

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Report Nos.: 91-11; 91-10
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: May 12, 1991 through June 22, 1991
Inspectors: W. A. Cook, Senior Resident Inspector, FitzPatrick
W. L. Schmidt, Senior Resident Inspector
R. R. Temps, Resident Inspector
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Approved by: Donald R. Haverkamp 7/11/91
Donald R. Haverkamp, Chief Date
Reactor Projects Section No. 1B

Inspection Summary: This inspection report documents routine and reactive inspections of plant operations, radiological controls, maintenance, engineering/technical support and safety assessment/quality verification activities.

Results: See Executive Summary.



EXECUTIVE SUMMARY

Nine Mile Point Unit 1 and Unit 2 Inspection Report Report Nos. 50-220/91-11 and 50-410/91-10 May 12 - June 22, 1991

Plant Operations

Unit 1 operations performance was good during this inspection period. The turbine torsional test was completed satisfactorily. Operations performance at Unit 2 was good, especially the response to the loss of an offsite power line.

Radiological Controls

Good receipt inspection practices and surveys identified that a radioactive material shipping cask delivered onsite for use in the Unit 1 spent fuel pool cleanup project had excessive contamination levels on its exterior surfaces.

Maintenance

Housekeeping and decontamination efforts at Unit 1 were deemed noteworthy. Actions to diagnose and correct various feedwater system problems at Unit 1 were timely and effective. Two isolated instances of poorly planned safety-related maintenance activities were noted at Unit 2, which resulted in unnecessary entries into Limiting Conditions for Operations; in response, Niagara Mohawk enhanced their daily work planning process to increase awareness of LCO maintenance activities.

Engineering and Technical Support

Review of the temporary modification log at Unit 1 and review of past audit findings identified the need for more timely resolution of identified discrepancies.

Safety Assessment/Quality Verification

Nine licensee event reports and one special report were reviewed and found acceptable.

Two site operations review committee meetings were observed to be thorough, effective and focused on safe operation of the plant.



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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

Niagara Mohawk Power Corporation (NMPC) operated Nine Mile Point (NMP) Unit 1 and Unit 2 at virtually full power throughout the reporting period. A short power reduction occurred at Unit 1 during repairs to a feedwater system flow control valve. Reactor operation at Unit 2 was not affected by the May 21 loss of one of the two 115 KV offsite power lines. However, the Division I and III emergency diesel generators started, the reactor building isolated and standby gas treatment system initiated. NMPC determined that the loss was caused by inadequate controls over work in the Scriba switchyard. On June 20, at Unit 2, the reactor building isolated and the standby gas treatment system initiated following deenergization of the normal reactor building ventilation dampers, during troubleshooting.

1.2 NRC Activities

1.2.1 Site Visit by the Regional Administrator

On May 22, the Regional Administrator visited the NMP facilities accompanied by the Reactor Projects Section Chief. The Regional Administrator conducted a tour of the facilities and met with senior NMPC corporate and station management to discuss recent performance and business plan progress.

1.2.2 Systematic Assessment of Licensee Performance Report Issued

On June 14, the Systematic Assessment of Licensee Performance (SALP) report for the period March 1, 1990 through March 31, 1991, was issued. Results were generally favorable with improvement noted in several functional areas. A management meeting to discuss the report was held near the site on June 28.

1.2.3 Removal of NMP from the NRC's Plant Watchlist

On the morning of June 20, during the briefing to the NRC Commissioners, it was made public that NMP Unit 1 and Unit 2 were removed from the NRC's list of plants requiring closer regulatory attention.

1.2.4 Change in Senior Resident Inspector Assigned to NMP

On June 16, Wayne L. Schmidt assumed the duties as NRC's Senior Resident Inspector (SRI) at NMP. Mr. Schmidt, formerly the SRI at the James A. Fitzpatrick nuclear power plant, succeeded Mr. William A. Cook who assumed the SRI duties at FitzPatrick.



2.0 PLANT OPERATIONS (71707, 93702)

2.1 Unit 1

2.1.1 Review of Turbine Torsion Test

The inspector observed good procedural adherence and communications during portions of the turbine torsional test conducted on May 29 and 30 in accordance with procedure N1-STP-14. Appropriate operations management oversight of the test was noted. The test results were satisfactory.

2.1.2 Feedwater Flow Control Valve Difficulties

The control room operators responded well to lowering water level in the reactor vessel. This condition was caused when the feed water control valve #13 appeared to become stuck in mid-position during operation in the automatic valve control mode. The operators stroked the valve in the remote-manual valve control mode and observed no further difficulties when the valve was returned to automatic control. Maintenance activities later conducted on this valve, see section 4.1.3 below, necessitated a power reduction, which was well controlled.

2.2 Unit 2

2.2.1 Loss of One 115 KV Offsite Power Supply

Control room operators responded very well to the loss of offsite power line 5 on May 21. As a result of the loss of emergency bus voltage the Division I and III emergency diesel generators (EDGs) started and automatically connected to their busses to supply power to safety related loads, as designed. The momentary loss of electrical power, from when the line was lost until the EDGs picked up load, resulted in a reactor building isolation and initiation of the standby gas treatment system. There was no effect on reactor operation as a result of this event. The loss of the one line placed the plant in a 72-hour shutdown limiting condition for operation (LCO), per Technical Specification 3.8.1.1.a. To allow for the securing of the EDGs operators transferred Division I and III switch gear to the alternate 115 KV power from line 6. Line 5 was restored and the LCO was exited approximately 15 hours after the loss. The proper 10 CFR 50.72 notification was made.

NMPC investigation revealed that excavation at the Scriba Switchyard resulted in damaging two underground control power cables which resulted in the loss of line 5. That investigation determined that the offsite NMPC work crew at the Scriba yard did not evaluate the potential impact on plant conditions by the underground work being performed. The plant manager held an accountability meeting with the NMPC system power deficiency manager, at which time it was decided that work at the Scriba Switchyard would be evaluated under the Unit 2 work control program.



The safety significance of this event was low because offsite power through line 6 remained available and the EDGs started and loaded, however, it did illustrate the need for NMPC to better evaluate non-nuclear activities which could affect the operation of their nuclear units.

2.2.2 Unnecessary Trip of the 'A' Reactor Water Cleanup Pump

On June 11 the 'A' reactor water cleanup (RWCU) pump was secured when it was noticed that the delta flow timer was running as indicated by the alarm of annunciator 602320. Surveillance N2-ISP-WCS-M001 (WCS delta flow functional test) was in progress and the automatic isolation function of the delta flow logic was defeated using bypass test switches. The operators tripped the RWCU pump as a conservative action to prevent a RWCU system isolation by stopping system flow, thinking that the timer was initiated by an error made during the performance of the surveillance test.

NMPC management identified the following weaknesses during their accountability meeting on this event:

- The procedure did not include mention of the specific annunciators that would be affected by the surveillance in the plant impact statement for work being performed.
- The procedure did not identify that the annunciator would alarm when the transmitters were valved out of service; thus it was unexpected by those involved.

For corrective actions, the procedure was revised to specifically identify affected annunciators in the plant impact statement and to clearly identify that the initiation of delta flow timer logic annunciator will alarm when the transmitters are valved out of service. The inspector determined that the safety significance of this event was minimal because the RWCU system was quickly restored to normal. NMPC management promptly investigated this event and took appropriate corrective actions.

2.2.3 Reactor Building Isolation and Standby Gas Treatment Automatic Start

On June 20 the reactor building normal ventilation (RBV) system sensed a low flow condition, which caused a reactor building isolation and an automatic start of the standby gas treatment system. In conjunction with this event operators noticed that the ECCS line keep fill annunciators alarmed on the control panels. Then the keep fill alarms cleared. An operator traced the power source for the keep fill annunciators and the RBV damper to a single power distribution panel.



As operators prepared to look for problems in this panel, that could have caused a loss of power, electrical maintenance identified that a technician had opened a breaker on this panel during a troubleshooting evolution. Operations personnel determined that the opening of the breaker caused the isolation, the SBTG start and the keep fill annunciator alarms. At the end of the inspection period NMPC was still reviewing the causes of the technician opening the breaker and planned to submit on LER documenting this event. The inspector determined that the initial operator and management response to this event was appropriate.

3.0 RADIOLOGICAL CONTROLS (71707)

3.1 Receipt of Contaminated Shipping Cask

On March 26, 1991, a rail shipping cask was shipped offsite with a liner containing waste materials (irradiated metal) generated as part of the Unit 1 spent fuel pool cleanup effort. When the cask was received at Hanford, Washington, it was found to have non fixed (removable) surface contamination levels in excess of regulatory requirements. These levels were attributed to a "weeping" phenomena in which ingrained contamination in the metal surfaces leached out. Details of the incident and enforcement action taken are discussed in inspection report 50-220/91-10, issued April 4, 1991.

On June 14 this same fuel shipping cask, now empty, was received onsite. Surveys of the cask exterior identified smearable contamination levels of up to 124,000 disintegrations per minute (DPM) per 100 square centimeters (cm²) which were above the 10CFR 20.205 maximum levels of 22,000 DPM per 100 cm². An emergency notification system call was made to NRC Headquarters and the resident inspector informed of the issue. NMPC did not accept the cask from the cask owner due to the contamination problem, which appears to be a repeat of the weeping phenomenon. However, NMPC moved the rail car with the cask into the Unit 1 reactor building outer track bay in order to prevent any spread of contamination to the environment. NMPC did not detect any appreciable contamination on the rail car itself nor on the protective cage around the cask. NMPC performed well when confronted with this problem and was pursuing resolution of this issue with the cask owner. At the end of the inspection period the resident and regional specialist inspectors were continuing their review of this matter.

4.0 MAINTENANCE (62703)

4.1 Unit 1

4.1.1 Hydraulic Control Unit (HCU) Potential Wiring Deficiency

During the Regional Administrator's plant tour on May 22, the appropriateness of using wire nuts on electrical connections to the scram valve solenoids on the hydraulic control units (HCUs) was questioned. Additionally, a missing wire nut on one of the spliced connections for HCU 50-23 was observed, which left the potential for grounding of the circuit if the exposed wires



came in contact with the nearby metal frame. Both concerns were identified to the electrical maintenance supervisor who was in the tour area at the time. The inspector also notified the control room of the potential grounding concern. Immediate action was taken by Unit 1 maintenance to issue a work request to replace the missing wire nut and the condition was corrected. The inspector walked down the other HCUs to ensure that no other similar wiring deficiencies existed, none were identified. A deficiency event report (DER) was initiated so that an engineering evaluation of the appropriateness of these spliced connections in the HCU system can be determined.

4.1.2 Plant Tours

During tours of the turbine and reactor building, the inspector noted good overall housekeeping. Especially noteworthy was the decontamination effort, cleaning and painting of the 237 foot level in the reactor building. The HCUs and north hall areas have been decontaminated and are accessible without protective clothing. Additionally, progress continues to be made in the cleaning and painting of the corner rooms. The inspectors noted that these efforts were consistent with the NMPC goal of reducing total Unit 1 contaminated areas to less than 6%.

4.1.3 13 Feedwater Train Flow Control Valve Repairs

As a result of feed control valve problems, NMPC connected a temporary data acquisition system to various feedwater system parameters in an attempt to identify the specific cause of the abnormal valve operation. On June 6 further investigation identified that the 13 north feedwater control valve actuator internal snubber had failed. Reactor power was reduced so the valve could be isolated for repairs. The inspector determined from discussions with maintenance and engineering representatives that the operating internal hydraulic snubber (which dampens positioner movement to prevent overshoot) piston connecting pin sheared. Though the precise cause of the failure was still being investigated, the entire actuator was replaced on the north feedwater control valve and as a precaution the south feedwater control valve actuator was rebuilt. The inspector noted that the repair activity was properly controlled and that control room operators properly responded to the feedwater control valve malfunction and restored full reactor power without incident.

4.1.4 Feedwater Sensor Line Repairs

The inspector reviewed repair activities involving a sensing line leak on one of the east feedwater flow venturi differential pressure transmitters (FW-1090A). The steam/water leak was at the threaded connection of the sensing line to the weldolet and unisolable from the feedwater header. Once that section of the feedwater header was isolated and the leakage minimized, a fillet weld repair was made at the union. The inspector verified that an ASME Code repair was not required because the piping was less than one inch in diameter. The inspector discussed the weld repair with the responsible engineer and the maintenance personnel, who performed the repair, and identified no safety concerns.



4.2 Unit 2

4.2.1 Work Request Review

The inspector observed and reviewed selected portions of preventive and corrective maintenance to verify compliance with regulations, use of administrative and maintenance procedures, compliance with codes and standards, proper QA/QC involvement, and equipment alignment and retest. The following activities were included:

- Work request 190575, electrical preventive maintenance on the diesel generator building fan motor control center per procedure N2-EPM-GEN R580. During disassembly, the contactor plastic housing broke and required replacement. Another work request was utilized to replace the contactor assembly. The new contactor was installed and the preventive maintenance was completed. The inspector noted that the technicians performed the work in accordance with procedure and station requirements.
- Work request 184841, mechanical corrective maintenance on control rod drive pump 2RDS*P1B to replace the outboard pump bearing.
- Work request 159188, mechanical corrective maintenance on pump 2RDS*P1B to repair a leaking bearing and seal cooler inlet line tee mechanical joint.
- Work request 190788, instrument and control corrective maintenance to replace a suppression pool level transmitter. In response to NRC Bulletin 90-01 and industry experience, NMPC identified the zero and span readings of the transmitter were drifting during each successive calibration. A loop calibration was performed on the transmitter to confirm the concern. The transmitter was replaced. Supervisory oversight and quality control coverage was evident at the job site. This maintenance activity is an example of NMPC being proactive by the identification of a degraded level transmitter in response to industry experience.

No safety concerns were identified during the above maintenance observations.

4.2.2 Control of LCO Maintenance Activities

During review of maintenance activities, the inspector noted that planning for two safety related maintenance jobs which required entries into Technical Specification Limiting Conditions for Operations (LCOs), was not complete.

- Calibration of 2DER*FT123, drywell equipment drain flow rate transmitter. During the work planning stage, work on the termination module was identified which was to be followed by a routine calibration per procedure GENE-001. After the LCO was entered and the work was released for performance, the I&C supervisor identified that the work could not be done at the termination module, but would require valving out the



transmitter, to be followed by calibration by a different procedure (N2-ISP-DER-R101). A prerequisite in procedure N2-ISP-DER-R101 required the plant to be in Operational Condition 4 or 5. The job was stopped, the LCO was exited with no work done and the work request was recoded "outage." There was no safety significance resulting because, although the transmitter was declared inoperable for 8 hours, it had not been isolated and remained functional.

- Troubleshooting of oil leak on 2GTS*MOV2A standby gas treatment outlet isolation valve. Confusion over whether or not a markup was needed between instrument and controls and operations departments resulted in a delay of troubleshooting. This work was not issued until approximately two days into the LCO maintenance window. The inspector noted that there were other work requests being worked during this time so the confusion did not actually add to the length of time the LCO was entered.

The inspector discussed with plant management these isolated instances of unnecessarily entering LCOs for maintenance when the work activities were not ready to be performed. In response, the daily work schedule was modified to clearly identify LCO maintenance and safety related items are now discussed more thoroughly to ensure the scope of activity. The inspector had no further questions regarding this matter.

5.0 ENGINEERING AND TECHNICAL SUPPORT (71707)

5.1 Unit 1

5.1.1 (Closed) Unresolved Item 50-220/89-81-08: Inadequate Review of Document Change Requests

This item dealt with a number of open quality assurance department audit corrective action reports issued in April-July, 1989, involving the 11 primary concerns over the lack of safety evaluations pursuant to 10 CFR 50.59 for a large number of issued document change requests.

To address these issues NMPC engineering revised the applicable control procedures (design, engineering and licensing procedures) to ensure appropriate 10 CFR 50.59 evaluation for all design changes. These revisions were acceptable to the NMPC QA staff and the applicable corrective action reports were closed.

Inspector review of this unresolved item identified that many of the original engineering, design and licensing procedures governing the design change process had been superseded due to a procedure upgrade program. However, the inspector verified that the original corrective actions were reflected in the new governing procedures. This unresolved item was closed.



5.1.2 Review of Temporary Modification Logbook and Controls

During review of the Unit 1 temporary modification log the inspector determined that the logbook was being maintained in most cases per the requirements of Administrative Procedure (AP) 6.1, Control of Equipment Temporary Modifications. Technical reviews and safety analyses for several of the temporary modification packages were reviewed and found to be sound. However, the inspector did identify several minor administrative problems in that several modification packages did not contain all of the supporting documentation required by AP 6.1. Further, the quarterly logbook review by the NMPC staff, per AP 6.1, performed using procedure S-TDP-41, Review of Equipment Temporary Modifications, had identified several of the same issues during the most recent review in February of 1991. Actions to correct the deficiencies had not yet been completed. The inspector discussed this finding with the superintendent of the System Support and Testing group, the individual tasked to perform S-TDP-41. The superintendent stated that coincident with the inspector's review, his personnel were performing the second quarter's audit, and that any discrepancies identified from that audit would be corrected expeditiously this time. The inspector had no further questions on this matter.

5.2 Unit 2

5.2.1 Review of Final Disposition of Divesco, Inc. Supplied Electrical Components

The inspector conducted a verification of the final disposition of non-traceable molded case circuit breakers supplied by Divesco, Inc. to Unit 2. These breakers were the subject of NRC Bulletin 88-10. The inspector confirmed that all these breakers were removed from the site. The four that had been installed during construction (three in battery chargers 2BYS*CHGR2A1, 2C1 and 2C2 and one in power supply 2VBA*UPS2A) were replaced with traceable circuit breakers during the first refueling outage. These four plus the remaining breakers, which had been held in the warehouse, were transported to the NMPC resource recovery center and sold during the last auction. The inspector concluded that NMPC action to resolve this issue was appropriate.

6.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (71707)

6.1 Review of Licensee Event Reports and Special Reports

6.1.1 Unit 1

The following licensee event reports (LERs) were reviewed and found satisfactory:

- LER 91-01, Revision 1, reactor scram due to spurious non-coincident logic trip signal. This revision to the LER, initially reviewed in IR 50-220/91-06, was made to correct typographical errors and to the cause of event section of the LER to reflect the final version of the root cause evaluation performed for this event.



- LER 91-04, operation of Nine Mile Point 1 above maximum lake temperature of containment spray (CS) due to inadequate design basis and configuration control. This LER was generated as a result of the review and analysis of data obtained on CS heat exchangers performance conducted during and subsequent to the power ascension test program. As discussed in inspection reports 50-220/91-02 and 91-09, cleaning of the CS heat exchanger tubes was performed to improve their thermal performance. However, further engineering review of design assumptions and information in the FSAR and TS bases, identified discrepancies in assumed flow rates for torus water flow which affect the calculated heat removal capacity of the CS system. These problems have been identified and documented in several problem reports, and engineering calculations and analyses are being performed to resolve this issue. In the interim, safety evaluation 91-008, "Short Term Lake Temperature Limit to Assure Required Heat Removal Capacity of the Containment Spray System" , was issued on March 14, 1991, and administratively limited the maximum lake temperature for CS operability to 68.7°F, until cleaning of the heat exchangers and engineering evaluations were completed.

At the end of the report period, NMPC had completed initial phases of the engineering review. As a result of this review, performed per safety evaluation 91-023, revised limits were placed on maximum lake and torus temperatures. Based on these new, more conservative limits (as compared to the valves used in the original design basis), NMPC's engineering department determined that the potential had previously existed for the core spray system to have become inoperable due to insufficient net positive suction head for the core spray pumps. A 10CFR 50.72 notification for the identified concern was made on June 15.

- LER 89-14, Supplement 1, redundant safety systems inoperable due to the lack of a complete program to calibrate non-Technical Specification instrumentation. This supplement was issued to reflect further NMPC evaluations on the reactor building emergency ventilation system (RBEV) and the lessons learned from this event.
- LER 90-08, Supplement 1, RBEV initiation due to personnel error. The supplement was issued to reflect long-term corrective actions to evaluate replacement of motor generator sets (loss of which caused the RBEV initiation) with uninterruptible power supplies to provide a reliable power service along with evaluating the need to modify RBEV logic. Discussion of the excessive number of RBEV initiations, identified by the NRC, is located in IR 50-220/90-06. This supplement to the LER also contains the results of Niagara Mohawk's investigation into the excessive number of RBEV system initiations.
- LER 89-12, Supplement 1, reactor scrams and RBEV initiations due to design deficiency. This supplement is a general rewrite of the original LER and reflects the results of further investigations into the above events and the corrective actions taken and planned.



- LER 91-05, local leak rate tests exceed allowable limit.
- LER 91-06, containment H₂/O₂ monitor inoperable due to use of non-safety related gas. NMPC determined that these monitors were inoperable because hydrogen and oxygen gas used to continuously calibrate the instruments could not be verified to meet ANSI standards for safety related gasses. Although actual chemical analysis of the difference between the gasses used previously and the safety grade gasses was not conducted, the monitors were reading consistently before and after the use of the certified gas, indicating that the compositions were relatively close. NMPC stated that the main cause of this problem was the lack of control over a 1987 re-classification of the H₂/O₂ system as safety-related without upgrading the requirements of the calibration gases. NMPC took action to ensure that in the future if such a re-classification was conducted, a deviation event report would be written to ensure proper review of component/equipment re-classification.
- Special Report, dated April 22, 1991, concerning inoperability of suppression chamber water level channel 11 (failed downscale) caused by the lifting of a lead from a plant process computer card during authorized troubleshooting. Niagara Mohawk determined that the plant impact evaluation for the troubleshooting plan was inadequate in that it failed to identify that the suppression chamber water level instrument would be rendered inoperable. The instrument itself was inoperable for one hour and 35 minutes on April 9, 1991.

6.1.2 Unit 2

The following LERs were reviewed and found satisfactory:

- LER 91-05, reactor building isolation and initiation of standby gas treatment due to low flow signal caused by procedural deficiency. Details of this event were discussed in inspection report 50-410/91-06, section 1.2.2. The root cause was determined to be inadequate procedural controls. The inspector agreed with the root cause, however, poor briefing practices and communications with the operators was identified by the inspector. In response to this concern, NMPC trained all test directors to ensure that proper briefs are conducted. The lessons learned transmittal was reviewed and the inspector considered that the test control problems were not adequately documented. This was discussed with the manager of technical support who committed to review the transmittal. In summary, the NMPC investigation of this event was narrowly focused and the lessons learned transmittal did not adequately describe the control of testing problems. The plant manager agreed with the inspector concerns and stated the newly implemented deviation event report system should prevent similar problems. At the end of the inspection period NMPC management implemented the use of a pre-evolution briefing checklist and was reviewing an update to the lessons learned transmittal.
- LER 91-10, reactor core isolation cooling system isolation due to a spurious reactor building high area temperature signal. This event was described in inspection report 50-410/91-09, section 2.7.



6.2 Review of Site Operations Review Committee Meetings

On May 28 and June 19, the inspector attended a joint unit site operations review committee (SORC) and a Unit 1 SORC meeting, respectively. During the meetings, procedures and revisions to procedures were approved as well as various safety evaluations. The inspector verified that the proper SORC quorums were satisfied and the designated Technical Specification oversight/review functions were addressed. The discussions observed were thorough, effective and focused on safe operation of the plant. No concerns were identified.

7.0 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.

