

# CATEGORY 1

## REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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FACIL:50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moha 05000410  
AUTH.NAME .. AUTHOR AFFILIATION  
BOSNIC,D. Niagara Mohawk Power Corp.  
DAHLBERG,K.A. Niagara Mohawk Power Corp.  
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 97-009-00:on 970827,determined failure to include control bldg relay room in surveillance.Caused by inadequate technical review.Revised surveillance procedure re testing of control bldg relay room & completed testing.W/970926 ltr.

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NIAGARA MOHAWK

GENERATION  
BUSINESS GROUP

NINE MILE POINT NUCLEAR STATION/LAKE ROAD, P.O. BOX 63, LYCOMING, NEW YORK 13093

September 26, 1997  
NMP2L 1728

United States Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555

RE: Docket No. 50-410  
LER 97-09

Gentlemen:

In accordance with 10CFR50.73 (a)(2)(i)(B), we are submitting LER 97-09, "Missed Technical Specification Surveillance of the Control Room Envelope."

Very truly yours,

Kim A. Dahlberg  
Plant Manager - NMP2

KAD/GJG/cmk  
Attachment

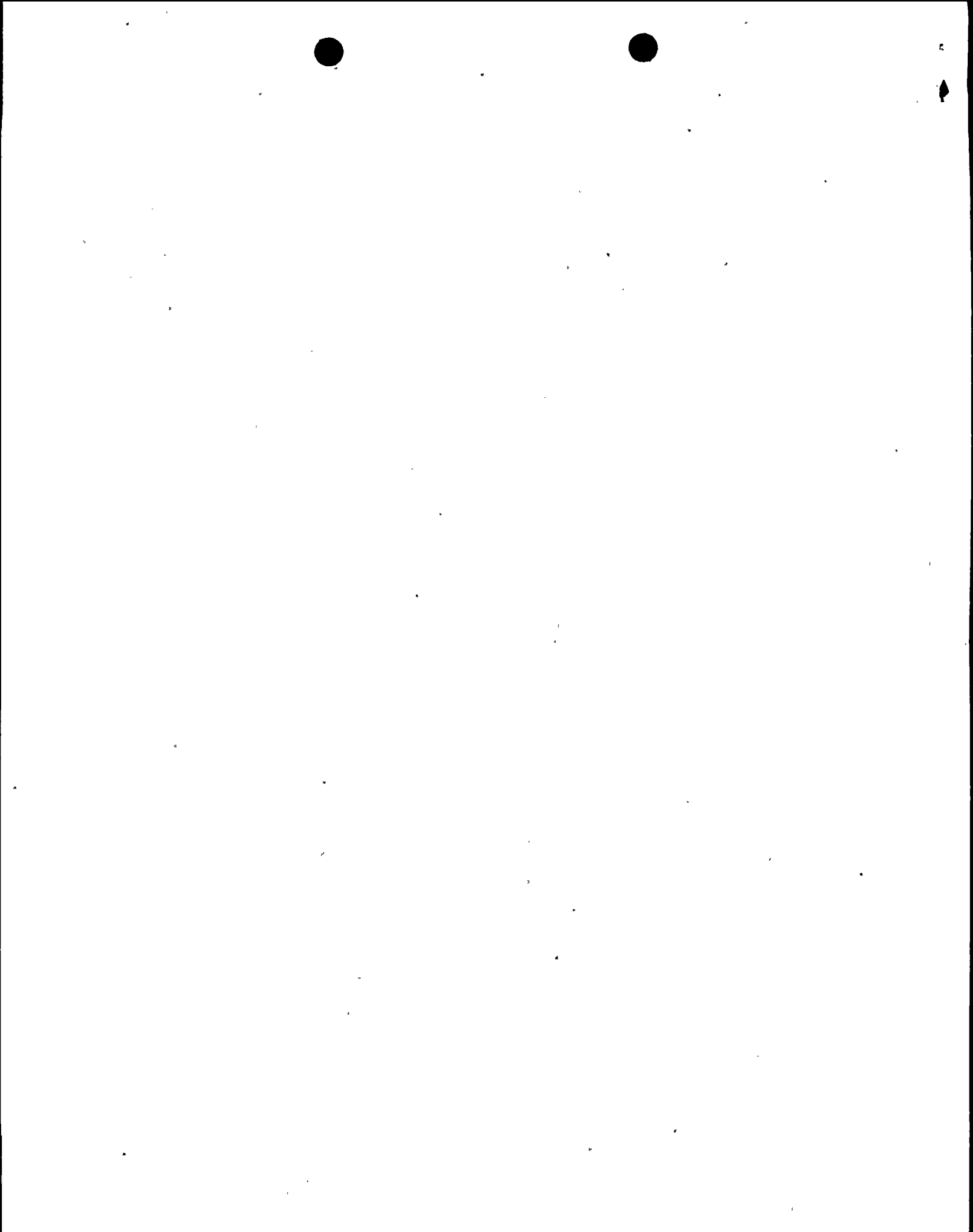
xc: Mr. H. J. Miller, Regional Administrator, Region I  
Mr. B. S. Norris, Senior Resident Inspector  
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-330), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

FACILITY NAME (1) Nine Mile Point Unit 2	DOCKET NUMBER (2) 05000410	PAGE (3) 1 OF 4
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TITLE (4)  
Missed Technical Specification Surveillance of the Control Room Envelope

EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)	
08	27	97	97	009	00	09	26	97	N/A	05000	
									N/A	05000	

OPERATING MODE (9) 1 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

POWER LEVEL (10) 95	<input type="checkbox"/> 20.402(b) <input type="checkbox"/> 20.405(a)(1)(i) <input type="checkbox"/> 20.405(a)(1)(ii) <input type="checkbox"/> 20.405(a)(1)(iii) <input type="checkbox"/> 20.405(a)(1)(iv) <input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c) <input type="checkbox"/> 50.36(c)(1) <input type="checkbox"/> 50.36(c)(2) <input checked="" type="checkbox"/> 50.73(a)(2)(i) <input type="checkbox"/> 50.73(a)(2)(ii) <input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(iv) <input type="checkbox"/> 50.73(a)(2)(v) <input type="checkbox"/> 50.73(a)(2)(vii) <input type="checkbox"/> 50.73(a)(2)(viii)(A) <input type="checkbox"/> 50.73(a)(2)(viii)(B) <input type="checkbox"/> 50.73(a)(2)(x)	<input type="checkbox"/> 73.71(b) <input type="checkbox"/> 73.71(c) <input type="checkbox"/> OTHER <small>(Specify in Abstract below and in Text, NRC Form 366A)</small>
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LICENSEE CONTACT FOR THIS LER (12)

NAME Don Bosnic - Manager Operations Unit 2	TELEPHONE NUMBER (315) 349-7952
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14) <input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limits to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On August 27, 1997, Niagara Mohawk (NMPC) determined that the surveillance test which had been performed to meet Surveillance Requirement (SR) 4.7.3.e.2 of the Nine Mile Point Unit 2 (NMP2) Technical Specifications (TS) did not appropriately include testing of the control building relay room, which is included in the control room envelope as described in the NMP2 Updated Safety Analysis Report (USAR) Section 6.4.2. In addition, it was determined that the procedure did not test the redundant air conditioning units (ACU) in the required lineups.

The cause of failure to include the control building relay room in the surveillance and not test the system in the required ACU alignments has been determined to be inadequate technical review.

Both divisions of the control room outside air special filter train were declared inoperable. TS limiting condition for operations (LCO) 3.0.3 was entered but actions were delayed based upon TS SR 4.0.3. The surveillance procedure was revised to incorporate testing of the control building relay room and verification of ACU alignments. Testing was completed and the control room outside air special filter trains were declared operable.



LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 30.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-330), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Nine Mile Point Unit 2	05000410	97	09	00	02 OF 04

TEXT (If more space is required, use additional NRC Form 366A's) (17)

## I. DESCRIPTION OF EVENT

On August 27, 1997, Niagara Mohawk determined that the surveillance test which had been implemented to meet Surveillance Requirement (SR) 4.7.3.e.2 of the Nine Mile Point Unit 2 (NMP2) Technical Specifications (TS) had not appropriately included testing of all areas considered to be within the control room envelope. Operations surveillance procedure N2-OSP-HVC-R001 (Control Room Outside Air Special Filter Train Functional Test) only verified that a positive 0.125 inch water gauge (WG) pressure was maintained in the control room. The control building relay room differential pressure had not been verified. In addition, since the ACUs provide some of the driving force to pressurize the Control Building, the surveillance did not demonstrate operability for all possible ACU alignments.

Immediately upon discovery of the missed surveillance, operations entered TS LCO 3.0.3. TS SR 4.0.3 was applicable, which allows actions to be delayed 24 hours for completion of the surveillance. Procedure N2-OSP-HVC-R001 was revised to include verification of the relay room differential pressure. The surveillance was performed on both divisions of control room outdoor air special filter trains. Division II successfully met the SR, but Division I failed to meet the SR. Since one control room filter train was operable, TS 3.0.3 and SR 4.0.3 were exited and TS 3.7.3 Action Statement "a" was entered, which allows seven days for repair. A one time only procedure change was then made to adjust balancing damper 2HVC\*DMPV84. Surveillance procedure N2-OSP-HVC-R001 was reperformed on the Division I control room filter train which then successfully met the SR. The Division II control room filter train was then retested to verify that the SR was still met. On September 1, 1997, both trains were declared operable.

## II. CAUSE OF EVENT

The cause of the failure to include the control building relay room in procedure N2-OSP-HVC-R001 has been determined to be inadequate technical review. A contributing factor is that NMP2 TS SR 4.7.3.e.2 requires that the "control room is maintained at a positive pressure of 0.125 inch WG relative to the outside atmosphere during subsystem operation at an outside air intake flow rate less than or equal to 1500 cfm." Previous reviewers did not interpret this to mean "control room envelope."

The failure to test all possible ACU alignments has also been determined to be inadequate technical review. When N2-OSP-HVC-R001 was developed and revised, personnel did not understand that the ACUs provide some of the pressurization to meet SR 4.7.3.e.2. Previously, personnel believed that pressurization was provided by the special filter train fans alone, and that the operation of the ACU was therefore not critical to demonstrating compliance with this SR.



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LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATIONESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION  
REQUEST: 30.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE  
RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY  
COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT  
(3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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Nine Mile Point Unit 2	05000410	97	- 09	- 00	03 OF 04

TEXT (If more space is required, use additional NRC Form 366A's) (17)

**III. ANALYSIS OF EVENT**

This event is reportable in accordance with 10CFR50.73 (a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications". TS SR 4.7.3.e.2 requires that at least once per 18 months, operability of the control room outdoor air special filter trains be demonstrated by verifying that the filter trains automatically switch to the emergency pressurization mode of operation and the control room is maintained at a positive pressure of 0.125 inch WG relative to the outside atmosphere during subsystem operation at an outside air intake flow rate less than or equal to 1500 cfm. This SR had not been demonstrated for the control building relay room.

The results of the initial surveillance performed on August 27, 1997 for the combined control room and relay room were as follows:

	Control Room (inches WG)	Relay Room (inches WG)
Fan 2A (Division I)	0.25	0.10
Fan 2B (Division II)	0.30	0.15 - 0.175

As can be seen from these results, the control room and relay room were both at a positive pressure for both divisions. However, the relay room did not meet the acceptance criteria of 0.125 inch WG for Division I.

The purpose of maintaining the control room envelope at a positive pressure is to prevent infiltration of radioactivity or other harmful gases into the control room environment. Even though the Division I control room filter train did not meet the acceptance criteria, the initial surveillance demonstrated that a positive pressure was attained which would have prevented infiltration. Therefore, this missed SR did not pose a threat to the health and safety of the public or NMP2 plant personnel.

**IV. CORRECTIVE ACTIONS**

- TS 3.0.3 was entered, but actions were delayed as allowed by SR 4.0.3. Procedure N2-OSP-HVC-R001 was revised to include verification of the relay room differential pressure and assure that required ACU lineups are verified. Adjustments were made to balancing damper 2HVC\*DMP8A and both divisions of the control room special filter trains were successfully tested and declared operable.
- This event will be reviewed in operator requalification training by February 28, 1998.



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LICENSEE EVENT REPORT (LER)  
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**IV. CORRECTIVE ACTIONS (cont'd)**

In addition, since the deficiencies which initiated this event occurred prior to 1994, previously implemented actions to address instances of inadequate managerial methods, relative to technical procedure preparation and review, are also applicable to this event. Specifically, a corrective action described in LER 94-003:

An inadequate technical review has been recognized in the past as being one of the major reasons for violating specific requirements. Niagara Mohawk has upgraded specific programs whose purpose is not only to ensure that adequate procedures are written, but also to ensure the review of these procedures is carried out in a manner that should eliminate events such as these. These include, but are not limited to, the following procedurally controlled programs:

- NIP-SEV-01, Applicability Reviews and Safety Evaluations
- NIP-PRO-03, Preparation and Review of Technical Procedures
- PWM-PRO-0105, Technical Procedure Verification and Validation

**V. ADDITIONAL INFORMATION**

A. Failed components: none.

B. Previous similar events: NMP2 has had a number of instances where inadequate procedure preparation or review caused missed or inadequately performed surveillance tests. As a result of previous events, enhancements were made to the procedure preparation, review, and issue process with the implementation of Nuclear Division Interface Procedure, NIP-PRO-03, "Preparation and Review of Technical Procedures." This event and those discussed in LERs 94-05, 96-01, 96-02, 96-07, 97-01, and 97-07 involved problems with past-practice identified by personnel involved in procedure review activities. Since this event occurred prior to the corrective actions taken for these similar events, it could not have been prevented by these corrective actions. In addition, in a letter from Mr. R. B. Abbott dated November 22, 1996 in response to Inspection Report 96-07, NMPC provided a status of NMP2 surveillance procedure review efforts. The attachment to that letter outlined our efforts to convert the NMP2 TS to the Improved Standard Technical Specifications. The missed SR reported in this LER was identified by the NMPC staff preparing those amendments.

C. Identification of components referred to in this LER:

COMPONENT	IEEE 803 FUNCTION	IEEE 805 SYSTEM ID
2HVC*DMPV84	DMP	VI

