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SUBJECT: Responds to NRC 890727 ltr re violations noted in Insp Repts 50-220/89-06 & 50-410/89-06.

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NIAGARA MOHAWK

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

NMP55293

September 18, 1989

United States Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

RE: Nine Mile Point Nuclear Station
Unit 1 Docket No. 50-220
Unit 2 Docket No. 50-410

Gentlemen:

Your letter dated July 27, 1989, transmitted a Notice of Violation pertaining to Nine Mile Point Units 1 and 2, which resulted from Inspection Number 50-220/89-06 and 50-410/89-06. Subsequently, we had requested an extension for the response to the Inspection Report.

Attached is Niagara Mohawk Power Corporation's response to the Notice of Violation.

Very truly yours,

L. Burkhardt, III
Executive Vice President
Nuclear Operations

LB/GHM/lmc
(0833V)

ATTACHMENT

xc: Regional Administrator, Region I
W. A. Cook - Senior Resident Inspector

IE01
1/1

ATTACHMENT

Niagara Mohawk Power Corporation
Nine Mile Point Units No. 1 and 2
Docket No. 50-220/DRP-63
Docket No. 50-410/NPF-69

Response to Notice of Violation (NRC Inspection Report No. 89-06)

Violation

As a result of the inspection conducted on May 13, 1989, through July 7, 1989, and in accordance with NRC Enforcement Actions, (10 CFR Part 2, Appendix C, 53 Fed. Reg. 40019) (October 13, 1988), the following violation was identified:

10 CFR Part 50, Appendix B, Criterion XVI, requires that measures shall be established to identify the cause for and promptly correct conditions adverse to quality to prevent repetition.

NMPC Quality Assurance Topical Report, QATR-1, Revision 4, Chapter 16 requires that conditions adverse to quality are identified and appropriate corrective action is taken in a timely manner to minimize similar problems in the future.

Contrary to the above:

A. Actions taken to correct the cause of TS violations of the Fire Protection Program on April 27, 1988, and October 27, 1987, at Unit 1, were ineffective because they did not preclude similar TS violations of the Program on April 30, May 17 and June 6, 1989, involving the establishments and implementation of appropriate compensatory measures (i.e., firewatches) for inoperable fire barriers or detectors.

B. Actions taken to correct the cause of a failure to properly secure the gate to a locked high radiation area at Unit 1 on December 21 and 23, 1988, were ineffective as they did not preclude the recurrence of similar events on February 17, 1989, and March 24, 1989, at Unit 1, on May 5, 1989, and June 2, 1989, at Unit 2 and on June 12, 1989, at Unit 1.

C. Actions taken to correct the late notification of the NRC of a condition reportable under 10 CFR 21 requirements on January 23, 1987, were ineffective as they did not preclude the recurrence of a similar event in which a condition reportable per 10 CFR 21 was determined to exist on May 31, 1989, but was not reported to the NRC until June 20, 1989.

Response to Violation/Actions Taken

Niagara Mohawk Power Corporation admits that timely corrective actions had not been implemented to preclude the recurrence of similar events identified in Appendix A of the Notice of Violation. The Nine Mile Point Unit 1 Restart

Action Plan (RAP) addresses several management and organizational effectiveness deficiencies. The conditions cited in the Notice of Violation are examples of management ineffectiveness in the areas of problem identification, resolution and communication.

Each event referred to in Items A and B of the Notice of Violation was identified by Niagara Mohawk. For each of the specific events, Niagara Mohawk took prompt corrective action to prevent recurrence. Niagara Mohawk has shown substantial improvement in the identification and timely resolution of problems. Also, Niagara Mohawk has shown improvement in communication through use of the chain of command.

Niagara Mohawk had recognized management problems in the area of fire protection and radiological control. Niagara Mohawk implemented organizational changes in both the Fire Department and Radiological Control Departments.

The final three events in the area of fire protection occurred before the transition in management. This management change was implemented to provide better definition of responsibility and accountability, and improve communications between Operations and the Fire Department.

Niagara Mohawk believes these changes will prevent recurrence of future problems.

Niagara Mohawk agrees that failure to maintain high radiation gates locked is a serious concern. After each event it was believed that effective corrective actions were in place to prevent reoccurrence of this type of event. However, Niagara Mohawk acknowledges that these corrective actions were ineffective.

The institution of the double verification program has been effective in maintaining the high radiation doors closed and ensuring that people realize the importance of this issue. Niagara Mohawk has also identified the deeper concern of ineffective management regarding this issue. We had failed to communicate the seriousness of this issue from management to the worker in the field. At the time of these events the Restart Action Plan had not progressed far enough to provide effective management controls in communication and teamwork. As of the date of this response Niagara Mohawk believes that the Restart Action Plan has and will continue to increase teamwork and communications between the station management and the workers in the field such that issues of this type will continue to decrease and become nonexistent.

Niagara Mohawk is confident that identification, communication and ultimate resolution of the conditions identified in Appendix A of the Notice of Violation is a positive indication that the Restart Action Plan is effective.

Specific Responses

A. Each missed fire patrol event identified in Item A of the Notice of Violation has been evaluated taking into consideration the circumstances

of the event, cause of the event and corrective actions implemented as a result of the event. Corrective actions were implemented for each individual event and corrective actions became more extensive with each event. The last corrective action implemented an interim program change. This program change included implementation of general building patrols which would eliminate the need for the establishment of specific roving fire patrols. Additional revisions to the administrative program for the issuance of markups on fire detection/protection components are also being considered for overall enhancement of the station fire protection program This is part of an assessment of the collective actions currently employed. Additionally, Niagara Mohawk has implemented new leadership in the Fire Department which is intended to provide improved communications between organizations such as Operations and the Fire Department.

Additional details of these events and their corrective actions are detailed in Licensee Event Reports 87-20, 88-02, 89-05, 89-06, and 89-08.

B. NMPC agrees that prompt corrective actions were not implemented to preclude recurrence of high radiation area door/gate events (areas greater than 1000 MR/HR). A root cause analysis for this event has been completed per Site Supervisory Procedure S-SUP-1, "Root Cause Analysis Program" and the Institute of Nuclear Power Operations Human Performance Evaluation System (HPES).

The overall root cause of the high radiation area door/gate events has been determined to be a managerial methods deficiency.

Niagara Mohawk has implemented the following comprehensive program to preclude recurrence of this event.

- A site wide double verification process has been implemented when personnel enter or exit high radiation area doors/gates. This action will provide greater assurance that these doors/gates will remain shut and locked. Implementation of this program is based on procedure number OI-12 and internal correspondence by both Station Superintendents.

- As an interim measure, the Radiation Protection Department has increased the high radiation area door/gate surveillance frequency to verify that doors/gates are closed and locked, from three times a week to daily. This action is intended to verify that actions being taken have been, and continue to be, effective.

- A pilot program is being implemented where security will provide door/gate alarm capability for response by Radiation Protection personnel. This program is being developed for twenty-three high radiation doors/gates frequently accessed at NMP2. Based on the performance of this pilot program, alarm capability may be installed

at both units. If successful, the double verification program and increased surveillance frequency may be discontinued.

- The Security maintenance procedure is being revised to increase the frequency of performing preventive maintenance on all high radiation area doors/gates to every 60 days; this action provides greater assurance that locks will work correctly and physical defects are identified promptly.

- Security maintenance and Radiation Protection have reviewed door lock mechanism and hardware source documents to ensure self-locking mechanisms are identified for replacement. At NMP1 door lock document DL-0100 had instances where manual locks were designated as replacements. Design change documents were initiated to ensure that self-locking mechanisms were specified. NMP2 was also reviewed for similar conditions. OI-12 has been revised to ensure that self-locking mechanisms are prescribed each time a security door is identified as a high radiation door.

C. Regarding the ineffective correction action taken for Part 21 notification, Niagara Mohawk did revise its procedures in 1987 to commit to notify the NRC of potential deviations that we determined to be substantial safety hazards even if they have already been reported by a previous method. Niagara Mohawk made this commitment in response to NRC Inspection Report No. 50-410/87-02. Niagara Mohawk's Part 21 procedure was revised to require reporting a defect or failure-to-comply which we considered to be a substantial safety hazard even if it had been previously reported by means other than a Part 21 report. This reporting would either be by submittal of a separate letter identifying that the condition was a substantial safety hazard or, if another submittal was being prepared and would be submitted within 5 days, then we would indicate in that submittal that the condition was considered to be a substantial safety hazard.

The reason for the current violation was poor implementation of revised procedures. The Licensing Engineer believed that a supplemental LER would be written and submitted within 5 days of the determination that the condition was reportable under 10CFR21. This supplement to the LER was to state that the condition was also considered to be a substantial safety hazard and also serve as the Part 21 notification. The Licensing Engineer failed to notify the site that this LER supplement was to be the notification to the NRC of the Part 21 safety concern and therefore was required to be written and sent out within 5 days. Additional training has been provided to all Licensing Engineers in June of 1989 to cover these reporting requirements and the Part 21 procedure will be revised by October 15, 1989 to ensure that the Part 21 report is submitted to the NRC within 5 days.