U.S. NUCLEAR REGULATORY COMMISSION

REGION I

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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 27 through October 31, 1992
Inspectors:	W. L. Schmidt, Senior Resident Inspector W. F. Mattingly, Resident Inspector (in training) R. K. Lorson, Reactor Engineer J. T. Yerokun, Project Engineer

Approved by: _____ 11/18/92
for Larry E. Nicholson, Chief — Date
Reactor Projects Section No. 1A
Division of Reactor Projects

Inspection Summary: This inspection report documents routine and reactive inspections of plant operations, radiological controls, maintenance, surveillance, emergency planning, security, and safety assessment/quality verification activities.

Results: See Executive Summary.

EXECUTIVE SUMMARY

Nine Mile Point Units 1 and 2
NRC Region I Inspection Report Nos. 50-220/92-24 & 50-410/92-28
September 27 - November 7, 1992

Plant Operations

NMPC operated Units 1 and 2 safely over the period. At Unit 1 two instances occurred which indicated that senior reactor operators did not fully understand their responsibilities. Specifically, a station shift supervisor left the control room unattended by a senior reactor operator for about five minutes. This represented an apparent violation. Also, a station shift supervisor failed to stop a surveillance test when an unanticipated half scram signal occurred. This represented a violation of NMPC procedure for the use of procedures.

Radiological Controls

The radiological controls observed over the period were good. Chemistry department actions following identification of a higher than expected offgas release rate were very good. The release rates indicated a small release of noble gases through the cladding of one or more fuel pins in the reactor core. The magnitude of the release rates remained at least 100 times less than the technical specification limits for gross noble gas releases.

Maintenance and Surveillance

Personnel performed well during routine maintenance and surveillance observations.

Engineering and Technical Support

Review of Unit 1 emergency diesel generator testing showed that the refueling cycle test did not demonstrate the design basis or the intent of technical specifications. This issue was unresolved. Unit 2 personnel took appropriate actions on an NRC information notice dealing with Potter Brumfield relays.

Security

Routine tours indicated good performance by the on-site security force.

Safety Assessment/Quality Verification

Several LERs were reviewed. Review of the LERs documenting a recent reactor scram and loss of one off-site power line showed that NMPC believed that previous corrective actions had been too narrow. An unresolved item was opened pending inspector review of other recent corrective actions.

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* The NRC inspection manual procedure or temporary instruction that was used as inspection guidance is listed for each applicable report section.

DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

1.1 Niagara Mohawk Power Corporation Activities

The Niagara Mohawk Power Corporation (NMPC) operated Nine Mile Point Unit 1 (Unit 1) safely, essentially at full power, during the period. On September 28, chemistry technicians noticed an increase in the gross noble gas activity level at the discharge of the offgas system hydrogen recombiner. This indicated that there was a small (approximately 100 times less than the technical specification limit) release of gaseous activity from the reactor fuel. NMPC continued to monitor the release rates over the period. On October 9, the station shift supervisor (SSS) on duty left the control room for about five minutes, without another senior reactor operator (SRO) being in the control room. On October 23, while conducting calibration surveillance testing on the reactor water level high/low instruments, operators and instrument and control (I&C) technicians failed to stop the procedure when unexpected alarms were received.

NMPC operated Nine Mile Point Unit 2 (Unit 2) safely and at essentially full power over the period.

1.2 NRC Activities

Resident inspectors conducted inspection activities during normal, backshift, and weekend hours over this period. There were seven hours of backshift (evening shift) and six hours of deep backshift (weekend, holiday, and midnight shift) inspection during this period.

During the weeks of October 19 and 26 a routine engineering inspection was conducted, the findings of which will be documented in Combined Inspection Report 50-220/92-26 & 50-410/92-30.

During the week of October 19 a routine security inspection was conducted, the findings of which will be documented in Combined Inspection Report 50-220/92-20 & 50-410/92-22.

2.0 PLANT OPERATIONS (71707, 71710, 93702)

2.1 Plant Operations Review - Unit 1

Routine observations of control room activities indicated that control room operators safely monitored and controlled plant operations. Regular tours of the plant were conducted to assess equipment conditions, radiological conditions, fire protection, security, general housekeeping practices, and personnel safety. The inspectors observed a very high level of performance and generally good conditions throughout the plant except as discussed below in section 2.1.1 and 2.1.2.

2.1.1 Less than Required Senior Reactor Operators in the Control Room

On October 9, the SSS, a licensed SRO, left the control room when the assistant station shift supervisor (ASSS), the other SRO on-shift, was not in the control room. This resulted in not having the technical specification required SRO in the control room, for about five minutes. While the ASSS was touring the plant, the SSS desired to discuss work planning with planning personnel and left the control room to go to a meeting room approximately 40 feet from the control room.

NMPC management learned of this issue five days after it occurred and took adequate actions to review the situation. A fact finding meeting with the individuals involved, conducted on October 14, indicated that the SSS did leave the control room without another SRO present. However, because of poor communications and understanding of the process for identification and reporting of technical specification violations, the issue was not documented on a deviation event report at the time that it occurred.

NMPC quickly developed an investigation plan to review the incident, which included interviews of the personnel involved and a review of control room security card reader printouts. NMPC discussed this issue with NRC management on several occasions. NMPC presented their overall conclusion of the investigation verbally on October 30. Based on the investigation, NMPC determined that this was an isolated event. NMPC decided that there were several corrective actions which needed to be taken, one of which was to remove the SSS from licensed duties. The SSS leaving the control room for five minutes was of low safety significance, as the unit was operating at steady state power. However, the failure to properly document and communicate the violation of technical specification to station management was more safety significant. This issue was considered an apparent violation of the technical specifications. **(220/92-24-01)**

2.1.2 High/Low Reactor Water Level Instrument Trip Channel Test

The inspector noted during a review of control room logs that the SSS terminated surveillance test procedure N1-ISP-036-003 following three unanticipated half-scrams and prior to completion of the procedure. The SSS stopped the test because low level half-scram signals, not identified by the applicable procedural step or plant impact statement, were actuated during performance of attachments one, two and three. The inspector interviewed the test and operations personnel who performed this procedure and concluded that the operating personnel were unsure of the expected test results and did not terminate the test until the same unexpected half scram occurred during performance of three procedure attachments. The inspector also noted that the plant impact statement in the procedure stated that a "turbine trip half-scram" and a "feedwater pump high level trip half-scram signal" would be actuated during this test. This was incorrect since neither of these functions existed in the plant. Inspector review of the procedure and electrical logic diagrams showed that the low water level instrumentation operated as designed during the testing. The failure of the procedure to provide operating personnel with the expected plant

impact assessment and the failure of operators to stop the procedure and assess the reasons for unexpected half-scram conditions were contrary to NMPC Nuclear Division Directive (NDD)-PRO-01, and was considered a violation of Technical Specification 6.8.1 requirements for the content and use of procedures. **(220/92-24-02)**

The inspector discussed the operator procedural adherence issue with unit management who took appropriate corrective action to resolve the problem. The inspector discussed the procedural weaknesses with instrument and control supervisory personnel who stated that this procedure would be corrected prior to the next performance. The inspector also reviewed Technical Specification Table 4.6.2a which delineated the surveillance test requirements for the low reactor water level instrumentation. The inspector reviewed the applicable surveillance procedures and the tracking system used to ensure that the technical specification requirements were met. The surveillance test schedule was tracked with the aid of a computerized data base which enabled planning personnel to generate the correct work requirements for the test personnel. The surveillance procedures and the tracking system satisfactorily ensured that the technical specification requirements discussed above were met.

2.1.3 Instrument Air System Walkdown

The inspector performed a comprehensive walkdown of the accessible portions of the safety-related instrument air system. The inspector noted several discrepancies between the actual system configuration and applicable drawings. The inspector identified these items to the cognizant system engineer who stated that the system drawings were being upgraded as part of the system design basis reconstitution; expected to be completed by December, 1992. The inspector also reviewed the Service, Instrument, and Breathing Air Operating Procedure (N1-OP-20, revision 19) and noted a procedural weakness in that none of the instrument air valves inside the reactor building were included in the procedure valve line-up. The inspector discussed this issue with the operations support supervisor who stated that this procedure would be upgraded to include these valves following completion of the drawing revisions discussed above. The inspector concluded that these drawing and procedural weaknesses could lead to a loss of air to a system load. The inspector noted that an adequate recovery procedure (N1-SOP-6, revision 2) existed to enable the operators to mitigate this event, and maintain the plant in a safe condition. Additionally, the inspector reviewed the loss of instrument air safety analysis in the updated safety analysis report (USAR), and verified that the plant could be shutdown and maintained in a safe condition with a complete loss of instrument air.

The inspector noted that the physical condition of the system was good. Pipe hangers were properly made up, system valves were properly aligned, support systems were operational, and the instrumentation was properly installed. However, some minor material deficiencies were noted which were discussed with the cognizant system engineer, who promptly addressed each issue in an appropriate manner. One deficiency, involving the labelling of valves inside the reactor building, was discussed with the operations support supervisor, who stated that labelling would be improved following completion of the drawing upgrades mentioned above.

Review of selected pressure switch calibration records and outstanding corrective maintenance items identified no deficiencies or significant issues. The instrument air compressor preventive maintenance procedure (N1-MPM-094-602, revision 0), and the results from the most recent performance of this maintenance were reviewed. The procedure contained a weakness in that the piston end clearance specifications did not agree with the values listed in the compressor's technical manual. The clearance readings obtained during the most recent measurement did conform with the technical manual specifications. This issue was discussed with a maintenance supervisor and the system engineer who stated that the procedure would be enhanced to conform with the vendor's recommendations.

In summary, the drawing and procedure controls for the instrument air system inside the reactor building were weak. Operators were provided with adequate procedural guidance to address the effects of loss of air conditions. NMPC was planning actions to correct these and other minor problems identified, as part of the ongoing design basis reconstitution.

2.2 Plant Operations Review - Unit 2

NMPC safely operated Unit 2 at near full power in conformance with approved procedures and regulatory requirements. Control room activities, including shift turnovers and crew briefings, panel manipulations, emergency operating procedure use, and operator response to alarms, were observed. Regular tours of the plant were conducted to assess equipment conditions, radiological conditions, fire protection, security, general housekeeping practices and personnel safety. The inspector observed a very high level of performance and generally good conditions throughout the plant.

2.2.1 Emergency Diesel Generator Fuel Oil Receipts

Unit 2 Technical Specification 4.8.1.1.2.c for emergency diesel generator (EDG) fuel oil and chemistry procedures permit up to 31 days to perform a complete analysis of new fuel oil, after an addition to the EDG fuel oil storage tanks. Before adding new fuel oil to the storage tanks, however, it is analyzed for five critical parameters: API gravity, kinematic viscosity, flash point, appearance, and cloud point. During two previous inspections (50-410/92-15 and 92-17) a concern was raised over the topping-off of all three EDG fuel tanks from a single tanker with oil that might not meet the requirements of the 31 day analysis. This potentially could allow the three EDGs to run on oil that did not meet the required specifications and might lead to a common mode failure of the EDGs. Both inspection reports stated that NMPC would change their procedure to include provisions for holding the fuel oil in the tanker until complete analysis results were received.

NMPC subsequently notified the NRC that their EDG fuel oil procedure would continue to allow 31 days to perform the complete analysis since this was the technical specification requirement. However, the corporate chemistry laboratory was providing analysis results within two weeks. Also, NMPC's goal was to have these laboratory analysis results within two days of sampling, before adding the new fuel to the storage tanks. This goal has been successfully demonstrated several times recently. The inspector found the sampling procedure satisfactory based on the above information.

3.0 RADIOLOGICAL AND CHEMISTRY CONTROLS (71707)

3.1 Routine Observations - Unit 1 and Unit 2

During routine tours of both units the inspectors observed generally good radiological conditions and personnel adherence to radiological postings.

3.2 Fuel Failure - Unit 1

During routine daily gross noble gas offgas system sampling on September 28, chemistry personnel identified an increased release rate downstream of the hydrogen recombiner, but before the offgas system holdup volumes. Offgas system release rates increased to a maximum of about 4700 μc/sec. Steady state release rates prior to this had been less than 2000 μc/sec. The doubling of the release rate caused NMPC to enter their failed fuel action plan.

Isotopic analysis of offgas samples indicated a release of gases generated in the reactor's fuel. Plotting of the sample data showed that the release rate peaked at approximately 4700 μc/sec. Then the release rate decreased to a new level, higher than the previous steady state level, but lower than the peak. Unit 1 Technical Specification Section 3.6.15c allows a noble gas release rate of 0.5 c/sec and up to 1.0 c/sec if the offgas system is functioning.

NMPC continued to monitor the offgas activity daily over the period. Aggressive sampling was undertaken during a control rod sequence exchange to gather data which might be useable to determine the general location of the leak in the core. The chemistry department performed well in identifying and trending this fuel failure information.

4.0 MAINTENANCE (62703)

4.1 Maintenance Observations Units 1 and 2

Maintenance activities were observed during this inspection period to ascertain that safety related activities were being conducted according to approved procedures, technical specifications, and appropriate industrial codes and standards. Observation of activities and review of records verified that: required administrative authorizations and tag outs were obtained, procedures were

adequate, certified parts and materials were used, test equipment was calibrated, radiological requirements were implemented, system prints and wire removal documentation were used, and quality control hold points were established. Maintenance activities observed included:

WR 1-208393 Recirculation flow master controller troubleshooting
WR 1-197020 EDG 103 air start compressor motor replacement
WR 2-207308 Low pressure core spray keep fill pump replacement
WR 2-209091 Division II emergency diesel generator output breaker relay troubleshooting
WR 2-195186 Service water pump A impeller and shaft replacement
WR 2-209425 EDG 1 service water relief valve replacement
WR 2-201901 EDG 1 speed sensor troubleshooting

The above activities were effective with respect to meeting the safety objectives.

4.2 Division II Emergency Diesel Generator Output Breaker Relay Troubleshooting

During a field inspection to support electrical maintenance on Division II supply breaker 103-13, the Division II EDG became inoperable for approximately 20 minutes. This occurred when one of three 87G phase differential current relays for the Division II EDG output breaker actuated due to the vibration of closing the breaker 103-13 cubicle door. Actuation of the 87G relay tripped its associated 86 relay which provided a trip and lock-out signal to the EDG breaker and caused several control room annunciators to actuate, indicating that the Division II EDG was inoperable. The EDG output breaker did not change position since it was already open, but it was now unable to shut and the EDG was blocked from starting. The operator's initial investigation found that the Division II EDG problems coincided with shutting the breaker 103-13 cubicle door. The operators subsequently reset the 86 relay and declared the EDG operable. A deviation/event report (DER) and subsequent work request were issued to troubleshoot the problem.

The inspector was concerned over the potential effects of a seismic event on the relay in question. The inspector monitored this maintenance activity by observing portions of the work in progress, reviewing the troubleshooting and maintenance procedures, and interviewing personnel involved with conducting the maintenance. The as found condition of the 87G relay met all of the calibration and vendor installation requirements, however, the relay continued to trip when subjected to certain vibrations. The relay was replaced and all three 87G relays in the cubicle were satisfactorily field tested for sensitivity to vibration. NMPC was conducting a root cause analysis of the failed relay and planned to discuss this vulnerability to certain vibrations with the vendor, in order to develop test methods to identify the failure mechanism on other relays.

The inspector concluded that the troubleshooting and repairs to the Division EDG output breaker relays were thorough, well planned, and properly executed to minimize any adverse plant impact.

5.0 SURVEILLANCE (61700, 61726, 61707)

5.1 Observation of Surveillance Activities - Unit 1

5.1.1 Containment Spray System Operability Test

The performance of the quarterly technical specification operability test for a containment spray and a containment spray raw water pump was observed. The inspector noted through direct observation that the test was well supervised and controlled. Interviews of the test personnel showed a high level of knowledge regarding test requirements. The inspector noted good material condition of the containment spray system components. The test data was promptly reviewed by appropriate licensee personnel who correctly determined that both pumps was acceptable. The inspector independently verified calculations, including the method of calculating the deep draft containment spray raw water pump suction pressure. Additionally, the test data was compared against the pump curves and no problems were identified. The surveillance test procedure (N1-ST-Q6C, revision 2) was satisfactory and met technical specification and IST requirements.

5.1.2 High Drywell Pressure Instrument Trip Channel Test

The high drywell instrument trip channel test was required by Technical Specification 4.6.2.a to verify the operability of the trip channels. The inspector observed a selected portion of the test and noted that the instrument trip channel functioned properly. The test data and the surveillance procedure were reviewed and no problems were identified.

5.2 Observation of Surveillance Activities - Unit 2

5.2.1 Low Pressure Coolant Injection Pumps B&C Automatic Start Time Delay Relays Functional Test

The inspector observed this testing for the B and C low pressure coolant injection (LPCI) pumps according to test procedure (N2-ESP-ENS-M731, revision 5). The monthly functional test of the LPCI automatic start time delay relays verified the operability of these relays under normal and emergency power conditions. A test switch simulated a loss of coolant accident (LOCA) which caused the associated emergency core cooling system (ECCS) time delay relays to actuate. The test was then repeated while simulating a loss of offsite power (LOOP) to verify operability of the time delay relays with emergency power. The inspector noted that the procedure was correctly performed and that the personnel involved were knowledgeable about the test requirements. The inspector confirmed that the test equipment was properly installed and that measured results were within procedural limits and met Technical Specification 3/4.3.3 requirements.

5.2.2 Automatic Depressurization Initiation Time Delay Relay Functional Test

The Division I automatic depressurization system (ADS) initiation time delay relay test satisfied Technical Specification 4.3.3.1-1.A.2.b. The test was performed by tripping the master trip units for the ADS logic while in the test mode and measuring the time delay until the actuation of the relay contacts. During this test, the inspector observed that the test was properly executed and that the relay contacts actuated within the technical specification limit.

6.0 SECURITY AND SAFEGUARDS (71707)

The inspectors routinely toured protected and vital areas at both units. These tours included night time walkdowns of the protected area and observation of security activities. No significant issues were identified. Further, the inspector observed good controls of temporary security fences to allow demolition of a site building.

7.0 ENGINEERING AND TECHNICAL SUPPORT (71707, 92703, 37700, 90700)

7.1 Unit 1

7.1.1 Review of Emergency Diesel Generator Testing

The inspector reviewed the outage surveillance test for EDGs and determined that the testing being performed by NMPC did not match the design basis for the EDGs. Specifically NMPC has not been testing the start of the EDGs in conjunction with LOCA signal. The outage test ST-R2 simulates a LOCA signal, which causes all ECCS pumps to start and all containment isolation valves to close. Then a simulated loss of emergency bus voltage signal is inserted to start each of the emergency diesel generators separately. This causes the emergency bus to strip loads and isolate from the off-site power system and remain de-energized until its EDG starts, energizing the ECCS loads on the bus in sequence.

This method did not appear to meet the intent of technical specifications or the system design basis as described in the USAR, in that the LOCA and LOOP were not simultaneous. The inspector discussed this with the NMPC engineering and technical personnel. NMPC was in the process of reviewing the technical rational for the conduct of this testing. This issue was unresolved at the end of the period. **(220/92-24-03)**

7.1.2 (Closed) Unresolved Item 50-220/91-12-03: Emergency Diesel Generator Fuel Oil Filter Design Review

The inspector reviewed the actions taken by NMPC to an EDG fuel oil system concern. The fuel oil system was not designed with differential pressure indication (or alarms) for the fuel oil filter. If the filter was to become clogged, the EDG could be starved of fuel and lose load prior to operators becoming aware of the clogged filter. Further, the filter consists of two elements in parallel with both elements continuously in service and cannot be replaced without shutting

down the EDG. Two sight glasses are provided on the filter: one shows that the engine is receiving full fuel flow and the second shows that the filter is clogged when an inlet fuel oil pressure of 60 psig is attained. At this pressure, flow to the filter is diverted through the second sight glass and back to the fuel oil tank. However, if this happens, the diesel engine would already be starved of fuel and indication in the sight glass would be of no help to maintain the EDG operating.

NMPC performed a review of the filter design. Their immediate corrective action was to revise Operations Monthly Surveillance Test, N1-ST-M4, "Emergency Diesel Generator Manual Start and One Hour Rated Load Test," to include recording the fuel oil pressure during testing to ascertain that the fuel oil filters are not becoming clogged. An acceptable pressure range of 15 to 50 psig is specified in the procedure. The vendor's recommended replacement schedule for the fuel oil filter is every two years. The plant replaces the filter every refueling outage as specified in procedure N1-NMP-GEN-852, "EDG Engine and Associated Equipment Inspection Diesel Generator 102 and Diesel Generator 103." Additionally, NMPC has generated a modification package, Conceptual Modification # N1-91-016, to replace the 2-element filter with two separate spin-on filters and to install a differential pressure indicator across the filter system. The inspector found that NMPC was taking adequate actions to assure the adequacy of the fuel oil filtration design. This was based on: the routine preventive maintenance performed to ensure that the filter remains unclogged; the specifications for the fuel oil ensure that debris is not introduced into the system; and the good results of the trend of the filter inlet pressure recorded during the monthly diesel runs. The pressure has remained at 25 psig, indicating that debris is not being deposited on the filter. Additionally, the installation of a differential pressure gauge during the next refueling outage would provide another method of monitoring pressure across the filter to let the operators know if the filter is becoming clogged. The inspector inspected the filter on both diesel engines and noted that the "adequate flow" sight glass was full on both engines. No discrepancies were observed. This item was closed.

7.1.3 (Closed) Unresolved Item 50-220/91-17-02: Improper Safety Related DC Breaker Setting

NMPC corrected a previously identified condition that would have led, during certain accident conditions, to the common DC output breaker from the battery charger and static inverter to battery board 12 tripping on an overcurrent before supplying it designed 400 amps. NMPC identified this when the breaker tripped during an installation test of the static inverter. Even though the trip setpoint was 400 amps, the trip occurred at a load of approximately 274 amps. Upon further review, NMPC determined that the breaker setpoint did not account for equipment tolerances and thus would trip under anticipated loading conditions. The breaker setpoint was raised to 460 amps to account for accuracy tolerance.

The NRC electrical distribution safety system functional inspection (EDSFI) team reviewed this issue in 1991. The team concluded that the licensee's actions were broad in scope and that they were taken in a timely manner. The team also determined that in addition to the actions taken by the licensee to prevent recurrence, the following actions must be taken:

- Revise applicable procedures to ensure that I&C setpoint changes are reviewed for impact on electrical equipment/system design.

- Review previous setpoint changes made under the I&C setpoint program for impact on electrical equipment.

- Issue a lessons learned transmittal to appropriate personnel

To accomplish these actions, NMPC revised three Nuclear Engineering and Licensing procedures: NEP-DES-120, "NMP1 Design Change Control Program"; NEP-DES-310, "Design Input"; and NEP-DES-340, "Design Calculations." The licensee also revised guideline NEG-1E-001, "I&C Setpoint Change Process" to improve in this area. The inspector reviewed previous setpoint changes made under the I&C setpoint program and no discrepancies were identified. Appropriate personnel have been briefed on the issue and the lessons learned. Based on these actions, the inspector concluded that adequate actions have been taken to address this issue. This item was closed.

7.2 Unit 2

7.2.1 NRC Information Notice 92-04 Potter Brumfield MDR Rotary Relay Failures

The inspector reviewed the actions taken by NMPC in response to NRC Information Notice 92-04 which discussed recent experience regarding Potter & Brumfield (P&B) MDR rotary relay failures. NMPC's computerized data base search identified that 136 of these relays were installed at Unit Two; in the reactor protection, main steam, standby liquid control and service water systems.

NMPC verified that routine surveillance testing periodically exercised all but one of these relays. Such periodic testing of the relay is important in identifying a relay failure. The relay that was not tested is normally de-energized and provides an input to a non-safety related system. The inspector independently reviewed selected relays and found that the relays were tested as specified by the licensee.

To date, four slow relay response failures have occurred, which could be attributed to the failure mechanism described in NRC IN 92-04. These failures were identified during the routine surveillance testing discussed above and the licensee replaced each relay using a "like for like" substitution. NMPC plans to replace all of these relays (with relays not subject to the failure mode described in NRC Information Notice 92-04) by the completion of refueling outage four. The inspector found the licensee's response to this issue comprehensive and appropriate.

8.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (71707, 92700)

8.1 Review of Licensee Event Reports (LERs) and Special Reports

8.1.1 Unit 1

The inspector reviewed the following LERs and Special Reports and found them satisfactory:

LER 92-10, dated October 5, 1992. Inadvertent operation with less than the minimum required average power range monitor channels per trip system due to personnel error.

8.2 (Closed) Unresolved Items 92-25-01: Review of August 28, 1992 Reactor Scram and 92-25-02, Review of Partial Loss of Off-Site Power

The inspector found that licensee event reports submitted by NMPC (92-17, for the August 28, 1992, reactor scram and 92-19 for the September 16, 1992, loss of off-site power line 5) adequately addressed the specific events. Based on this review the unresolved items were closed. However, each report stated that previous corrective actions could have been broader in scope and may have prevented these instances. The inspector reviewed the previous corrective actions taken for the December 18, 1991 reactor scram due to feed water system problems and the three other instances of losing off-site power in the last two years. The inspector concluded that the corrective actions taken for each event were focused and did not address broad actions. The inspector considered this an unresolved issue **(220/92-24-04 and 410/92-28-04)** pending review and evaluation of the adequacy of the corrective action breadth and depth on recent issues.

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