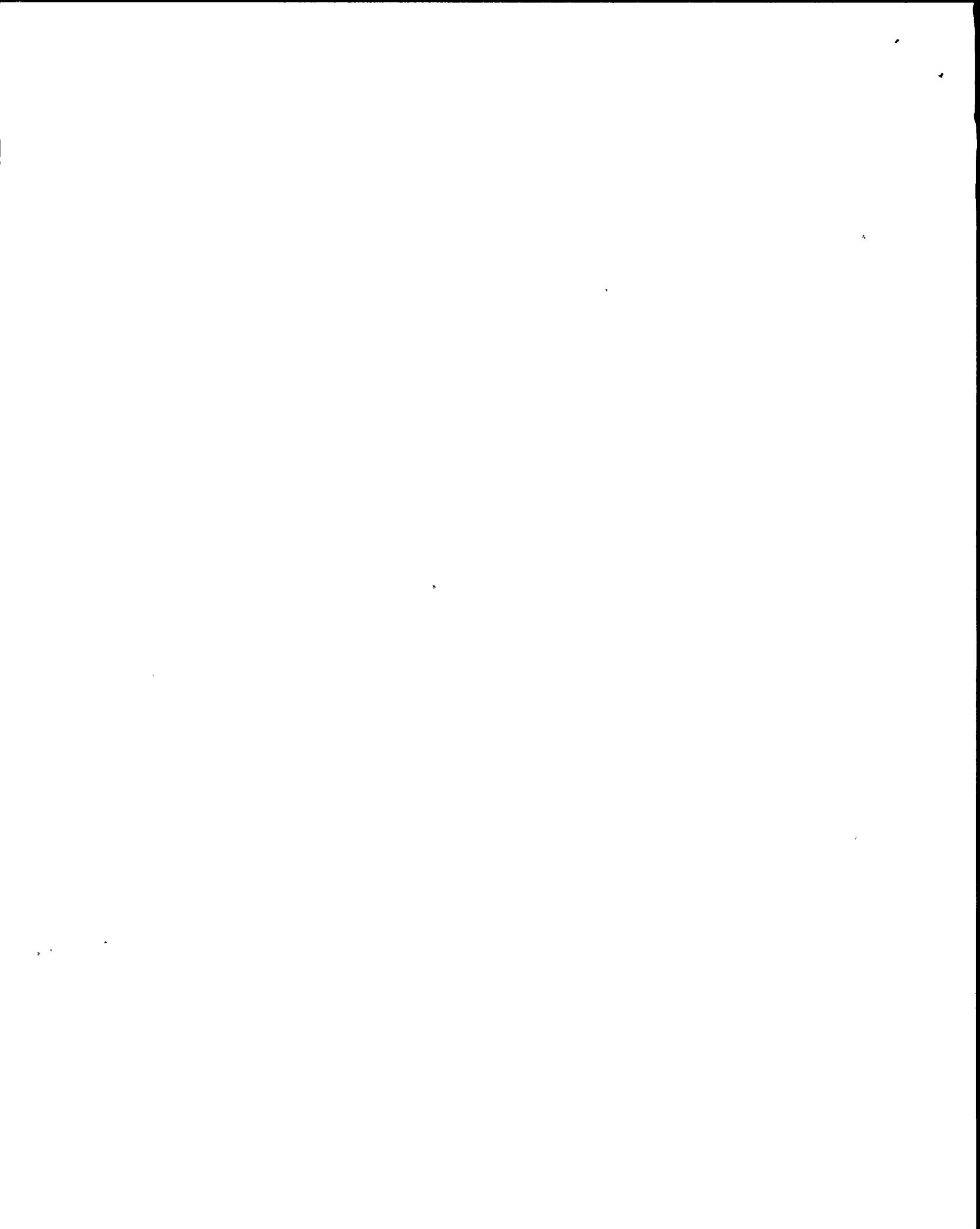
C. Unplanned Shutdowns, Plant Trips and Forced Outages

1. Unit 1

<u>Date/Event</u>	<u>Power Level</u>	<u>Description</u>	<u>Cause</u>	<u>Functional Area</u>
6/25/88 Automatic Scram	0%	Reactor scram signal due to lower than normal voltage on protective bus.	Lightning Strike, See LER 88-15	N/A

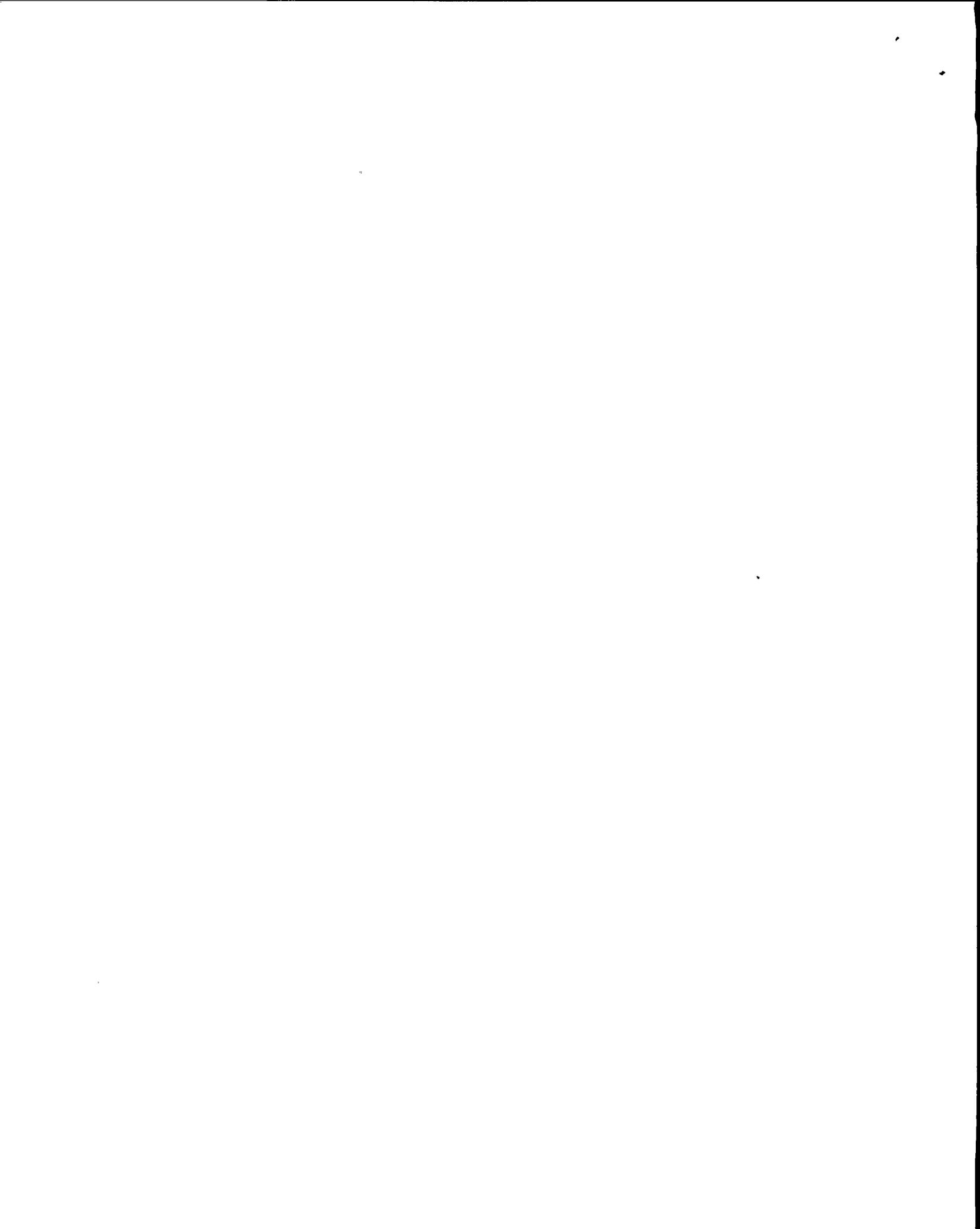
2. Unit 2

<u>Date/Event</u>	<u>Power Level</u>	<u>Description</u>	<u>Cause</u>	<u>Functional Area</u>
3/13/88 Automatic Scram	43%	Low reactor water level, due to failed pressure transmitter and poor design.	Equipment Failure and Design Deficiency, See LER 88-14	ENG/TS
3/21/88 Automatic Scram	97.5%	Loop calibration on feedwater flow transmitters	Personnel error, Inadequate Plant Assessment, See LER 88-17	MAINT/SURV and OPS
5/23/88 Forced Shutdown	5%	Recirculation pump seal leak	Personnel Error, due to improper installation	MAINT
6/2/88 Automatic Scram	25.5%	High reactor vessel water level, failure of feedwater control valve feedback linkage	Equipment Failure, due to design error, See LER 88-19	ENG/TS



(SHUTDOWNS CONTINUED)

<u>Date/Event</u>	<u>Power Level</u>	<u>Description</u>	<u>Cause</u>	<u>Functional Area</u>
6/22/88 Automatic Scram	98%	Low reactor water level, feedwater level control valve ramp closed	Manufacturing design deficiency, See LER 88-25	SAFETY/QUAL
6/28/88 Automatic Scram	9%	APRM Upscale trip during start-up	Personnel error, not controlling steam loads properly, See LER 88-26	OPS
7/11/88 Manual Scram	45%	EHC oil leak	Personnel error (Fitting not properly torqued), See LER 88-28	MAINT
8/6/88 Automatic Scram	53%	Loss of EHC system pressure due to piping failure caused by excessive vibration	Design deficiency, due to inadequate support, See LER 88-39	ENG/TS
9/2/88 Forced Outage	100%	Generator stator cooling water leak	Equipment Failure	N/A
		Missed snubber testing	Personnel error, See LER 88-40	ENG/TS
9/22/88 Manual Scram	98%	Loss of service water	Personnel error, inadequate assessment of plant impact	OPS
12/1/88 Automatic Scram while shutdown	0%	ARI system actuation during surveillance testing	Design deficiency See LER 88-66	ENG/TS



III. CRITERIA

Licensee performance is assessed in selected functional areas, depending on whether the facility is under construction or operational. Functional areas normally represent areas significant to nuclear safety and the environment. Some functional areas may not be assessed because of little or no licensee activities or lack of meaningful observations. Special areas may be added to highlight significant observations.

The following evaluation criteria were used, as applicable, to assess each functional area:

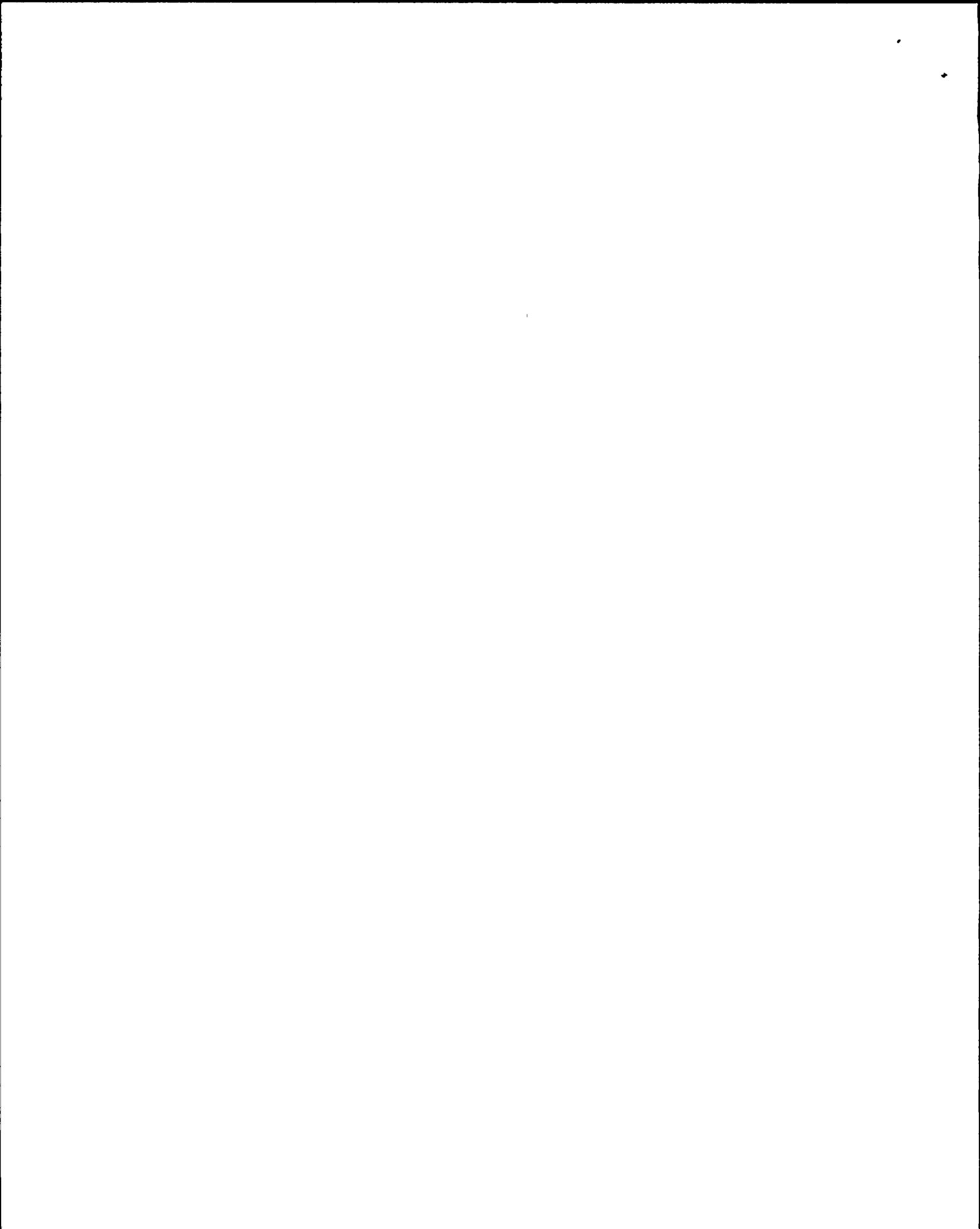
1. Assurance of quality, including management involvement and control.
2. Approach to the resolution of technical issues from a safety standpoint.
3. Responsiveness to NRC initiatives.
4. Enforcement history.
5. Operational and construction events (including response to, analyses of, reporting of, and corrective actions for).
6. Staffing (including management).
7. Effectiveness of training and qualification programs.

On the basis of the NRC assessment, each functional area evaluated is rated according to three performance categories. The definitions of these performance categories are as follows:

Category 1. Licensee management attention and involvement are readily evident and place emphasis on superior performance of nuclear safety or safeguards activities, with the resulting performance substantially exceeding regulatory requirements. Licensee resources are ample and effectively used so that a high level of plant and personnel performance is being achieved. Reduced NRC attention may be appropriate.

Category 2. Licensee management attention to and involvement in the performance of nuclear safety or safeguards activities are good. The licensee has attained a level of performance above that needed to meet regulatory requirements. Licensee resources are adequate and reasonably allocated so that good plant and personnel performance is being achieved. NRC attention may be maintained at normal levels.

Category 3. Licensee management attention to or involvement in the performance of nuclear safety or safeguards activities are not sufficient. The licensee's performance does not significantly exceed that needed to meet minimum regulatory requirements. Licensee resources appear to be strained or not effectively used. NRC attention should be increased above normal levels.



The SALP Board may assess a functional area to compare the licensee's performance during the last quarter of the assessment period to that during the entire period in order to determine the recent trend. The trend if used, is defined as:

Improving: Licensee performance was determined to be improving near the close of the assessment period.

Declining: Licensee performance was determined to be declining near the close of the assessment period.

A trend is assigned only when, in the opinion of the SALP Board, the trend is significant enough to be considered indicative of a likely change in the performance category in the near future. For example, a classification of "Category 2, Improving" indicates the clear potential for "Category 1" performance in the next SALP period.

It should be noted that Category 3 performance, the lowest category, represents acceptable, although minimally adequate, safety performance. If at any time the NRC concluded that a licensee was not achieving an adequate level of safety performance, it would then be incumbent upon NRC to take prompt appropriate actions in the interest of public health and safety. Such matters would be dealt with independently from, and on a more urgent schedule than, the SALP process.

It should also be noted that the industry continues to be subject to rising performance expectations. NRC expects licensees to use industry-wide and plant-specific operating experience actively in order to effect performance improvement. Thus, a licensee's safety performance would be expected to show improvement over the years in order to maintain consistent SALP ratings.

IV. PERFORMANCE ANALYSIS

A. Operations

1. Analysis (2274 hours, 29.3%)

Unit 1 (1464 hours, 18.9%)

In the last assessment period, performance in this area showed little improvement and was rated Category 2. Contributing to that rating was the noted complacency of operators with respect to overall station quality of operations. During the last assessment the NRC staff identified the need for corporate and station management to provide positive incentives to revitalize, motivate and better integrate the Operations staff with other departments.

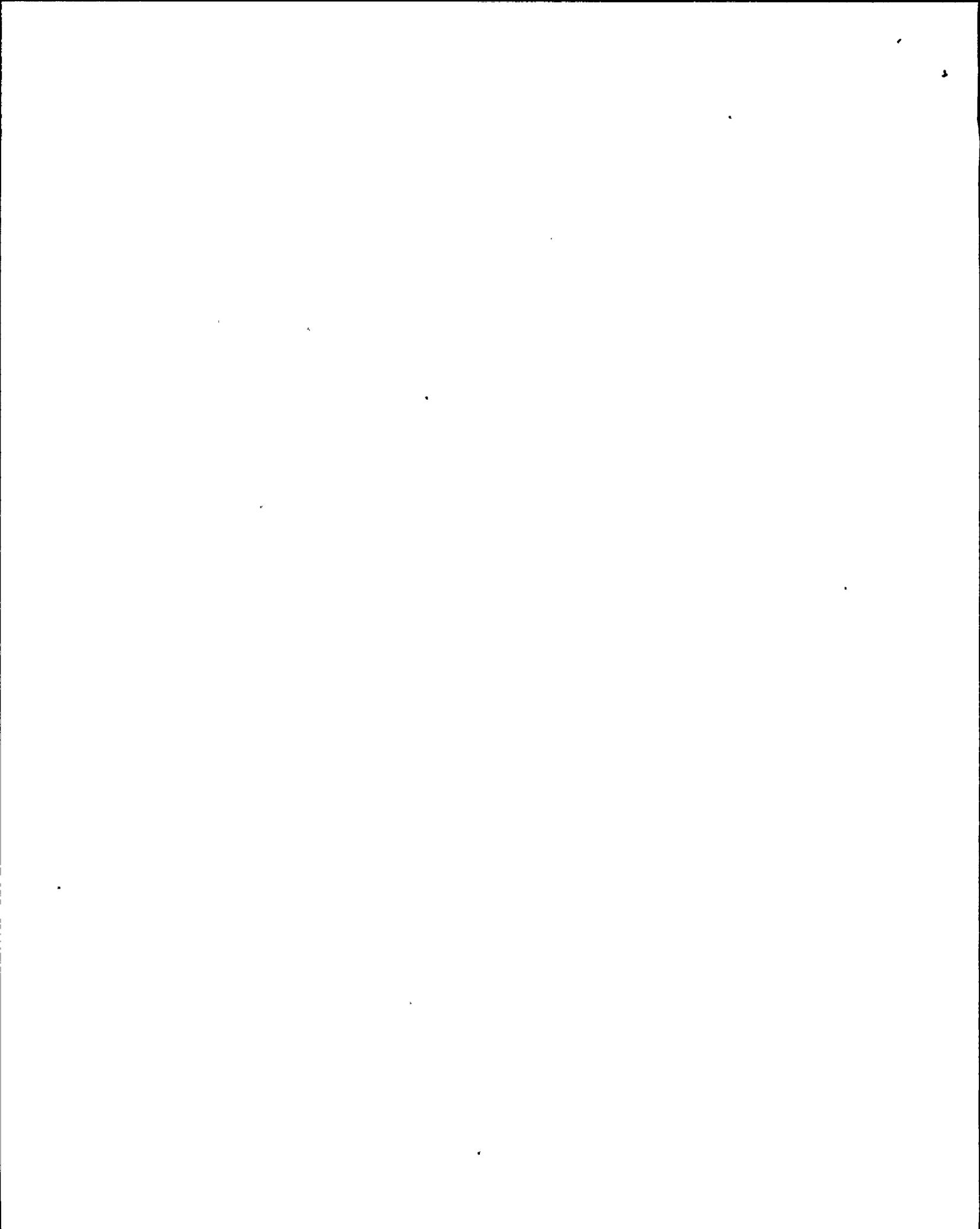
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During this assessment period, the unit remained shut down and defueled, thereby prohibiting assessment of operators' performance for at-power operations. However, observations of Operations staff support of major maintenance, modification and testing activities (including defueling of the vessel) indicated technical competence and a good level of knowledge of systems operation during the plant shut down. This was particularly evident during the Safety System Functional Inspection conducted in September 1988 in the operators' support provided to the inspection team. Personnel errors by Unit 1 operators were infrequent and isolated this assessment period.

Efforts by management to better integrate the Operations staff with other departments have been made during this assessment period. These efforts included; initiation of the Operators Training Program Advisory Committee (OTPAC) and interface meetings between the Operations and the Training departments; assignment of oversight responsibility for the Licensed Operator Requalification Training Program to the Operations Superintendent; rotational assignments of Reactor Operators (RO) and Senior Reactor Operators (SRO) to the Training Department; and special assignments of licensed operators to the Maintenance and Engineering staff, as needed during outages. While several of these efforts have not been in place long enough to provide evaluative results, the OTPAC was viewed as a positive step to resolve longstanding problems and has been generally well received by the operators.

One area requiring continued management attention was the matter of operators' attitude towards continued training as demonstrated by their behavior during training sessions. Specific instances of abusive and disruptive behavior by licensed individuals during requalification training were noted by the NRC, as well as NMPC management. There continued to be resistance by some operators towards integration with the training department. In addition, station management's efforts to improve operators' attitude and performance were ineffective. This concern was identified in the previous SALP and continues to be a significant concern to the NRC.

During this assessment period, the NRC identified that Unit 1 operators were not attending the requalification classes as required. Senior management was not ensuring that all requalification requirements were completed prior to submitting licensed operator renewal applications. A review of the Licensed Operator Requalification Training Program revealed that 39 licensed operators had not completed the required training prior to the end of the annual requalification period. In addition, deficiencies were noted in the facility senior management involvement in the requalification program, in that the operator renewal license applications contained inaccurate information concerning the completion of the



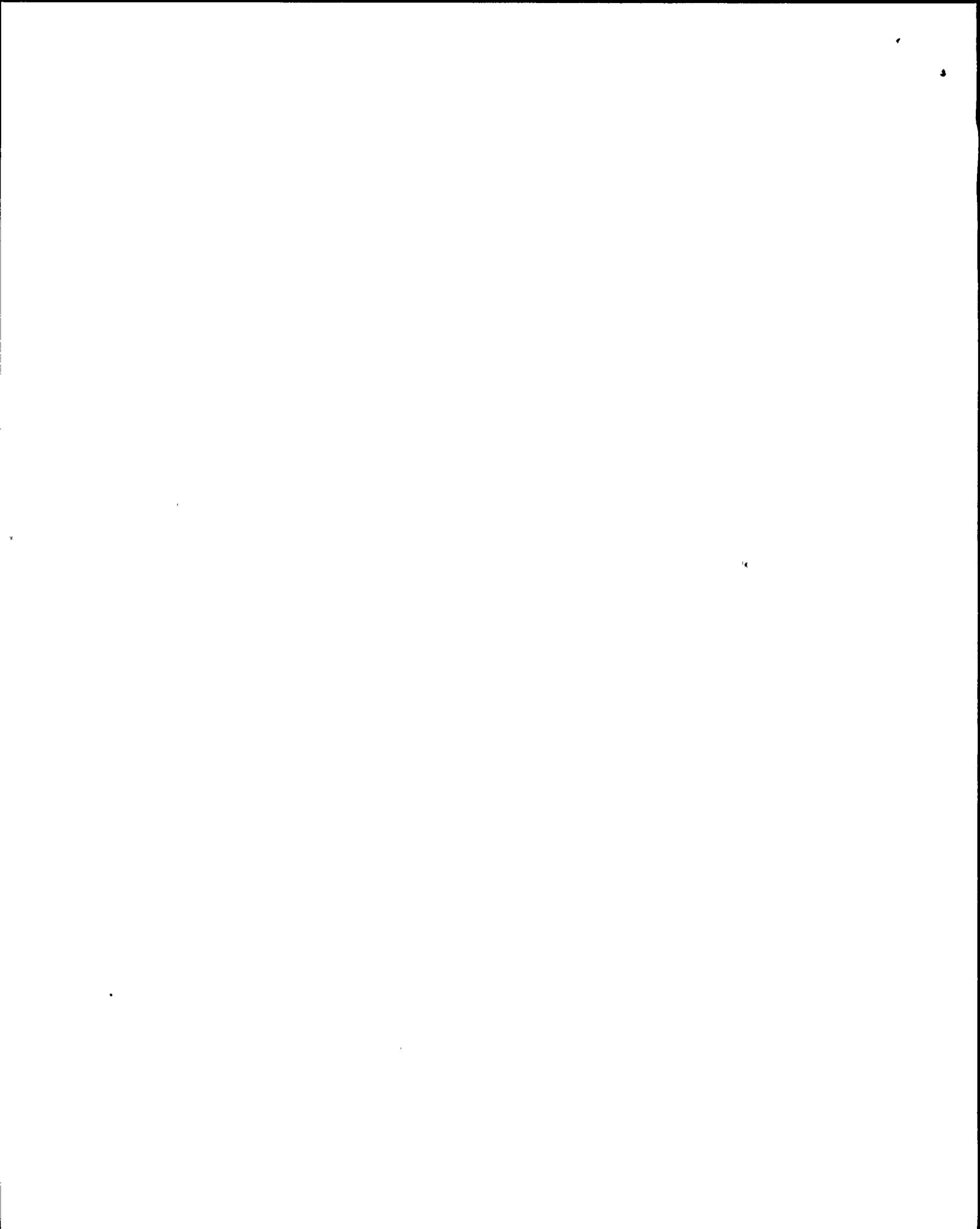
requalification program requirements. These deficiencies led to the issuance of Confirmatory Action Letter (CAL) 88-13 which identified actions that were to be taken to correct the deficiencies. Subsequent inspection showed that the licensee had completed the immediate actions necessary to comply with CAL 88-13.

During the inspection of the Unit 1 Emergency Operating Procedures (EOPs), the NRC observed that the more experienced operators were not able to adequately use the EOPs. The operations crew observed could not properly implement the EOPs and lacked an understanding of the basis for the EOPs. Specific EOP training deficiencies included: a fundamental understanding of the EOPs, the understanding of the accident mitigation strategies, the ability to implement the EOPs, poor team work and communications, and the recognition of emergency system status and degraded plant conditions. The inspection determined that the EOPs were generally well written and useable. The lack of operator familiarity of the EOPs was due to inadequate training during requalification and the lack of operations management involvement in assuring the training was effective. It was subsequently identified that licensed operators had expressed concerns to station management about the quality and quantity of training on the new EOPs. However, neither the operators or station management pursued these concerns to appropriate resolution until it became a regulatory concern.

In summary, the Unit 1 Operations concerns raised during the previous assessment, with respect to operator complacency and the strained relationship with the Training Department, were not adequately addressed this assessment period and continue to be of major concern to the NRC. Operators' attitude have not significantly changed and station management's efforts have been unsuccessful in dealing with these concerns. However, it is noted that subsequent to the end of this assessment period disciplinary action was taken against certain individuals in the Operations Department indicating that certain patterns of behavior would no longer be tolerated.

Unit 2 (810 hours, 10.4%)

This area was rated Category 2 (Improving) in the previous assessment. During that assessment period, the licensee had progressed through initial criticality and the majority of Test Condition 6 of the Power Ascension Testing Program. Minor weaknesses were noted in the control room environment, the control of operator aids, the lack of familiarity of operators with emergency equipment location, the lack of emergency diesel generator operating logs and the lack of an efficient method of tracking the operating time on special filter trains for the purpose of meeting Technical Specifications sampling requirements. A more significant weakness was



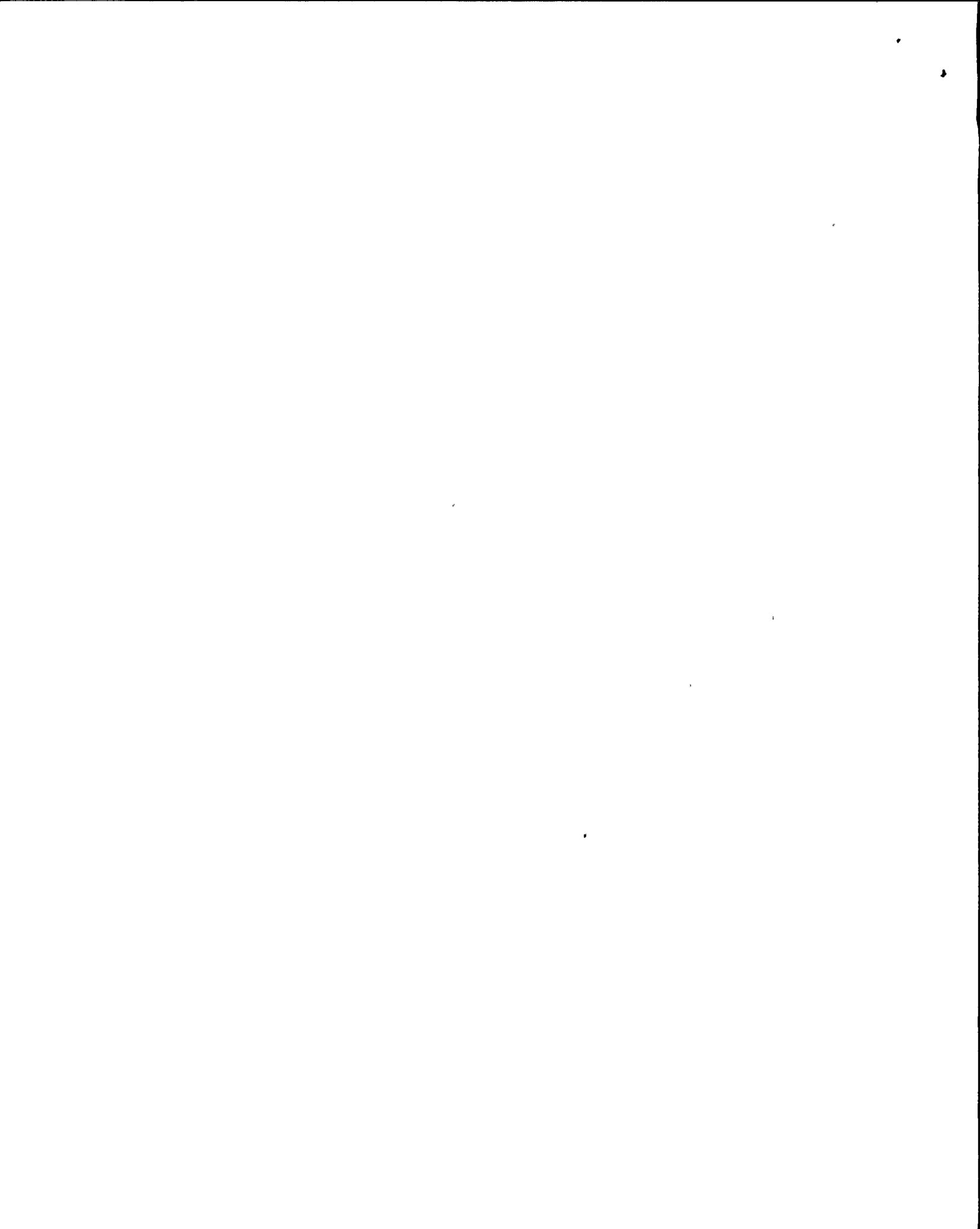
identified in the area of operator attention to detail as demonstrated by numerous personnel errors and procedural compliance violations. Improvement was noted in the area of operations management oversight of day-to-day activities, communications and responsiveness to identified concerns. In addition, Operations Department support of the Power Ascension Test Program was both enthusiastic and professional. Operator conduct of testing was cautious and response to testing anomalies was prompt and conservative.

Personnel errors continued to occur at a high rate during this assessment period. The majority of these errors were caused by inattention to detail or failure to follow procedures. An inadequate plant impact assessment for the performance of a loop calibration on a feedwater flow transmitter resulted in the 3/21/88 scram. Improper operator control of steam loads during start-up resulted in the 6/28/88 reactor scram. Improper assessment of the impact of cycling of a service water alternate cooling outlet valve on a spent fuel pool cooling heat exchanger resulted in a loss of Reactor Building Closed Loop Cooling water and a manual scram on 9/22/88.

Several personnel errors were made during the work release process, which resulted in inadvertent Engineered Safety Features actuations, a spill of 1000 gallons of acid, and a temporary loss of shutdown cooling. Although these personnel errors relevant to the work release process resulted in events of relatively minor safety significance, the potential effects of these types of errors could result in more serious problems.

Other miscellaneous personnel errors occurred during this assessment period. For example, during the performance of a monthly surveillance test, an operator performed a switch line-up incorrectly which resulted in a Low Pressure Coolant Injection to the reactor vessel. Another error occurred while securing from an Emergency Diesel Generator (EDG) surveillance test. An operator inadvertently opened the offsite power breaker instead of the EDG output breaker.

This broad spectrum of personnel errors exemplifies the lack of attention to detail and failure to follow procedures. As noted in the previous assessment period and as discussed above, numerous personnel errors continue to be experienced by the licensee. Corrective actions, to date, have not been effective in reducing the number of errors. This lack of effective corrective action to reverse this trend indicates inadequate management response to an identified concern and inadequate assessment of the root causes. More significantly, these continuing personnel errors represent station and corporate management's low expectations and acceptance of the present level of employee performance.



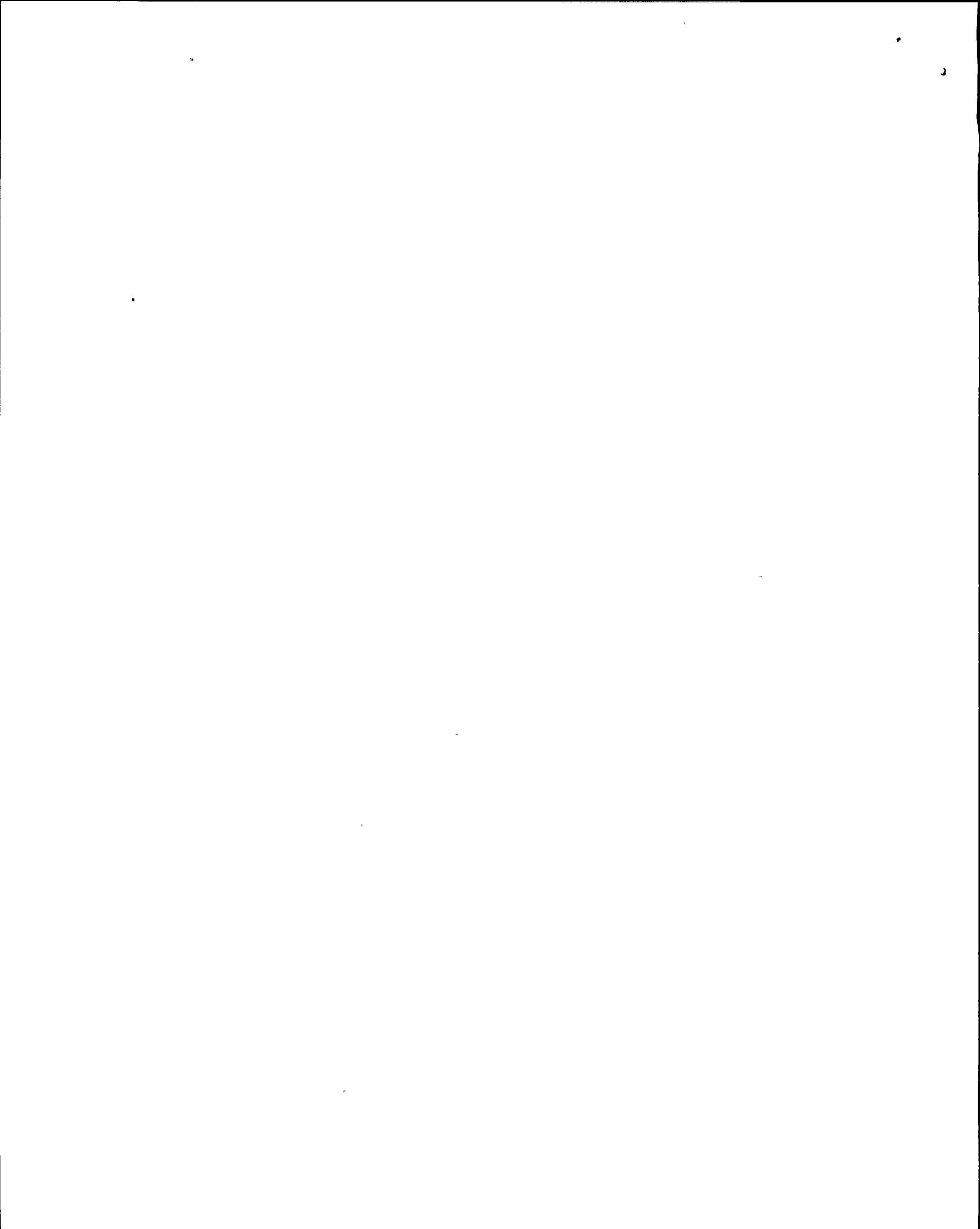
Other observations of control room activities indicate that the operators are experienced, knowledgeable and alert to off-normal indications or potential problems. An example of this was the performance of Automatic Depressurization System (ADS) testing during this assessment period. The control room operators and technicians conducting the test identified a significant system wiring error that effectively disabled the Division I ADS and which had gone undetected since initial fuel load.

Control room formality was observed to be satisfactory; however, there is a large number (approximately 50-60) of lit annunciators in the control room that exist during normal plant operations and which could mask a potential problem. This also reflects an environment that accepts a low standard. The licensee does have a program to reduce the number of normally lit annunciators, but progress to date has been slow. More emphasis should be placed on this item by station and Engineering Department management.

Evidence exists to demonstrate that Operations management has become more involved and aggressive in improving the operations staff training, professional development, and working environment. Examples include: minimization of overtime; successful negotiation for five additional SRO positions; approval of an SRO inter-departmental rotation policy for career development; increased training for non-licensed operators, including simulator training; and the development of an improved equipment mark-up-instruction for the Operations Department. An example of the Operations staff being proactive involves the implementation of BWR Owners' Group recommendations for actions to take when experiencing power oscillations subsequent to a recirculation pump trip. Procedures were revised and operators trained well in advance of the NRC Bulletin being issued.

The concern identified at Unit 1 regarding operators' inability to understand and adequately use the Emergency Operating Procedures (EOPs) did not exist at Unit 2 when the Unit 2 operators were subjected to the same type of scenarios. The major difference was determined to be that the Unit 2 operators were accustomed to the EOPs as part of their initial license training and conduct more frequent training on EOPs in the Qualification Training Program.

In summary, the Unit 2 Operations Department is staffed with experienced and competent personnel; however, closer attention to detail by operations staff and licensed operators is needed to stem the numerous personnel errors. More importantly, station and corporate management's performance expectations were too low and have resulted in complacency as exemplified by the overall poor performance trend during this assessment period.



2. Performance Rating:

Category: Unit 1 - 3
 Unit 2 - 3

3. Board Recommendations:

NRC: Restart Panel continue to monitor licensee performance and assist in directing NRC inspection efforts at NMP.

Licensee: Unit 1 - (See note below)

 Unit 2 - Raise performance expectations of the Unit 2 Operations Department and closely monitor progress.

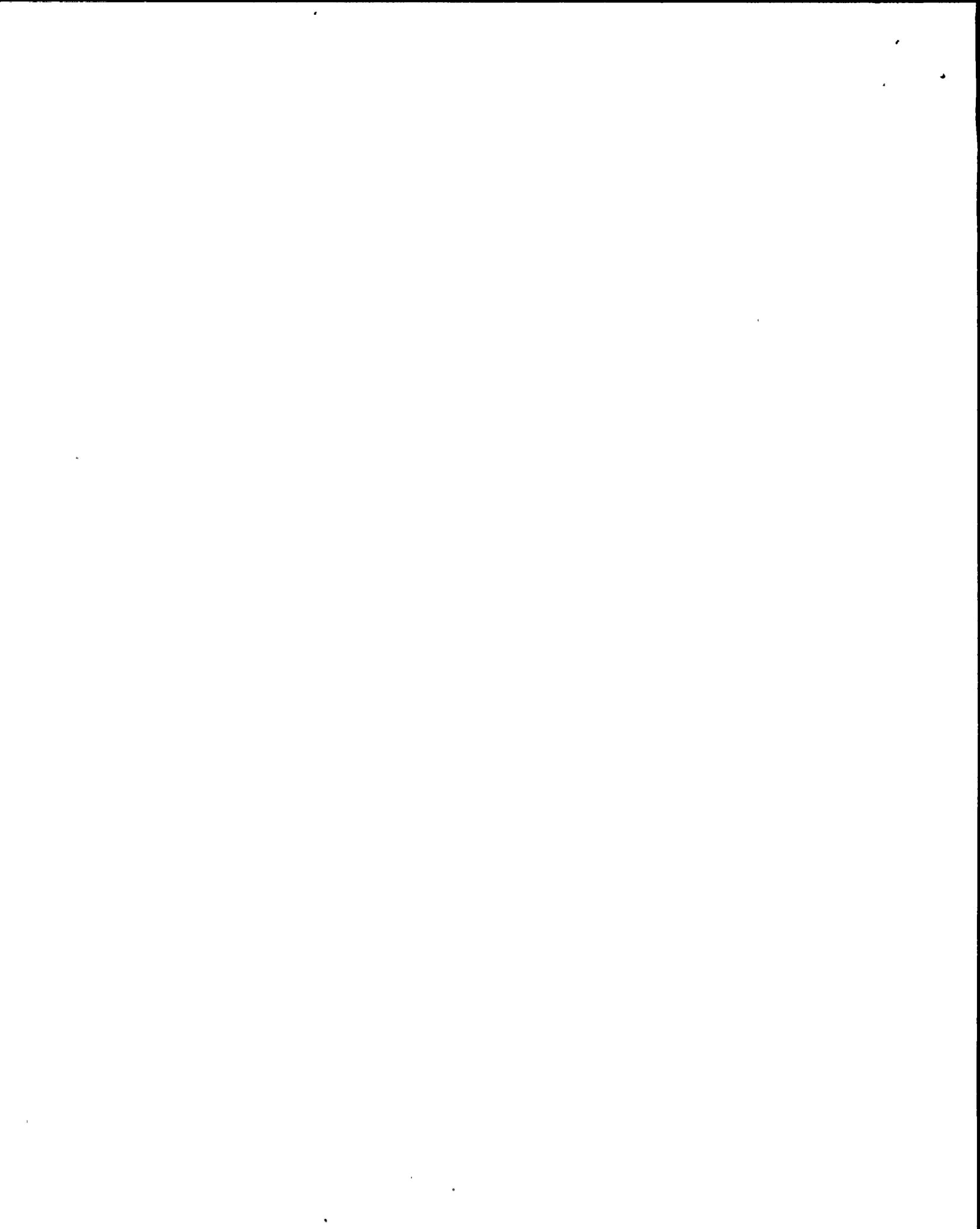
- Develop and implement a detailed and timely plan to reduce the number of lit annunciators on the main control panel.

Note: .No specific recommendations have been made for this or any other functional area, if it is addressed in the licensee corrective actions documented in the Restart Action Plan and Nuclear Improvement Program which have encompassed the major areas of concern to the NRC.

B. Radiological and Chemistry Controls (513 hours, 6.6%)1. Analysis:

The combined Radiological Control Programs at Nine Mile Point Unit 1 and Unit 2 were rated as Category 2 (Declining) during the previous assessment period. Program weaknesses identified last period indicated a need to improve supervisory oversight of ongoing work activities; personnel attention to detail; the corrective action program to ensure personnel are adhering to good radiological control practices and procedure requirements; contamination control; ongoing job ALARA reviews and non-radiological water chemistry.

During this assessment period, region-based inspectors performed seven routine inspections. Radiological controls were also examined during a Maintenance Team Inspection. The resident inspectors reviewed this area on an on-going basis.



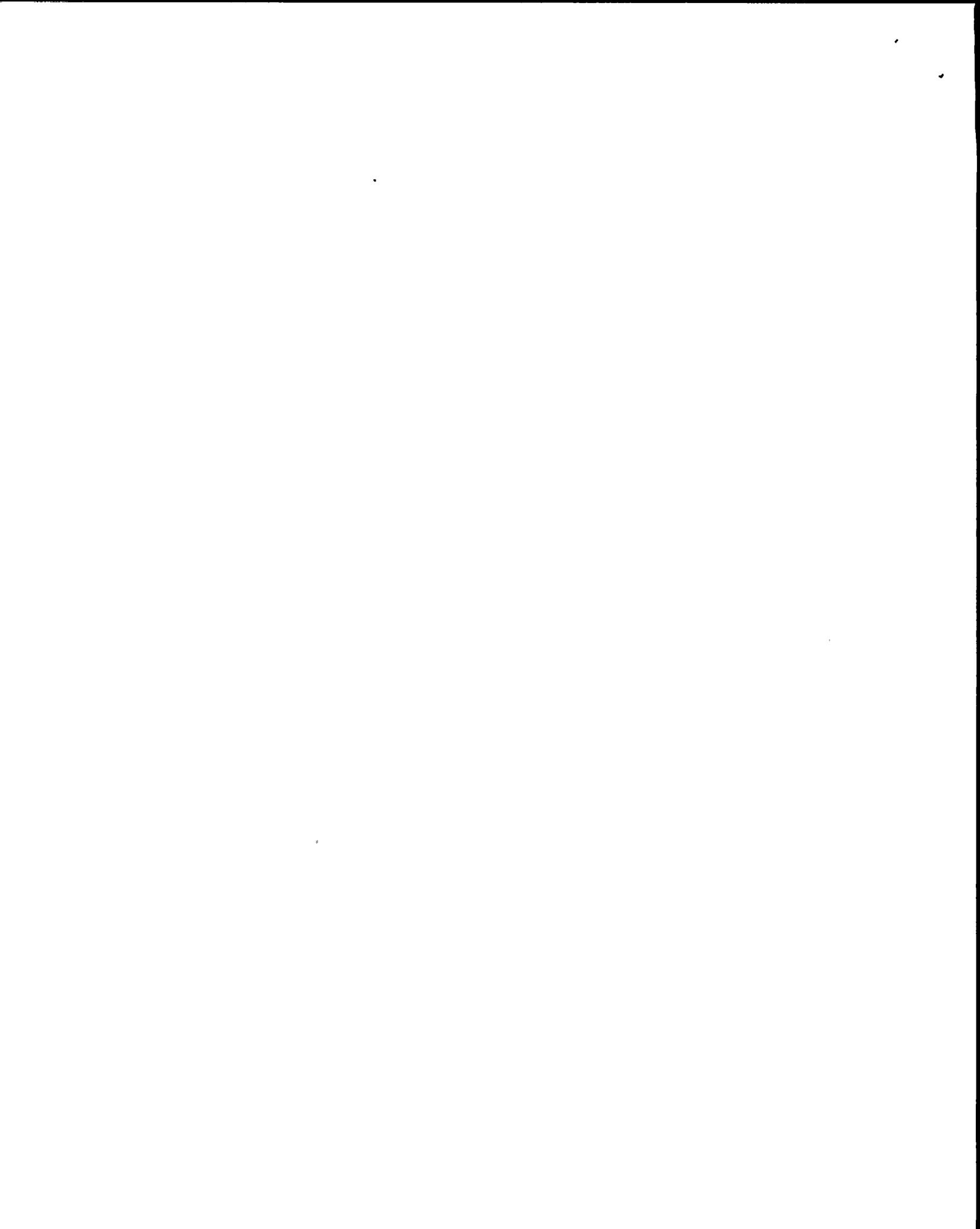
Radiation Protection

The radiation protection program is common to both units and is implemented through two separate radiation protection groups reporting to a common manager. During this assessment period, the licensee implemented several personnel and organizational changes, the most significant being the replacement of the Unit 1 Radiation Protection Supervisor and the creation of a dedicated Site ALARA Coordinator.

NRC observations late this assessment period indicated that first line supervisory oversight of ongoing work activities has improved with the addition of several new Chief Technicians. However, the licensee failed to identify, over an extended period of time, a situation where permanently installed ladders allowed unauthorized access to the Radwaste Sample Tank Room, an area controlled as a Locked High Radiation Area. In addition, the Radiation Protection Manager and the Supervisor of Radiological Support had infrequently entered the Reactor Buildings indicating a continuing need for additional management oversight.

An adequately defined personnel training and qualifications program is maintained and implemented. For contract health physics technicians, the licensee verifies experience, administers a screening exam to evaluate technical background and provides additional site specific training as necessary. The program to maintain radiation protection personnel cognizant of new procedures and procedure changes, a weakness identified in the previous assessment period, is adequate. The appropriate personnel were trained on the required procedures in a timely manner and procedure adherence has improved.

The licensee's ALARA program management has shown improvement during the current assessment period. The use of detailed isometric diagrams of the drywell helped reduce exposures associated with locating individual components. In addition, improvements were realized by the use of a mockup at Unit 2 in planning corrective maintenance on the recirculation loop isolation valve. In response to NRC concerns, the site ALARA program responsibilities were transferred from the Respiratory Protection Coordinator to a dedicated Site ALARA Coordinator. To strengthen and upgrade the site ALARA program, a consultant is currently assessing the program's effectiveness and recommending improvements. Improvements included changes to the Radiation Exposure Monitoring System (REMS), the addition of hold points on jobs not initially requiring an ALARA review, and methods to reduce the person-rem exposures associated with miscellaneous RWP's. In addition, to improve corporate oversight of the program, a Health Physicist from the site organization was transferred to the corporate staff to coordinate ALARA improvements.



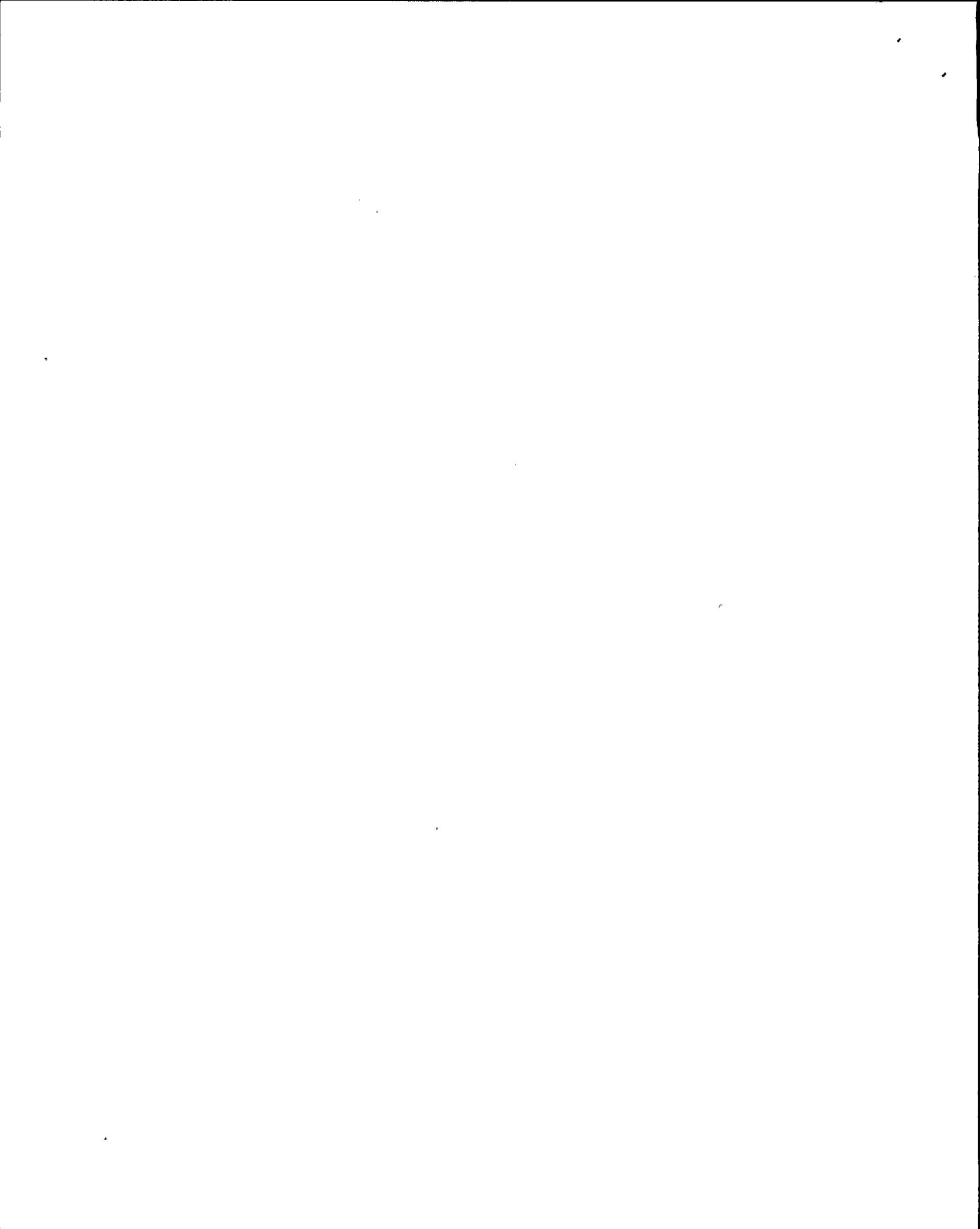
Licensee exposure for 1988 totaled approximately 804 person-rem for Unit 1 (outage year) and 85 person-rem for the startup year at Unit 2. Although above the industry's annual BWR average of approximately 500 person-rem, the extended outage at Unit 1 and significant ISI rework contributed to the higher exposures. Licensee performance during 1988 was adequate given the additional work scope and high inplant source term and showed improvement during the second half of the SALP period. Goals for 1989 have been set aggressively at 509 person-rem for Unit 1 and 128 person-rem for Unit 2 (its first full operating year). Unit 1 continues to suffer from a high inplant source term. Chemical decontamination efforts originally planned for 1988 have been delayed and is currently under consideration for the 1990 refueling outage. These delays are contributing to the continued high person-rem exposures at Unit 1.

Adequate internal exposure controls and contamination controls were provided for ongoing work. Licensee corrective actions and assurance of quality were generally adequate although occasional weaknesses were exhibited. For example, a review this period of corrective actions associated with a workers ingestion of a hot particle indicated an aggressive approach to both the worker's concerns and the technical evaluation of the existence of a discrete particle and its characteristics. In contrast, the licensee incorporated a new type of respiratory protection equipment into the emergency kits without first establishing and implementing the necessary procedures.

The licensee took actions to improve intra-departmental coordination of work activities. A Work Control Center was established at Unit 1 for the processing of all work requests and a dedicated Health Physics Planner provides a single interface with the Radiation Protection (RP) department in the processing of required Radiation Work Permits and pre-job ALARA reviews. In addition, two RP liaisons were assigned to the Unit 1 Maintenance department to coordinate on-the-job support of work activities. These licensee initiatives have improved the coordination of work activities with the RP group during the Unit 1 extended outage.

Radioactive Effluent Controls

The program for Unit 1 was evaluated in the areas of instrument calibration, release permits, the Off-Site Dose Calculation Manual and the semi-annual effluent reports, and found to be effectively implemented. The program for Unit 2 has shown improvement from the last assessment period. As identified in the previous SALP, operability of the Gaseous Effluent Monitoring System (GEMS) has been a continuing problem at Unit 2. Further, alternate methods for gaseous effluent monitoring when the GEMS was inoperable had been lacking. The licensee has taken action to improve the



operability of the GEMS and has developed and implemented procedures for alternate monitoring methods when the GEMS is inoperable. During the assessment period there were no unplanned effluent releases, and planned releases were at levels normal for a Boiling Water Reactor site.

Radiological Environmental Monitoring Program

The licensee has contracted with a vendor laboratory to perform the analysis of environmental samples required for the Radiological Environmental Monitoring Program (REMP). The licensee's environmental dosimetry program results show good agreement with both the State of New York and NRC environmental dosimeters. Audits in this area of both the vendor laboratory and the REMP were found to be thorough, with all recommendations addressed in a timely manner.

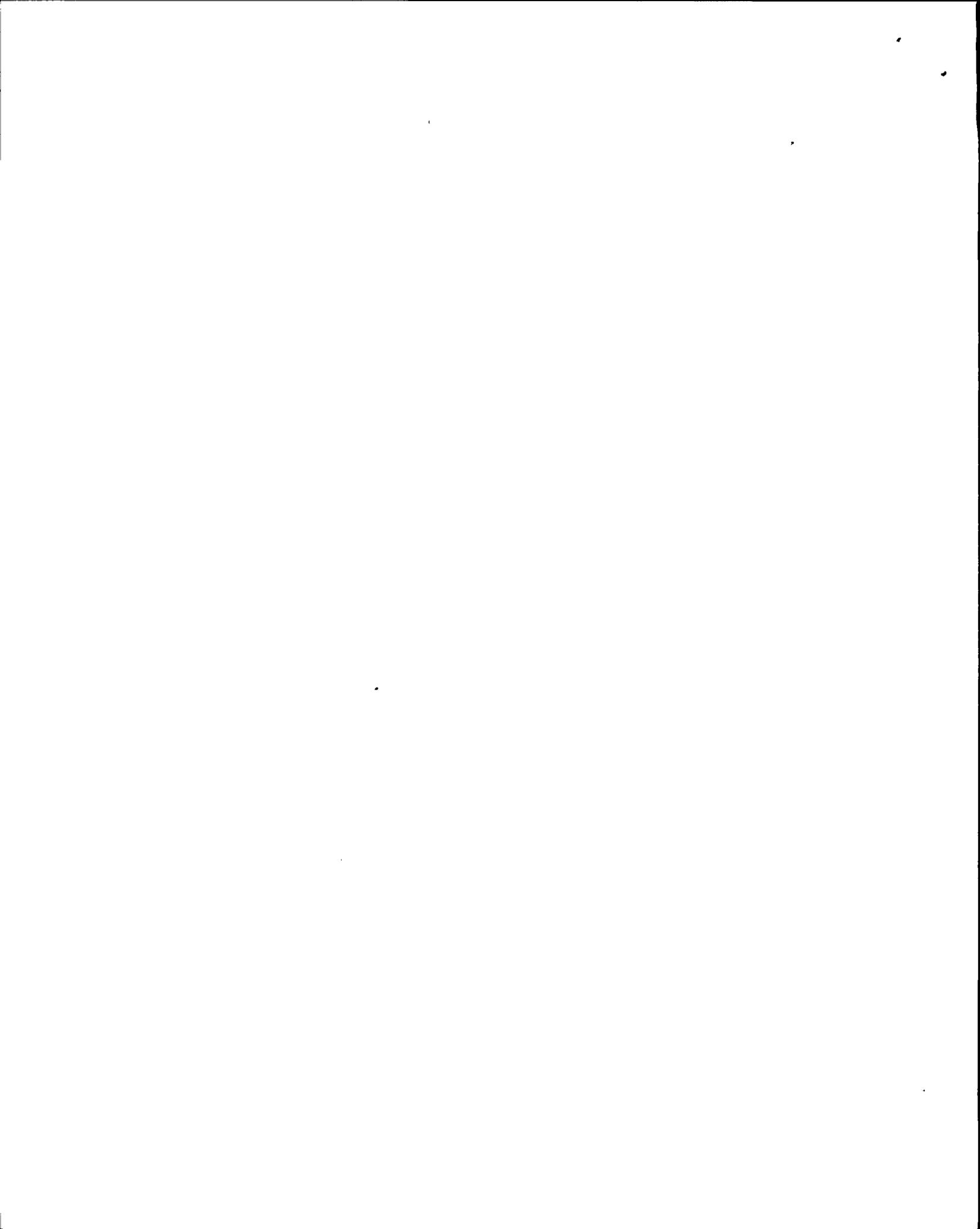
Transportation

The transportation program is conducted by a site Materials Shipping group which has shown significant improvement since the hiring of a group supervisor during the second half of the SALP period. Filling of this position has led to additional management review of shipments prior to leaving the site, which reduces the chances of errors while shipping. There were no major problems noted during this period. The licensee is in the process of implementing the use of a computer code for the purposes of determining transportation and waste classification which will further enhance this program by reducing calculational errors.

Solid Radioactive Waste

Each unit at the site continues to maintain its own program for the processing and packaging of radwaste. Although these two programs utilize separate vendors and processes, each has continued to improve its program. Continued developments by both units in the area of waste solidification will further enhance these programs. Audits by the licensee's quality assurance department were thorough, with all recommendations addressed in a timely manner.

During this assessment period the licensee could not account for several small, non-irradiated, local power range monitor fission chambers. The licensee identified that this small amount of special nuclear material was missing as a result of an annual audit, and believes that the fission chambers were disposed of with radioactive waste. The discovery of the missing material is commended; however, the loss is reflective of a previously ineffective special nuclear material control program.



Overall Summary

The licensee made several enhancements to address previously identified weaknesses and the overall program has shown steady improvement over the SALP period. Observations indicate that although supervisory oversight of ongoing work has improved, RP management oversight is weak. In addition, significant licensee initiatives which began late in the assessment period are expected to improve accountability and oversight of ongoing work.

2. Performance Rating:

Category: 2

3. Board Recommendations:

NRC: None

Licensee: Place more emphasis on Unit 1 decontamination

C. Maintenance and Surveillance (2639 hours, 34%)

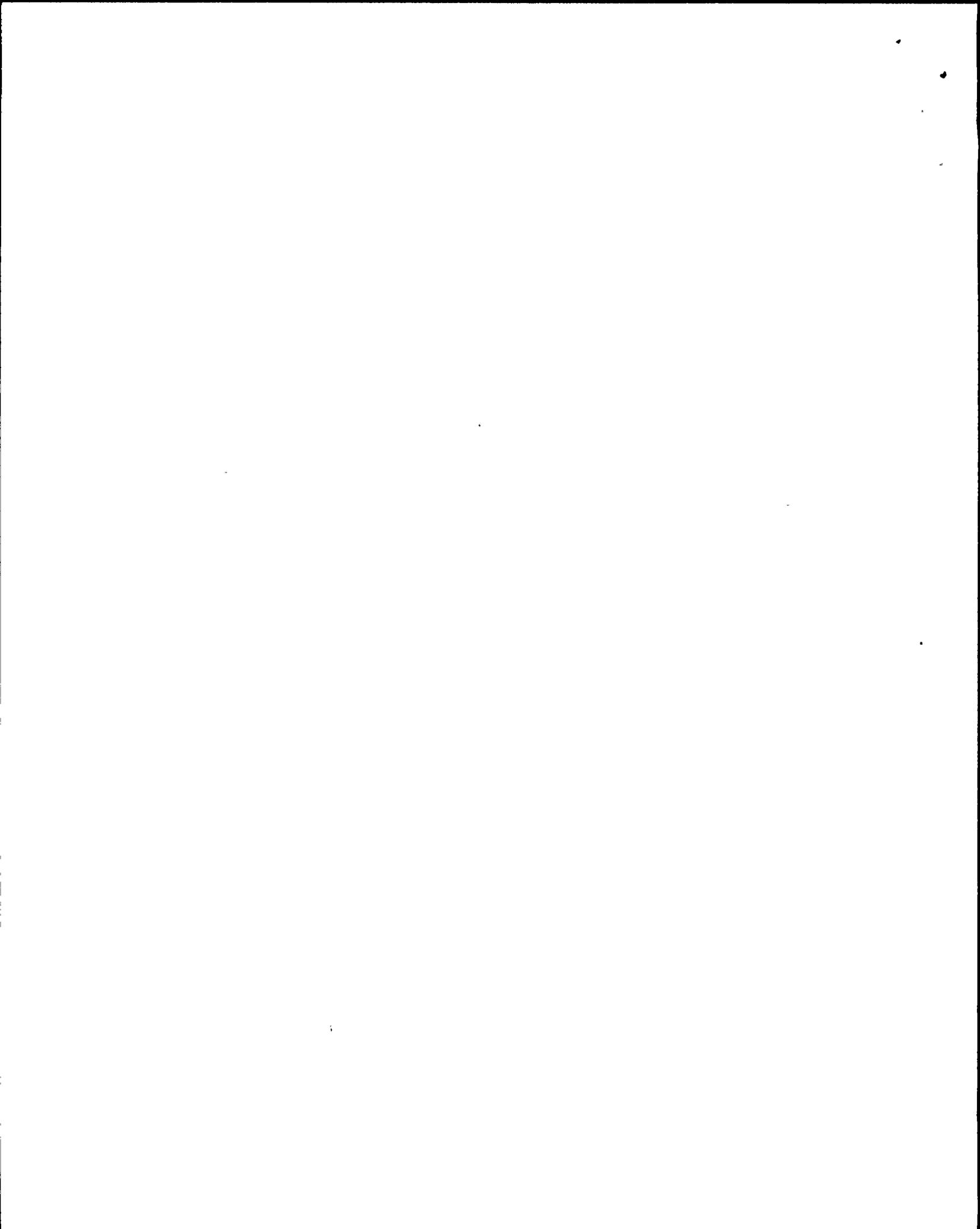
1. Analysis

During the previous assessment period, the maintenance and surveillance areas were evaluated separately and each area was rated Category 2. For this assessment both functional areas have been combined and one category rating is assigned.

During this assessment period the licensee transferred the responsibility for the Instrumentation and Controls (I&C) organization from the Technical Superintendent to the Maintenance Superintendent as part of a station reorganization. The Unit 1 and Unit 2 Maintenance Superintendents and Unit Supervisors presently have a dual reporting responsibility to the Site Superintendent of Maintenance and the Station Superintendents of Units 1 and 2.

Maintenance - Unit 1 and 2

During the last assessment, improvement in first line supervisory oversight and higher visibility and interaction of senior maintenance management in the field were noted. Root cause evaluations and attention to detail in maintenance implementation were noted as weaknesses, but were showing signs of improvement.



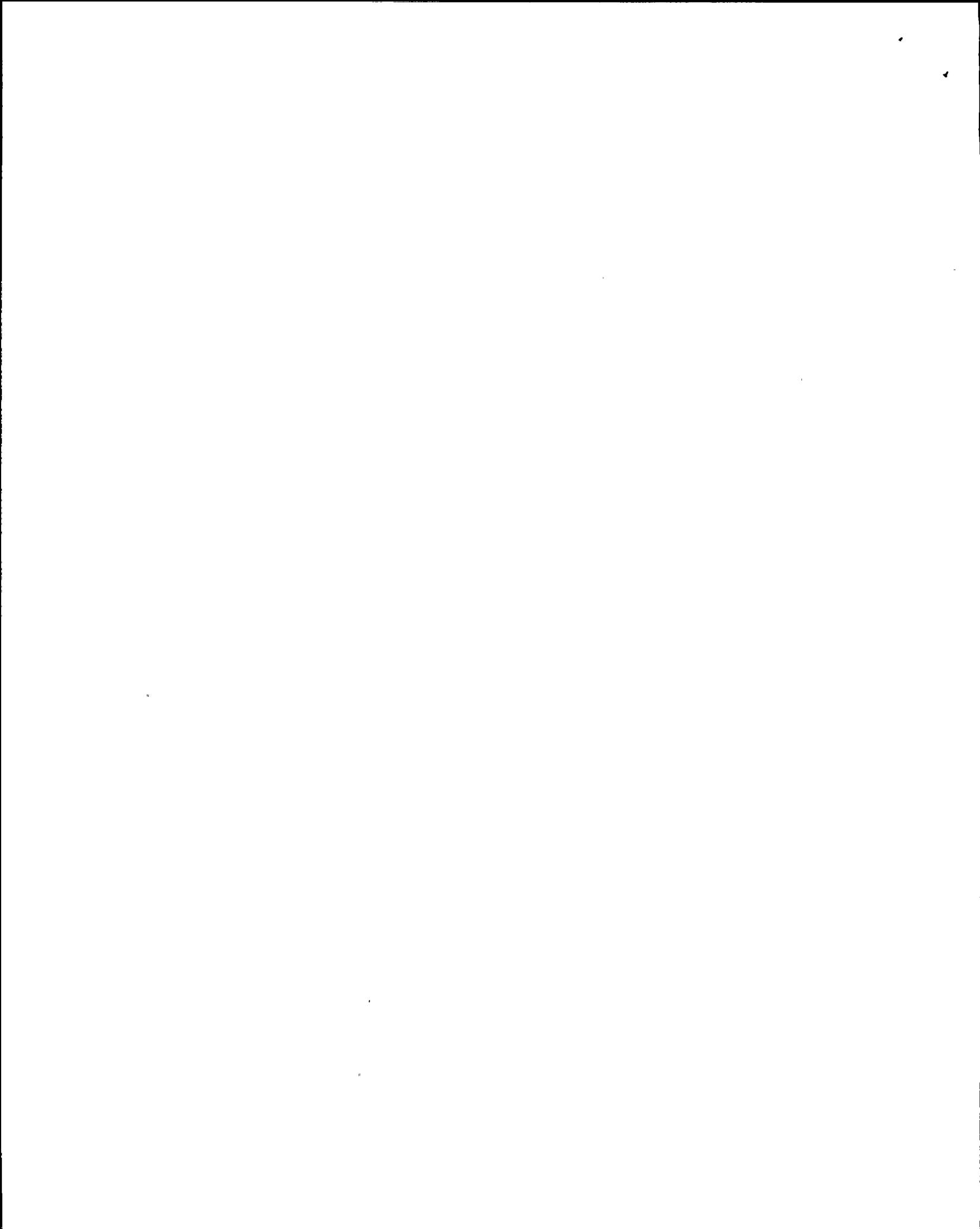
Improved management involvement in housekeeping, selective observation of work in progress and interface and feedback meetings with craft personnel indicated management's contribution to an overall effectively implemented maintenance program this assessment period. Maintenance Department management benefits from experienced and knowledgeable personnel who provide continuity by their long term involvement and low turnover rate.

Contractor maintenance work was effectively controlled; however, weaknesses existed in the type of checklist used for the surveillance of the contractors. A system for maintenance trending and performing root cause analysis has been established with both corporate and site personnel trained in the analysis techniques. The Nuclear Engineering Organization has established a central program to evaluate the effectiveness of the maintenance program.

In addition to a sound corrective and preventive maintenance program the licensee has initiated the increased use of predictive and diagnostic techniques. A rotating equipment vibration analysis program and use of infrared thermography techniques are among the new techniques being used. An additional initiative developed is the functional work control program. Work is being planned, prioritized and scheduled in accordance with directives. Backlog monitoring has been established through the use of maintenance performance indicators and the work tracking system.

Despite these initiatives, weaknesses in procedural adequacy and compliance were observed this assessment period. The written periodic maintenance program did not appear to include all vendor recommendations and some of the periodic maintenance activities were being performed without the benefit of written guidance. A review of Unit 1 waste surge tank pump and diesel fire pump and Unit 2 emergency diesel generator maintenance indicates procedures were either not being complied with or were poorly written. Some maintenance personnel appeared to be insufficiently trained to properly implement these procedures or change them if necessary. The maintenance personnel continuing training program was also found to be lacking and inconsistently implemented. Concerns regarding procedural compliance were brought to the licensee's attention early in the assessment period and periodically thereafter. However, the licensee did not take prompt and effective action to reverse this trend.

Another weakness that continues to exist is in the area of followup and correction of previously identified problems. An example was poor followup on the maintenance self-assessment performed in 1987. A licensee audit identified that no program or responsible organization was made accountable for reviewing maintenance self-assessment item resolutions and recommending corrective actions.



In contrast to the weaknesses addressed above, the repair of the recirculation loop isolation valve at Unit 2 was an example of a well planned and executed maintenance activity. The licensee utilized a mock-up to ensure proficiency during the actual maintenance and to fine tune the work instructions. No significant problems were encountered physically or procedurally. During the last assessment, problems in the area of repetitive equipment failure due to inadequate root cause determination were documented. In this assessment period, no problems of this nature were observed.

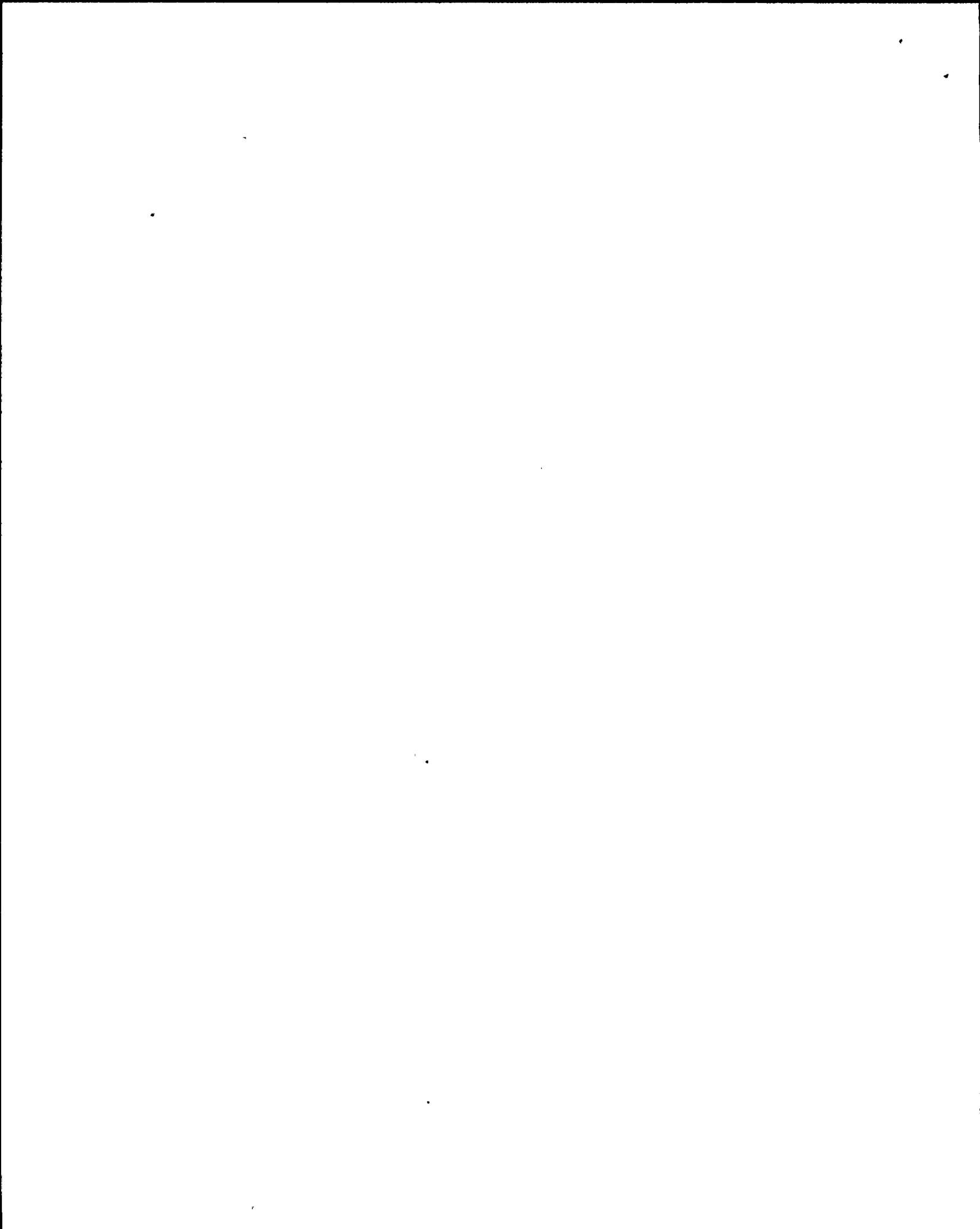
During this assessment period several deficiencies were noted with house-keeping, in particular with the material condition of the HPCI/FW, shutdown cooling and core spray systems at Unit 1. In addition, the 237 foot elevation of Unit 1 reactor building including the entrance to the drywell and the CRD hydraulic control units area were in poor condition and inhibited routine tours by plant personnel. Typically the remote areas of the plants and the high work areas have been of concern; however, overall improvements in housekeeping were observed during this assessment period. For example, the condenser bay and refueling floor areas were much improved. Increased management and station employee attention to this area was evident.

Surveillance - Unit 1

During the previous assessment period, the Technical Specification surveillance testing program was determined to have been effectively implemented with only minor problems identified. However, numerous problems identified in the Inservice Inspection (ISI) Program demonstrated the need to strengthen corporate and station management oversight of the program.

During this assessment period, missed surveillance tests and surveillance related problems remained at a low level. Licensee corrective actions for the known ISI problems resulted in the identification of more ISI Program deficiencies. Additionally, problems were identified by the licensee in the Inservice Testing (IST) Program this assessment period. Problems in the ISI and IST Programs are attributed to past management ineffectiveness in the oversight of these programs.

Followup NRC inspections early in the assessment period identified additional ISI weaknesses in the area of licensee overview of contractor activities involving thickness measurements of piping systems and the torus shell. Additionally, the licensee's own Quality Assurance (QA) Department issued a Stop Work Order on contractor's ISI activities because of the poor quality of examination documentation and result evaluation. This action, although indicative of good QA oversight, indicates weak oversight by the Engineering staff who were responsible for revising and implementing the ISI Program and associated corrective actions.



Throughout the assessment period, licensee management devoted considerable resources to resolve the issues related to ISI on Unit 1. NRC reviews near the end of the assessment period determined that the licensee had established satisfactory control systems and a new organization staffed with appropriately qualified individuals to effectively implement the new ISI Program.

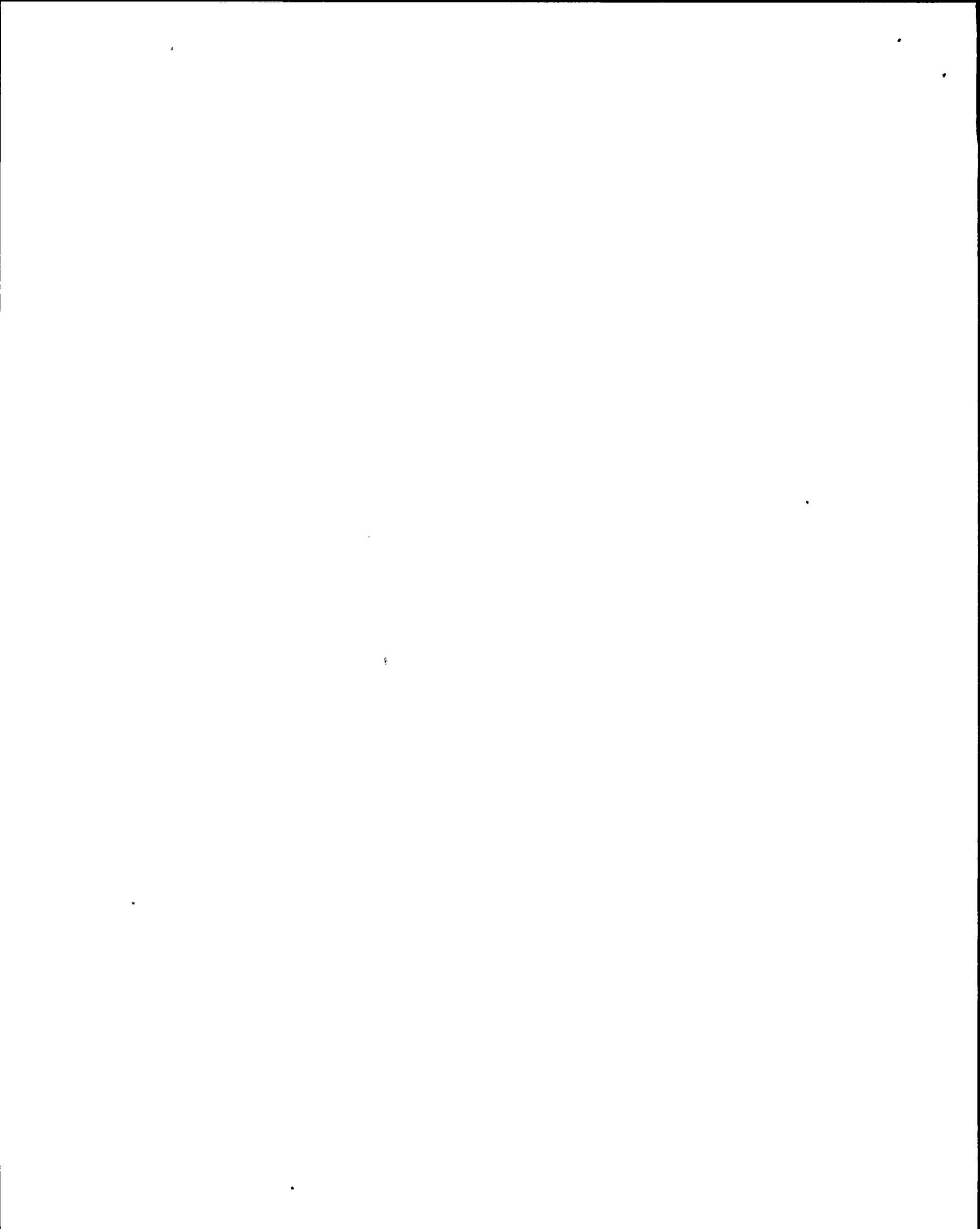
The Unit 1 Safety System Functional Inspection (SSFI) team found some examples where the surveillance testing data collection, results review and acceptance criteria would not adequately support system operability decisions. This weakness appeared to be a direct result of poorly defined system design requirements. A subsequent team inspection identified examples of poor procedural compliance and adequacy. Frequently performed surveillance tests were not followed step-by-step and in some instances the attached checklists were used without reference to the written procedure.

Surveillance - Unit 2

During the previous assessment period, several surveillance tests were missed because of inattention to detail and insufficient supervisory oversight. In addition, numerous unanticipated events occurred during the performance of surveillance testing. These events were generally the result of test procedure inadequacies or personnel errors. The implementation of the Surveillance Testing Program was found to be adequate during the initial phase of power operations; however, closer management attention was needed.

During this assessment period, the licensee's failure to perform required surveillance tests was again a concern. Examples of missed tests included: failure to record surveillance data during reactor cooldown subsequent to a reactor scram due to operator error; failure to perform a surveillance test on a primary containment penetration due to personnel error; missed snubber surveillance tests due to an inadequate list of snubbers; and missed Average Power Range Monitor surveillance due to programmatic deficiencies. As in the previous assessment period, this high number of missed surveillance tests indicates inattention to detail and insufficient supervisory oversight. The missed surveillance tests were spread between the different station departments and the Engineering staff.

The unit again experienced many unanticipated events during the performance of surveillance testing during this assessment period. The preponderance of these events was caused by procedural inadequacies or personnel error.



Examples of events caused by procedural problems include an inadvertent actuation of the standby liquid control system (SLS) discharge valves during SLS surveillance testing and a temporary loss of shutdown cooling during leak detection surveillance testing. These test procedure inadequacies were not considered to be a significant problem, but indicate technical procedural development could be improved.

Examples of events caused by personnel errors include a high pressure core spray (HPCS) system initiation during surveillance testing when an I&C technician failed to follow the procedure by measuring resistance across an open contact vice measuring voltage as specified in the procedure, and a reactor scram which resulted from an inadequate plant impact assessment before performing loop calibrations on feedwater flow transmitters. These procedural problems and personnel errors collectively indicate poor station management oversight, especially since the same concerns were identified during the last assessment period.

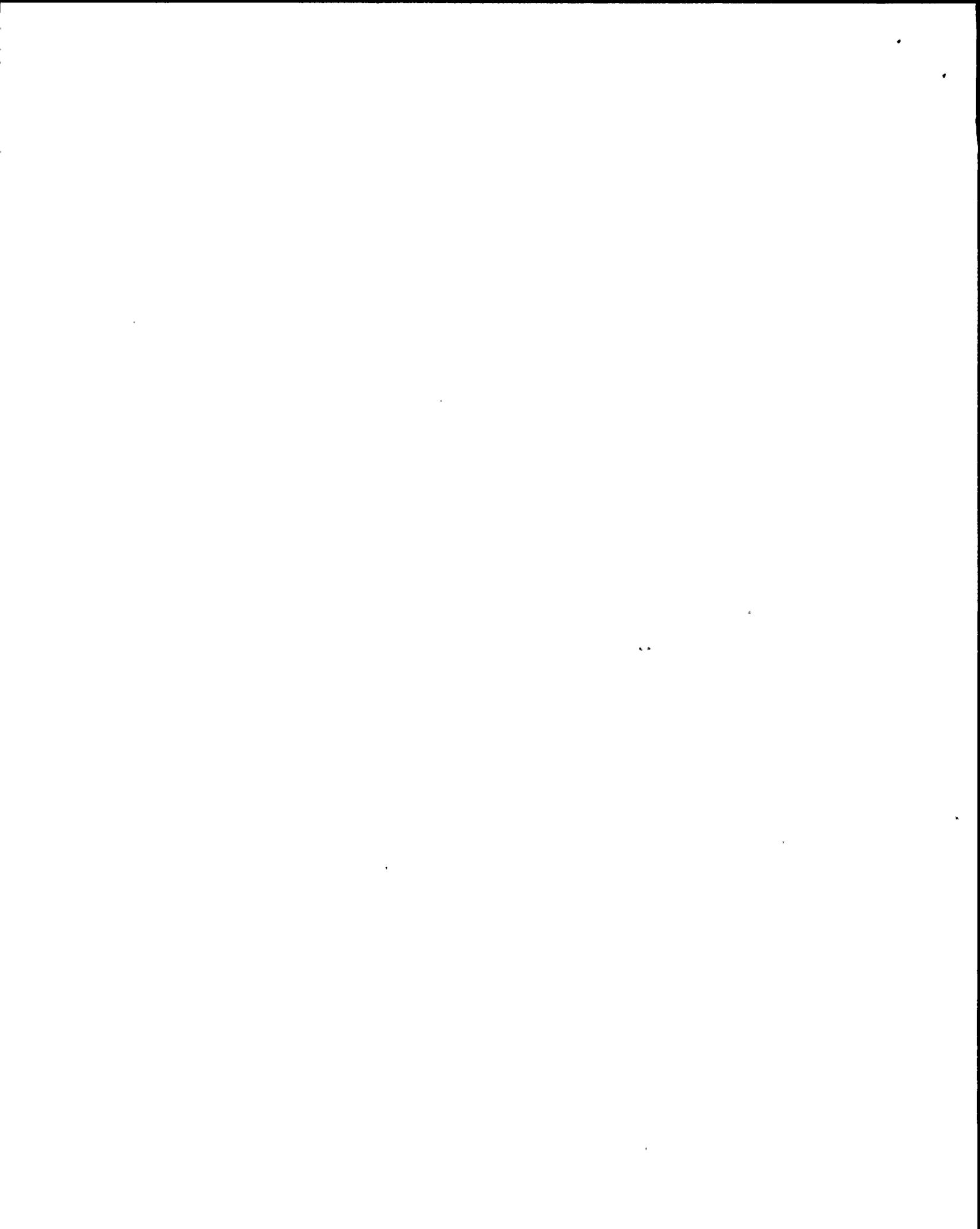
Corrective actions to address these concerns include the development of a more formalized tracking system, the implementation of an Engineering Department control program for Technical Specification equipment surveillance lists, and (subsequent to the end of the assessment period) the clarification of, and training on, the procedural compliance policy and requirements documented in Station General Order 89-03.

NRG-review of the Unit 2 ISI Program identified that staffing was adequate and personnel were experienced and knowledgeable. Examination data were well documented, licensee reviews were thorough and professionally done. The disposition of results was technically justified and the closeout of findings was based on sound engineering analysis. Implementation of the Unit 2 ISI Program was considered good.

The Power Ascension Testing Program (PATP) was completed during the assessment period. The results indicated that the testing occurred without major exceptions and was consistent with the good quality of the PATP as discussed in the previous assessment. The minor exceptions were adequately analyzed and resolved. The program was closed with no major technical problems.

Fire Protection - Units 1 and 2

During the previous assessment period frequent and recurring personnel errors were noted in the implementation of the station Fire Protection Program with an improving trend at the conclusion of the assessment period. This trend did not continue throughout this assessment period as similar personnel errors occurred. In addition, the licensee identified a significant breakdown in their Technical Specification fire barrier



penetrations surveillance program which led to the discovery of a multitude of improperly designed and/or installed fire barrier penetration seals at Unit 1. Further, this Unit 1 penetration surveillance problem, was identified to the licensee in 1985 as the result of a contractor audit; however, comprehensive corrective action was not taken until this assessment period.

Although personnel errors have persisted and management followup of previously identified concerns was inadequate, the licensee's Fire Protection/Prevention Program for both units was observed to be generally adequate. The deficiencies identified during this assessment period by the licensee and NRC inspectors, and inspector's review of the licensee's corrective actions indicated that the Fire Protection/Prevention Program requires improved overall day-to-day coordination and management guidance.

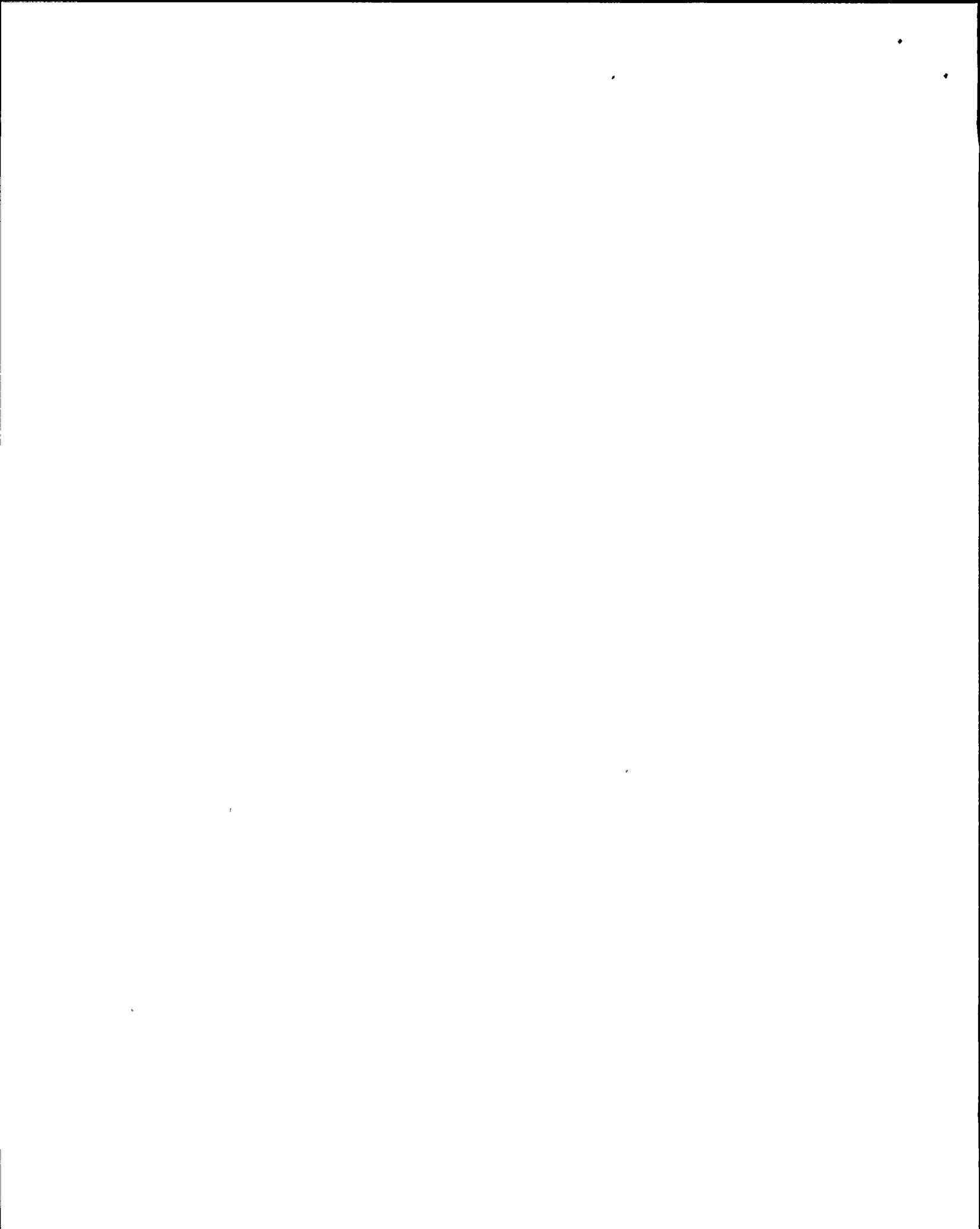
Overall Summary

The licensee has implemented an effective maintenance program. The material condition of the plant, the experience and knowledge of onsite personnel, the controls for the performance of maintenance, the interaction between Maintenance and Operations staffs, and the documentation of maintenance activities were considered adequate. However, corporate and station management attention is required to address improved oversight of performance, effectiveness and timeliness of corrective actions, and adequacy and compliance with maintenance procedures.

The surveillance program at Unit 1 is adequate. The ISI program which was considered poor at the beginning of the assessment period shows significant improvement, thus demonstrating that the licensee's management is capable of ensuring correction of identified problems once their attention is focused on it. This same focus by management needs to be applied to ensure the IST program is properly implemented and that surveillance procedures are adequate and adhered to by station employees.

Implementation of the Unit 2 surveillance testing experienced various procedural and personnel deficiencies during this assessment period. Follow-up of technical testing problems has generally been good. The licensee has implemented more stringent control in the surveillance testing area, effectiveness of which has not been fully determined. In summary, performance in the surveillance area was minimally acceptable.

Overall, performance in the fire protection area has declined over this assessment period.



2. Performance Rating:

Category: 3

3. Board Recommendations:

NRC: None

Licensee: None

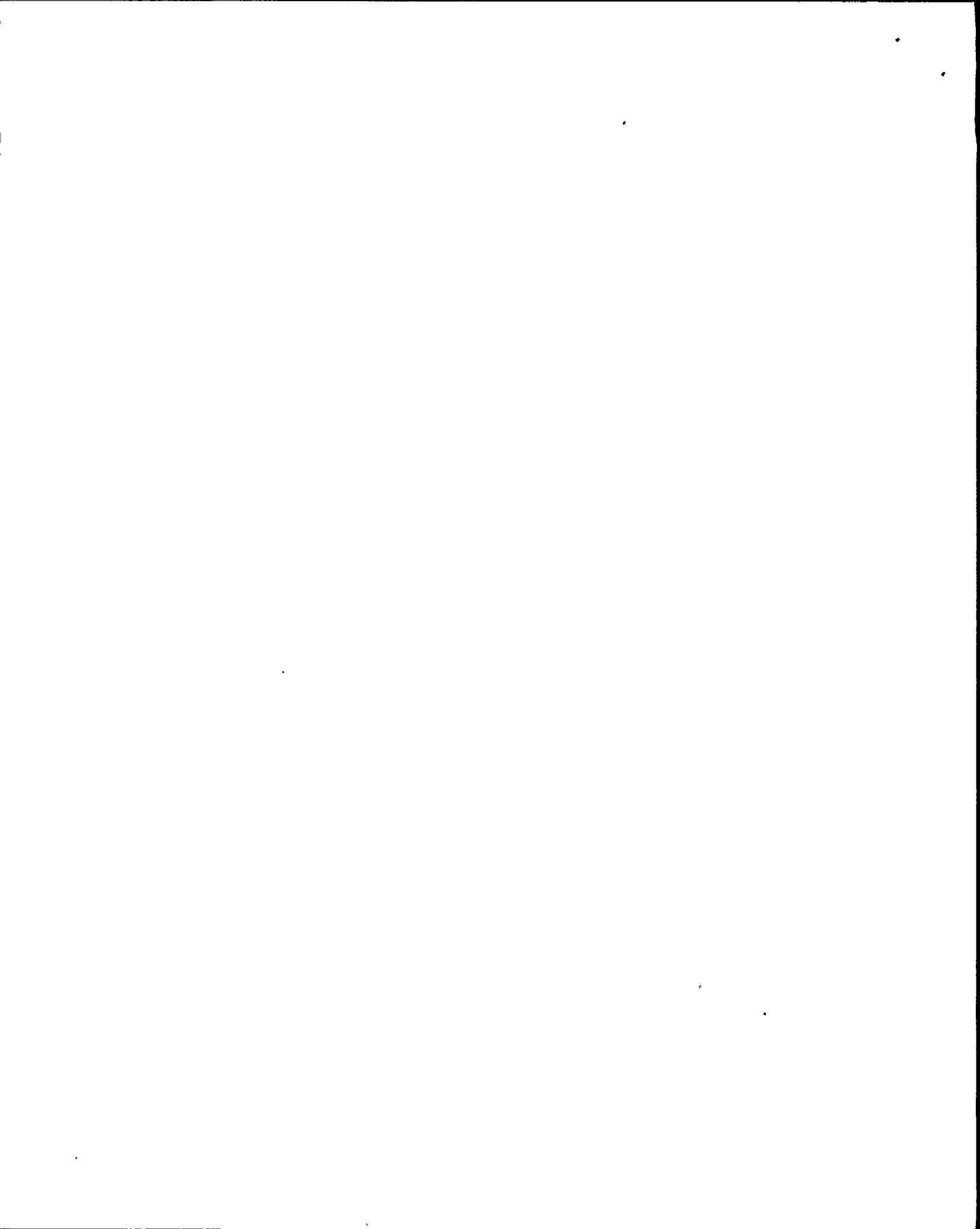
D. Emergency Preparedness (224 hours, 2.9%)1. Analysis

During the previous assessment period, licensee performance in this area was rated Category 1. This assessment was based upon good exercise performance and the licensee's own initiatives in routine emergency preparedness activities.

During the current assessment period, one partial-participation emergency exercise was observed, a routine safety inspection was conducted, and a special Emergency Response Facility (ERF) Appraisal was conducted to verify licensee implementation of NUREG-0737, Supplement 1 orders.

In the partial-participation exercise held on August 2, 1988, the primary objective of the scenario was to test the interface between the licensee's Emergency Plan and Security Contingency Plan. The licensee's execution and participation demonstrated thorough response and a strong commitment to emergency preparedness. The NRC team found that personnel demonstrated complete knowledge of procedures under emergency conditions, interfaced well with the security force, and implemented the emergency plan efficiently. Analysis and classification of events were timely and command and control exhibited by managers of each emergency response facility were effective. No significant deficiencies were identified and only minor facility and performance weaknesses were noted. The licensee concurred with the NRC-identified findings and initiated appropriate corrective action.

In conjunction with the annual exercise, the ERF Appraisal was also performed. Results of the appraisal identified certain programmatic areas which were either incomplete or in need of increased licensee attention. Of primary concern was the licensee's dose assessment model. The NRC team found that improvements were needed in all aspects of the dose assessment program including undefined isotopic distributions and release rates associated with all Unit 2 FSAR accidents and post-accident sample results not properly incorporated into dose calculations. Other identified

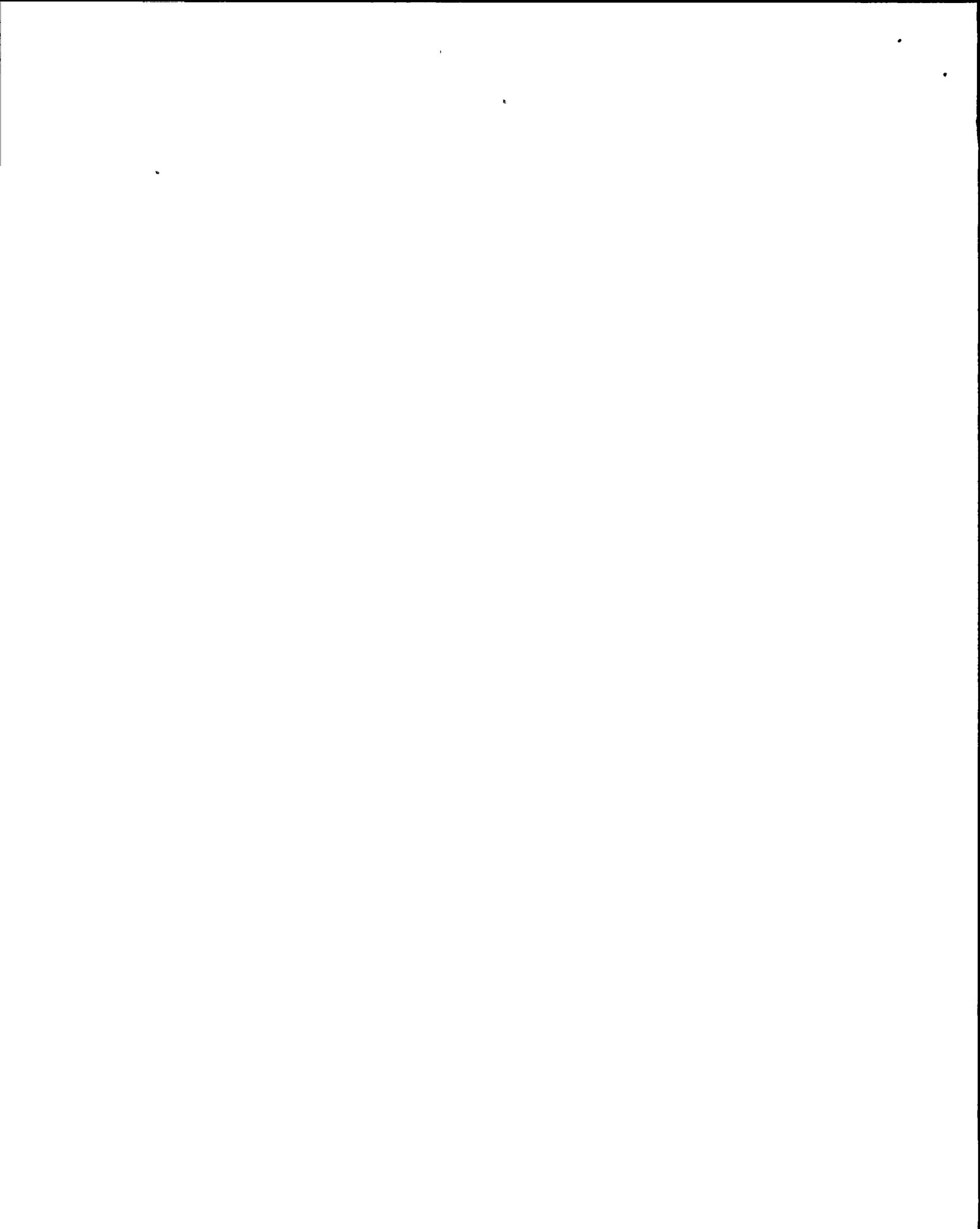


deficiencies were found in the storage capacity of the Unit 1 Plant Computer System to report pre-event and post-event plant data, and Emergency Operations Facility habitability. In response to NRC initiatives the licensee addressed all appraisal findings and committed to resolving each item to the next scheduled refueling outage. Following the appraisal, on September 25, 1988, a separate concern was identified with Technical Support Center habitability when dampers within the TSC ventilation system failed. This problem was not corrected until the end of the period.

During the routine safety inspection conducted in February 1989, all major areas of the licensee's emergency preparedness program including program changes, emergency equipment, organization and management control, training, program audits and follow-up of open items were reviewed. No significant deficiencies were found regarding the programmatic changes or walkthroughs (training) of key emergency response personnel with the exception of licensed operator knowledge of the operation and capability of the Tone Alert System. Minor concerns were identified with the licensee's recent revisions to and distribution of the Emergency Plans and Implementing Procedures, personnel used to conduct independent program reviews, and information provided in general employee training.

Coordination of onsite and offsite emergency preparedness activities are administered by the Emergency Coordinator from the site. The training department is responsible for instruction of most emergency response personnel and scenario development and preparation is provided through contract support. During the recent reorganization of the Nuclear Services Division, two additional full-time equivalent staff members were authorized for the emergency preparedness program. In addition, the Emergency Coordinator position has been upgraded to a manager level with direct access to the Manager, Nuclear Services. Such changes are an indication of strong program support from upper-level corporate staff.

Each calendar quarter the licensee coordinates with the State of New York and other power reactor licensees within the State concerning offsite emergency preparedness issues. The EP staff also maintains membership on the Oswego County Planning Committee and is currently assisting the State and local authorities in the development of procedures for meteorological forecasting. During an accident, this process would ensure that inputs into the dose assessment model are identical at each jurisdictional level. Prompt notification (siren) system capability was degraded on several occasions during the period and the licensee notified NRC immediately after identification of these problems.

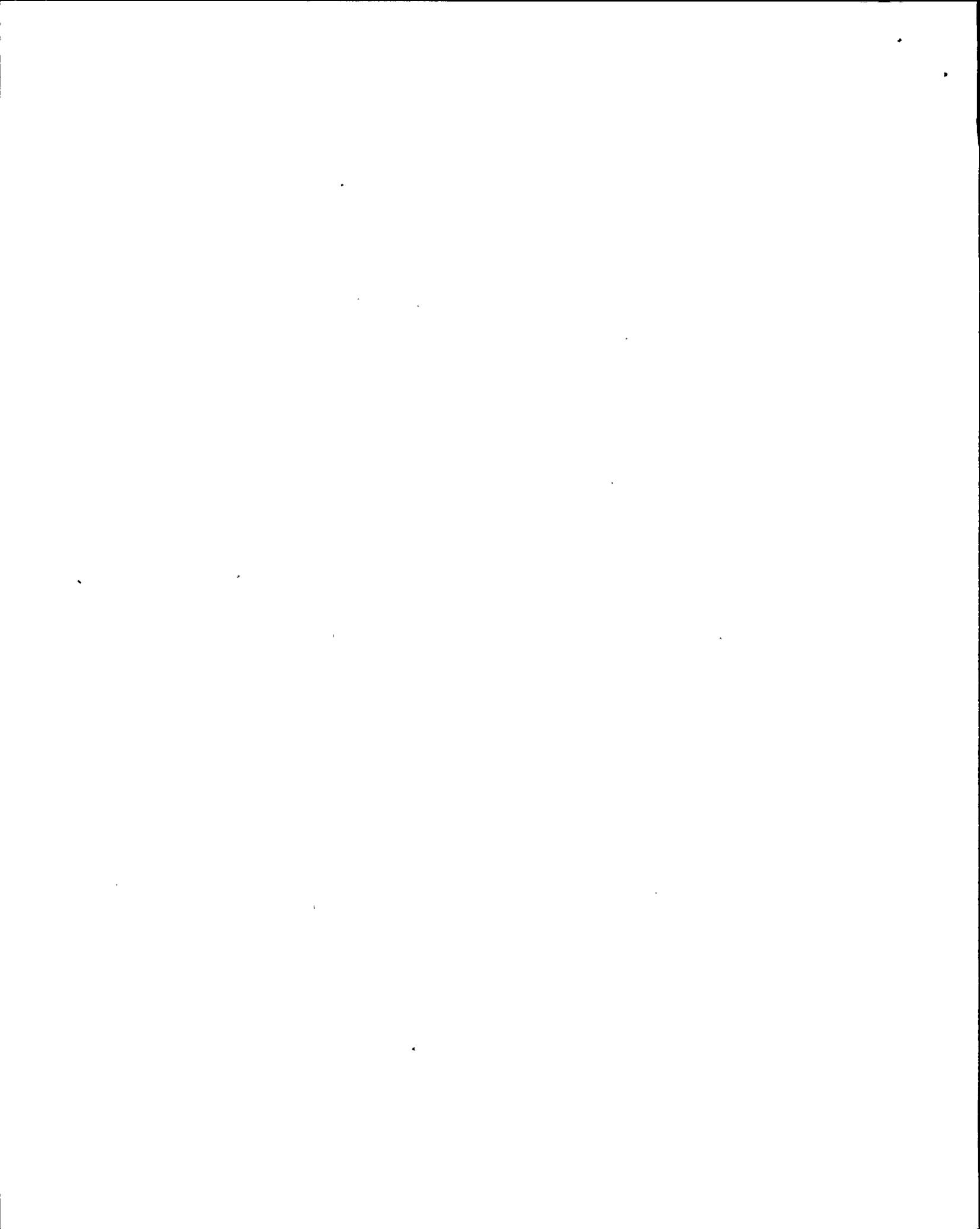


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In summary, the licensee has demonstrated a positive continued commitment to emergency preparedness. The relationship between the licensee and off-site authorities continues to be strong. Training of all levels of emergency response personnel was effective as evidenced by exercise performance. Although items identified during the ERF Appraisal remain incomplete, responsiveness to NRC initiatives has been timely and the licensee has made progress in correcting most NRC concerns. Management involvement is of the level necessary to ensure that the emergency preparedness program can be efficiently implemented.

2. Performance Rating:

Category: 1

3. Board Recommendation:

NRC: None

Licensee: None

E. Security and Safeguards (137 hours, 1.8%)

1. Analysis:

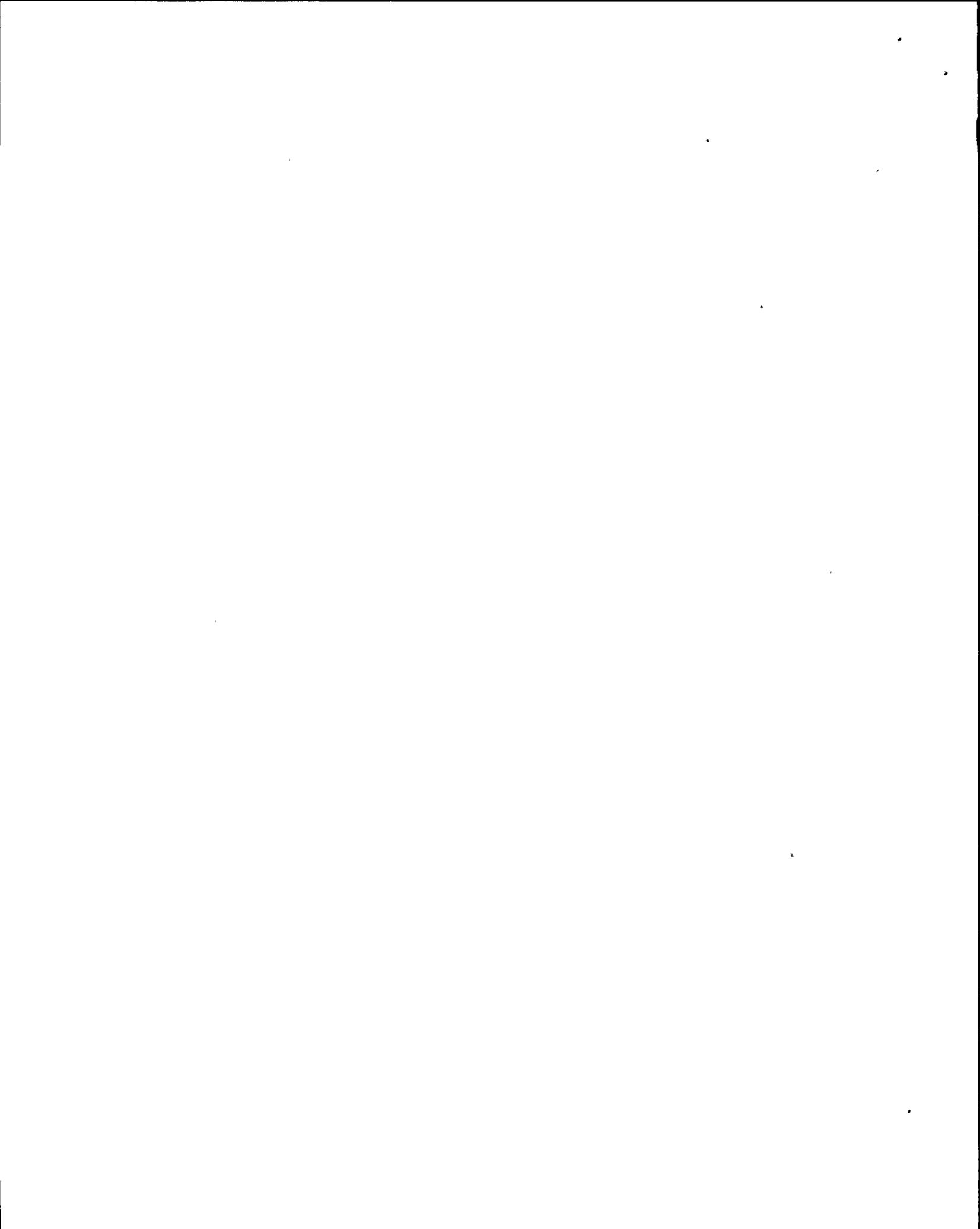
During the previous assessment period, the licensee's performance was rated as Category 1. No regulatory issues were identified by either region-based or resident inspectors.

During the assessment period the licensee continued to demonstrate a thorough understanding of NRC security objectives and maintained an excellent enforcement history. One unannounced routine security inspection was performed by region-based inspectors. Routine inspections by the resident inspectors continued throughout the period.

Corporate management involvement and interest in the security program remained evident during this assessment period by the continued on-site presence of the Security Manager who reports directly to the corporate Executive Vice President for Nuclear Generation.

The Security Manager and his supervisory staff are well-trained and qualified security professionals who are vested with the necessary authority and discretion to ensure that the station's nuclear security program is carried out effectively and in compliance with NRC regulations.

Security management also continues to actively participate in the Region I Nuclear Security Association and in other groups engaged in nuclear plant security matters.



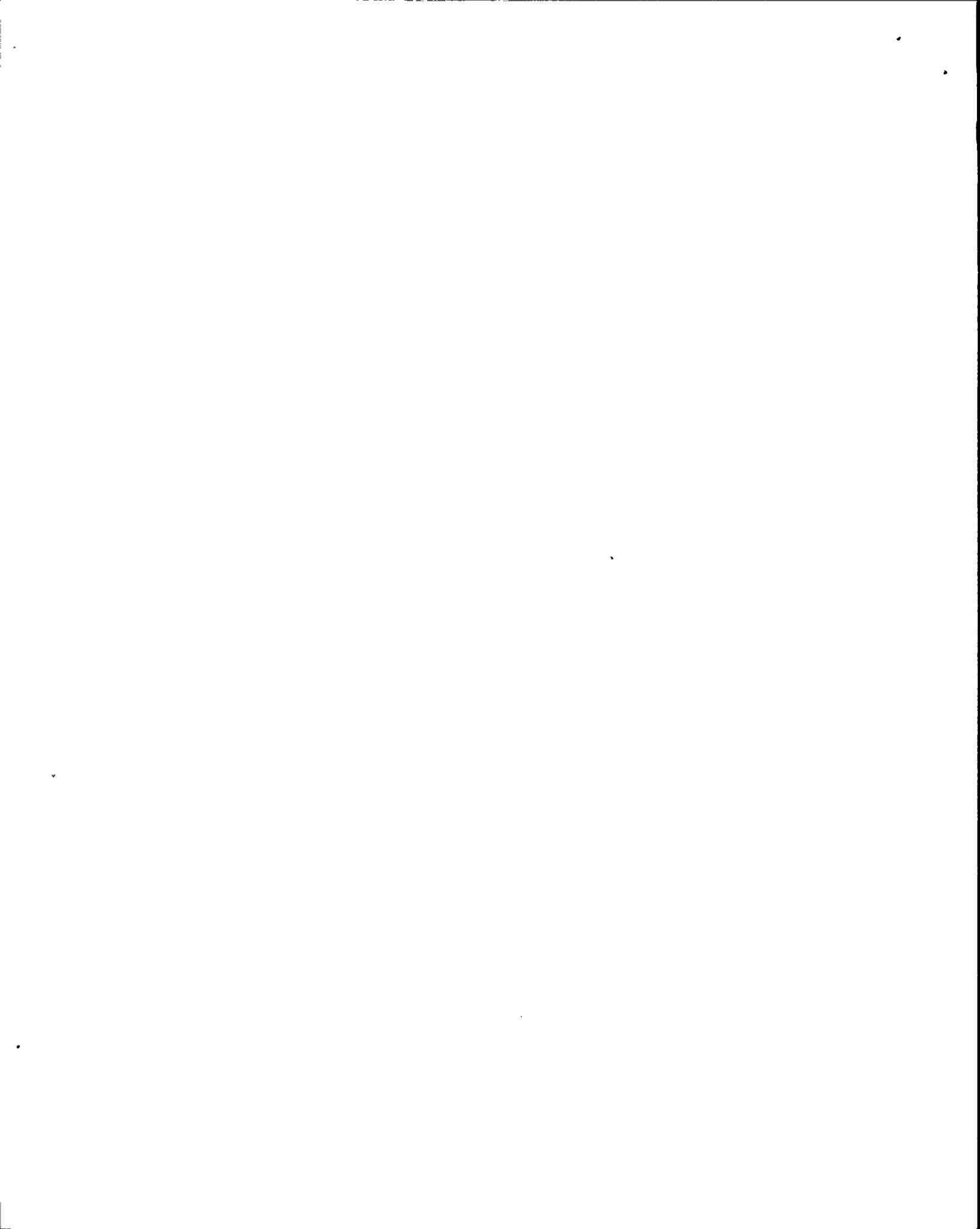
The licensee continued to enhance the security program during this assessment period. All search equipment in both access control portals was upgraded, vehicle barriers and double fences are being erected at the protected area boundary, the Unit 1 intrusion detection system was upgraded and plans have been developed to upgrade the Unit 2 intrusion detection system. Security systems and equipment are tested and maintained by dedicated instrumentation and controls (I&C) and maintenance groups (a total of 22 personnel). These are indications of the licensee's commitment to maintain a quality and highly effective program.

To ensure a comprehensive annual audit of the security program, the licensee's Safety Review and Audit Board used the services of nuclear security consultants. The licensee continued to implement the Commitment to Excellence Program in security. The program centered around three areas: 1) performance testing of security force members; 2) conducting an in-house regulatory effectiveness style review; and 3) daily audits/surveillances of security posts including at least twenty-percent inspections on backshifts. These are further indications of the licensee's commitment to the program.

A review of the licensee's security event reports and reporting procedures found them to be consistent with NRC regulations (10 CFR 73.71). There were two security event reports submitted during the assessment period. One event involved the loss of offsite local law enforcement communications capabilities and the other, the discovery of drugs on-site. The licensee took prompt and effective compensatory and/or corrective measures for each event.

Staffing of the proprietary security force continues to be adequate as evidenced by a limited use of overtime. The security force training and qualifications program is well-developed and is administered by an experienced staff of five, full-time individuals (including the supervisor). Facilities for training and requalification are available on site or on adjacent, owner-controlled property. These facilities are well-equipped and maintained. Security contingency response drills are conducted at least once each month. These drills are effectively used for training purposes and the drill critiques are integrated into the formal training program. The licensee instituted a procedure during this assessment period to ensure the participation of the operations organization during contingency drills if the scenario could affect plant operation..

During the assessment period, the licensee submitted one revision to the Physical Security Plan under the provisions of 10 CFR 50.54(p). This revision was of high quality, technically sound, and reflected well-developed policies and procedures. Security personnel involved in maintaining the program plans are very knowledgeable of NRC requirements and objectives.



In summary, the licensee continues to maintain a very effective and performance-oriented security program. Significant enhancements to the program continued during this assessment period which is indicative of management attention to and support for the program. The efforts to upgrade the operation and reliability of systems and equipment during this period are commendable and demonstrate the licensee's commitment to maintain an effective and high quality program.

2. Performance Rating:

Category: 1

3. Board Recommendations:

NRC: None

Licensee: None

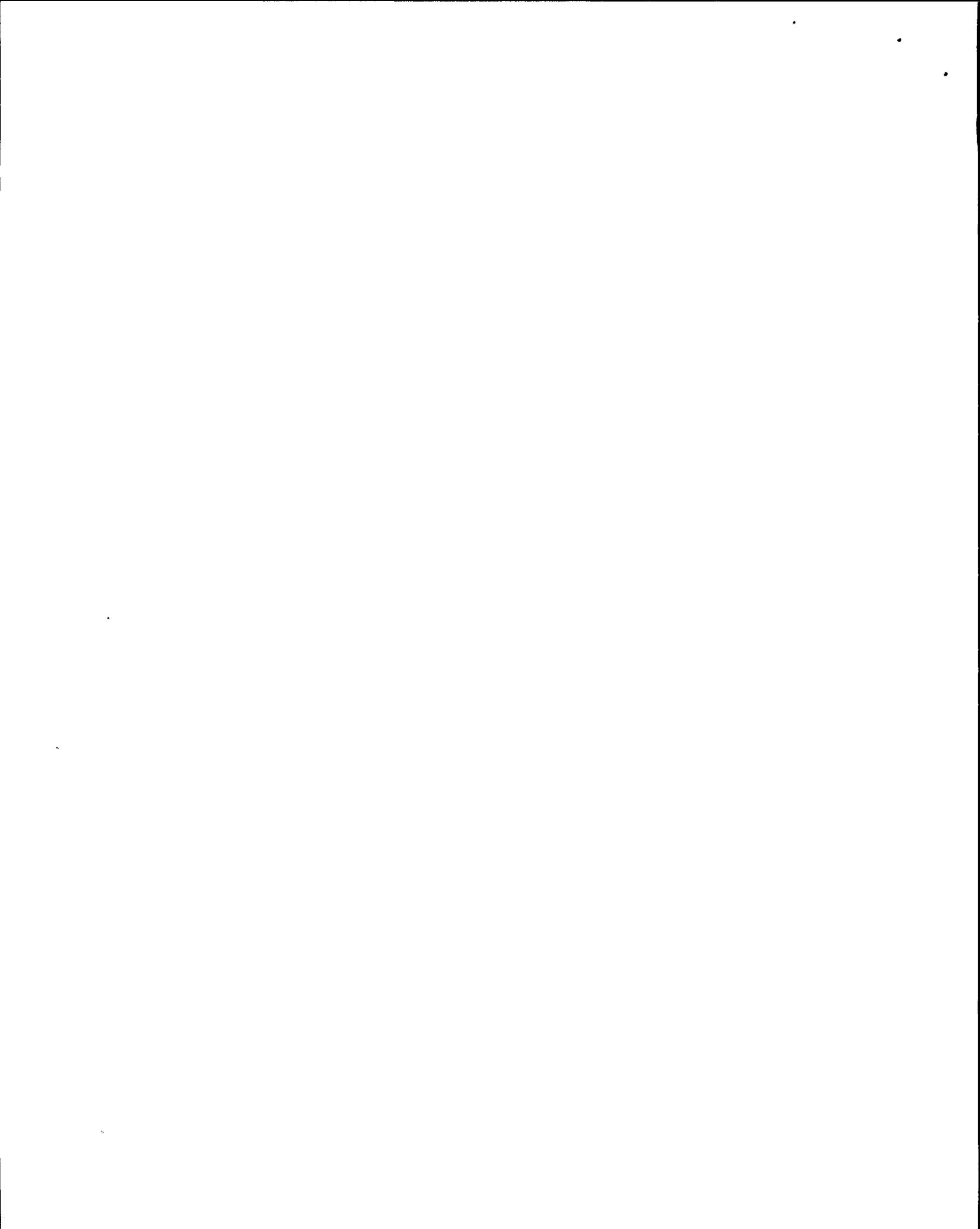
F. Engineering and Technical Support (523 hours, 6.7%)

1. Analysis

During the previous assessment period, the licensee's performance was rated Category 2 in this functional area. Problems were identified in the following areas: insufficient station-to-engineering department interface; inadequate involvement of engineering in the resolution of ISI program concerns; and, inadequate control over contractors.

In order to improve station-to-engineering department interfaces, the Engineering Department now includes a permanent site engineering group that reports directly to the Vice President of Nuclear Engineering and Licensing. This group was established during the middle of the SALP cycle and is responsible for coordinating and implementing engineering modifications and expediting corporate engineering support for plant operations. Greater engineering staff participation in routine station meetings was evident and appears to have a positive impact on the assignment and accountability for Engineering Department action items.

One area of particular concern during this SALP period was the reverification of the first 10 years of the Inservice Inspection (ISI) Program for Unit 1. Early in the SALP period numerous deficiencies were identified in the program involving many required inspections which had not been performed because of improper development and implementation of the ISI Program by a contractor and insufficient licensee oversight of that contractor. However, an NRC team inspection conducted near the end of the SALP period concluded that the licensee has effectively corrected deficiencies previously identified in the ISI Program. As a result of increased management attention to these deficiencies, the program is presently defined, structured and adequately staffed with qualified individuals to effectively implement the new program.



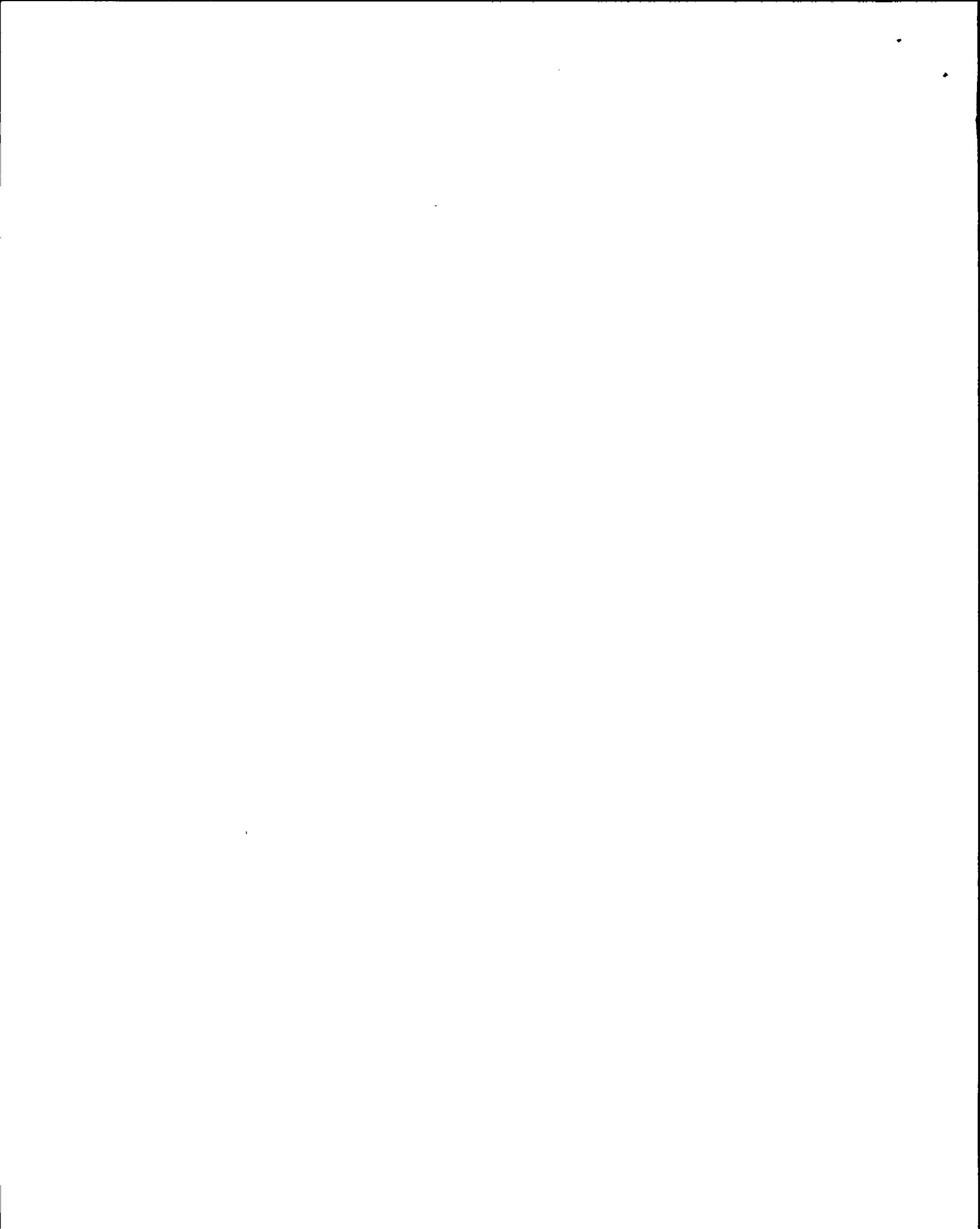
Problems previously identified regarding the adequacy of the licensee's control over contractors were also noted during this period. Specific problems noted during this period included: weaknesses in the licensee's review of contractor procedures and inspection results; deficiencies regarding contractor dedication of commercial grade items for Unit 2 and oversight of Unit 1 ISI program contractors. These deficiencies indicate poor engineering management oversight to assure adequate control of contractors.

To enhance plant safety and provide better direct plant support, the licensee has established a priority system whereby all safety significant projects are Priority 1 and other work which affects safety systems are Priority 2. All Priority 1 and 2 projects are on schedule. Additionally, the Vice President, Engineering and Licensing holds a weekly staff meeting to discuss the status of each project. This system is effective as evidenced by all priority safety significant projects being on schedule and the observation that there was no appreciable backlog of projects during the Unit 2 and ongoing Unit 1 outages.

The licensee's Engineering and Technical Support staff were generally effective in resolving engineering concerns at both units with notable improvement in design change activities. However, during this period, performance by the Engineering staff was inconsistent and is a matter of concern to the NRC and merits attention by management. While a number of activities and specific projects for which the engineering staff had control over were conducted in a professional manner, weaknesses in other areas were detrimental to the overall assessment of the engineering support function. Examples of both are discussed below.

The licensee has developed a detailed commercial grade dedication program to upgrade equipment to safety-related status. This program was developed based upon discovery by the licensee of weaknesses in the General Electric commercial grade items dedication process and the necessity to resolve potential electrical equipment safety concerns prior to Unit 2 initial licensing. The licensee's program employs the EPRI guidelines and the documented engineering evaluations were determined to be thorough and technically sound.

Several design and replacement activities were performed well including the replacement of the Unit 1 feedwater check valves, the Unit 1 Anticipated Transient Without Scram - Alternate Rod Injection modification, and the upgrade of the Unit 1 Mark I containment to meet the acceptance criteria of NUREG 0661. The licensee addressed all of the significant



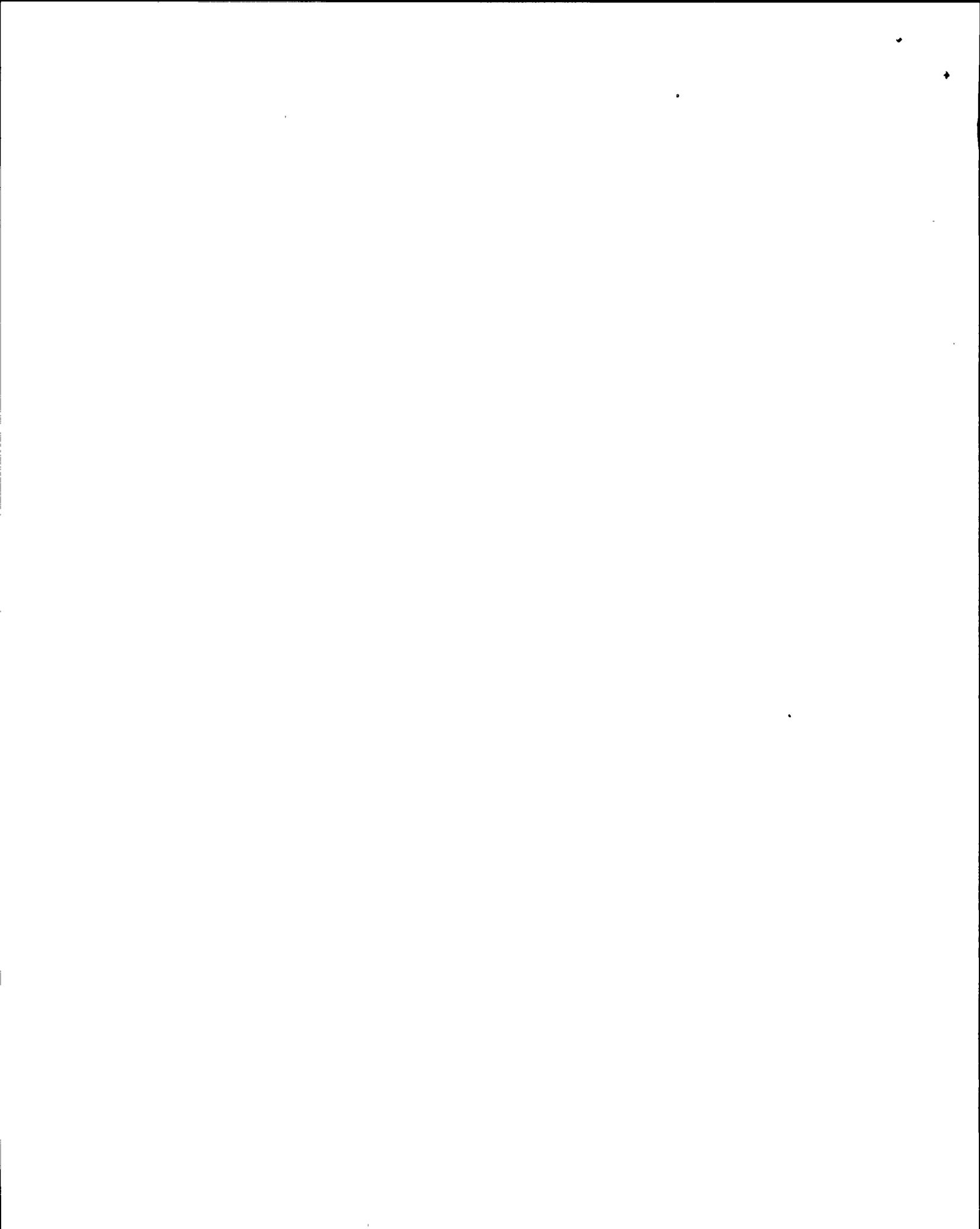
technical aspects of the Bulletin 85-03, "Motor Operated Valve Common Mode Failures During Plant Transients Due to Improper Switch Settings" at both units. The necessary corrective actions were properly coordinated with the maintenance and operation staffs.

However, poor performance in other areas indicates an inability of the engineering department to consistently deliver quality work. Examples of these inconsistencies include: the numerous deficiencies identified in the implementation of Regulatory Guide 1.97 for Unit 1; the failure to report the 125 Vdc design deficiencies in a timely manner for Unit 1; the failure to detect and resolve an automatic depressurization system (ADS) wiring error which rendered one division of ADS inoperable for Unit 2; inadequate corrective actions to identify all improperly sealed penetrations and conduits for internal flooding for Unit 2; and the inadequate resolution of post-accident sampling system divisional power supply problems at Unit 2.

Slow resolution of design deficiencies at Unit 2 have resulted in plant transients and unnecessary safety system actuations. Examples included the reactor building ventilation problems, reactor vessel instrumentation common reference leg sensitivity concern and the feedwater control valve problems.

A Safety System Functional Inspection (SSFI) performed by an NRC team at Unit 1 concluded that design information for both the core spray and HPCI/FW systems was not adequately controlled or supported by sufficiently detailed analysis. This lack of defined design analysis for the core spray and HPCI/FW systems degraded the quality of system operating and surveillance procedure guidance. A specific concern was the Appendix K reload analysis. Inadequate analyses led to operation of the plant outside of the design basis on two separate occasions. These potential problems were known by the licensee in early 1987, but were not resolved until brought to the licensee's attention by the NRC. This was another example of inadequate licensee followup to identified deficiencies.

The licensee has developed a comprehensive training program for individuals at all levels in the Engineering organization. The permanent training staff is supplemented by individuals from various disciplines assigned as instructors. If required, consultants are retained for specific courses. At the end of the SALP period, the NRC identified significant deficiencies in the implementation of the licensee's engineering training program. A review of the training records and licensee QA audits revealed that most of the engineers were not receiving adequate training according to the projects training program. While the licensee has developed a comprehensive training program, the program has not been effectively implemented.



In summary, the licensee has made limited progress in addressing engineering and technical support deficiencies that were identified during the last SALP period. While some engineering activities exhibited strong engineering control, numerous examples of poor performance of engineering activities were identified. These examples, collectively, indicate poor control and coordination of engineering efforts and inadequate management oversight of the engineering function to assure consistency of performance of the on and off site engineering staff. Performance in this area contributed to the issuance of Confirmatory Action Letter 88-17 and continues to be of concern to the NRC staff.

2. Performance Rating:

Category: 3

3. Board Recommendations:

NRC: None

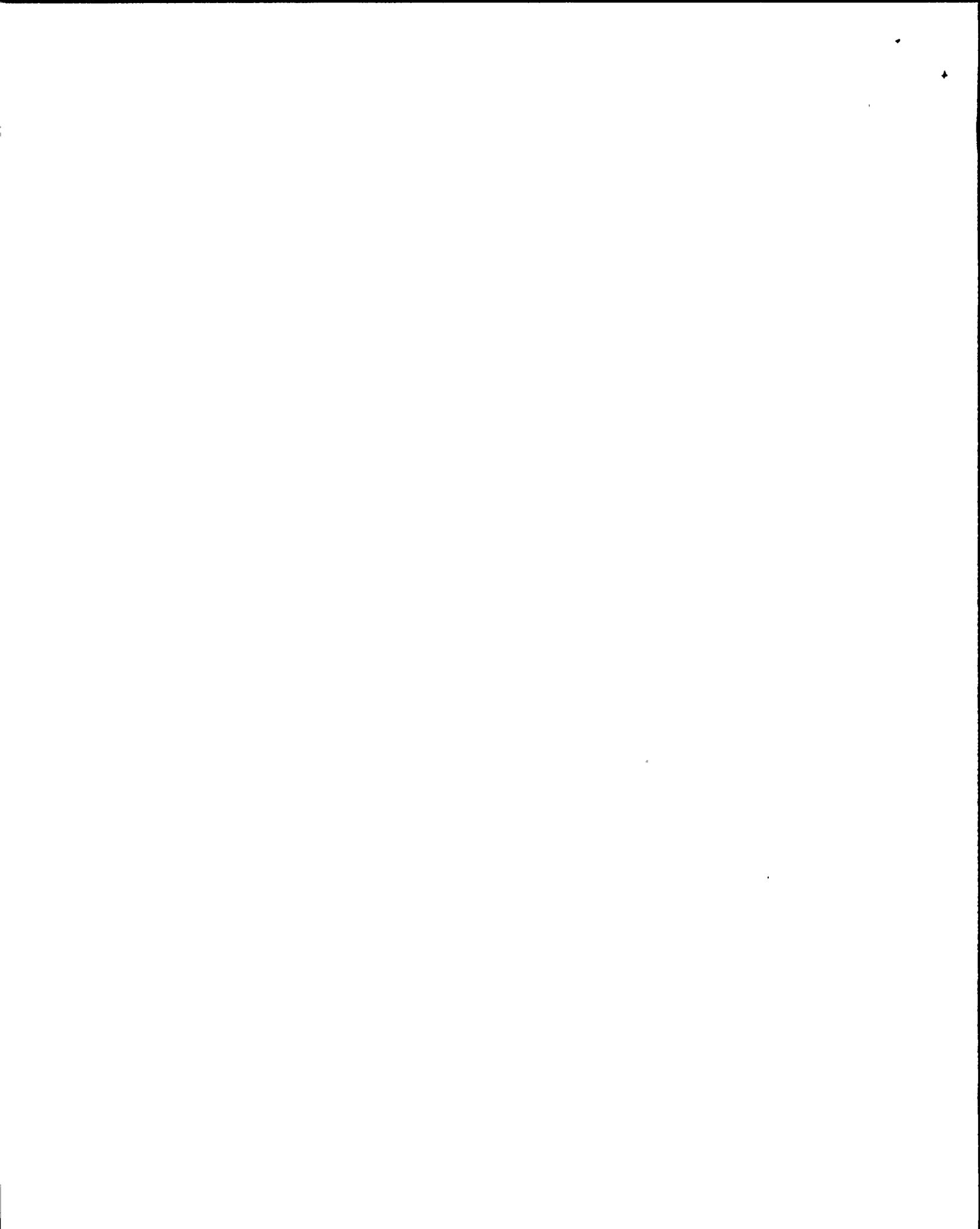
Licensee: None

G. Safety Assessment/Quality Verification (1446 hours, 18.7%)

1. Analysis

This new functional area assesses the effectiveness of the licensee's programs provided to assure the safety and quality of plant operations and activities. It is a compilation of the Licensing and Assurance of Quality functional areas provided in the previous SALP reports, but also incorporates relevant indications discussed in all other current functional areas.

During the previous SALP period, the licensee was evaluated as Category 3 in the area of Assurance of Quality and Category 2, declining, in the area of Licensing. Performance in the Assurance of Quality area was noted to be inconsistent. Improvements occurred in problem identification and resolution, effectiveness of the Quality Assurance organization, Unit 2 operations, staff performance, and Technical Specification interpretations. Weaknesses were identified in station and corporate management oversight and coordination, radiological controls, teamwork and communication, and housekeeping. In the licensing area it was noted that the technical approach to, and resolution for issues were generally sound and conservative; however, on occasions, the licensee demonstrated a lack of understanding of regulatory requirements and a reluctance to make independent conservative decisions on issues involving regulatory compliance.

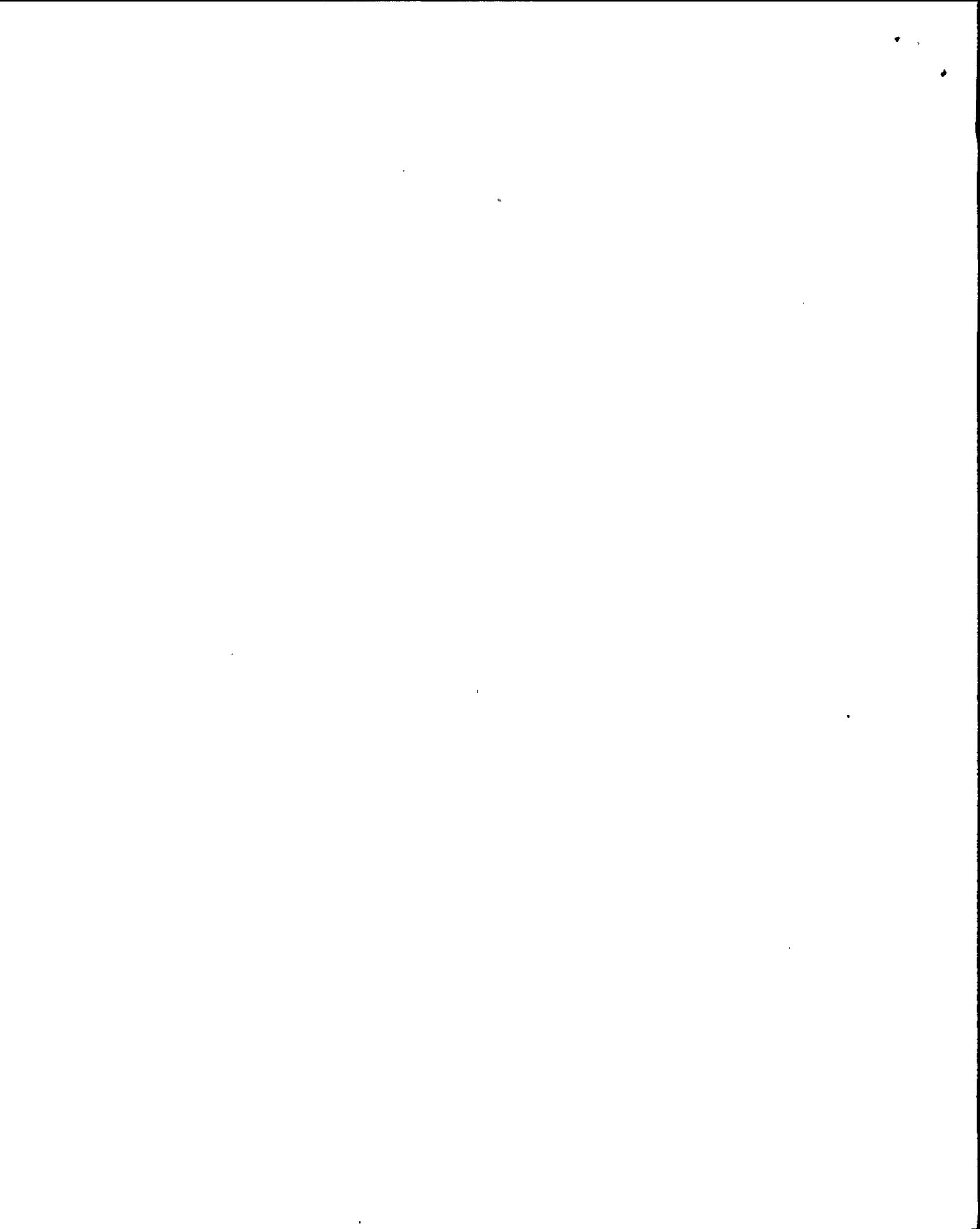


During this assessment period the licensee's performance in correcting the SALP identified weaknesses, in responding to plant events, and in conducting other activities and functions impacting quality and safety assurance has been inconsistent. However, at the end of the rating period, the licensee took significant action to demonstrate senior management's commitment to identify and resolve long-standing problems in the Nuclear Division. In response to CAL 88-17, a number of assessment programs and corrective actions were initiated including the Restart Task Force, the Restart Action Plan (RAP), and the Nuclear Improvement Program (NIP). Particularly noteworthy is that the licensee established a new position of Executive Vice President Nuclear Operations. The hiring of a senior individual from outside the organization broke a long-standing tradition of promoting from within and demonstrated that senior management is serious about breaking down the organizational "culture" and correcting the leadership deficiencies that have contributed to many of the problems at Nine Mile Point. The licensee has made several additional organizational changes in an attempt to strengthen the organization including the establishment of a Regulatory Compliance Group. This group provides a continuity to the organization which was not previously observed. It has facilitated improvements in: 1) tracking and timely resolution of identified problems, concerns and commitments; 2) interdepartmental communications; 3) defined responsibilities and accountabilities; and 4) consistency in operations and administration between Units 1 and 2.

The licensee has also requested independent organizations to assist them in evaluating the effectiveness of the Nuclear Organization and has scheduled a self-evaluation before restarting Unit 1. These efforts indicate that Niagara Mohawk is making a concerted effort to correct the leadership weaknesses identified in the previous SALP. The effectiveness of the above changes is still being evaluated.

Throughout the period the licensee has demonstrated increased effectiveness in problem identification, both programmatic and technical. However, corrective actions in general have not been properly implemented to prevent recurrence. This is evident for both units and is attributed to the inability to clearly identify the applicable root cause and the lack of defined responsibility and accountability within the organization.

In contrast, the licensee's recent corrective actions with respect to the Unit 1 Inservice Inspection Program deficiencies represent a true commitment to develop and maintain an effective Inservice Inspection Program. Significant technical manpower resources have been dedicated to this effort, increased management attention and control have been observed and there is evidence of a heightened sensitivity by all station employees of the proper implementation of the program. The licensee's actions concerning the identification of the ADS logic circuitry deficiencies, and service water system single failure corrective actions were also commendable.

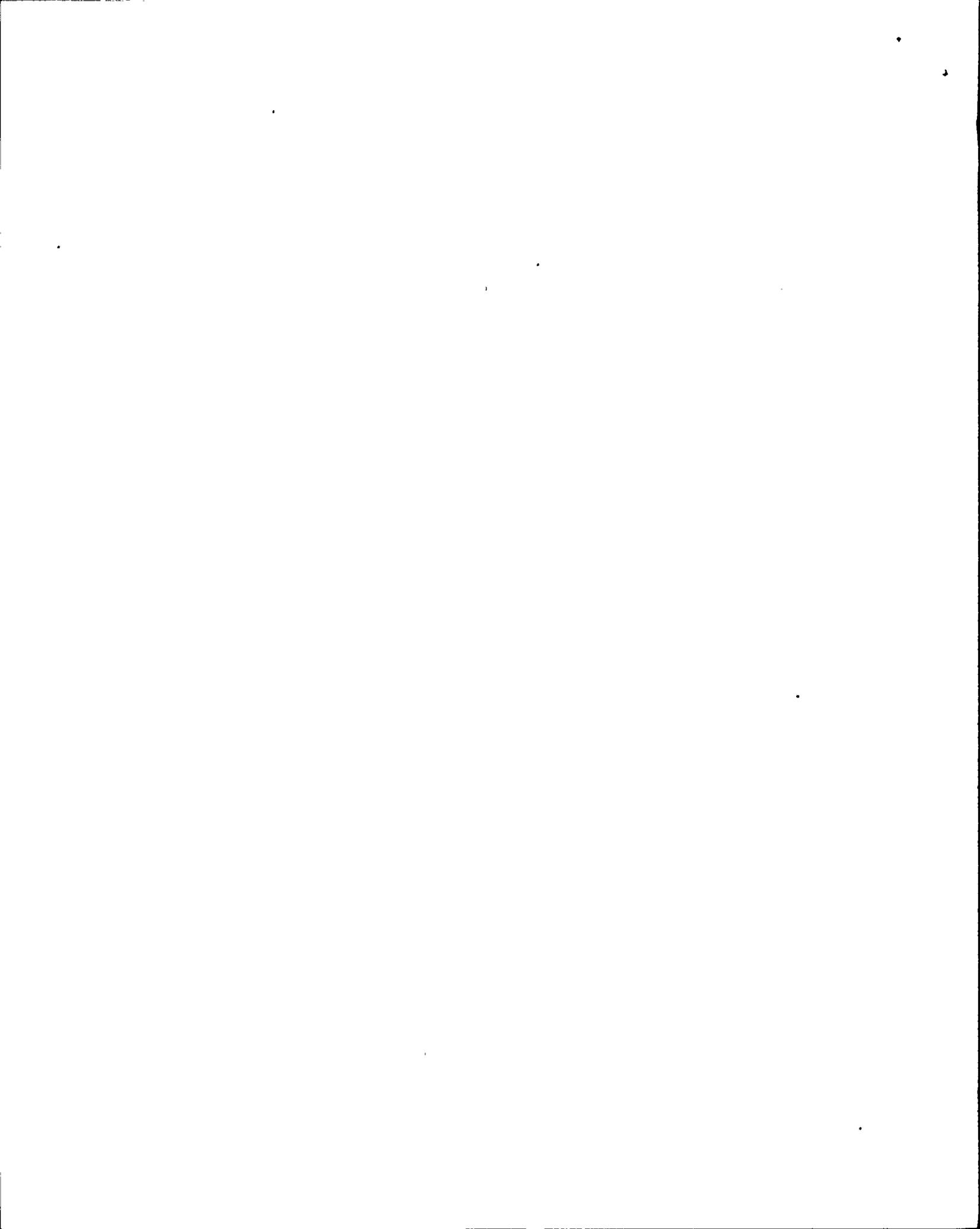


The licensee's approach to the resolution of technical issues from a safety standpoint has not always been timely and conservative. For example, the licensee has not been effective at reducing the number of scrams, Engineered Safety Feature (ESF) actuations, and personnel errors experienced at Unit 2 following the completion of the Power Ascension Testing Program early in the rating period. This problem appears to result from the licensee's (inappropriate) willingness to accept the high number of events as being normal and acceptable for a newly licensed facility. In addition, the licensee has not always been aggressive in pursuing safety issues it did not perceive to be restart issues on Unit 1, such as resolution of a vital area question regarding the diesel generators and the development and implementation of a long-term program for the torus wall thinning issue.

The station Quality Assurance (QA) Surveillance Group is an aggressive and thorough oversight group. It is particularly flexible and active in responding to recognized independent oversight needs. Corrective actions resulting from the QA Surveillance Group effort now appear to reverse negative trends prior to the development of major problems. This represents a measurable improvement over previous assessments. However, weaknesses have been identified in the technical quality of the QA audits performed by the QA Audit Group. Audits have been noted to be weak and shallow despite past NRC criticism in SALPs. The licensee is aware of this and is taking steps to strengthen the group's technical abilities. Weaknesses have also been identified in the threshold for highlighting QA identified deficiencies and significant adverse trends to senior station and corporate management. Added corporate management attention should be given to ensuring that significant findings are properly escalated so that prompt and effective action can be taken.

One instance observed during this assessment period indicated a reliance, by the line organization, on the QA organization to identify problems. Corrective actions taken by the Engineering staff to address Unit 1 ISI program deficiencies were too dependent upon the QA staff to ensure proper implementation. This ultimately resulted in a QA Stop Work Order because of ineffective program implementation. Increased Engineering and contractor supervisory oversight resulted.

During the assessment period, the Site Operations Review Committee (SORC) and the Safety Review and Audit Board (SRAB) have not demonstrated their effectiveness in overseeing station activities. Observations indicated that these committees get bogged down in too much detail. Many of the presentations made to these committees have been ill-prepared and ineffective. SRAB consultants were observed to be very active and provided excellent input to the SRAB meetings and reviews. Observations made of the Independent Safety Engineering Group (ISEG) indicated that this group was also not fully effective. Members of the group were too far removed from day-to-day station activities and their assessments appeared to be lost at too low a level in the organization.



A review of the Licensee Event Reports (LERs) submitted during the period indicates that the reports were thorough, detailed, well written and easy to understand. The root cause of the event was clearly identified in most cases. The LERs presented the event information in an organized pattern that led to a clear understanding of the event information.

Significant weaknesses in the area of reportability were identified during the Safety System Functional Inspection. As an example, delayed corrective actions for an improper Technical Specification Limiting Condition for Operation allowed the plant to be placed in an unanalyzed condition and resulted in untimely reporting. Additional corporate management attention is needed to improve the prompt evaluation and reporting of significant potential safety issues.

Responses to bulletins, generic letters and multi-plant action items such as Generic Letter 83-28, and the ATWS Rule (10 CFR 50.62), have been generally timely and complete. The licensee's requests for amendments and reliefs have been adequate and indicate appropriate planning and assignment of priorities. The quality of the reviews performed by the licensee under the requirements of 50.59 has also improved over the last rating period. However, the licensee's analysis of industry operating experience has been slow and in some cases inadequate.

In summary, licensee performance in the areas related to Safety Assessment and Quality Verification has been inconsistent. Strengths have been noted in the areas of: 1) demonstration by management that it has begun to aggressively pursue correction of identified leadership deficiencies; 2) increased effectiveness in problem identification; 3) establishment of the Regulatory Compliance group; 4) an aggressive and thorough QA surveillance group; and 5) detailed and thorough LERs. In contrast weaknesses have been identified in the areas of: 1) defined responsibilities and accountability; 2) implementation of corrective actions; 3) continuing high event rate at Unit 2 attributable to a complacent attitude with respect to new plant operations; 4) aggressiveness in pursuing potential safety issues; 5) shallowness of QA audits; and 6) inadequate review of industry operating experience.

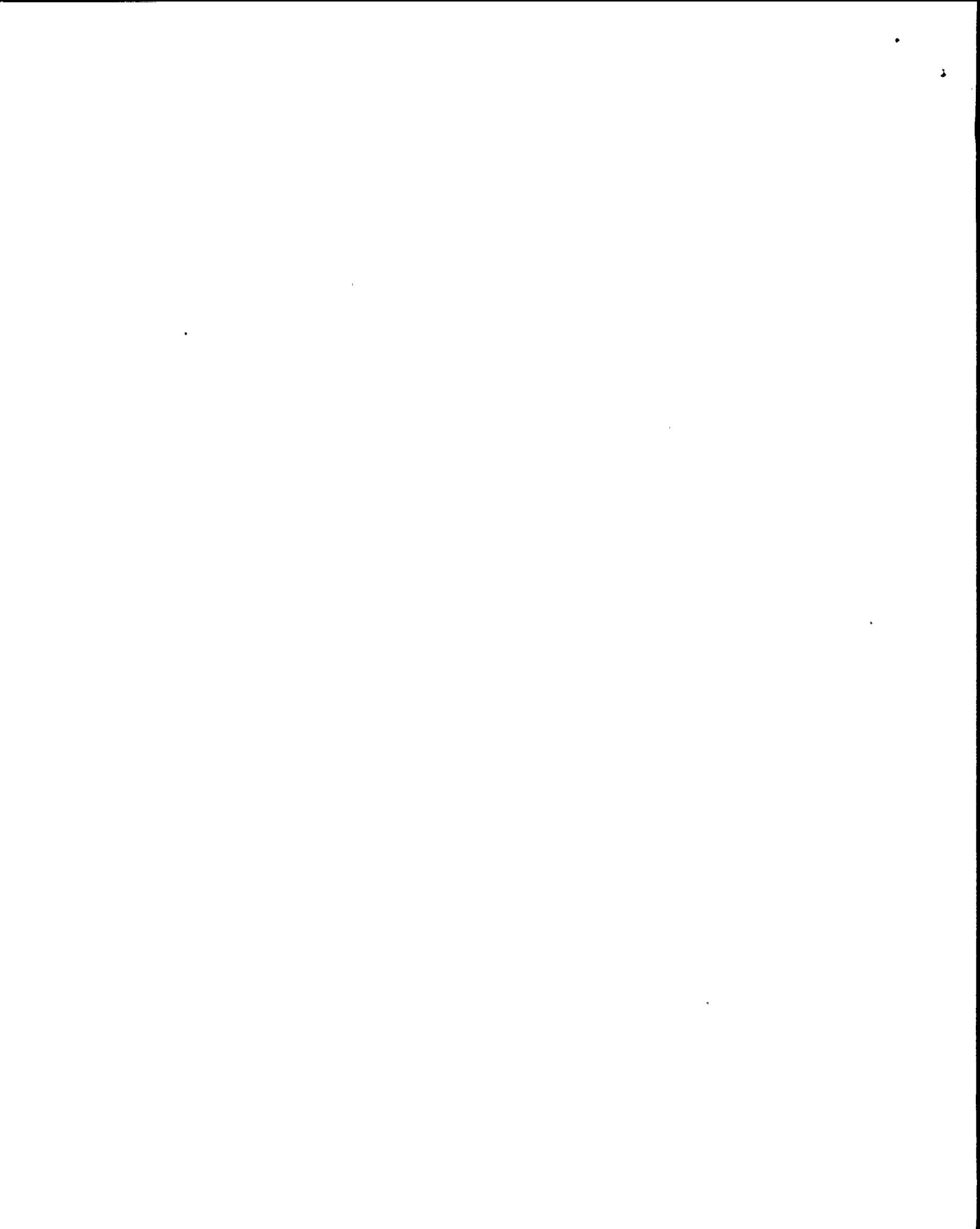
2. Performance Rating

Category: 3 Improving

3. Board Recommendation:

NRC: None

Licensee: Management attention should be focused to ensure that the increased emphasis on correcting deficiencies at Unit 1 does not result in insufficient attention to problems at Unit 2.



V. SUPPORTING DATA AND SUMMARIESA. Enforcement Activity

Table 1.1

Unit 1 Enforcement ActivitiesViolations Versus Functional Area By Severity Level

Functional Area	No. of Violations in Each Severity Level					Total
	V	IV	III	II	I	
Plant Operations	-	2	-	-	-	2
Maint/Surv	-	-	-	-	-	0
Eng/Tech Support	1	3	-	-	-	4
Emergency Preparedness	-	-	-	-	-	0
Security & Safeguards	-	-	-	-	-	0
Radiological Controls	-	1	-	-	-	1
Safety Assessment Quality Verification	-	-	-	-	-	0
TOTAL	1	6	0	0	0	7

Note: There are five apparent violations pending final staff review.

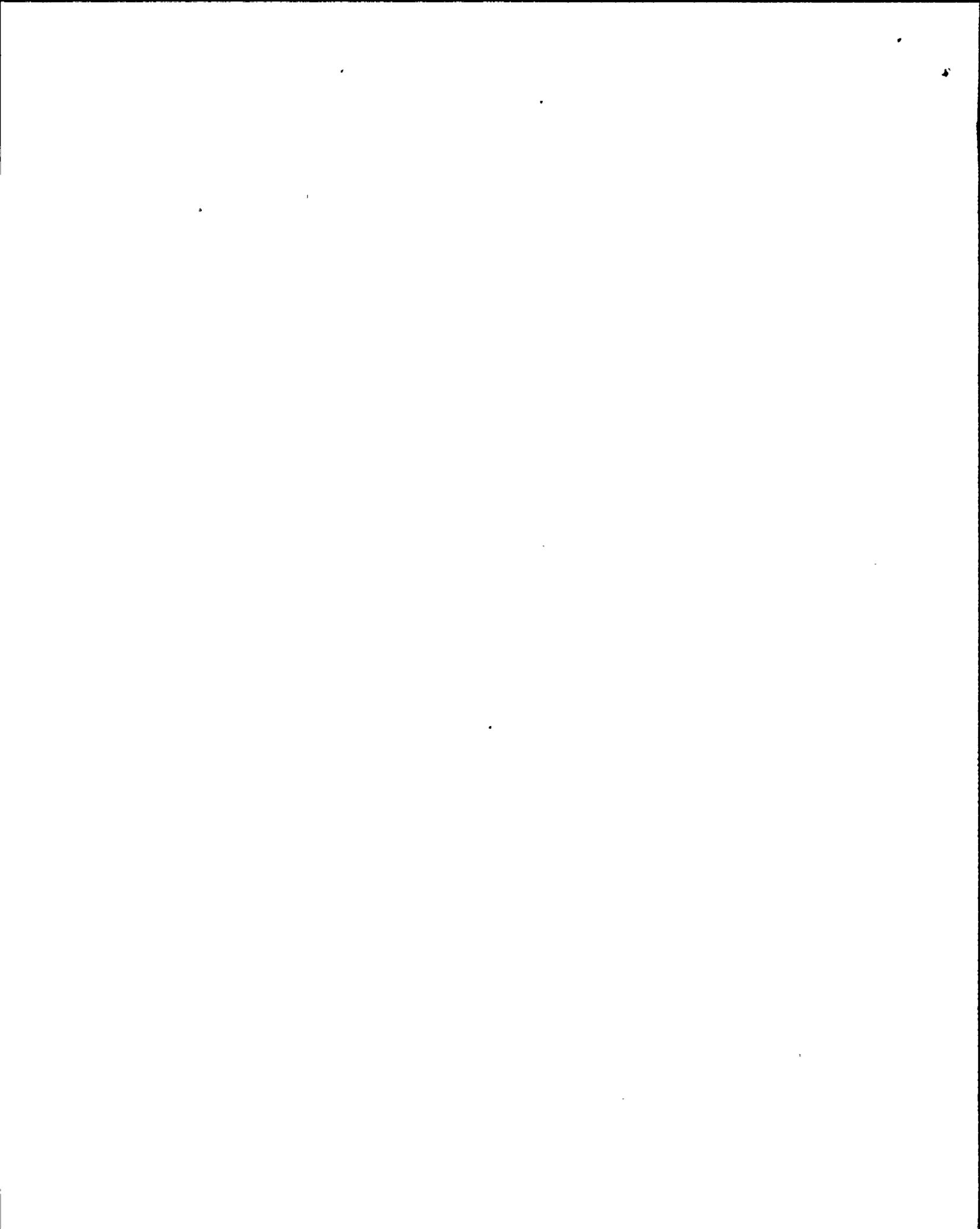


Table 1.2

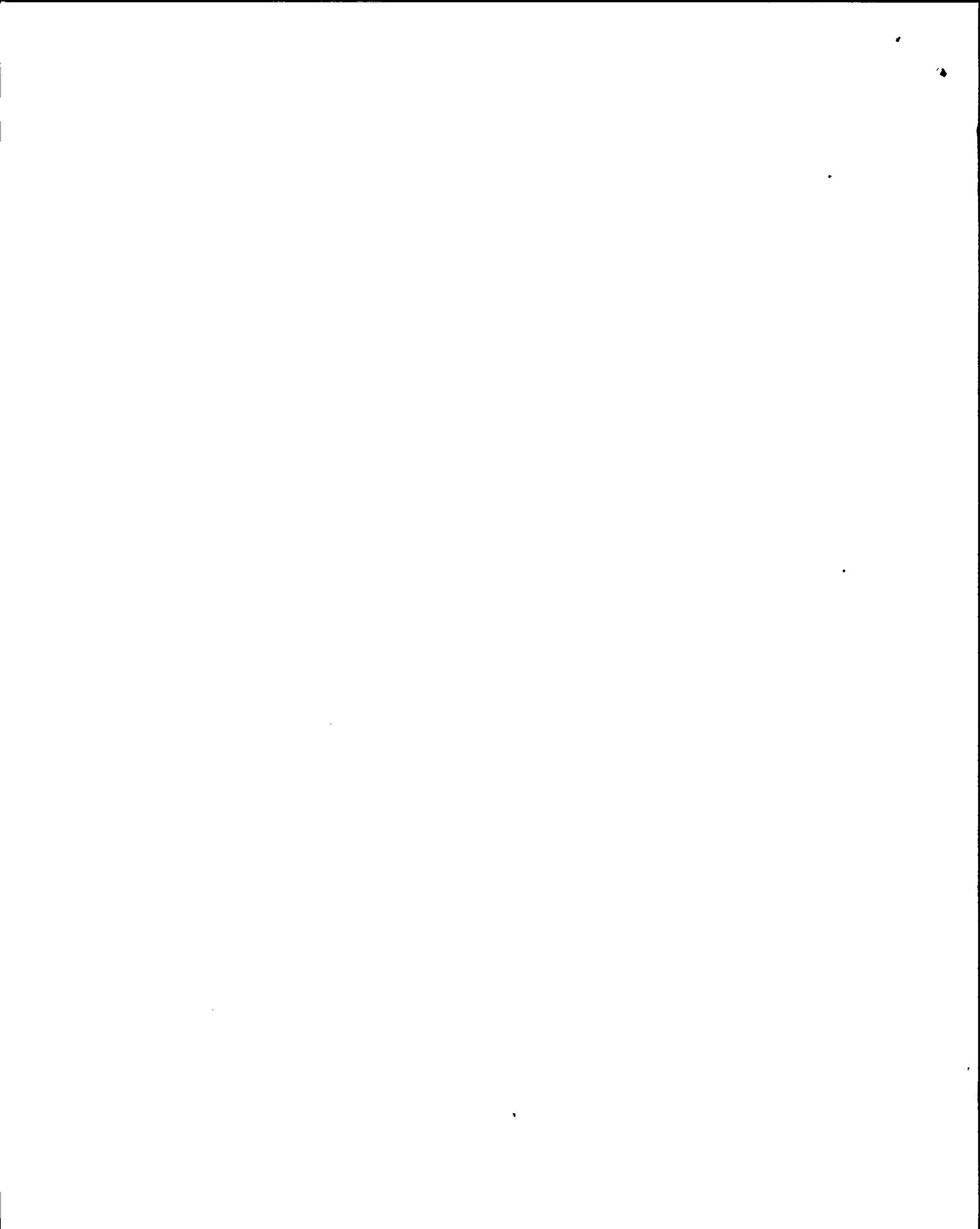
Unit 2 Enforcement ActivitiesViolations Versus Functional Area By Severity Level

Functional Area	No. of Violations in Each Severity Level						Total
	LI	V	IV	III	II	I	
Plant Operations	6	-	2	-	-	-	8
Maint/Surv	4	1	1	1	-	-	7
Eng/Tech Support	4	-	1	-	-	-	5
Emergency Preparedness	-	-	-	-	-	-	0
Security and Safeguards	-	-	-	-	-	-	0
Radiological Controls	3	-	-	-	-	-	3
Safety Assessment/Quality Verification	-	-	-	-	-	-	0
TOTAL	17	1	4	1	0	0	23

Escalated Enforcement Action

An Enforcement Conference was held on July 11, 1988 for Unit 1 to discuss an apparent violation of 10CFR50 Appendix R "Fire Protection Program for Nuclear Power Facilities Operating Prior to January 1, 1979". Two severity level IV violations were issued on September 19, 1988 citing the licensee against Appendix R and Appendix B, "Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants".

An Enforcement Conference was held on February 2, 1989 for Unit 2 to discuss a wiring error in the Automatic Depressurization System Division I actuation logic. A Notice of Violation was issued on March 13, 1989 citing an aggregate severity level III violation with no civil penalty.

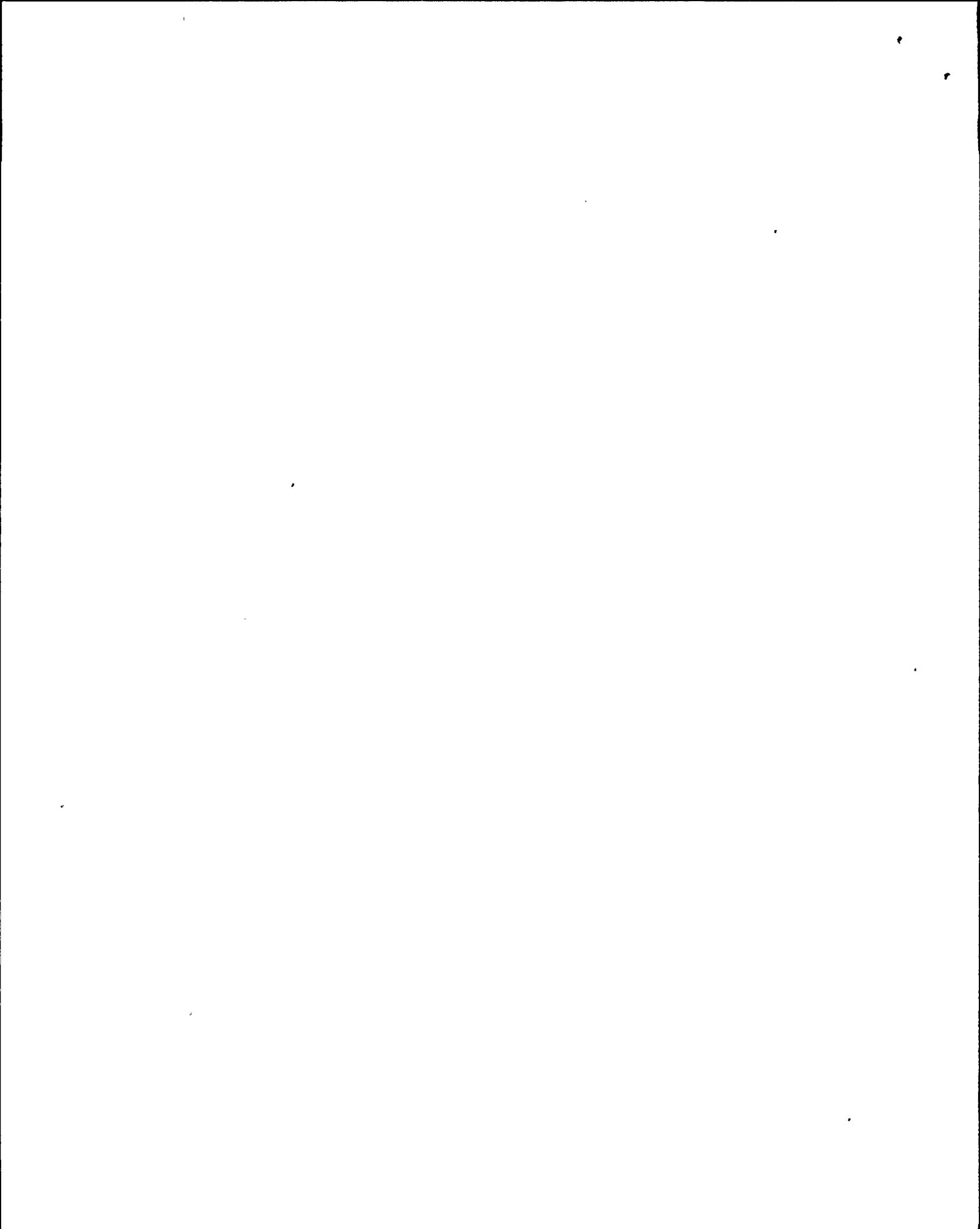


An Enforcement Conference was held on March 30, 1989 for Unit 1 to discuss Licensed Operator Requalification Training Program deficiencies identified early in this assessment period. Potential violations from the Safety System Functional Inspection, and Inservice Testing deficiencies and 125 VDC battery concerns are being included in this action. Enforcement actions are pending.

B. Confirmatory Action Letters (CAL)

On March 28, 1988, the NRC issued CAL 88-13 which documented the licensee's commitment that Unit 1 would not restart until Operator Requalification deficiencies were corrected.

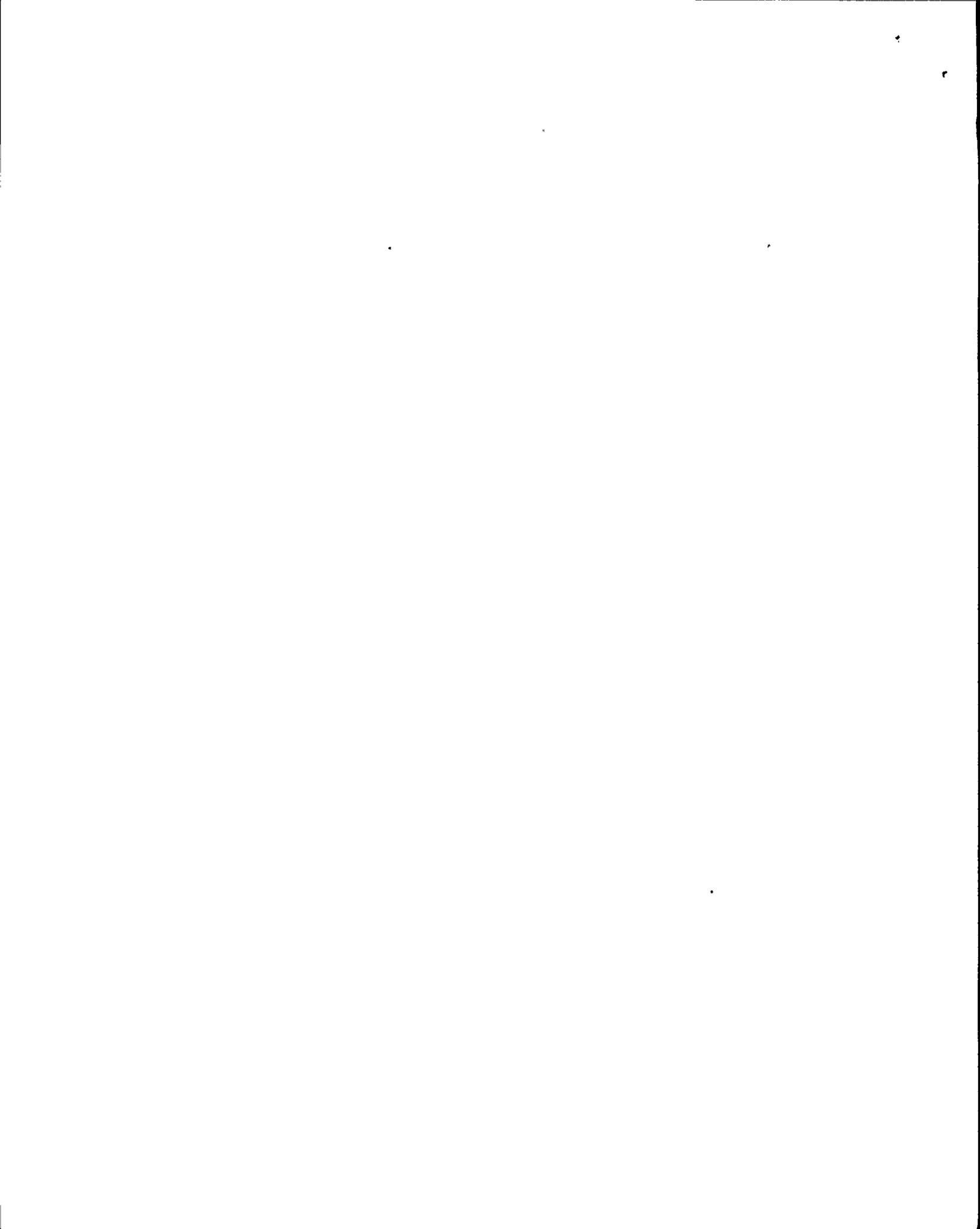
On July 24, 1988, the NRC issued CAL 88-17 which documented the licensee's commitment that Unit 1 will not be restarted until problems in several areas are resolved and NRC approval is obtained. CAL 88-17 superseded CAL 88-13.



C. Inspection Hours Summary

TABLE 2

<u>Area</u>	<u>Unit 1</u>		<u>Unit 2</u>	
	<u>Hours</u>	<u>% of Time</u>	<u>Hours</u>	<u>% of Time</u>
Plant Operations	1464	27.9	810	32.3
Radiological Controls	232	4.4	281	11.2
Maintenance and Surveillance	2041	38.9	598	23.9
Emergency Preparedness	117	2.2	107	4.3
Security and Safeguards	70	1.3	67	2.7
Engineering and Technical Support	413	7.9	110	4.3
Safety Assessment/ Quality Verification	913	17.4	533	21.3
TOTALS	5250	100.0	2506	100.0



D. LICENSEE EVENT REPORTS CAUSAL ANALYSIS

TABLE 3

Cause Determined by SALP Board

An assessment has been conducted to determine the root cause of each event from the perspective of the NRC. The causes fell into the following categories and sub-categories.

Personnel Errors (PE)

1. Lack of Knowledge (LK) - the individual was not properly trained or provided with instructions from supervision.
2. Inattention to Detail (ID) - the individual failed to pay proper attention to a task and was careless.
3. Poor Judgement (PJ) - the individual failed to make the correct assessment with the proper amount of training and attention to facts.

Equipment Malfunction/Failure (EM/F)

1. Random (R) - isolated component problem not of generic concern.
2. Design Deficiency (DD) - poor design was the cause of the malfunction/failure.
3. Construction Deficiency (CD) - improper installation during construction/modification caused or could have caused the malfunction failure.
4. Maintenance Deficiency (MD) - improper preventive or corrective maintenance.

Procedural Error (PROE)

The procedure failed to provide adequate instruction, was poorly worded or was not properly reviewed for use.

Ineffective Corrective Action (ICA)

Action was not taken by management or the action taken on a previously identified item was not timely or did not correct the root cause and allowed this occurrence.

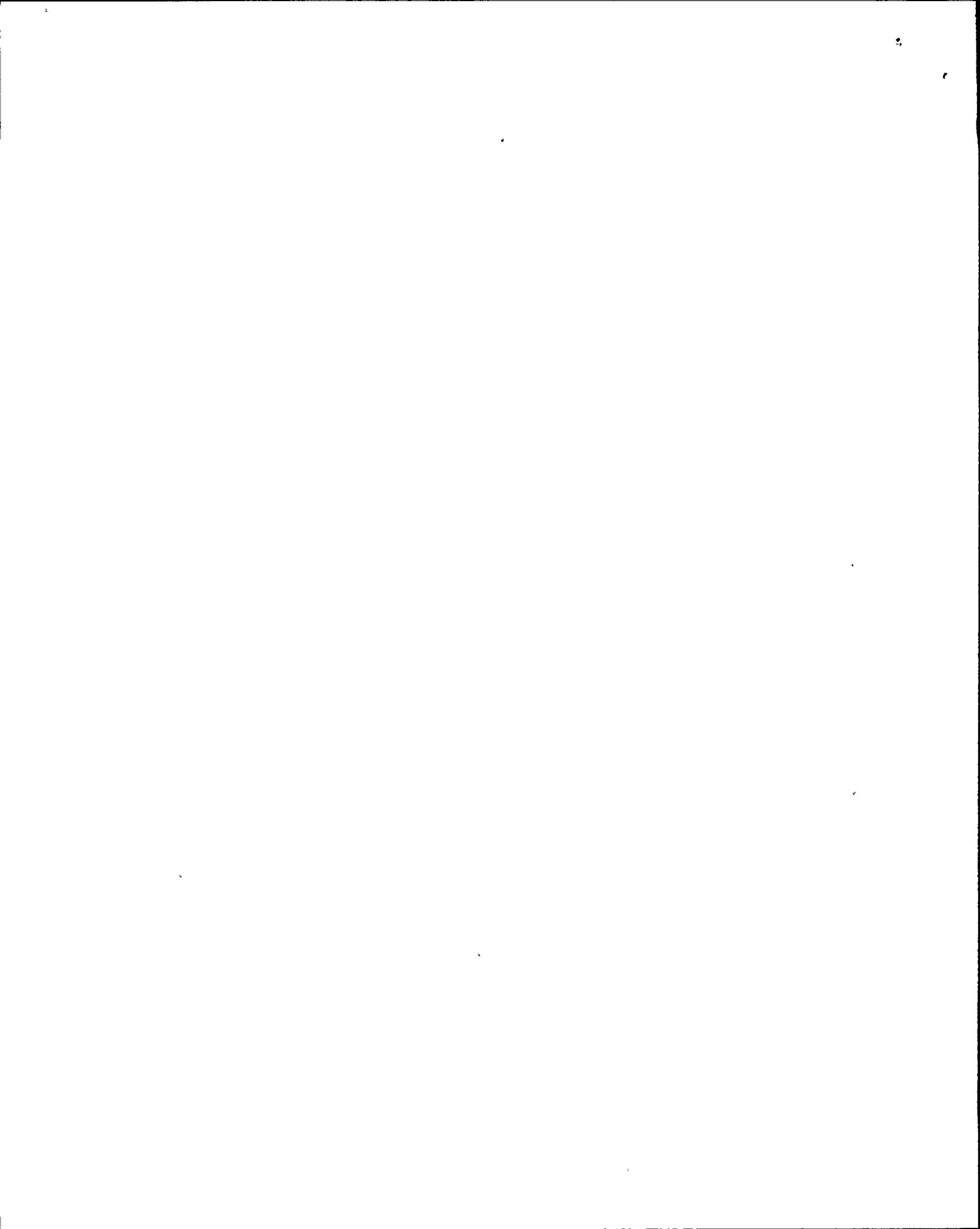


TABLE 3 (Cont'd)

LICENSEE EVENT REPORTSUnit 1 Summary of Cause Determined by SALP Board by Functional Areas

<u>CAUSE</u>	<u>OPS</u>	<u>RAD</u>	<u>MAINT/SURV</u>	<u>ENG/TS</u>	<u>EP</u>	<u>SEC</u>	<u>SAFETY/QV</u>	<u>TOTAL</u>
PE/LK								0
PE/ID	4			1				5
PE/PJ								0
EM/F/R	1		2					3
EM/F/DD				1				1
EM/F/CD			1					1
EM/F/MD								0
PRDE	3		1	2			1	7
ICA	1			3			3	7
TOTAL	9	0	4	7	0	0	4	24

*Total is greater than the number of LERs since some LERs have more than one cause code assigned. The licensee issued a total of 16 LERs this assessment period.

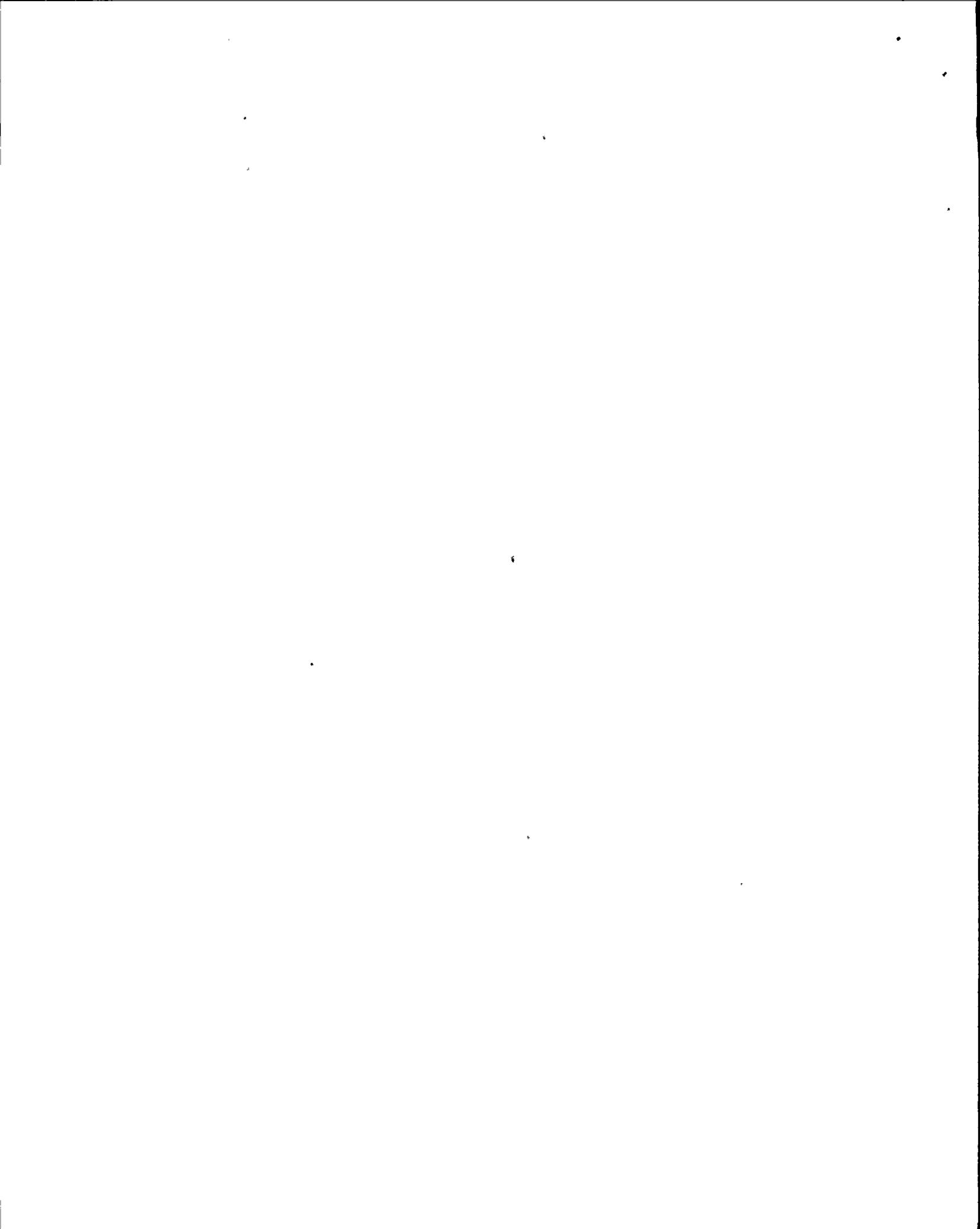
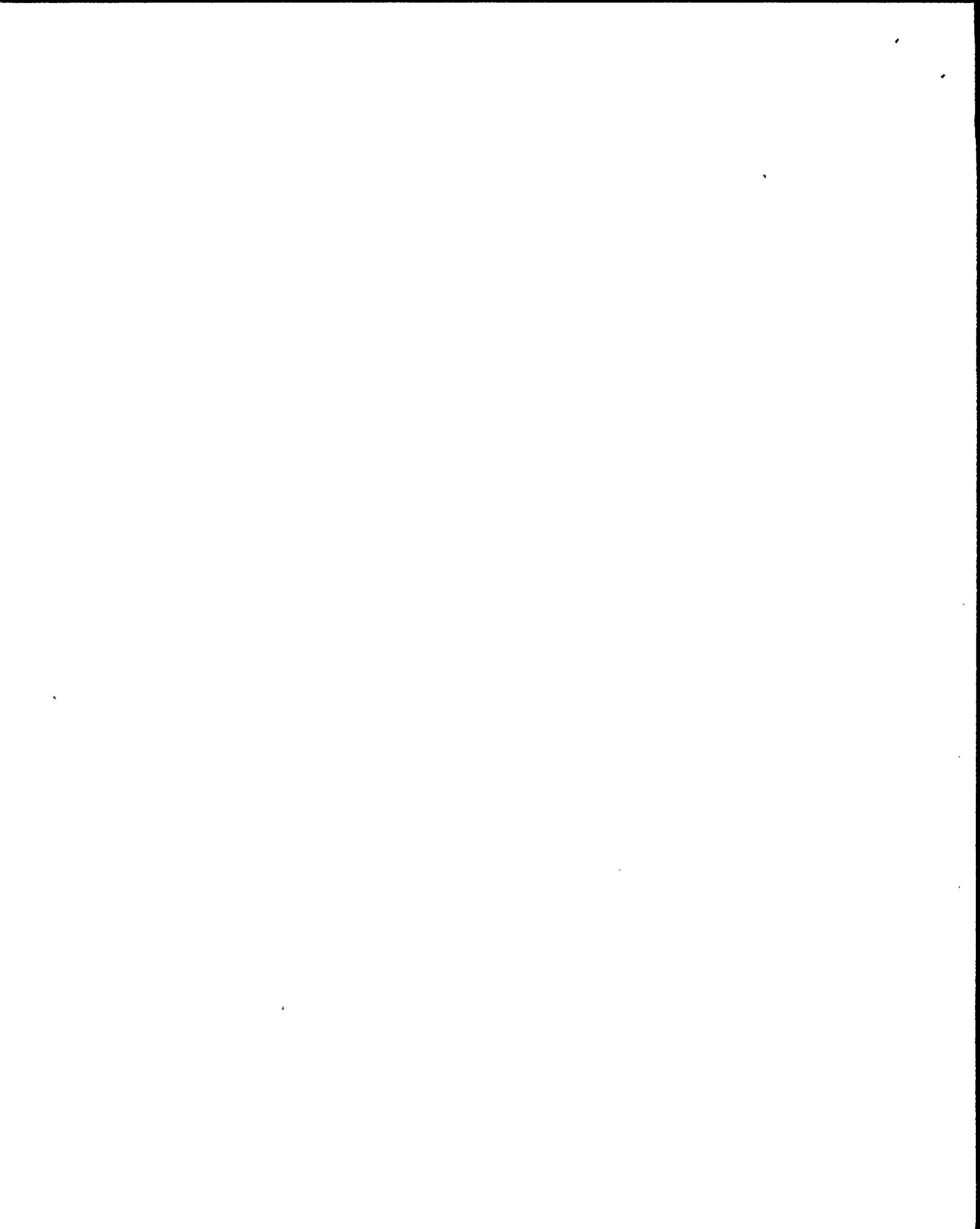


TABLE 3 (Cont'd)

LICENSEE EVENT REPORTSUnit 2 Summary of Cause Determined by SALP Board by Functional Areas

<u>CAUSE</u>	<u>OPS</u>	<u>RAD</u>	<u>MAINT/SURV</u>	<u>ENG/TS</u>	<u>EP</u>	<u>SEC</u>	<u>SAFETY/QV</u>	<u>TOTAL</u>
PE/LK	2	1	2					5
PE/ID	4	2	11	1				18
PE/PJ	1			1				2
EM/F/R	1		5	3				9
EM/F/DD			3	16				19
EM/F/CD			7	2				9
EM/F/MD			2					2
PROE	2		2					4
ICA			3					3
TOTAL	10	3	35	23	0	0	0	71*

*Total is greater than the number of LERs since some LERs have more than one cause code assigned. The licensee issued a total of 65 LERs this assessment period.



E. Other

Investigations and Allegations Summary

An Office of Investigation (OI) Review was prompted following a Region I inspection of the Unit 1 Licensed Operator Requalification Training Program which identified potential material false statements made on License Renewal Form 398s. The OI Report concluded that there were no intentional material false statements made by licensee management or licensed operators.

During this assessment period, a total of nine allegations were received and reviewed by the NRC. Six allegations were determined to be unsubstantiated and one allegation was a valid concern. The two remaining allegations were still under review at the end of the assessment period.

Management Conferences

On April 26, 1988, the licensee gave a presentation to NRC Management on torus thinning and Inservice Inspection issues for Unit 1.

On May 4, 1988, a meeting was held to discuss the licensee's approach to issues requiring resolution prior to Unit 1 restart.

On May 10, 1988, SALP management meeting was conducted on-site.

On July 25, 1988, the Regional Administrator, Executive Director of Operations, and the Associate Director for Projects, NRR met with the licensee on-site to discuss NRC's concern over the licensee's continued poor performance and issue Confirmatory Action Letter (CAL) 88-17.

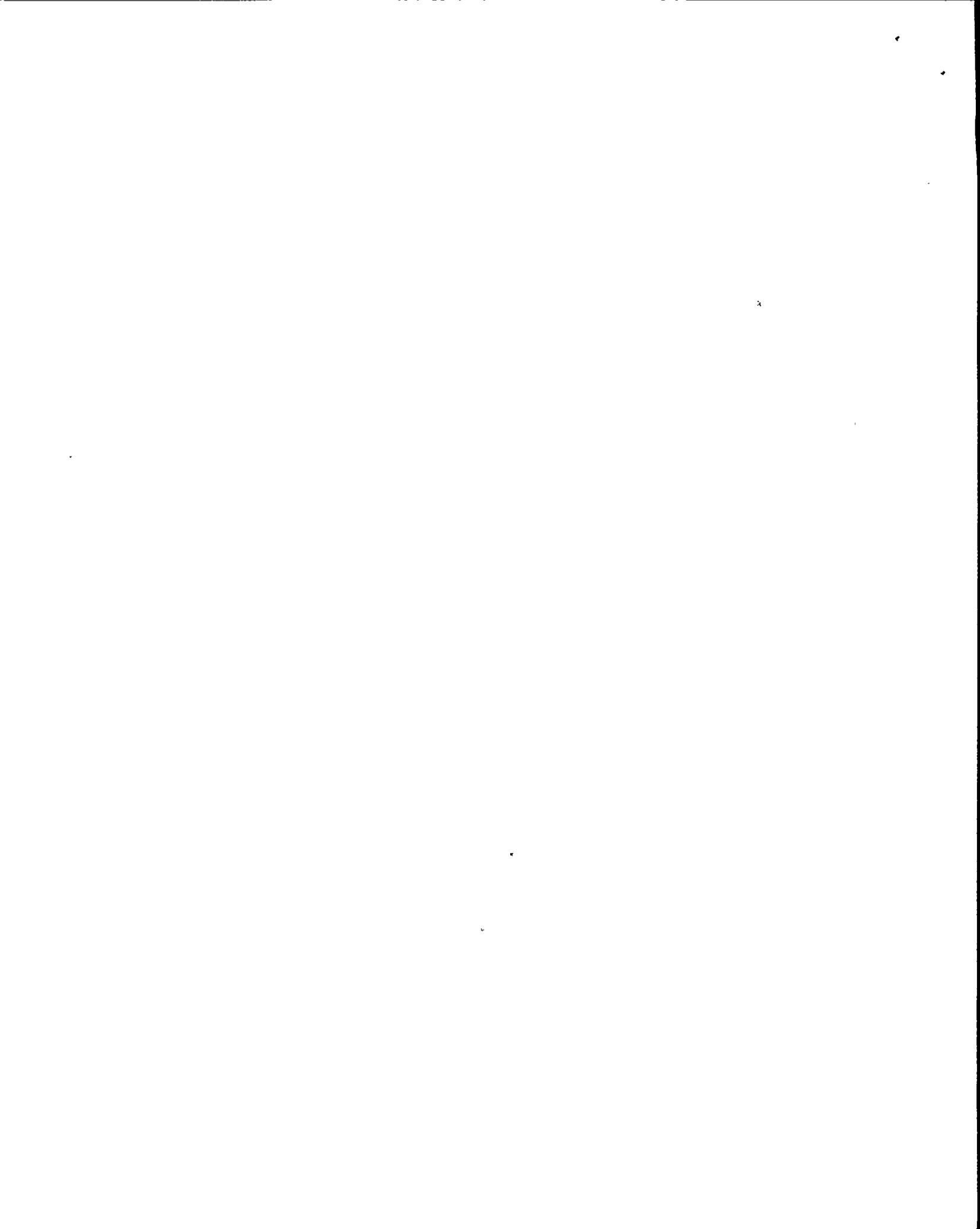
On August 18, 1988, the Regional Administrator was on-site to discuss corrective actions concerning CAL 88-17 with site and corporate officials.

On October 18, 1988, a meeting was held in Region I to review progress in resolving restart issues.

On October 21, 1988, NRC senior staff met with the licensee to discuss restart issues for Unit 1.

On October 27, 1988, the licensee made a presentation in Region I concerning the status and scheduling of Unit 1 Inservice Inspection Program.

On November 25, 1988, a management meeting with the Executive Vice-President was held concerning the Restart Action Plan.



On December 6, 1988, NRC management met with the President of Niagara Mohawk to discuss the Restart Action Plan.

On December 20, 1988, the licensee gave a presentation to NRC staff in Headquarters concerning improvements made in the Unit 1 Inservice Testing Program.

On December 22, 1988, the licensee presented the Restart Action Plan to the NRC for review in a management meeting in Region I.

On January 19, 1989, the NRC Restart Panel was on-site to present the licensee with comments on the Restart Action Plan.

On January 31, 1989, the licensee made a presentation to the NRC staff regarding details concerning Conformance with Regulatory Guide (RG) 1.97.

On February 21, 1989, the licensee made a second presentation to the NRC staff in Headquarters concerning RG 1.97.

