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SUBJECT: Responds to NRC 900410 ltr re violations noted in Insp Repts 50-220/89-08 & 50-410/89-08.

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NIAGARA MOHAWK

NIAGARA MOHAWK POWER CORPORATION/301 PLAINFIELD ROAD, SYRACUSE, N.Y. 13212/TELEPHONE (315) 474-1511

May 10, 1990
NMP1L 0502

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

Re: Nine Mile Point Unit 1
Docket No. 50-220
DPR-63

Gentlemen:

Attached is Niagara Mohawk Power Corporation's response to the Notice of Violation transmitted by your April 10, 1990 letter.

Your letter also asked that we discuss the difficulties and delays in resolving the design basis of the Emergency Ventilation System. Such delays can be attributed to several factors. The primary reason is that the design basis of the Emergency Ventilation charcoal filter deluge system relative to operation following a Loss of Coolant Accident (LOCA) was not explicitly stated in our design documents. This resulted in an assumption by the people initially responding to the inspector's questions that the fire deluge system was intended for post LOCA use. Thus, it was not until personnel familiar with the Emergency Ventilation deluge system design basis got involved in this issue during the preparation for the Enforcement Conference that we determined post-LOCA operation was beyond the design requirements for Nine Mile Point Unit 1. Additional research was then conducted to confirm this. Admittedly, personnel familiar with the charcoal filter deluge system design basis should have been involved in our initial response to the inspector's concerns. Our failure to do so contributed to the delays. Because of the resultant delays in finalizing our position, we were, regretfully, unable to review this with you prior to the Enforcement Conference. We are currently pursuing an upgrade of our design bases documents which should alleviate such problems in the future.

Should you have any further questions regarding this matter, please call.

Very truly yours,

NIAGARA MOHAWK POWER CORPORATION

L. Burkhardt, III
Executive Vice President
Nuclear Operations

BDW/mjd
8601G
Attachment
xc: Regional Administrator, Region I
Mr. R. A. Capra, Director
Mr. R. E. Martin, Project Manager
Mr. W. A. Cook, Resident Inspector
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IE01
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Nine Mile Point Unit 1

Docket No. 50-220

DPR-63

Response to Notice of Violation Contained in

Inspection Report #50-220/89-08 and

#50-410/89-08

VIOLATION

A. Unit 1 Technical Specification 6.8.1 states that written procedures shall be established and implemented to meet or exceed the requirements of Appendix A of Regulatory Guide 1.33. Regulatory Guide 1.33 states that appropriate procedures should be provided for the periodic calibration of gauges, instruments, controls and other measuring devices to maintain their accuracy.

Contrary to the above, since the Reactor Building Emergency Ventilation System was initially declared operable in 1969 until October, 1989, the 1 KW strip heaters for both ventilation trains have not been calibrated.

This is a severity level IV violation (Supplement 1).

RESPONSE

Admission Of The Violation

Niagara Mohawk Power Corporation admits to the violation as stated. As discussed at the March 9, 1990 Enforcement Conference, our evaluation determined the root cause of the violation was a failure of Engineering to take ownership for specifying test requirements to ensure system operability. We also determined there was minimal safety impact as a result of the deficiency, since the 10 KW heater was operable and would have prevented condensation from forming on the charcoal filters during a design basis accident. As also discussed at the Enforcement Conference, we are confident we would have detected the subject deficiency prior to plant restart as a result of our setpoint review program which had been initiated prior to the date of the inspection in question.

Corrective Actions That Have Been Taken

Surveillance procedure N1-ISP-R-202-003 has been revised to include calibration of the 1 KW strip heaters and the heaters have been calibrated accordingly. Additionally, a Lessons Learned report has been issued to heighten awareness that equipment not covered by Technical Specifications could affect system operability.

Actions to Avoid Further Violations

Actions to prevent recurrence include reviewing/developing setpoints for safety related equipment and completion of Restart Action Plan (RAP) Corrective Actions 1.2.3 and 1.2.5. Prior to the inspection, Niagara Mohawk had initiated a program to review setpoints and associated bases for safety related equipment. The 1 KW heaters are safety related and are within the scope of this program. RAP Corrective Action 1.2.3 states "Develop a controlled and consolidated matrix showing implementing procedures and assigned responsibilities for all Technical Specification test requirements. Develop and implement procedures that are missing". RAP Corrective Action 1.2.5 states "Develop a controlled list to identify specific types of equipment subject to preventative maintenance, surveillance testing, or other operational requirements". These actions provide for a systematic review of equipment needed for system operability and provide assurance that operability is demonstrated and maintained. The setpoint review program and RAP Corrective Actions 1.2.3 and 1.2.5 will be completed before startup.

In addition, as discussed with you on September 28, 1989, Niagara Mohawk has initiated an Engineering Program Integration project to systematically review design and operating requirements for systems. An outcome of this project will be system design bases documents which detail applicable design and operating criteria for the system and its components. Systems and components will be reviewed to ensure that surveillance, operating and calibration procedures appropriately address design basis requirements. Because of the breadth of the project, this comprehensive effort will take several years to complete.

Date When Full Compliance Will Be Achieved

The corrective actions already completed ensure compliance with the requirement to provide procedures for calibrating the 1 KW strip heater. Additionally, the corrective actions which will be completed before restart provide reasonable assurance that violations of this nature will not recur.

VIOLATION

B. 10CFR50, Appendix B, Criterion V states that activities affecting quality shall be prescribed by documented instructions or procedures appropriate to the circumstances and shall be accomplished in accordance with these instructions or procedures.

Nine Mile Point Nuclear Station Unit 1, Temporary Procedure No. N1-88-6.6, System and Area Walkdown for Restart Procedure, states that the primary purpose of the system walkdown visual inspection program is to assure core reload systems do not exhibit any conditions which would inhibit them from performing their operability design function.

Contrary to the above, on August 2, 1989, N1-88-6.6 was completed for the reactor building emergency ventilation system, and 1 KW heater thermostats were not calibrated (in addition to numerous other undetected inspection attributes), which adversely impacted the system operability design function as described in the FSAR.

RESPONSE

Admission Of The Violation

Niagara Mohawk admits to the violation in that Revision 2 of Temporary Procedure N1-88-6.6 was not adequate to identify the types of conditions which were identified by the Resident Inspector on August 2, 1989, i.e., lack of calibration of the 1 KW duct heater thermostats. The cause of this violation was a failure of station management to convey expectations of the walkdown intent.

Background

In Niagara Mohawk's response to USNRC Inspection Report 50-220/88-17, Niagara Mohawk committed to performing system and area walkdowns per a special test procedure. The procedure implementation was to be completed prior to unit startup.

The primary purpose of the system and area walkdown visual inspection program was to assure that, for core reload systems, corrective maintenance had been identified and performed and that systems, equipment and components did not exhibit any observable condition which would inhibit them from performing their operability design functions. A secondary purpose was to identify new work items as part of the enhanced Nine Mile Point Unit 1 system operability standards, maintenance and housekeeping standards and safety requirements. Each item resulting from the system walkdown was prioritized in accordance with the requirements of NMP1 temporary procedure N1-88-6.6.

The original inspection criteria for items which would affect system operability was defined in Revision 2 of Procedure N1-88-6.6 as any system component/equipment or device which by visual observation had sufficient physical damage or deterioration, was missing, or exhibited any evidence that the item being examined could impair the system's ability to perform it's operational design functions. Examples would be exposed wiring to electrical devices/components, bent/damaged pipe supports or valve stems, excessive leakage of lubricants and similar items. These criteria were insufficient to detect the calibration deficiency and did not fully represent management's expectation.

Corrective Actions That Have Been Taken

Temporary Procedures N1-88-6.6 (reload system walkdowns) and N1-88-7.6 (restart system walkdowns) have been revised. The revisions require that piping and instrument drawings be reviewed against plant configuration and provide additional inspection criteria to include control devices or trip function type devices that are out of calibration. Station management interviewed walkdown teams prior to revising the procedures to identify areas needing clarification and to convey management's expectations. Additionally, system walkdown teams were expanded to include a System Engineer as the Team Leader, plus a representative from Radiation Protection, Mechanical Maintenance, Electrical Maintenance, Instrumentation and Control, Quality Assurance and an Operator or Operations Department Supervisor. System walkdowns using the revised procedures have been performed.

To ensure complete and proper implementation of the Reload System Walkdown Procedure, select systems were also walked down by an independent verification team to assess the accuracy and adequacy of the system and area walkdown process. The verification walkdowns were conducted by senior Station Management including the Station Superintendent and the General Superintendent and confirmed the adequacy of the revised walkdown process. Results of these assessments were presented to SORC for final review. This approach is also being used for restart system walkdowns.

Actions To Avoid Further Violations

Actions to prevent recurrence of this type of deficiency include implementation of the writer's guide for site procedures and the Nuclear Improvement Program Corrective Actions summarized below:

Corrective Action 3.2.2 -	Supervisory skills training on teambuilding, group dynamics and interpersonal skills
Corrective Action 4.1.8 -	Develop and communicate specific standards of performance at the department level
Corrective Action 4.2.2 -	Develop departmental self-assessment programs which include an assessment of the effectiveness of corrective actions
Corrective Action 5.1.8 -	Training to improve oral and written communications
Corrective Action 5.1.13 -	Getting supervision into the plant

These actions address establishment of clear management expectations, communicating those expectations to employees and self-assessment of our performance. In addition, recognition by the Station Superintendent that his expectations were not understood provided a valuable lesson and will, in itself, help prevent occurrences of this nature.

Date When Full Compliance Will Be Achieved

The actions already completed as described above establish full compliance with the applicable requirements. Specifically, the walkdown procedures were revised to accurately reflect management's expectations and the walkdowns have been re-performed.