

U. S. NUCLEAR REGULATORY COMMISSION

REGION I

REPORT NO: 93-27
DOCKET NO: 50-410
LICENSE NO: NPF-69
LICENSEE: Niagara Mohawk Power Corporation
301 Plainfield Road
Syracuse, NY 13212
FACILITY: Nine Mile Point, Unit 2
INSPECTION AT: Oswego, NY
DATES: November 29 to December 3, 1993
INSPECTORS: S. L. Hansell, Operations Engineer
J. H. Williams, Senior Operations Engineer

LEAD INSPECTOR:

J. H. Williams for

12/22/93

J. H. Williams, Sr. Operations Engineer Date
BWR Section, Operations Branch
Division of Reactor Safety

APPROVED BY:

Richard J. Conte

12/22/93

Richard J. Conte, Chief Date
BWR Section, Operations Branch
Division of Reactor Safety



Inspection Summary: Inspection on November 29 to December 3, 1993 (Report No. 50-410/93-27)

Areas Inspected: The inspection was in the area of plant operations. The objective was to ensure that the facilities' operations department conducted activities in a safe manner and in accordance with both regulatory requirements and licensee-approved procedures.

Results: The inspectors found no significant safety issues during this inspection. A few minor performance errors were noted and brought to the attention of appropriate personnel. The problems were quickly corrected. Control room operations were orderly and plant evolutions were smooth. Operators used procedures when necessary and appeared to have an appropriate attitude towards safety. Shift turnovers were effective and shift briefings were meaningful.

The material conditions in the reactor building was good, especially for a plant coming out of an outage.

Two issues that were opened in previous inspection reports were reviewed and closed. One issue was a violation associated with an inadequate ADS procedure. The second issue dealt with the review and revision of the written question exam bank for requalification training.



DETAILS

1.0 PURPOSE OF INSPECTION

The primary objective was to ensure that the facility's operations department conducted activities in a safe manner and in accordance with both regulatory requirements and licensee approved procedures. The inspection was performed in accordance with NRC Inspection Procedure IP 71715. In accordance with IP 92701 and IP 92702, a second objective was to review the corrective actions associated with a procedure violation (410/93-14-01) and those associated with an inspector follow item (410/92-23-01).

2.0 SUMMARY OF PLANT ACTIVITIES

Nine Mile Point, Unit 2, was starting up from a refueling outage and was at 25%-rated thermal power when the inspection began. Plant evolutions to bring the unit to full-rated thermal power occurred during the week of the inspection.

3.0 REVIEW OF FACILITY OPERATIONS

3.1 Scope

Because this was a performance-based inspection, the inspectors spent most of their time in the control room observing operator performance. The observations were made during the day and evening shifts. The inspectors reviewed work in progress, observed operator response to plant equipment malfunctions, reactivity manipulations, shift turnovers, logkeeping, control room management, and inspected the overall condition of the plant.

3.2 Findings

3.2.1 Control Room Observations

Operators were attentive and responsive to plant parameters and conditions. Before major evolutions, the operators reviewed the appropriate procedure. During the evolution, one operator read the procedure to a second operator who performed the task. Shift supervision observed the activities.

The inspectors reviewed and observed the implementation of the plant start-up procedure. The procedure N2-OP-101A, "Plant Start-up," was comprehensive and contained detailed information to ensure an orderly plant startup. The operators followed the procedure and performed each step in the proper sequence. The shift supervision ensured the plant startup progressed at a controlled and manageable pace.

Annunciators were generally responded to in a cautious manner. However, during shift turnover briefings, the annunciators were often silenced by a licensed operator other than the operator at the controls. This practice could cause the responsible operator to lose track of plant status and does not conform to the operator good practices described in N2-ODI-5.08. Discussions with the licensee indicated that they were already reviewing shift turnover practices for areas of improvement.



Nonroutine plant evolutions appeared to be well planned and included preevolution briefings. When the evolution of upshifting the recirculation pump speed had to be repeated because of a faulty minimum flow valve, the briefing was repeated to ensure the information was fresh in the operators' minds.

The inspectors reviewed the control room operators' logs. The logs were readable and accurately reflected plant activities and status.

The inspectors observed the control room environment. The environment was adequate for the conduct of activities, but at times the control room became crowded. Shift management was sensitive to overcrowding and took steps to reduce the number of people in the control room when appropriate. At no time was the area around the control panels overcrowded.

Two shift turnovers were observed by the inspectors. The turnovers were thorough and professional and provided oncoming shift personnel with adequate information on plant condition. Shift briefings were meaningful and provided a good forum for crew discussions about plant activities.

The administrative work load is spread among the shift supervisor, his assistant, and the chief shift operator. This appears to prevent any one person on shift from being overburdened with administrative tasks.

Reactivity manipulations were performed by licensed operators or appropriate trainees under the direction and observation of a licensed operator. When a trainee placed a control rod in the wrong position, even though it was quickly identified, the licensee stopped all training on the reactor to investigate and determine the root cause of the event. The investigation was ongoing at the conclusion of this inspection and was being followed by the resident inspectors.

The inspectors reviewed the tagging associated with three main steam line steam tunnel temperature trip unit switches (E31-N622D, E31-N623D and E31-N624D). The shift technical advisor was questioned about these out of service temperature trip units, and it was determined that the trip units were spares. They were part of a modification to investigate their performance for possible future use. The shift technical advisor demonstrated adequate knowledge of plant equipment status and tagging procedures.

No technical specification limiting condition for operation (LCO) was identified beyond those already identified by the licensee.

3.2.2 In-Plant Observations

The inspectors toured plant facilities to observe equipment and material condition. No work in progress was noted during these tours.

The licensee has provided a safe working environment in the reactor building. All elevations of the reactor building were maintained in a clean condition. No tools, spare parts, or trash



was observed to be lying around in the building. The inspectors noted that there was not much scaffolding set up in the reactor building. All work areas were well lighted. Radiation and contamination areas were clearly marked.

Plant equipment was clearly labeled and maintained in good working order. The inspectors observed few fluid leaks while touring the plant. The inspectors noted that a portable pump used for the emergency operating procedures was chained to a pipe rather than a support structure. Also, the inspectors noted a fire watch sign off sheet was marked for unit 1 by mistake and a 55 gallon drum with paper trash in it inside a zone where combustible material could not be stored. When these conditions were brought to the licensee's attention, they were quickly corrected.

3.3.3 Summary of Conclusions

The inspectors found no significant safety issues during this inspection. A few minor performance errors were noted and brought to the attention of appropriate personnel. The problems were quickly corrected. Control room operations were orderly and plant evolutions were smooth. Operators used procedures when necessary and appeared to have a positive attitude towards safety. Shift turnovers were effective and shift briefings were meaningful.

The material condition in the reactor building was good, especially for a plant coming out of an outage.

4.0 LICENSEE ACTIONS ON PREVIOUS INSPECTION FINDINGS

4.1 (Closed) Violation (410/93-14-01): Inadequate Procedure

Operating procedure OP-71D, "Uninterruptible Power Supplies," was changed and not reviewed for adequacy in that the procedure would have permitted both logic trains of the Automatic Depressurization System (ADS) to be made inoperable during the restoration of one electrical power supply train.

The inspector reviewed the licensee's response to the Notice of Violation. The licensee addressed the specific procedure problem immediately. An immediate Procedure Change Evaluation (PCE) was issued to remove the procedure option of inhibiting ADS during restoration of the uninterruptible power supply (UPS) 2B electrical loads. The inspector verified that the current revision of procedure OP-71D no longer contains the option to disable both logic trains of the ADS.

The licensee also conducted individual technical reviews of recently revised procedures to address the inadequate procedure review activities and associated management oversight. The management expectations for procedure review and preparation were reinforced with the Qualified Technical Reviewers. In addition, the Operations Department management emphasized that the safety and quality of work have priority above the schedule demands.

The inspector reviewed the operations support staff's independent technical review of 21 procedures, which were recently revised and issued. The review sampled one procedure for



each Qualified Technical Reviewer. The review was performed to determine the technical adequacy of the procedures and to verify that personnel correctly performed the technical verification and validation. No technical errors were identified. An independent Quality Assurance (QA) audit of the recently upgraded procedures also noted that the procedures were technically correct.

The plant response was thorough and looked beyond the specific procedure problem and addressed the apparent root cause for the violation. Based on the above information this item is closed (410/93-14-01).

4.2 (Closed) Inspector Followup Item (410/92-23-01): Examination Bank Review/Revision

This item deals with the facility's section B requalification examination bank. Because of the number of changes made to questions for the NRC Requalification Exam, the facility committed to review the question bank and upgrade the bank as necessary. The licensee conducted a root cause analysis and developed a plan of action for this activity. A procedure was written (OTG Guideline 93-01) to provide guidance on the format and complexity of written examination questions. The inspectors reviewed the root cause analysis, plan of action, OTG Guideline 93-01, and about 200 questions from the exam bank. The inspectors also discussed the exam bank with licensee training personnel. Based upon this review, the inspectors determined that most of the questions in the bank were at the comprehension cognitive level. The facility procedure requires that each question be reviewed prior to use on an exam. The inspectors determined that the facility had met their commitment and this item is closed (410/92-23-01).

4.3 Summary of Conclusions

Two issues that were opened in previous inspection reports were reviewed and closed. One issue was a violation associated with an inadequate procedure. The second issue dealt with the review and revision of the written question exam bank for requalification training. Corrective actions were appropriate to the circumstances.

5.0 EXIT MEETING

The inspectors met with licensee representatives identified below at the conclusion of the inspection on December 3, 1993. The inspectors summarized and discussed the findings and observations made during the inspection.

Niagara Mohawk

Allen Zallnick, Supervisor Site Licensing
Glen Bridges, Training Specialist
John Conway, Operations Manager, Unit 2
John Mueller, Plant Manager, Unit 2



U.S. Nuclear Regulatory Commission

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