

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Report Nos.: 50-220/90-03
50-410/90-03

Docket Nos.: 50-220
50-410

License Nos.: DPR-63
NPF-69

Licensee: Niagara Mohawk Power Corporation
301 Plainfield Road
Syracuse, New York 13212

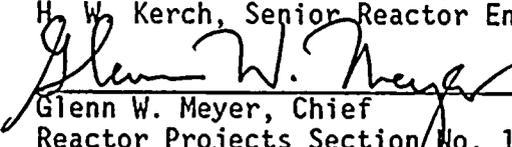
Facility: Nine Mile Point, Units 1 and 2

Location: Scriba, New York

Dates: March 1, 1990 through April 10, 1990

Inspectors: W. A. Cook, Senior Resident Inspector
R. R. Temps, Resident Inspector
R. A. Laura, Resident Inspector
R. W. Winters, Reactor Engineer
H. W. Kerch, Senior Reactor Engineer

Approved by:


Glenn W. Meyer, Chief
Reactor Projects Section No. 1B

5-17-90
Date

Inspection Summary:

This inspection report documents routine and reactive inspections during day and backshift hours of station activities including: plant operations; radiological protection; surveillance and maintenance; emergency preparedness; security; engineering and technical support; and safety assessment/quality verification.

Results:

One NON-CITED VIOLATION was identified as a result of the followup to an Special Team Inspection (STI) unresolved item concerning Site Operations Review Committee (SORC) review of Technical Specification (TS) violations. An Executive Summary follows.

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EXECUTIVE SUMMARY

Plant Operations: At Unit 1 three different equipment problems impacting the scheduled restart are discussed and assessed. At Unit 2, the use of heat lamps on the Containment Monitoring System (CMS) radiation monitors was determined to be poorly controlled. Also reviewed was the handling of a calibration issue with the drywell high range hydrogen analyzer. The overall assessment for this issue was that engineering performed well in identifying the problem and station management acted conservatively when they entered a 48 hour shutdown action statement while resolving the issue.

Radiological Protection: No noteworthy findings.

Surveillance and Maintenance: Work on several activities was performed competently and in accordance with procedures.

Emergency Preparedness: No noteworthy findings.

Security: Handling of an accidental discharge of a firearm at the Unit 1 firearms locker and subsequent notification was assessed as adequate.

Engineering and Technical Support: Engineering response to the feedwater and reactor building closed loop cooling heat exchanger problems at Unit 1 was assessed as positive; whereas, the troubleshooting and resolution of the MG set problems appears to be progressing slowly.

Safety Assessment/Quality Verification: General improvement in the area of problem identification and resolution was noted. All of the Special Team Inspection (IR 89-200) items were closed, a total of sixteen items covering both units. One NON-CITED VIOLATION was identified, regarding a 1988 Technical Specification violation at Unit 2 which was not adequately reviewed by SORC.



DETAILS

1. Plant Operations (Modules 71707, 71710, 93702)

1.1 Unit 1

The plant remained shutdown during this period. Efforts for restart of the unit are nearing completion. However, several equipment problems were impacting the schedule and are discussed below.

- a. On March 29, during preparations for performance of N1-88-7.11, "HPCI Pump Curves Field Validation Test", problems were encountered when the motor driven feedwater pumps were started. Cavitation was noted during the two times that the #11 pump was run. Flow oscillations and excessive pipe movement on the #12 recirculation line to the condenser occurred when the #12 pump was run. Engineering walkdowns of both the recirculation lines and pumps revealed some damage. Minor damage to the #11 pump recirculation line was identified consisting of rotated support collars. Three broken pipe supports were identified on the #12 recirculation line. No damage to either feed pump and no cracks in any of the major welds in the system (examined by non-destructive testing) were identified.

It was believed that the cavitation problem on the #11 pump was due to entrapped air in the feedwater system which was not fully vented from the system following extended dry layup and maintenance. The flow oscillations on the #12 side were believed due to a combination of entrapped air and cycling of the recirculation line flow control valve. At the conclusion of the inspection report period, Niagara Mohawk was still developing the root cause evaluation for this event. Any corrective actions beyond repair of the broken supports will depend on this evaluation. Final resolution of this event, as well as the final N1-88-7.11 testing, will be reviewed in a subsequent report.

- b. As an adjunct to the 125 VDC problems, extensive efforts have been underway to troubleshoot and correct the cause of various electrical and mechanical problems with the unit motor generator (MG) sets. To date, efforts have identified and corrected numerous deficiencies in the MG control circuits. However, problems are still being encountered with the stability of some of the MGs in various modes of operation. Inspector assessment of Niagara Mohawk's resolution of the MG set problems was that the problems appear to be taking considerable time and do not reflect timely resolution. Only towards the conclusion of the inspection period did it appear that a focused engineering effort was being expended on the problem.



- c. Tube and tube support damage was identified in the reactor building closed loop cooling (RBCLC) heat exchangers (HXs) during this inspection period. The first HX identified as having a problem was #13 (one of three HXs) as a result of routine chemistry sampling which indicated high conductivity in the RBCLC water, which is indicative of tube leakage. Examination of the #13 HX identified numerous damaged tubes and some damage to several of the tube supports. As a result of this finding, plant management decided to examine the #12 and then #11 HXs. Similar damage was noted when these HXs were inspected, but not to the extent found in the #13 HX. Corrective actions for the damaged RBCLC HXs was not formulated at the conclusion of this inspection period. The inspectors plan to closely monitor Niagara Mohawk resolution of this hardware concern.

1.2 Unit 2

The unit operated at or near full power throughout the period with only short duration power reductions to make rod pattern changes and to change operating feedwater pumps.

- a. During a tour of the reactor building, the inspector noted heat lamps were installed next to the Containment Monitoring System (CMS) radiation monitors. The inspector noted that the lamps were not controlled as temporary modifications. During discussions with operations personnel, the inspector was informed the lamps were installed to prevent the particulate filters from becoming wet due to condensation in the sample line. These monitors draw an air sample from the containment via a small sample line and pump. Due to higher than expected drywell operating temperatures, the sample cools below the dewpoint causing moisture to accumulate in the sample line and on the monitor filter paper. Collection of moisture in the sample line and on the filter paper renders the monitor inoperable for particulate analysis. The inspector determined that the lamps have been installed for over one year.

The inspector was concerned that these heat lamps should have been controlled as a temporary modification as provided for in Administrative Procedure 6.1. After discussion with Niagara Mohawk management, they agreed that this type of temporary equipment should have been more formally controlled as a temporary modification. As a result, the lamps were removed. Existing heat tracing had to be adjusted to prevent accumulation of moisture in the sample lines and on the filter paper.



The inspector concluded that Niagara Mohawk was slow to address the root cause of the containment monitor moisture problems and relied on heat lamps, a temporary fix, for an extended period of time. In addition, the heat lamps should have been more appropriately controlled as temporary modifications. As stated above, Niagara Mohawk agreed and as additional corrective action performed a complete plant walkdown to look for similarly uncontrolled temporary modifications. No others were found.

- b. During the week of March 19, a routine review by a Systems Support Test Group engineer identified that the drywell high range hydrogen analyzer was calibrated only to 4% and not to 30%. Technical Specification (TS) Table 4.3.7.5-1, item 10, notes ** a and b, specify that the calibration shall be done using 0% and 4% hydrogen gas concentrations. The surveillance is silent on the high range calibration gas concentration requirement. However, the Updated Safety Analysis Report (USAR) Table 1.8-1 states that Unit 2 is committed to Regulatory Guide (RG) 1.97, without exception. RG 1.97 specifies the drywell hydrogen analyzer shall have the capability of monitoring from 0 to 30% volume hydrogen.

Based upon this information, the operators declared the hydrogen monitors inoperable and entered TS Table 3.3.7.5-1 limiting condition for operation (LCO) action 80.b which specifies the inoperable channels be restored within 48 hours or be in at least HOT SHUTDOWN within the next 12 hours. Within the 48 hour LCO, Niagara Mohawk calibrated one of the two hydrogen analyzers using a 30% hydrogen test gas and entered a less restrictive seven day LCO. The redundant hydrogen analyzer was subsequently calibrated and the LCO was exited.

The inspector determined the safety significance of an uncalibrated high range hydrogen monitor was low, based on the plant design and current drywell hydrogen control procedures. Currently, no operator action is specified by the emergency operating procedures (Revision 3) for hydrogen concentrations above 4%. Above 4%, hydrogen indication would only serve to determine proper operation of the hydrogen recombiners. When issued, Revision 4 to the emergency operating procedures will direct operator actions when hydrogen concentration exceeds 4%. Also, Niagara Mohawk determined that the high range monitor was reasonably within calibration between 4% and 30%, as a result of the original calibration during the preoperational phase and the recent calibration with the 30% test gas. It appears that the preoperational phase calibration procedure did not get translated into the new surveillance program due to an oversight.



The inspector concluded that Niagara Mohawk engineering performed well in identifying this deficiency. Once identified, station management acted conservatively and entered the 48 hour LCO action statement, despite the lack of a clear requirement to enter the TS LCO and the inconsistency between the TS and the USAR. Niagara Mohawk also reviewed all RG 1.97 instruments for similar calibration concerns. None were found.

- c. During control room panel walkdowns, the inspector identified six unauthorized operator aids hanging on various control switches and instrumentation. The tags contained various component status information. The inspector was concerned the tags should be treated as operator aids per Procedure S-SUP-6, Operator Aids, or removed. When brought to the attention of operations management, the tags were promptly removed. Although there was no obvious safety significance, the inspector was concerned that S-SUP-6 was not closely adhered to and that this discrepancy was not self-identified by the operations shift crews and management. Recent past performance in this area has been good.

2. Radiological Protection (Module 71707)

No noteworthy findings or observations were identified this inspection period.

3. Surveillance and Maintenance (Modules 71707, 61726, 62703)

The inspectors observed portions of the surveillance testing and maintenance activities 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, appropriate system or component isolation was provided and the system was correctly restored following the testing or maintenance activity.

3.1 Unit 1

The following maintenance/surveillance activities were observed and/or reviewed by the inspector.

- Engineering and maintenance activities involving the feedwater system damage following the HPCI testing.
- Eddy Current testing and tube pulling on the RBCLC HXs.
- Repairs to the reactor building airlock and the inner trackbay rollup door inflatable seal.



- ✓ -- Repairs to feedwater heaters 134 and 135.
- Troubleshooting and testing of the motor generator sets.

No concerns were identified and work appeared to be carried out properly, competently and in accordance with procedures.

3.2 Unit 2.

- a. During a tour of the reactor building, the inspector identified the bonnet of HPCS injection valve CSH*MOV107 was full of water, and the packing was leaking one drop every 10 seconds. No deficiency tag was hung indicating the leak was not known by Niagara Mohawk management. This condition was reported to the station shift supervisor and a work request was initiated. The inspector was concerned this deficiency was not identified by operations, maintenance or management personnel during plant tours.
- b. (Closed) Violation (50-410/89-08-02): Failure to perform a post maintenance test on the Division III emergency diesel generator unit cooler following maintenance. In their response, dated March 16, 1990, Niagara Mohawk admitted to the violation, as stated. Numerous personnel and programmatic improvements were made to prevent recurrence of the multiple personnel errors made during this September 1989 event. Niagara Mohawk also agreed that additional corrective actions could have been taken, at the time, to prevent the series of errors that occurred during that time period. This violation is closed.
- c. The inspectors observed portions of safety related maintenance on the C service water pump discharge check valve. Performance of this activity was acceptable.
- d. Portions of the following surveillances were observed by the inspector:
 - Standby gas treatment monthly functional test per N2-OSP-GTS-M001.
 - Electrical preventive maintenance on the low pressure core spray pressure pump.

Performance of these tests was acceptable.



4. Emergency Preparedness (Module 71707)

On March 14, the loss of 23 offsite emergency response sirens due to a transformer problem was properly addressed in a timely fashion. Appropriate notifications were made to the local, state and federal emergency response organizations. Power was restored to the sirens within a few hours.

5. Security (Module 71707)

On March 29, a security guard going off shift accidentally discharged his weapon in the Unit 1 fire arms locker. No one was injured. Niagara Mohawk made an appropriate telephone notification of this event to the NRC Headquarters Duty Officer and plans to submit a complete written report of the event and corrective actions within 30 days.

6. Engineering and Technical Support (Module 71707)

6.1 Unit 1

As previously discussed in Section 1.1 of this report, engineering response to the feedwater and RBCLC HX problems was assessed to be good; whereas, final resolution to the MG set problems appears to be slow. The root cause analysis of the feedwater problem was pending, as well as, the root cause analysis of the damage to the RBCLC HXs. HX damage was believed to be flow induced due to improper design and/or operation of the coolers. The Station Operations Review Committee had not reviewed or approved the final root cause analysis for either of these problems by the end of the inspection period.

6.2 Unit 2

- a. (Closed) Unresolved Item (50-410/89-03-01): A review of Niagara Mohawk's NDE specific examination disclosed that the examination was administered as an "open book" test in that reference material was provided for each question in the test. An in-office review of the licensee's response to this unresolved item was performed during the week of January 29, 1990. Niagara Mohawk letter dated December 7, 1989, file #NQA089-357 verified that the appropriate action has taken place in that the test was modified to satisfy the closed book requirements. This item is closed.

7. Safety Assessment/Quality Verification (Modules 40500, 71707)

7.1 Submittal of Quality Assurance Program Description

During this period Niagara Mohawk submitted Revision 5 of the Quality Assurance Topical Report for Nine Mile Point Nuclear Station Operations for review, pursuant to 10 CFR 50.54(a)(3). This revision to the QATR is being reviewed in the Region I office and the results of the review will be reported later.



7.2 Close-out of Special Team Inspection (STI) Unresolved Items

- a. (Closed) Unresolved Item (50-220/89-200-01 and 50-410/89-200-01): This item was open based on concerns about apparent inconsistencies in the guidance provided to station personnel on the standards for procedural compliance and the use of Temporary Change Notices (TCNs). In response to these concerns, the inspector determined that Niagara Mohawk instituted several corrective actions. First, Station General Order (SGO) 89-03, "Procedure Adequacy and Compliance" was issued to all Nuclear Division personnel and training on it was conducted by supervisors. The resident inspectors attended several of these training sessions and determined that the training was satisfactory (reference IR 50-220/89-04). Following completion of the training for all Nuclear Division personnel, Niagara Mohawk responded by letter dated March 30, 1989 to the NRC stating that meetings had been held with all Nuclear Division personnel to stress the need for all personnel to follow procedures.

Secondly, the IATI in October 1989 reviewed this issue and did not identify any related concerns (reference IR 50-220/89-81). Lastly, observations by the resident staff as well as specialist inspectors indicated that personnel understood and have implemented the requirements for procedural compliance. This item is closed.

- b. (Closed) Unresolved Item (50-220/89-200/02): This item was opened when the STI team identified two examples of potential design problems that had been identified by Nuclear Engineering and Licensing Department (NELD) personnel, but had not been pursued to satisfactory resolution.

The inspector reviewed copies of Problem Reports (PR) 1201 and 1202, which were generated to document the two potential design problems. The inspector determined that both PRs had been dispositioned satisfactorily.

In the August 4, 1989 response to this item, Niagara Mohawk stated that the two problems identified in the STI report occurred prior to the time Unit 1 NELD personnel were included within the PR process, but that situation had been corrected. The inspector verified that a common PR methodology is now used company wide. NELD personnel use procedure NEL-900, whereas the site uses procedure S-SUP-2. Both procedures were previously reviewed by the resident inspector and determined to be adequate and consistent in their methodology for identifying and obtaining resolution to problems. This item is closed.



- c. (Closed) Unresolved Item (50-220/89-200-03): This item concerned the use of a series of design guidelines and criteria documents that were not subject to quality assurance (QA) program requirements or the NELD document control system, but appeared to be in regular use as design information.

The inspector reviewed information on this subject and determined that the design criteria were issued as a controlled document on August 31, 1989. This item is closed.

- d. (Closed) Unresolved Items (50-220/89-200-04 and 05): These items concerned the use of purchase order information and telecon data used in engineering calculations. Specifically, they centered around the apparent lack of written guidance regarding the validation or verification of Unit 1 design information and information sources.

In Niagara Mohawk's response to these unresolved items the specific examples cited in the STI report were addressed as well as a discussion given as to the difficulty, in general, of obtaining data and information from vendors. The inspector determined that this issue was being resolved for the long term through the Engineering Program Integration effort. This effort, to take place over the next five years, includes design basis recovery efforts and systematic evaluation of design data and calculation input. For the short term, the inspector was concerned that no procedural guidance existed to address the STI concern. In response to this concern and following discussion with the cognizant individual from the NELD, a temporary procedure change (TCN) was issued on March 6, 1990 to procedure NEL-022.A, Rev. 2, "Detailed Guidelines for Design Calculations." The TCN stated that where possible, design data should be based on certified vendor data or confirmed by in-plant testing. However, when that data is unavailable, the TCN specified four sources, in order of preference, that may be used for obtaining data.

Based on the actions for short and long term correction of these concerns, these items are closed.

- e. (Closed) Unresolved Item (50-410/89-200-02): This item was opened based upon the concern that certain generic maintenance procedures at Unit 2 merely referenced the vendor manual. The STI team was concerned that the procedures might not provide adequate guidance for safety related maintenance.



The inspector determined that Niagara Mohawk's procedural upgrade program, scheduled for completion in December 1991, addressed this concern. As part of this program, procedures needing revision have been prioritized according to the frequency of use and any information contained in vendor manuals is now included directly in the procedure during the revision process. Referencing vendor manuals is no longer allowed. The STI identified one procedure for which this concern existed, and Niagara Mohawk identified eleven others during the STI. The STI identified procedure has since been superseded. Of the remaining eleven identified by Niagara Mohawk: six have been cancelled or expired; two were corrected as part of procedure revisions described above; and Niagara Mohawk committed to TCN the three unchanged procedures to require 100% QA coverage if the procedures are used prior to being revised. Performance of the three procedures is not expected soon. The inspector concluded that these corrective actions were acceptable. This item is closed.

- f. (Closed) Unresolved Item (50-220/89-200-06): This item was opened based on the STI concern that technicians appeared to be unaware of or were insensitive toward such problems as loop accuracy and its affect on the acceptability of test results. A concern was also identified with regard to material condition of reactor safety instrumentation cabinets and the lack of training provided to technicians in identifying material condition concerns.

The inspector discussed this item with the Unit 1 Maintenance Superintendent and determined that adequate actions have been taken to address both concerns. First, training has been provided to technicians regarding loop calibration accuracy. Secondly, with regard to the material condition of the instrumentation drawers, procedure N1-EPN-GEN-V352 was revised to include material condition inspection requirements. Additionally, Niagara Mohawk has completed inspection of all instrumentation panels and will complete inspection of the pullout instrumentation drawers prior to Unit 1 restart. This item is closed.

- g. (Closed) Unresolved Item (50-220/89-200-07): This item concerned the adequacy of the annual licensed operator requalification tests performed on the simulator with respect to over-emphasis on the Emergency Operating Procedures (EOPs). Subsequent to the STI, in November and December of 1989, an NRC inspection assessed Niagara Mohawk's administration of annual licensed operator requalification examinations. No significant deficiencies were identified, and the examinations met the requirements of 10 CFR 55.59. Based on the results of the inspection, as documented in IR 50-220/89-31, this item is closed.



- h. (Closed) Unresolved Item (50-410/89-200-03): This item concerned a Unit 2 Instrumentation and Control (I&C) surveillance procedure which directed exercising contacts if the "As Found" relay times were found out of specification. The concern was that this amounted to preconditioning of the system to meet the acceptance criteria of the test.

The inspector determined that Niagara Mohawk performed a review of all surveillance dating back to August 1987. That review identified six cases where relays did not meet their tolerance requirements. Five of these relays were recalibrated; however, the sixth had been exercised and subsequently passed. This was the only instance identified where the relay was cycled to meet the test requirement. Since the STI finding, the specific procedure has been corrected and no longer allows exercising the contacts if found out-of-specification. Now, if the contacts are found to be out-of-tolerance, they are calibrated immediately. Additionally, as the relays are tested monthly, the one relay which was exercised under the old exercising criteria has been tested several times under the new requirements. Lastly, during the IATI, Niagara Mohawk's corrective actions were verified and it was determined that no other procedures allowed exercising relays. This item is closed.

- i. (Closed) Unresolved Item (50-220/89-200-08 and 50-410/89-200-04): This item concerned inadequate implementation of engineering training programs. The inspector reviewed Niagara Mohawk's response to this item and discussed the issue with the cognizant NELD manager. Basically, three programs are being implemented for training: Critical Needs; Long Term; and Consultant.

The first program, Critical Needs Training, was designed to identify and conduct training to meet the most critical needs of the Engineering Department. The inspector determined that a substantial portion of this training has been completed. The second program, Long Term Training, has been established to improve the longer term training program for NELD personnel and has not been fully implemented yet. This program as well as the issue of training in the NELD was recently inspected and is discussed further in IR 50-220/90-13 and 50-410/90-14. The last program involving training for consultants was addressed by the issuance of a new procedure, NEL-108, which requires indoctrination of each consultant and identification of required training which is then tracked to closure. This program has been implemented. The inspector concluded that these corrective actions were acceptable. This item is closed.



- j. (Closed) Unresolved Item (50-220/89-200-09 and 50-410/89-200-05): This item concerned the Technical Specification (TS) requirement, per TS 6.5.1.7.a for both units, that the SORC be responsible for investigating all TS violations and provide a written determination regarding whether or not the violations constituted an unreviewed safety question. The STI report called out three TS violations documented in IRs 88-08, 88-09 and 88-18, which had not been evaluated by SORC.

Niagara Mohawk's response to this item stated that the requirement to review TS violations is satisfied by SORC's review of Licensee Event Reports (LERs) or Occurrence Reports (ORs) when these reports concern TS violations. Further, they stated that of the three IRs referenced, the TS violations in those reports were, in fact, reviewed by SORC as there were LERs (88-09, 88-18 and 88-40) which addressed these events. However, the inspector determined that Niagara Mohawk's claim that LER 88-40 covered the TS violation in IR 88-18 was only partially correct as IR 88-18 contained two different TS violations. However, only one of the violations, 50-410/88-18-01, was covered by LER 88-40. The other violation, 50-410/88-18-02, was never incorporated into an LER or OR and therefore did not receive SORC review as required by TS 6.5.1.7.a. This is a violation, however, as this was the only example identified and due to actions taken since the STI, the violation is not being cited in accordance with the criteria in Section V.A. of the Enforcement Policy. NON CITED VIOLATION (50-220/90-03-01 and 50-410/90-03-01).

In their response, Niagara Mohawk also committed to revise procedure AP 10.2.2 (Reportable Occurrences) by August 1989 to formalize the requirement for an OR to be written for any TS violation. When performing the inspection on March 6, 1990, the inspector determined that the present revision to AP 10.2.2 (Rev. 6) did not contain the above requirement. However, a draft copy of Rev. 7 to AP 10.2.2 was provided to the inspector and contained the requirement for an OR to be written for any TS violation. Rev. 7 to AP 10.2.2 was subsequently issued on March 30, 1990. Another action taken by Niagara Mohawk was a revision to AP 3.4.1 (Site Operations Review Committee), which clarified that SORC will review all TS violations and make a determination regarding whether or not the violation constitutes an unreviewed safety question. The inspector verified that Rev. 4 to the AP containing this requirement.



Lastly, due to the STI concern about review of Corrective Action Requests (CARs) and Non-Conformance Reports (NCRs) by SORC for TS violations, Niagara Mohawk reviewed all Unit 1 CARs issued since January 1, 1988 to the present to confirm that these CARs did not identify violations unreviewed by SORC. This review was completed and did not identify any unreviewed TS violations. This item is closed.

- k. (Closed) Unresolved Item (50-220/89-200-10 and 50-410/89-200-06): This item concerned the knowledge level of SORC and SRAB members with respect to 10 CFR 50.59 criteria for what constitutes an unreviewed safety question.

The inspector determined that all SORC members received required training on the 10 CFR 50.59 process. The resident staff attended one of the training sessions and determined that it was satisfactory. AP 3.4.1 was revised to require initial training and refresher training at least every two years and was also revised to include the definition of what constitutes an unreviewed safety question.

The inspector also determined that all but one member of the SRAB had also received the 10 CFR 50.59 training. Additionally, the SRAB Administration Manual, Section VI, effective February 1990, was revised to procedurally require continuing training on this subject on a minimum two year basis. This item is closed.

- l. (Closed) Unresolved Item (50-220/89-200-11 and 50-220/89-200-07): This item concerned the use of polling by SORC and SRAB members. The inspector determined that the issue of polling by SORC members was addressed satisfactorily by a procedure revision to AP 3.4.1. For SRAB meetings, the polling issue was addressed procedurally by requiring discussion in subsequent meetings of any issues polled by telephone. This item is closed.
- m. (Closed) Unresolved Item (50-220/89-200-13 and 50-410/89-200-08): This item concerned the status of the trending and analysis of ORs. The inspector talked with individuals from Niagara Mohawk's Incident Investigation Group and determined that the process for trending and analysis of ORs is in the development phase. A draft procedure is currently being developed which will provide overall guidance for the program, and a computer data base, comprised of ORs from several years past, is being created from which the trending analysis will be done. Based on the progress being made in this area, the item is closed.



- n. (Closed) Unresolved Item (50-410/89-200-09): This item concerned a comment from a Niagara Mohawk QA report which stated that ORs were frequently reviewed in an untimely manner by SORC. The inspector determined that this item has been satisfactorily resolved procedurally through a change to AP 10.2.2 which provides time limits for OR resolution and SORC review. The revision was issued in June of 1989 and appeared to have been effective in resolving the issue. This item is closed.
- o. (Closed) Unresolved Item (50-220/89-200-14): This item concerned the untimely closure of Corrective Action Requests (CARs). The inspector determined that several actions were taken by Niagara Mohawk to address the issue. A process is now in place which requires approval for extension of CARs to be escalated through higher levels of management each time an extension is requested. Station General Order (SGO) 90-02 was issued to address the processing of CARs. Outstanding CARs for Unit 1 were reviewed once prior to reload through the use of Temporary Reload procedure 88-6.7 and will be reviewed again prior to restart by Temporary Restart procedure 88-7.7. Lastly, Quality Assurance Procedure (QAP) 16.03, was revised on January 10, 1990 to encompass timely review of CARs. This item is closed.
- p. (Closed) Unresolved Item (50-220/89-200-12): This item dealt with concerns that the status of some open ORs was uncertain and that ORs were not being tracked for timely closure. The inspector discussed this item with members of the Nuclear Regulatory Compliance Group (NRCG) to determine actions taken as a result of the STI finding, specifically with respect to the assessment, prioritization and goals for the tracking and closeout of ORs.

The inspector was informed that there are currently about 750 open ORs at Unit 1. However, of this number, 500 were written as a result of Non-Conformance Reports (NCRs) on pipe supports. Niagara Mohawk staff review indicates that none of these are reportable to the NRC. Another 150 ORs are with the engineering staff awaiting disposition for reportability and the remaining 100 are in different stages of disposition. The inspector reviewed the computerized listing which contains all open ORs, as well as, their status and the responsible party for disposition as required by NRCP-1, Occurrence Reports. For the short term, all ORs were reviewed for impact on core reload via temporary reload procedure, N1-88-6.9. This completed procedure was SORC reviewed. This same review will be repeated prior to restart via procedure N1-88-7.9. For the long term, AP 10.2.2 will be revised to require 60 day turnaround time on ORs so as to preclude a large backlog of old ORs from developing. Lastly, the NRCG's long term goal is to have less than 100 open ORs at each unit. Based on the progress being made in this area, the item is closed.



7.3. Underlying Root Causes 2 and 4 Performance

The IATI, conducted in October 1989, concluded that Niagara Mohawk progress in the Restart Action Plan underlying root cause areas of problem solving and standards of performance/self assessment was weak. Accordingly, increased inspection emphasis has been placed in these areas to monitor Niagara Mohawk progress in support of Unit 1 restart and overall performance improvement. Overall, performance in these two areas was observed to be mixed, but improving during this inspection period.

In this report period, the following activities were identified as representative of improvement in root cause areas 2 and 4: identification and prompt resolution of the high range hydrogen monitor calibration concern; resolution of feedwater system testing concerns; and actions to comply with a Technical Specification forced shutdown due to the Division II hydrogen/oxygen monitor failure while the Division I emergency diesel generator was inoperable for preventive maintenance.

In contrast, Niagara Mohawk progress in resolving the motor generator set voltage, current and speed regulation concerns, have been slow and until recently, not well focused on the issues. Also, the recent identification of the RBCLC heat exchanger concerns, although good from the standpoint of recent identification, cast doubts on the adequacy of the original engineering involvement with respect to procurement design specification and engineering oversight of the supplier. The inspectors acknowledge that a Niagara Mohawk final root cause analysis has not been performed, to date.

8. LER Review (Module 92700)

The following LERs were reviewed and found satisfactory:

Unit 1

- LER 88-20, Supplement 1, November 18, 1988, Plant potentially operated outside design basis due to design deficiency of 125 VDC distribution system. The supplement was issued to clarify and assess the impact of deficiencies identified in the 125 VDC system. When the LER was initially issued, the full scope of problems in the system were unknown.



-- LER 90-02, February 28, 1990, Design deficiency resulting in possible failure of the RBCLC to perform its safety function. This problem was separate from the tube damage issue and deals with the adverse effect that the fail position of the RBCLC temperature control valve could have.

No concerns were identified with the reports reviewed.

9. Management Meetings (Module 30703)

Restart Panel Meeting

On March 29, the NRC Restart Review Panel met on site to discuss with Niagara Mohawk the status of preparations for Unit 1 restart. The panel received a briefing by Niagara Mohawk management on the status of the Restart Action Plan five underlying root causes and a summary of the Independent Assessment Groups activities, to date. The meeting was chaired by William Kane, Director, Division of Reactor Projects, Region I.

Management Meetings Conducted by Region Based Inspector During this Inspection Period

<u>Date</u>	<u>Subject</u>	<u>Report No.</u>	<u>Inspector</u>
3/19-21	Unit 2 Fuel Handling License Exams	90-12 (OL)	Bonnett
3/19-23	Radiological Protection	90-14/15	Dragoun
4/2-6	125 VDC Followup	90-15	Cheung

Preliminary Inspection Findings

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 Niagara Mohawk representatives, it was determined that this report does not contain safeguards or proprietary information.

