U.S. NUCLEAR REGULATORY COMMISSION

REGION I

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License Nos.: DPR-63
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Licensee: Niagara Mohawk Power Corporation
301 Plainfield Road
Syracuse, New York 13212

Facility: Nine Mile Point, Units 1 and 2

Location: Scriba, New York

Dates: September 7, 1989 through October 18, 1989

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Approved by: for Glenn W. Meyer, Chief — 2/5/90 Date
Reactor Projects Section No. 1B
Division of Reactor Projects

Inspection Summary:

Areas Inspected: Routine inspection by the resident inspectors of station activities including Unit 1 refueling activities and Unit 2 power operations, licensee action on previously identified items, plant tours, safety system walkdowns, surveillance testing reviews, maintenance reviews, preparations for refuel at Unit 1, and allegation followup.

Results: For Unit 1, several reactor scrams due to problems with Motor Generator Set 162 (MG 162) are discussed in Section 2. Section 3 updates and closes several open items. System walkdowns resulted in identification of several apparent violations and are discussed in Section 4. A detailed review of Unit 1 preparations for reload is discussed in Section 1. Closeout of two allegations is documented in section 9.

A Unit 2 violation concerning the failure to perform a post-maintenance test is discussed in Section 2.2.b. A Unit 2 unresolved item concerning use of the 10 CFR 50.59 process is discussed in Section 5.2.b. Three Unit 2 reactor scrams, two of which were caused by personnel error, are discussed in Sections 2.2.a, 2.2.f and 2.2.g. A Unit 2 incident concerning valves out of position in the reactor water cleanup system causing an unplanned system transient is discussed in Section 2.2.d.

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## DETAILS

1. Review of Preparations for Core Reload

During this report period, the resident staff conducted a review of NMPC's preparations to reload the core at Unit 1. Specific areas of interest and reload related activities were inspected. Our findings and assessment of the subject areas are summarized below.

1.1 Technical Specification (TS) Review

The inspector reviewed the Unit 1 TS and prepared a list of all sections with applicability to the REFUEL mode. This list was then reviewed against NMPC's TS Matrix and was found to be in agreement. Additionally, NMPC's TS Matrix contained additional items which, through conservative interpretation, were determined to be applicable to reload activities.

The inspector questioned the ability of NMPC to meet the operability requirements for some of the systems required for reload. It appeared that for some systems, such as Reactor Building Closed Loop Cooling and Core Spray, that the system's physical condition or surveillance testing status did not necessarily support the requirements to make the system TS operable. The inspector determined that for these systems, as well as others, NMPC is relying on engineering evaluations to declare systems operable for the REFUEL condition only. In other instances TS interpretations are being used to support the operability requirements for REFUEL. The inspector has requested that NMPC provide a list of all TS interpretations and 10 CFR 50.59 reviews which will be used to satisfy the refueling systems operability requirements.

Pending inspector review of the above requested material, it appeared that NMPC had adequate methods in place to ensure that operability requirements for systems necessary to support the REFUEL condition are identified and met.

1.2 TS Surveillance Review and Verification

An adjunct to the TS review was a review of TS required surveillance tests for systems required for reload. The inspector reviewed the Unit 1 Surveillance Test Matrix, a document which correlates TS required surveillances with the NMPC surveillance test procedures. The Test Matrix also lists all modes in which the surveillance test must be satisfied. Inspector review of this document identified no deficiencies.

By use of a separate computer listing of the Test Matrix, the inspector reviewed when a particular surveillance procedure was last performed. Through discussion with NMPC personnel, the inspector determined that not all TS Matrix entries reflect the most current surveillance procedure revision and/or procedure number. Therefore, the last completion date for some surveillance procedures was not available. However, the inspector determined that NMPC personnel were aware of these discrepancies and that measures were being taken to address them. Overall, the Surveillance Test Matrix appeared to be a complete document which should be beneficial in ensuring that TS required surveillance tests are identified and performed within their periodicity.

1.3 Safety System Walkdowns

Part of NMPC's preparation for reload was a walkdown of systems determined to be necessary for reload activities. This was accomplished using Temporary Procedure N1-88-6.6, Restart Requirements for Core Reloading System and Area Walkdown for Restart Procedure. This procedure required walkdown of 26 systems, as well as, general area walkdowns in various parts of the plant.

The inspectors chose two systems which NMPC had completed per N1-88-6.6. The inspectors performed independent walkdowns using the observation criteria listed in N1-88-6.6. The first walkdown was performed on the Emergency Ventilation (EV) System. Comparing walkdown deficiency lists, the inspectors noted that none of their findings were contained in the NMPC list of material deficiencies. (EV system walkdown findings were discussed in IR 89-07 and in Section 4 of this report). Based on the results of the EV system walkdown, the inspectors were concerned that NMPC had not performed an adequate walkdown per N1-88-6.6 and discussed this concern with NMPC management.

In response, NMPC reinspected the EV System and confirmed the inspector's findings. They also reinspected the Fuel Pool Filtering and Cooling System (FPF&CS) per N1-88-6.6. Their reinspection of the FPF&CS showed good correlation between initial walkdown findings and their recent list. Consequently, NMPC concluded that the EV walkdown findings of the NRC inspectors were isolated only to that system and that a broader problem with implementation of N1-88-6.6 did not exist.

To validate their initial concern the inspectors conducted a walkdown of the Control Room Emergency Ventilation (CREV) System (see Section 4.1.c). Similar to the EV system walkdown results, the inspectors identified numerous deficiencies which were not noted in the NMPC walkdown of the CREV system. Collectively, these findings led the inspectors to further question the adequacy of NMPC's system walkdowns per N1-88-6.6.

The inspectors again met with NMPC management to communicate their concerns in this area. At that meeting, NMPC management indicated that they were also starting to question the adequacy of their walkdowns as a result of an in-office review of the results of their completed walkdowns.

Subsequent to this meeting, NMPC evaluated the walkdown procedure and the manner in which it was implemented and identified major inconsistencies. As a result, NMPC substantially revised the walkdown procedure to give clearer guidance to personnel and provided training on how and what to inspect per the new revision. The revision also required walkdowns to be performed by a team of individuals from various departments and also required QA to provide an individual to accompany each walkdown team. Additionally, all systems previously inspected were reinspected per the new procedure and inspection criteria.

Inspector Assessment

The inspectors concluded that there had been a breakdown in management effectiveness in oversight of the walkdown procedure. The Unit Superintendent's expectation of how system walkdowns should be done was not effectively communicated to the staff. The walkdown procedure was not uniformly implemented by the personnel performing the system walkdowns, and line management did not provide oversight and training on the initial walkdown requirements. Additionally, line management oversight of the implementation of the walkdowns was deficient in that, while in-office reviews of the completed paperwork were performed, no independent field verifications were performed. Lastly, the site Quality Assurance Department missed an opportunity to assess unit readiness for reload and provide management feedback on the same. The inspector concluded that the ineffective walkdown procedure and the inconsistent implementation of the procedure represented an apparent violation of 10 CFR 50, Appendix B, Criterion V. (50-220/89-08-01)

1.4 Problem Report Program Review and Item Status

The inspector reviewed the Unit 1 Problem Report (PR) Program and current status with the responsible site manager. The inspector reviewed PR processing and observed several PRs in various stages of resolution. The inspector observed that PRs are closely tracked via a computer program from their origin to final resolution and that

NMPC management receives daily status reports to monitor overall progress. The inspector determined that the PR originators are provided the resolution to their concern prior to final closeout of the PR. Disagreements on the final resolutions are appropriately resolved with the originator.

The inspector reviewed the status of critical reload PRs with the responsible manager. The number of open PRs impacting reload is also tracked via the daily outage schedule. No discrepancies were noted, and the inspector concluded that PRs were being evaluated properly.

1.5 Nuclear Commitment Tracking System (NCTS) Review

The inspector reviewed Niagara Mohawk's actions for assuring that all commitments required for reload and restart had been identified and were included in NCTS. The process involved an item by item review of all entries in the NCTS and comparison with the priority definitions specified in procedure N1-88-6.11 "Restart Requirements for Core Reloading, Plant Procedures Checklist, Surveillance Tests, and NCTS Review for Core Reloading". Source documentation (e.g., memos to NRC, meeting minutes) were reviewed if items were questionable. In addition, Niagara Mohawk is reviewing all 1987, 1988, 1989 NRC inspection reports for potential or "implied" commitments as well as the Unit 1 Restart Action Plan. The inspector reviewed approximately one half of the NCTS items and noted that Niagara Mohawk had been conservative in its classification of items as "required for startup." The inspector noted no concerns and concluded that implementation of NCTS was adequate.

1.6 Control Drawing Review

The inspector reviewed the NMPC program for maintaining up-to-date drawings in the control room at Unit 1. The program is outlined in Nuclear Design Procedure ND-160, Revision 1, "Drawing Change Control for Nuclear Design - Unit 1."

The inspector discussed the drawing control program with the lead electrical/I&C engineer at the NMPC corporate office. The engineer stated that NMPC currently has about 4000 total drawings for Unit 1. Of these drawings, 900 are designated as controlled critical drawings and are available in the control room.

Due to concerns identified by the Quality Assurance (QA) Department regarding drawing control and the incorporation of design changes into these drawings, the QA Department issued Stop Work Order (SWO) 87-500 against the Engineering Department in January, 1987. As a result, Revision 1 to ND-160 was developed.

The inspector concluded that updating and control of drawings were acceptable based on the following reviews. The inspector reviewed ND-160, as well as a representative sample (31) of critical drawings. The inspector reviewed the correspondence related to the resolution and lifting of SWO 87-500. In addition, the inspector reviewed several operator aid drawings in the plant to determine the status and timeliness of updating these drawings.

1.7 Quality Assurance Department Activities Review

On September 25, 1989, the inspector contacted the site QA Manager to determine what plans, if any, QA had for special monitoring of reload/restart activities. The inspector was informed, at that time, that no special inspection or surveillance activities were planned. However, the normal QA surveillance routine would be in effect, but on a more frequent surveillance schedule. The QA Manager indicated that the normal QA program, at an enhanced surveillance schedule, would be adequate to handle the upcoming activities. If problems were detected in monitored activities, then the QA Department would react to them, at that time. As stated above in Section 1.3., the inspectors considered the lack of additional QA Department oversight in the area of reload preparation to be a valuable missed opportunity for assessment. For the QA Department not to take a more proactive role in monitoring these activities also indicated a weakness in senior NMPC management planning for the upcoming activity.

1.8 Review of Selected Specific Activities/Issues

a. Satin American Overcurrent Trip Devices

The inspector reviewed the replacement of General Electric Type EC-1,EC-1B, and EC-2A series overcurrent trip devices supplied by Satin America Corporation (SAC). These breakers had been identified by the NRC in Information Notice 89-45 as potentially substandard because of modifications and refurbishment which did not meet the original design.

NMPC reviewed all purchase orders with SAC and determined that 154 of the trip devices had been purchased. NMPC subsequently performed a walkdown of all 600 volt power boards and identified 22 applications at Unit 1 where SAC trip devices were installed in power boards with safety-related applications. The inspector reviewed documentation which concluded that no SAC equipment was installed at Unit 2.

Niagara Mohawk originally completed a justification to reload the core with SAC breaker trip devices still installed in the plant. Near the end of this inspection period, NMPC decided to replace all these trip devices prior to reload. The inspector concluded that this approach resolved the technical concern with SAC trip devices.

b. SSFI Followup - (see Section 3.1.1.a, b, c, d, and e.)

c. SCRAM Discharge Volume (SDV) Test Results - (see Section 3.1.2.b.)

2. Review of Plant Events

2.1 Unit 1

The reactor remained shutdown and defueled throughout the report period. Efforts continued towards core reload in the near term. Latest reload and restart target dates determined by NMPC are October 27, 1989, and January 13, 1990, respectively, as of the end of the inspection period.

a. Between September 17 and 28, four reactor scrams and associated Emergency Ventilations System initiations occurred due to a loss of power on Reactor Protection System (RPS) bus 11. The loss of power on RPS bus 11 was believed to have been caused by a malfunctioning voltage regulator/speed controller on motor-generator (MG) Set 162 which provides continuous power to RPS bus 11. The problem was first identified during the performance of the Loss of Offsite Power/Loss of Coolant Accident surveillance test. Troubleshooting on MG Set 162 was still ongoing at the close of this inspection period. Resolution of this problem will be discussed in a later report.

2.2 Unit 2

The reactor was manually scrammed on September 8, at which time NMPC commenced a planned two week maintenance outage. The outage was completed on schedule and the reactor was taken critical on September 22.

a. On September 25, NMPC determined that the screenwell building sump at Unit 2 was radioactively contaminated. The source of the contamination was determined to be from the radwaste floor drain header to which the sump pump for the screenwell sump is connected. The contamination apparently occurred due to a design deficiency with the screenwell sump pump discharge line which allowed radioactive material in the floor drain header to collect in the line and problems with a check valve in the line which allowed the backflow of radioactively contaminated water through the line. No offsite release of contamination occurred.

The inspector toured the affected areas, examined the piping configuration and discussed the problem with the radwaste operations supervisor and the Unit 2 radiation protection supervisor. Corrective actions to prevent a recurrence of this event were being developed. The inspector concluded that cleanup efforts on the sump were appropriate.

b. On September 8, with the reactor at 88% power, both reactor recirculation pumps downshifted to slow speed for no apparent reason. Core thermal power and core flow decreased to 44% and 34%, respectively. After consulting Procedure N2-OP-29 (flowchart for sudden decrease in flow), the SSS directed that the reactor be manually scrammed by placing the mode switch to the SHUTDOWN position. This action was taken because the downshift of the recirculation pumps placed the unit in the restricted zone of the power to flow map where the reactor is vulnerable to power oscillations. No emergency core cooling systems initiated and plant systems responded as designed. There were no indications of power oscillations on average power range monitors while the unit was in the restricted zone of the power to flow map. The inspector responded to the site shortly after the scram and observed that NMPC's actions were proper.

NMPC conducted an investigation to determine the cause of the downshift of the reactor recirculation pumps to slow speed. From troubleshooting and computer point analysis, it was found that oscillations in the Feedwater Control System D.C. power supply unit (C33A-K613) caused the recirculation pump low reactor water level trip relays to drop out, resulting in a recirculation pump downshift. This power supply was replaced and post-maintenance testing was satisfactorily performed. The inspector reviewed the post scram report and identified no concerns. Inspector assessment of this event was that the operators took the proper actions in accordance with station procedures. Operator technical expertise was reflected in their quick diagnosis of the faulty power supply which caused the recirculation pump downshift.

c. While performing the shift turnover Control Panel walkdown on the evening of September 9, the oncoming Chief Shift Operator (CSO) found the Division III emergency diesel generator (EDG) control room unit cooler (2HVC*U2C) was not available for operation. The Station Shift Supervisor was informed and the Division III EDG was immediately declared inoperable. Maintenance had been completed on 2HVC*U2C the previous day and the Division III EDG was declared operable at 6:50 p.m. on

September 8, with the unit in Operating Condition 3 (HOT STANDBY). Subsequent Niagara Mohawk staff investigation identified a knife switch in the power supply circuit had been inadvertently left open following maintenance on the unit cooler breaker per Electrical Maintenance Procedure N2-EPM-CSH-R583. This condition existed for approximately 12 hours.

Inspector followup of this event identified a number of concerns. Procedure N2-EPM-CSH-R583, 600V G.E. HPCS MCC Starter/ Breaker and Motor Inspection, was inadequately written for the specific maintenance task performed. Step 7.5 contains instructions to perform a megger of the 2HVC*U2C motor and to measure the winding resistance phase to phase. To accomplish this, a local knife switch must be opened to gain access to the load side of the local controller. The procedure did not contain steps to open and reclose the knife switch. The electrical maintenance technician failed to close the knife switch when the maintenance was completed. Electrical Maintenance personnel have been operating knife switches for this purpose on the HPCS unit cooler motor and other motor local controllers informally for some time. This maintenance practice conflicts with the requirements of Station General Order 89-03 which stipulates strict procedural compliance.

The inspector concluded that the operator appeared to have been inattentive to the activity being performed. Upon completion of the maintenance, the system markup was cleared by a control room operator. After removing the tags and supposedly reenergizing the circuit the operator failed to recognize the breaker position indication was de-energized. In addition, a lit annunciator and a lit trouble light were in an alarmed state indicating no power was available to the cooler.

The most significant concern identified by the inspector was that no post-maintenance test (PMT) was performed on 2HVC*U2C following the preventive maintenance conducted on September 8. Procedure N2-EPM-CSH-R583 lists general guidance on what PMT may be used, but does not clearly specify that it must be performed.

The electricians performing the maintenance are procedurally required to only inform Operations Department that the maintenance is complete and that the equipment is available for testing. The inspector determined that neither the electrician or the on-duty operators discussed PMT of the unit coolers. In addition, the Equipment Status Log entry for this maintenance activity was ambiguous as to the need for PMT.

Although procedural inadequacies existed and several station personnel erred in restoring and verifying safety equipment restoration to operability, the performance of a post-maintenance test may have identified these oversights. 10 CFR 50, Appendix B, Criteria XI states, in part, that preoperational proof tests be performed on nuclear power plant systems and components to ensure they will perform satisfactorily in service. The station staff did not perform any post-maintenance testing of the Division III EDG control room unit cooler following the performance of maintenance on the cooler motor on September 8. This is a violation (50-410/89-08-02).

The following corrective actions were taken in response to this event:

1. Retraining was conducted with all maintenance personnel stressing the applicable portions of Station General Order 89-03 which emphasize strict procedural compliance.

2. NMPC reviewed all completed preventive maintenance procedures to ensure system/component operability subsequent to the maintenance.

3. All preventive maintenance procedures will be accompanied by a PMT report which will clearly delineate the PMT requirements and their completion.

4. The Unit 2 Superintendent issued a lessons learned transmittal that covered the programmatic and personnel breakdowns that occurred. The inspector reviewed this transmittal and found it to be satisfactory.

The inspectors were concerned that the personnel errors discussed above and a number of similar events indicated a trend in poor control of equipment/system status. Other recent examples include:

-- On May 11, the HPCS keep fill pump was removed from service without performing a safety evaluation.

-- On June 13, the Division II service water bay unit cooler was returned to service with outstanding maintenance and resulted in a TS violation.

-- On June 29, the closing contact for an offgas system compressor exploded when the compressor was attempted to be started. The compressor was declared inoperable earlier, but not tagged to prevent use.

-- On September 25, valves WCS*V344 and *V345 were left out of their normal position and resulted in an unexpected reactor water cleanup system transient (see Section 2.2.e).

d. On September 14, while preparing to test the "C" Transversing Incore Probe (TIP) squib valve, an unplanned retraction of the "A" TIP occurred. The "A" TIP withdrew from approximately 50 inches below the core to its shield location in the TIP room. Workers evacuated the TIP room upon notification of movement of the "A" TIP. These workers did not receive any appreciable exposure due to this event. In response to this event, Radiation Protection supervision issued a Stop Work Order and initiated a Radiological Incident Report (N2-89-5).

Niagara Mohawk investigation determined that the procedure in progress, N2-ISP-TIP-R001, was initially written such that all TIP detectors not being tested must be stored in their shield in the TIP room prior to testing any single TIP detector. Shortly prior to this event, a Temporary Change Notice (TCN) was initiated that required all TIP detectors not being tested to be inserted into the drywell area below the core to reduce personnel exposure of the workers in the TIP room. This was accomplished, however, Niagara Mohawk concluded that this TCN was inadequate because it did not de-energize the TIPs which were not being tested to prevent inadvertent retraction. Subsequent to this event another TCN was issued to accomplish this function.

Secondly, due to poor communications between the supervisor and I&C technician performing the surveillance test, work was commenced on the incorrect TIP drive, A vice C. As a result, the runback feature of the A TIP was inadvertently actuated by the I&C technician. The inspector was concerned that the initial TCN was not adequately researched and the workers were not adequately briefed or supervised.

e. On September 25, a Reactor Water Cleanup System (WCS) isolation occurred as a result of high Non-Regenerative Heat Exchanger (NRHX) inlet temperature. During the event, the Reactor Building Close Loop Cooling (CCP) pumps tripped and a waterhammer occurred in the WCS system piping. The CCP pumps were restarted immediately and NMPC commenced an investigation to determine the cause. An inspection of snubbers in the WCS system per TS Surveillance 4.7.5.d was initiated due to the potentially damaging transient.

After several days, NMPC identified the following chronology to be the cause of this event. During the dayshift, a twenty gallon per minute leak was discovered in the WCS valve room. In an attempt to isolate the leak, an operator secured "D" filter demineralizer and depressurized it by opening valves WCS*V345 and WCS*V344. This valve lineup established a path from the WCS system to the phase separator tank in the radioactive liquid waste system. This method of depressurizing the "D" filter demineralizer was not recognized by the Operating Procedure and was performed under emergency circumstances to stop the leak. However, these actions did not stop the leak. The operator realized the leak was actually from a mechanical fitting in the "C" filter demineralizer and isolated the "C" filter demineralizer, leaving the "D" filter demineralizer secured and vented. The operator failed to note in the log book and/or notify the Station Shift Supervisor (SSS) that the "D" filter demineralizer was vented to the phase separator tank via valves WCS*V345 and WCS*V344. Later on September 25, the next operating crew placed "D" filter demineralizer in service, not realizing the vent path to the phase separator tank was established. Consequently, several thousand gallons of water was inadvertently sent to the phase separator tank causing increased flow through the NRHX resulting in high NRHX inlet temperature, CCP pumps to trip and waterhammer in the WCS system.

As a result of the snubber inspections, NMPC identified and repaired one snubber which was sluggish. NMPC took the following corrective actions in response to this event:

-- A Lessons Learned transmittal was issued.

-- Disciplinary action was taken against the operator who left valves WCS*V344 and WCS*V345 open and neither informed the SSS nor logged it in the logbook.

-- The Operations Superintendent conducted training with all shifts on the Lessons Learned from this event and the corrective actions.

The inspector considered that NMPC's loss of control of WCS system status was noteworthy. The actual safety significance was low since the isolation feature of WCS initiated, as designed, and was not inhibited by the valves being out of position. The inspector planned additional review of corrective actions as part of reviewing LER 89-33.

f. On October 13, a reactor scram occurred from 60 percent power. The scram resulted from a turbine trip on turbine control valve fast closure due to low condenser vacuum. Investigation of the scram identified that Electrical Maintenance personnel were performing preventive maintenance on the B mechanical vacuum pump motor breaker. When the breaker was closed in the TEST position, the steam jet air ejectors inlet isolation valve (AOV-104) closed, as designed, resulting in the loss of condenser vacuum. The vacuum pumps remained mechanically isolated from the vacuum stream via another valve (AOV-105) which is also electrically interlocked. Upon receipt of the low condenser vacuum alarm, operators attempted to maintain vacuum by reducing reactor power via lowering recirculation flow and driving rods in. Reactor power was 100 percent at the beginning of the transient.

The cause of this scram was determined to be operator and technician error. Plant impact of this maintenance activity had not been properly evaluated. Placing AOV-104 valve control switch in the OPEN position vice the AUTO position would have prevented the automatic interlock function from initiating. This interlock is designed to prevent reverse flow through the mechanical vacuum pumps. The unit was restarted on October 15.

The inspector was concerned since the inadequate plant impact assessment represented a repeat problem. The inspectors will review the Licensee Event Report (89-35) to assess NMPC corrective actions.

g. On October 17, operators identified an increasing reactor coolant leak rate and at 11:28 p.m. station management ordered a unit shutdown to investigate the source of leakage. The leak rate had increased to approximately 4.0 gpm by the time reactor power reduction was started.

While reducing reactor power and attempting to transfer recirculation pumps to slow speed, the B recirculation pump failed to start on slow speed. Subsequent attempts were unsuccessful and action was taken to adjust the APRM and Rod Block Monitor (RBM) flow biased setpoints in accordance with Technical Specification

(TS) 3.4.1.1 for single recirculation loop operation. At approximately 4:30 a.m., (four hours after the B recirculation pump failed to start on slow speed), Niagara Mohawk entered a forced shutdown (12 hour LCO) due to the inability to complete the flow bias setpoint adjustments within the TS four hour time limit. I&C technicians completed the adjustments at 6:13 a.m. and the operators exited the TS 3.4.1.1 forced shutdown LCO.

At 6:16 a.m., a Reactor Protection System reactor scram occurred due to IRM High Flux. The reactor was operating at approximately 500 psig with IRMs in range six and seven at the time of the scram. All protective systems functioned as designed and no ECCS actuations occurred. The cause of the IRM High Flux trip was the result of concurrent additions of positive reactivity. The reactivity additions consisted of a combination of an increase in feedwater flow and a slight increase in pressure due to a fairly rapid isolation of steam to the steam jet air ejectors. The unit was restarted on October 26.

In the Night Notes book, Operations management stressed the highly sensitive nature of the IRMs to any power changes; Senior Reactor Operators need to increase their involvement of activities associated with reactivity changes; and operators should not perform more than one activity at a time that affects reactivity. The inspector will review final NMPC corrective actions once the LER (89-36) is issued.

3. Followup on Previous Identified Items

3.1 Unit 1

3.1.1 The inspector held followup meetings with Niagara Mohawk on August 15, 1989 and September 8, 1989, to review the status of open items from Safety System Functional Inspection (SSFI) Followup Report Number (50-220/89-18). The status of these items is as follows:

a. (Open) Unresolved Item (50-220/89-18-01): Core Spray System Design Deficiencies:

1. System Performance Curves (Open - Section 2.2(A)) - In order to resolve concerns regarding the appropriateness of values used for system resistance in ECCS performance analyses, Niagara Mohawk committed to perform a special test of the system to determine actual resistances. Test procedure N1-88-7.12 "Core Spray System Injection Test" was approved by SORC on 8/31/89. This item will remain open pending satisfactory completion of this testing.

2. Net Positive Suction Head Analysis (Closed - Section 2.2(B)) - The core spray system net positive suction head (NPSH) calculation provided during the initial SSFI inspection were non-conservative. The licensee provided additional information to NRR for review in letters dated March 28, 1989 and July 6, 1989. The NRR safety evaluation was provided in a memorandum from M. Slosson to J. Wiggins dated August 9, 1989 and concluded that for design basis accidents with the expected containment conditions, sufficient NPSH will be available for the core spray pumps. On the basis of the NRR evaluation, this item is closed.

3. Core Spray System Susceptibility to Water Hammer (Open - Section 2.2(C)) - During the SSFI a concern was raised that nearly two-thirds of the core spray system piping may be voided in normal system standby conditions. System initiation with such a voided condition could result in damage from water hammer. Niagara Mohawk, in a letter dated July 6, 1989, provided an analysis of the water hammer concern and committed to perform a core spray injection test prior to plant startup. Both small break and large break sequences will be tested to verify that dynamic loads during startup will not damage the systems. Closeout of this item is dependent upon the successful completion of this test.

4. Adequacy of Alarm Setpoints (Open - Section 2.2(D)) - The review of this item in Inspection Report 50-220/89-18 included the statement "the licensee plans to complete the review of the other engineered safeguard system alarms prior to unit restart". NMPC indicated that the review had been completed and recommendations were currently under evaluation. NMPC committed to provide, prior to restart, a summary of the findings and the NMPC decisions on the study recommendations. The inspector will followup on this item in a subsequent report.

b. (Open) Unresolved Item (50-220/89-18-02): Inadequate Core Spray System Test Flow Rate. During the followup inspection to the SSFI the concern was raised that testing of the core spray system is performed at flow rates well below those assumed in ECCS performance analyses. NMPC indicated that testing is performed at the lower flow rate to avoid vibration problems and lifting of the minimum flow relief valve. At a September 8, 1989 meeting, NMPC indicated that gagging of the relief valve (an option proposed earlier) would not be used after startup. New relief valve internals will be tested before restart, but even if successful, the flow in the test line would still be less than ECCS flow. A decision on a long-term fix is expected by the end of this year. This item remains open pending NRC review of NMPC's long term fix.

c. (Open) Unresolved Item (50-220/89-18-03): Core Spray System Testing:

1. Control of Pump Curves (Open - Section 2.7(A)) - The SSFI identified specific inadequacies with regard to the control of core spray pump curves which are used in ECCS performance analyses. The followup inspection report concluded that NMPC had taken adequate actions to correct the core spray pump deficiencies. However, a broader concern with regard to other pump curves remained open. NMPC committed to validate the performance of all pumps required by Technical Specifications prior to plant startup. The acceptance criteria are given in MDC-11,"Nine Mile Point Unit 1 Pump Curves and Acceptance Criteria Specification". This item remains open pending inspector review of the validation results.

2. Lack of FW Check Valve Testing (Open - Section 2.7(E)) - The SSFI team was concerned with the lack of surveillance for the feedwater (FW) pump and FW booster pump discharge check valves. NMPC had committed to check valve testing prior to startup and a periodic surveillance program. At a September 8, 1989 meeting, NMPC indicated that test procedures N1-ST-Q3 "HPCI Pump and Check Valve Operability Test" and N1-ST-V12 "Condensate and Feedwater Booster Pump Operability Test" had been drafted and were undergoing review. This item remains open pending NRC review of the final surveillance procedures.

3. ASME Section XI Testing on the Core Spray MOVs and Pumps (Open - Section 2.7(F)) - The SSFI team raised the generic concern that the existence of limited design margin may preclude the detection of pump or valve degradation prior to reaching Technical Specification limits. At a meeting on September 8, 1989, NMPC committed to provide the NRC, prior to restart, a summary of the margin required to perform ASME Code Section XI trending for each pump and valve in the IST program and the margin actually available. This item remains open pending NRC evaluation of NMPC's ability to implement ASME Code Section XI acceptance criteria.

d. (Open) Unresolved Item (50-220/89-18-04): HPCI/FW System Testing. The SSFI identified that Niagara Mohawk failed to adequately control HPCI/FW pump curves. NMPC had committed to develop and validate individual pump performance curves for the FW, FW booster, and FW condensate pumps. At a meeting on September 8, 1989, NMPC indicated that test procedure N1-88-7.11 "High Pressure Coolant Injection Pump Curves Field Validation Test" had been approved by SORC and the test was tentatively scheduled for the third week of October. This item remains open pending successful completion of the testing and NRC evaluation of the validated pump performance curves.

e. (Open) Unresolved Item (50-220/89-18-05): NRC Reporting. This item pertains to the failure to take adequate corrective action relative to 10 CFR 50.72 and 50.73 reports to the NRC and to address how they would identify unanalyzed safety conditions in the future. At a meeting on September 8, 1989, NMPC indicated that a formal response was prepared and under internal review. This concern is open pending NRC evaluation of the response.

3.1.2 Other Unit 1 Operations

a. (Closed) Temporary Instruction (TI) 2500/17 - Heat Shrinkable Tubing. Information Notice (IN) 86-53 was issued to notify NRC licensees of installation problems observed with Raychem Heat Shrinkable Tubing. To ensure that licensees properly implemented the recommendations contained in IN 86-53, TI 2500/17 was issued to provide guidance to inspectors for review of this issue.

This TI was reviewed in Inspection Report 50-220/89-17; however, the inspector did not document closure of the TI in that report. TI 2500/17 is closed.

b. (Closed) Unresolved Item (50-220/87-24-02): Scram Discharge Volume testing. This issue was previously reviewed in Inspection Report 89-04 and the licensing concerns regarding this issue were considered resolved. This issue is addressed in the Restart Action Plan and the inspector reviewed NMPC's actions regarding the testing of the scram discharge volume as committed to in NMPC correspondence dated June 3, 1988 and in the proposed Technical Specification amendment, submitted on December 27, 1988. In these submittals, NMPC agreed to perform a test once per operating cycle and following maintenance to the scram discharge volume (SDV). This test involves filling the SDV and timing the draindown time of the water from the system. If the time to drain the volume is consistent with the initial preoperational testing of the SDV, then the test confirms that there is no blockage of the system. In addition, the time for the high and low water level alarms to clear in each of the instrument lines will be compared to verify that one instrument line is not draining faster than the other, indicating that one of the instrument lines may be plugged.

The inspector reviewed NMPC Operations Surveillance Test N1-ST-C21," Control Rod Drive SDV, Vent, Drain, Header and Holding Tank Performance Test", Revision 0, dated May 24, 1989. The test was performed on June 16 and 17, 1989, and the results of the test were determined to be satisfactory. The inspector reviewed the test procedure, as well as, the acceptance criteria and determined them to be technically correct. While the inspector did note that the test was rewritten on two previous occasions (attempts to conduct this test in June, 1988 and February, 1989 ended with tests results that were determined to be unacceptable due to accuracy and repeatability concerns), no problems with the testing method used in the present procedure were noted. This item is closed.

c. (Update) Violation (50-220/88-09-01): (1) NMPC did not establish adequate controls over the nondestructive testing measurement locations used in their erosion/corrosion program, and (2) torus shell thickness measurements were not taken to a sufficient degree of accuracy to provide meaningful data for evaluation.

This violation was previously reviewed in Inspection Reports (IRs) 50-220/88-81 and 50-220/89-04. Regarding item (1), IR 88-81 reviewed NMPC's proposed corrective actions for this portion of the violation, but did not verify that the corrective actions had been implemented. The inspector reviewed these corrective actions at NMPC's corporate office in March, 1989 and determined that these corrective actions were acceptable. However, the violation was left open since the Restart Action Plan (RAP) activities on this item and item (2) remained open.

Regarding item (2), the thickness measurements of the torus shell wall were reviewed in IR 88-81 and IR 89-04. During IR 88-81, NMPC committed to performing torus shell thickness measurements every six months versus every twelve months, as previously committed. During IR 89-04, the inspector reviewed NMPC's program for nondestructively examining the torus shell thickness and identified no problems with the program. He noted that NMPC was taking torus thickness measurements to three digit accuracy, has expanded the size and number of locations that are examined on the torus, and has improved the markings/identification of the grid locations examined on the torus to ensure repeatability of the results.

Item (2) remained open following IR 89-04 pending additional information being gathered by NMPC on torus wall thinning. This violation remains open pending the satisfactory resolution of the torus wall thickness concerns and review by specialist inspectors.

d. (Closed) Unresolved Item (50-220/88-32-01): NMPC could not provide an engineering evaluation, as required by Administrative Procedure 7.2, for the adequacy of the Turbine Building floor elevation 261 to support material stored on that floor.

The inspector reviewed Engineering Department calculation number S6-TB261-C508 which addressed the projected loading on this floor in a worst case loading scenario. The calculation, dated May 4, 1987, concluded that the floor would not be overstressed by the use of the noted area of the Turbine Building for material storage. Given that the evaluation was performed prior to storing this material in this area and prior to the conduct of IR 50-220/88-32, no violation of NRC requirements occurred. This issue is resolved.

e. (Closed) Violation (50-220/89-06-03): NMPC failed to take adequate corrective actions to prevent the recurrence of conditions adverse to quality. NMPC admitted that the violations occurred and that timely and adequate corrective action had not been implemented. NMPC considered these events to be examples of management ineffectiveness in the area of problem identification, resolution and communication. Further, NMPC claimed that part of the reason why the events occurred was that the Restart Action Plan had not progressed far enough to provide effective management controls for communication and teamwork.

The inspector reviewed the corrective actions for each of the incidents cited in the violation and agreed that they appeared thorough and adequate to prevent a recurrence of these events. He noted that no repeat of any of these incidents has occurred since the last event in late June. This violation is closed.

f. (Closed) Unresolved Item (50-220/87-24-01): Licensee identified violation of Technical Specification (TS) thermal limit parameter (total peaking factor). On November 16, 1987, during the supervisory review of completed surveillance procedure N1-RPSP-1, Reactor Physics Daily Surveillance, it was determined that the Maximum Total Peaking Factor (MTPF) had been in excess of the specified limit for a period of approximately 19.4 hours on November 15, 1987. Licensee Event Report (LER) 87-22 documents Niagara Mohawk's investigation of this event, the root causes and the corrective actions to preclude recurrence.

Review of LER 87-22 and discussions with responsible station employees determined that the consequence of this TS violation was to reduce the available safety margin. This event did not initiate or result in a cladding failure. With a MTPF greater than 3.00, action should have been taken per TSs to reduce the APRM rod block and scram setpoints.

The cause for this event was determined by Niagara Mohawk to be personnel error. Lack of procedural clarity was identified as a contributing factor. Corrective actions taken by station management were: disciplinary action against the reactor analyst who failed to identify the thermal limit violation; clarification of N1-RPSP-1 and similar procedures; and, training for all reactor analysts on the Lessons Learned for this event. The inspection also determined that to ensure more timely supervisory review of completed reactor analyst's surveillance procedures the reactor analyst unit supervisor (Unit 1 & 2) have had telephone facsimile machines installed in their homes. The inspector considers these corrective actions to be satisfactory. In accordance with the Enforcement Policy Guidance of 10 CFR 2, Appendix C, Section a.1, a Notice of Violation is not being issued for this licensee identified TS violation.

3.2 Unit 2

(Open) Unresolved Item (50-410/88-201-01): Deficiencies concerning the performance of safety related circuit breaker testing per Procedure N2-EPM-GEN-V582. An NRC Vendor Branch inspection performed in August, 1988 identified three potential deficiencies. NMPC has resolved one deficiency concerning the setting of adjustable trip settings on breakers by changing their test methodology. Breaker trip settings are set to the maximum value for testing and then returned to the "as-found" setting. NMPC Engineering and Electrical Maintenance personnel are evaluating the two remaining issues concerning test acceptance criteria and where the breaker trip settings should be set for the particular application. This item remains open.

4. Safety System Operability Verification

4.1 Emergency Ventilation System (EV) (Unit 1)

Report 89-07 contained preliminary findings regarding an inspector's walkdown of the EV system. Resolution of some of those findings, as well as additional findings identified during this inspection period, are discussed below:

a. Resolution of concerns identified in IR 89-07:

1. The 1 KW thermostats were determined to be incorrectly set. NMPC performed a surveillance procedure on the EV system, N1-ISP-R-202-003, to check the EV filter train heater thermostat settings. Using a heat probe and recording the surface temperature of each filter train, the following results were obtained:

   -- Train 11 (Heater 202-72) as-found temp: 126°F

   -- Train 11 Initial thermostat setting of: 150°F

   -- Train 12 (Heater 202-73) as-found temp: 145°F

   -- Train 12 Initial thermostat setting of: 165°F

   Procedure N1-ISP-R-202-003 provided guidance to set the train 11 and 12 thermostats to achieve a temperature probe contact reading on the filter train of 162-168 degrees F. To achieve this value, it was necessary to raise each thermostat to a setting of 200 degrees F.

   After reviewing the completed procedure test results, the inspector questioned NMPC as to whether the as-found thermostat settings for trains 11 and 12 affected past operability of the EV system. The inspector determined that neither NMPC Engineering nor the station staff had considered this question. As a result, a Problem Report to address the inspector's concern was written.

   Disposition of the Problem Report indicated that with temperature maintained less than 165 degrees F, the EV system would not meet its design basis. Temperatures below this limit could allow condensation on the charcoal filter beds and thereby reduce adsorption of radio-iodides by the EV system in the event of an actual emergency actuation. Subsequently, NMPC made a notification under the requirements of 10 CFR 50.72.b.2.i.

   Inspector Assessment

   The inspector concluded that prior to issuance of procedure N1-ISP-R-202-003 (issued 9/89) that there were no procedural controls in place for the proper setting or calibration of the EV system thermostat units. Failure to control these units under a calibration or surveillance procedure is an apparent violation of Technical Specification 6.8.1

and Regulatory Guide 1.33 (50-220/89-08-03). The consequence of not calibrating the thermostat units was that the EV system may not have been able to function per its design basis and thus may not have been operable per TS 3.4.4. The potential exists for the EV system not having been operable since 1969 when it was initially put into operation.

2. The inspector was concerned over the identification and labeling of components, sample points, and other portions of the EV system. Discussion with NMPC reveals that they have plans to implement a unit wide program for the identification and labeling of plant equipment. The process used will be similar to that used at Unit 2. The inspector judged this approach to be acceptable.

3. The wooden blocks under flow element 201.2-367A were removed. No satisfactory explanation for their presence under the flow element was provided by NMPC.

4. Heater 202-76 was determined to be a 10 KW heater. The electrical schematic was in error regarding it being a 9 KW heater. The FSAR was determined to be correct in referencing the heater to be 10 KW.

b. Subsequent to the findings discussed in IR 89-07, the inspector identified the following concerns:

1. P&ID, C-18013-C, identifies sample connections in the EV system that can be used for flooding the system when required. The inspector determined that this statement on the P&ID was no longer applicable as, in 1981, a manually initiated water deluge system (for combatting a charcoal bed fire in an EV train) was installed in the EV system.

   The inspector was concerned that initiation of the deluge system could affect system operability and requested a copy of NMPC's safety evaluation be provided so that he could determine if, or what, system operability concerns were considered prior to installing the deluge system. After a two week search, NMPC concluded that there was no existing safety evaluation for the modification. A parallel evaluation completed during the inspection period was found by the inspectors to be incomplete as it did not address the inspectors' concerns. Failure to perform a safety evaluation for the modification to the EV system is an apparent violation of the requirements of 10 CFR 50.59 (50-200/89-08-04).

2. Operating Procedure (OP) 10, "Reactor Building Heating, Cooling and Ventilating System," Section H.7, provides instructions on two methods of cooling the EV filter trains following a Loss of Coolant Accident (LOCA), yet the alarm response procedures (ARPs) section of OP-10 and the Emergency Operating Procedures (EOPs) never direct the operators to Section H.7.

3. The ARPs in OP-10 for "Emergency Vent System Temp High" contain vague instructions on required actions. Additionally, many of the manual actions required may not be realistically carried out under actual, emergency use of the EV system due to radiation exposure concerns.

4. Similarly, the ARPs in OP-21 for "RB Charcoal Filters" contains vague instructions and are also potentially unrealistic as they too call for manual actions to be taken in the vicinity of the EV system.

Inspector Assessment

NMPC was questioned as to the above concerns. The inspector concluded that the existing procedures (OP-10 & 21) contained actions which are vague and potentially unrealistic. The inadequacy of these procedures represents an apparent violation of 10 CFR 50, Appendix B, Criterion V, regarding procedures (50-220/89-08-05).

c. Control Room Emergency Ventilation System (CREV) (Unit 1)

The inspectors performed a walkdown of a portion of the CREV system, focusing on visual inspection requirements of NMPC's reload procedure N1-88-6.6, "System and Area Walkdown for Restart Procedure." The inspector identified numerous material and equipment deficiencies. The inspectors compared their list with NMPC's list of deficiencies identified during NMPC's walkdown of the system in July 1989. The inspectors determined that none of their identified deficiencies were contained on NMPC's completed system walkdown punchlist. The inspector's findings were discussed with the Unit Superintendent, and the inspectors are awaiting NMPC's response. Inspector followup of these observations will be performed in a later inspection period.

5. Plant Inspection Tours

During this reporting period, the inspectors made tours of the Unit 1 and 2 control rooms and accessible plant areas to monitor station activities and to make an independent assessment of equipment status, radiological conditions, safety and adherence to regulatory requirements. The following were observed:

5.1 Unit 1

The inspector did not identify any concerns and concluded that conditions were acceptable.

5.2 Unit 2

a. The inspector reviewed a video surveillance system and concluded that this enhancement was an example that NMP proactively implemented the ALARA concept. During the September 1989 two-week maintenance outage, NMPC installed a video surveillance system in each feedwater bay and in the condenser area of the Turbine Building. These surveillance systems consisted of remotely operated cameras and monitors. As a result, entry into high radiation areas was not required during operator rounds. Two spare cameras were also provided for job coverage in other high radiation areas, as the need arises. These video systems could result in a reduction of personnel exposure while maintaining the intent of the inspection performed during operator rounds, an example of a good ALARA approach.

b. While reviewing the SSS logs on October 11, the inspector noted an entry where the humidity inputs to the temperature control valve (2HVR*TV22B) in the chilled water system for the Control Building Relay Room were "broken" and did not affect system operability. This problem developed while I&C technicians were performing a loop calibration of 2HVR*TV22B inputs. The humidity inputs were found out of specification and could not be corrected in a timely manner.

The inspector reviewed the equipment status log, but found no explanation of why the system was operable with the "broken" humidity inputs. The inspector reviewed the FSAR and found that this system, including the humidity input, is described pictorally and in words. After much discussion with the station staff, the inspector determined that at a meeting held on October 10 between mangement and technical staff, it was concluded that the system was operable without the humidity input and that a written engineering safety evaluation would follow.

The inspector expressed concern to station management that Niagara Mohawk did not utilize a formal and controlled 10 CFR 50.59 process to assess the impact of this component malfunction on overall system operability or the potential for an unreviewed safety question being introduced. This item remains unresolved pending further discussion with the station management. UNRESOLVED ITEM (50-410/89-08-02)

6. Surveillance Review

The inspectors observed portions of the surveillance testing listed below to verify that the test instrumentation was properly calibrated, approved procedures were used, the work was performed by qualified personnel, limiting conditions for operations were met, and the system was correctly restored following the testing.

6.1 Unit 1

The inspector reviewed portions of the "Mini-R2" test which simulates loss of off-site power coincident with LOCA conditions. This test supports operability verification requirements of the one train of Core Spray needed to support reload. The inspector also reviewed procedure N1-ISP-R-202-003 which tests the operation of the 1KW and 10 KW heaters on the EV system.

6.2 Unit 2

a. The inspector reviewed the local leak rate testing on feedwater system check valves per N2-ISP-CNT-R@005, "Type 'C' Valve Leakage Test Feedwater Valves 2FWS*AOV23A." No concerns were noted.

b. The inspectors observed numerous Operations shift turnovers including the performance of the turnover surviellance checklist by an oncoming CSO prior to assuming the watch. The inspectors also attended shift turnover briefings held by the SSS. No concerns were identified.

7. Maintenance Review

The inspector observed portions of various safety-related maintenance activities to determine that redundant components were operable, that these activities did not violate the limiting conditions for operation, that required administrative approvals and tagouts were obtained prior to initiating the work, that approved procedures were used or the activity was within the "skills of the trade", that appropriate radiological controls were implemented, that ignition/fire prevention controls were properly implemented, and that equipment was properly tested prior to returning it to service. The inspectors concluded that the maintenance program was being effectively implemented.

7.1 Unit 1

Maintenance was observed on the Emergency Diesel Generators and on the Core Spray Topping Pumps. No discrepancies noted.

7.2 Unit 2

a. During the outage, the major work items were: general inspection and preventive maintenance on the Division III Emergency Diesel Generator (EDG); leak testing feedwater valves for Appendix H requirements; minor modifications to the feedwater minimum flow valve circuit; drywell to suppression chamber leak test; and cooling tower maintenance. The outage was finished on schedule. During the course of the outage, the inspector observed several maintenance activities and noted the following:

-- The inspector observed the work performed on the Division III EDG under Procedure N2-MSP-EGS-R002. The work was performed by the mechanical maintenance group. The technicians followed the procedure and used good work practices. Quality Control coverage and supervisory oversight was present at the work site. The inspector noticed the maintenance crew brought a large radio into the diesel space and was playing music. The technicians stated that this was an accepted practice. The inspector was concerned that the music could potentially drowned out station alarms and announcements and brought this concern to management's attention. The radio was removed from the work site and such practices are not allowed per Unit Superintendent policy.

-- Niagara Mohawk identified that an incorrect grade of crankcase lube oil was provided and added to the Division III EDG lube oil sump. This resulted in additional work of pumping down the EDG sump and adding the correct grade lube oil which was specified by the procedure. The inspector was concerned that the maintenance technicians failed to verify the correct lube oil was obtained prior to adding it to the crankcase. Additionally, materials management personnel incorrectly changed the material issue sheet which caused the incorrect lube oil to be delivered to the work site.

These examples indicated more care was needed to obtain procurement parts and deliver the correct parts to the work site to support maintenance activities.

b. During the review of training on the lessons learned from the valves left out of position (discussed in Section 2.2.e of this report), the inspector learned of other problems experienced during routine operation of the reactor water cleanup system. The inspector obtained a printout of the maintenance backlog for the WCS system. There were 113 total work requests (WR) outstanding in this particular system. Sixty-eight WRs were related to a specific type of air operated valve in the system that would not fully shut on a loss of air, as designed. These valves are scheduled to be repaired during the next refuel outage. The inspector reviewed the impact of these valves on WCS operability and found they did not inhibit the containment isolation feature.

8. Allegation Followup

During the inspection period, the inspectors conducted interviews and inspections in response to allegations presented to the NRC. The inspector and licensee actions resulting from these allegations are noted below:

8.1 Unit 1

RI-89-A-0094: Allegation concerning a contractor employed at NMP. Specifically, it was alleged that information may not have been provided to NMP Security personnel by the individual during completion of the background questionnaire and that the employee was an occasional drug user while off-duty. (Reference NRC Letter, J. T. Wiggins to L. Burkhardt, III, dated August 24, 1989).

The inspectors first became aware of the allegation on August 16, 1989. At that time, the individual's name was provided to NMPC Security along with pertinent details of the allegation. Results of NMPC's investigation follow.

Regarding the allegation of drug use, the individual was questioned by NMPC Security on August 18, and was drug tested the same day. The individual was cooperative with NMPC Security during questioning and in agreeing to the drug test. Results of the drug test, returned several days later, were negative for the presence of illegal drug metabolites. Therefore, the allegation of off-site drug use was uncorroborated.

The other aspect of the allegation concerning discrepancies in background information was partially correct, in that a discrepancy was found in the individual's background information. However, NMPC Security had already identified a problem with this when contacted by the inspector on August 16. NMPC Security allowed the individual 90 days to clarify the discrepancy in the background information. The individual, through the services of an attorney, was able to explain the discrepancy to the satisfaction of NMPC Security. The inspector reviewed the information with NMPC Security personnel and was satisfied with the resolution.

This allegation is closed.

8.2 Unit 2

RI-86-A-0129: In a letter dated July 18, 1989, Region I requested NMPC to investigate two additional concerns generated by the review of an NRC investigation. The NRC's review of the completed investigation report identified two additional safety concerns. First, the alleger named five individuals alleged to have either used drugs onsite or known to have used/purchased drugs onsite. Second, the alleger claimed that he informed a QC Supervisor of his findings (i.e., improper weld activities) and that this information was contained in five (5) logbooks turned over to that supervisor.

NMPC Security and the Quality First Program investigated these two safety concerns. Results of the investigation were discussed in detail with the inspectors. A summary of NMPC's findings follows:

Regarding the drug allegations, NMPC was able to locate and talk with the five individuals named. None of the individuals named presently work for NMPC nor are they in the New York State area. All individuals contacted denied drug use onsite. Only one individual admitted to casual drug use off-site, but denied ever working onsite while under the influence. Three of the individuals have been drug tested at their sites (since employment with NMPC) with negative results. One individual no longer works in the nuclear field and the other has not been tested since employment with NMPC. It should be noted that the alleged period of onsite drug use predates the new Fitness For Duty rule recently promulgated by the NRC. Overall, the inspector was satisfied with the depth and thoroughness of NMPC's investigation into the drug use concern and considered this matter closed.

Regarding the five weld logbooks, NMPC confirmed that the books existed and were reviewed for additional safety impact during the original investigation of the allegations in 1986. The books have subsequently been disposed of by SWEC as they were no longer needed and there was no regulatory requirement to keep them as they are personal logs kept by the weld inspector. The inspector was satisfied with NMPC's review of this issue and considered this allegation closed.

9. Management Meeting

On November 3, Niagara Mohawk managment met with the NRC staff in the Region I office to discuss the Unit 1 Power Ascension Program and Niagara Mohawk's readiness for the NRC's Integrated Assessment Team Inspection (IATI). Niagara Mohawk provided the staff with on overview of the Power Ascension Program and committed to provide the staff with informational copies of the power ascension control and testing procedures via the resident inspector office. In addition, Niagara Mohawk committed to brief the NRC staff, via the resident office, of the completion and results of the three power ascension testing plateaus and the results of the testing plateau self-assessments prior to proceeding with the next test phase.

Lastly, Niagara Mohawk provided the Unit 1 Restart Assessment Panel with an overview of the their self-assessment and the status of completion of Underlying Root Cause corrective actions. Executive Vice President Lawrence Burkhardt III stated to the Panel that Niagara Mohawk was, in his estimation, prepared for the NRC's IATI.

There were no decisions made during these meetings, and no actions were taken, directed, or approved. The meetings were solely for the purpose of better understanding the plans and status of NMPC actions in these areas. Subsequent to the meeting and partially based on information provided at the meeting, William Kane, Director, Division of Reactor Projects, in consultation with William Russell, Regional Administrator, directed an NRC integrated assessment team to inspect Unit 1.

10. Exit Meetings

At periodic intervals and at the conclusion of the inspection, meetings were held with senior station management to discuss the scope and findings of this inspection. Based on the NRC Region I review of this report and discussions held with licensee representatives, it was determined that this report does not contain Safeguards or 10 CFR 2.790 information.