

CATEGORY 1

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 AUTH. NAME AUTHOR AFFILIATION
 BOSNIC, D. Niagara Mohawk Power Corp.
 DAHLBERG, K.A. Niagara Mohawk Power Corp.
 RECIP. NAME RECIPIENT AFFILIATION

SUBJECT: LER 97-012-00: on 970922, missed TS surveillance of control bldg relay room temp occurred. Caused by inadequate technical review. Operations procedures revised. W/971021 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

October 21, 1997
NMP2L 1732

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

RE: Docket No. 50-410
LER 97-12

Gentlemen:

In accordance with 10CFR50.73 (a)(2)(i)(B), we are submitting LER 97-12, "Missed Technical Specification Surveillance of the Control Building Relay Room Temperature."

Very truly yours,

Kim A. Dahlberg
Plant Manager - NMP2

KAD/GJG/lmc
Attachment

xc: Mr. H. J. Miller, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Records Management

9710310011 971021
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LICENSEE EVENT REPORT (LER)

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 (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

TITLE (4)

Missed Technical Specification Surveillance of the Control Building Relay Room Temperature

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)
09	22	97	97	012	00	10	21	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(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> OTHER
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	(Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

Don Bosnic - Manager Operations Unit 2

TELEPHONE NUMBER

(315) 349-7952

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)

NO

EXPECTED SUBMISSION DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limits to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On September 22, 1997, Niagara Mohawk Power Corporation (NMPC) determined that the surveillance test which had been performed to meet Surveillance Requirement (SR) 4.7.3.a of the Nine Mile Point Unit 2 (NMP2) Technical Specifications (TS) did not appropriately include verification of the Control Building Relay Room temperature, which is included in the control room envelope as described in the NMP2 Updated Safety Analysis Report (USAR) Section 6.4.2. This condition existed from initial operation of NMP2 to September 30, 1996 when shiftly surveillance procedures were revised to verify relay room temperature as a result of the disposition of Deviation/Event Report (DER) 2-96-2348.

The cause of the failure to include the Control Building Relay Room temperature in the surveillance of the control building has been determined to be inadequate technical review. The cause of not identifying this event as reportable when DER 2-96-2348 was dispositioned is inadequate written communication.

No immediate corrective actions were required since procedures have been previously revised to verify and log Control Building Relay Room temperature.



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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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-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)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Nine Mile Point Unit 2	05000410	97	- 12	- 00	02 OF 04

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

I. DESCRIPTION OF EVENT

On September 22, 1997, Niagara Mohawk Power Corporation (NMPC) determined that the surveillance test which had been implemented to meet Surveillance Requirement (SR) 4.7.3.a of the Nine Mile Point Unit 2 (NMP2) Technical Specifications (TS) had not appropriately included temperature verification of the required areas considered to be within the control room envelope prior to September 30, 1996. Operations surveillance procedures had only verified that temperature was less than or equal to 90°F in the control room.

Prior to the receipt of the NMP2 Initial License, in 1986, the control room ambient temperature limit in TS SR 4.7.3.a was proposed to be 104°F. The NRC was concerned with that ambient temperature limit since internal panel temperatures could potentially affect the operability of safety-related electronic equipment in these panels. On October 24, 1986, NMPC submitted a letter proposing to lower SR 4.7.3.a to 90°F and committed to perform confirmatory testing to determine the internal temperature rise within the safety-related control room panels. Therefore, the initial review of confirmatory testing was limited to panels located in the control room. Subsequently, panels within the relay room were also included in the confirmatory testing as the relay room panels were similar in design to the control room panels. Accordingly, on December 18, 1986, NMPC provided the results of the confirmatory testing which had been completed for the control room and relay room. The conclusion of the December 18, 1986 response was that the 90°F limit assures that the 120°F maximum internal panel temperature will not be exceeded.

NMPC personnel involved in the 1986 discussions and correspondence, recall that the interpretation of NMPC was that the NRC's concern was with the control room and not the relay room. NMPC decided to perform confirmatory testing on both the control room and relay room panels as a matter of prudence. Therefore, the resulting documentation was unclear with regard to that SR. For example, NMP2 USAR Table 9.4-1, "Environmental and System Design Parameters for HVAC Systems," lists both the control room and relay room and has separate footnotes regarding the design maximum temperature. The footnote associated with the control room clearly indicates that TS 3/4.7.3 applies, whereas, the relay room footnote does not specify any TS requirement. In addition, the Staff's "Safety Evaluation Report related to the operation of Nine Mile Point Nuclear Station, Unit No. 2" NUREG-1047, Supplement 5, Section 7.9, describes the confirmatory test as related to the control room panels.

On September 30, 1996, Deviation/Event Report (DER) 2-96-2348 was initiated by NMPC personnel to identify that the relay room temperatures were not being tested. The DER disposition incorrectly concluded that the relay room temperature verification was not required to meet TS SR 4.7.3.a and therefore, was not reportable in accordance with 10CFR50.73. The conclusion of that DER was based upon the discrepancies in the licensing basis information described above. As a conservative action, the operations procedures were revised on September 30, 1996 to include relay room temperature verification and logging. Therefore, NMPC has been in compliance with the TS SR 4.7.3.a since September 30, 1996.



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LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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 (150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Nine Mile Point Unit 2	05000410	97	- 12	- 00	03 OF 04

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

II. CAUSE OF EVENT

The cause of the failure to include the Control Building Relay Room temperature in surveillance procedures has been determined to be inadequate technical review. The surveillance procedures were developed prior to the license bases correspondence described in Section I above, and based on the wording in TS SR 4.7.3.a that requires "that the control room air temperature is less than or equal to 90°F." Previous reviewers did not interpret this to mean "control room envelope," which includes the control room and relay room.

The cause of the incorrect disposition of DER 2-96-2348 is inadequate written communication. As discussed in Section I, the NMP2 USAR, NMP2 TS and related correspondence between NMPC and NRC failed to clearly define the control room SR.

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."

NMPC developed administrative guidance which described actions required for inoperable unit coolers. Since the initial issuance of that guidance on February 20, 1987, all relay room and control room coolers were required to be operable or actions consistent with the TSs were to be taken. This administrative guidance was incorporated into an operations procedure. Therefore, adequate cooling has been provided to the relay room, or a shutdown would have been required.

Since operations surveillance procedures were revised on September 30, 1996, data for the control room and relay room have been verified and logged to meet SR 4.7.3.a. NMPC has sampled that data and determined that the temperatures recorded are generally lower in the relay room than the control room and are lower than 75°F. Therefore, it is reasonable to assume that prior to September 30, 1996, similar conditions existed. The design of the air conditioning systems for the control building have not changed over that period.

Operators also perform shiftly rounds in the Control Building Relay Room, and temperatures in excess of 90°F would have been identified. Furthermore, a trip of a cooler in the relay room would be annunciated in the control room and thereby alert the operator to a loss of cooling for the relay room panels. Finally, the relay room coolers return duct has a high temperature alarm of 80°F. Accordingly, NMPC is confident that the temperature in the relay room has not exceeded 90°F. Based upon the requirements of the administrative guidance, shiftly rounds and the high temperature alarm, the missed SR did not pose a threat to the health and safety of the public or NMP2 plant personnel.



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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-330), U.S. NUCLEAR REGULATORY
COMMISSION, WASHINGTON, DC 20535, 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)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Nine Mile Point Unit 2	05000410	97	- 12	- 00		04 OF 04

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

IV. CORRECTIVE ACTIONS

- Operations procedures were revised on September 30, 1996 to include the verification and logging of Control Building Relay Room temperature.
- This event will be reviewed in operator requalification training by February 28, 1998.
- An LDCR has been initiated to revise the NMP2 USAR Table 9.4-1.
- The NMP2 Improved Technical Specifications (ITS), currently being drafted, will accurately define this TS and its Bases.

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

- Failed components: none.
- Previous similar events: LER 97-09, "Missed Technical Specification Surveillance of the Control Room Envelope" describes that the surveillance test which had been performed to meet SR 4.7.3.e.2 of the NMP2 TS did not appropriately include testing of the Control Room Building Relay Room. Personnel who had dispositioned DER 2-96-2348 identified that the deviation described in that DER was similar to that in LER 97-09. Therefore, personnel reevaluated this deviation and determined that control room should have been interpreted to mean the control room envelope and that the original disposition was not appropriate. Therefore, LER 97-09 resulted in the initiation of this LER.
- Identification of components referred to in this LER: N/A

100-100