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MUELLER, J.H. Niagara Mohawk				
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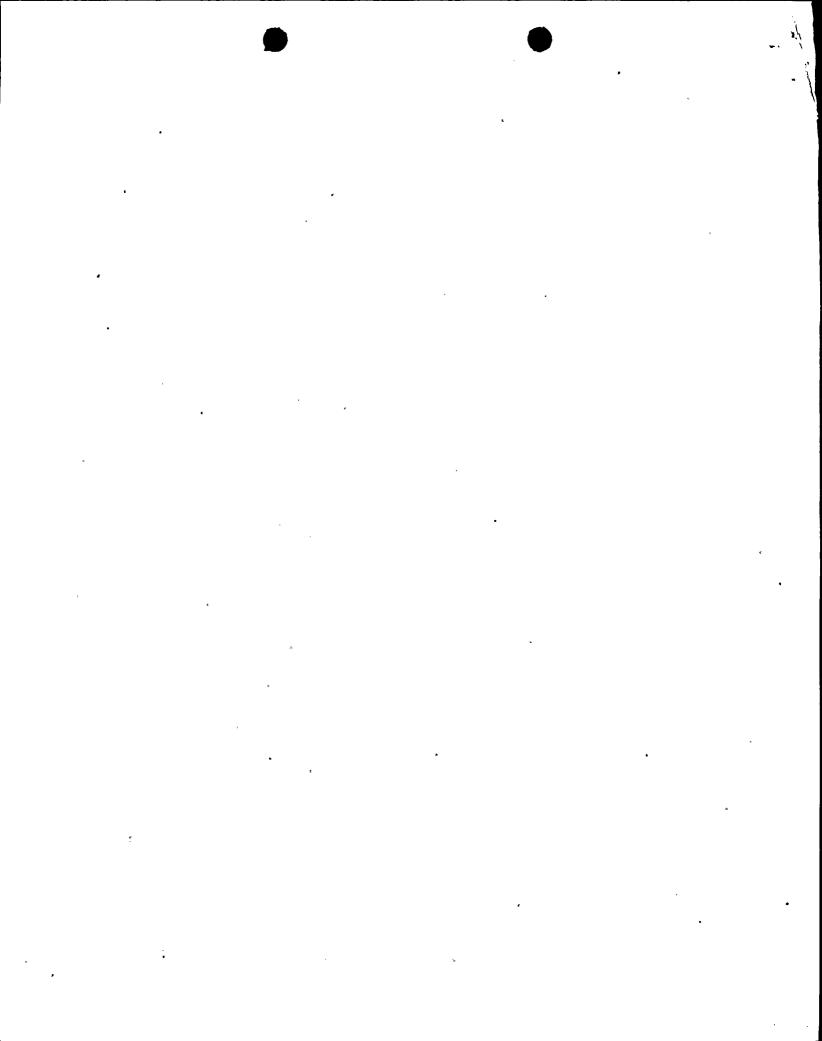
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Mr. John H. Mueller
Chief Nuclear Officer
Niagara Mohawk Power Corporation
Nine Mile Point Nuclear Station
Operations Building, 2nd Floor
P.O. Box 63
Lycoming, NY 13093

Dear Mr. Mueller:

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - NINE MILE POINT UNITS 1 AND 2

On April 28, 1998, the NRC staff completed the semiannual Plant Performance Review (PPR) of Nine Mile Point (NMP). The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for NMP involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period October 1997 to April 1998. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC Systematic Assessment of Licensee Performance (SALP) and senior management meeting (SMM) reviews.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and Niagara Mohawk Power Corporation. The PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the NMP PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. Resident inspections are not listed due to their ongoing and continuous nature.

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John H. Mueller

We will inform you of any changes to the inspection plan. If you have any questions, please contact me at (610) 337-5378.

Sincerely,

Original Signed by:

Lawrence T. Doerflein, Chief Projects Branch 1 Division of Reactor Projects

Docket Nos. 50-220

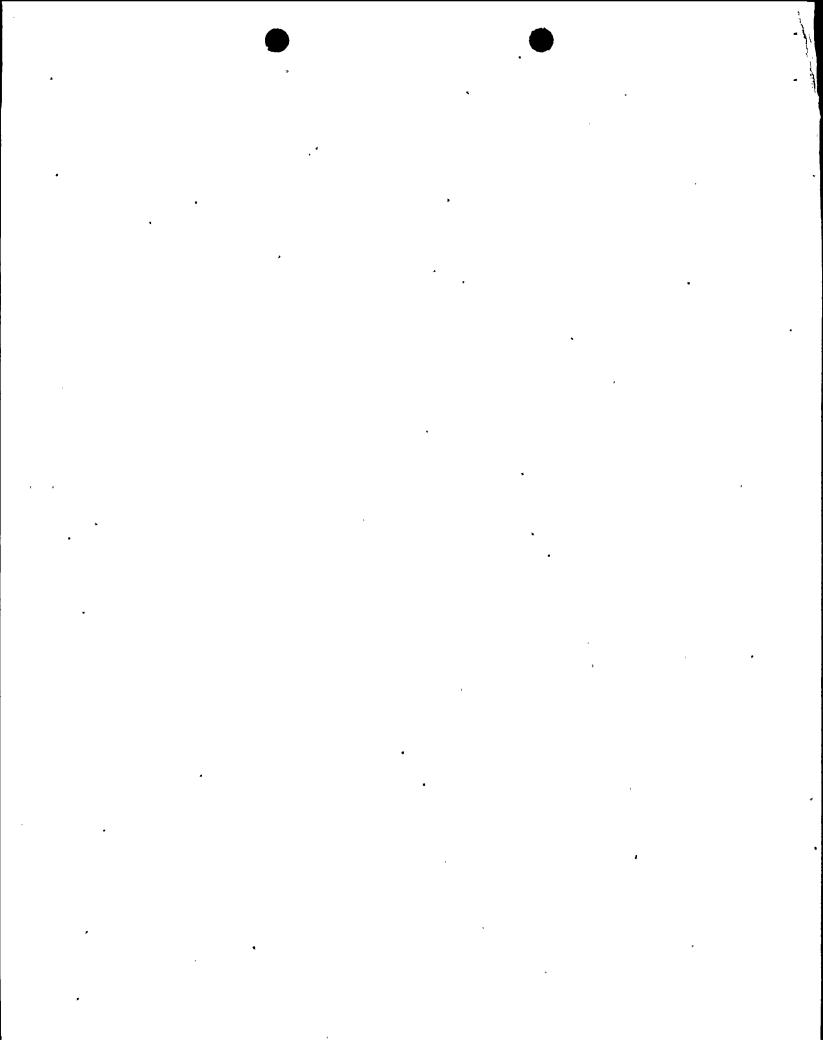
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#### **Enclosures:**

- 1. Plant Issues Matrix
- 2. Inspection Plan

#### cc w/encls:

- G. Wilson, Senior Attorney
- M. Wetterhahn, Winston and Strawn
- J. Rettberg, New York State Electric and Gas Corporation
- P. Eddy, Electric Division, Department of Public Service, State of New York
- C. Donaldson, Esquire, Assistant Attorney General, New York Department of Law
- J. Vinguist, MATS, Inc.
- F. Valentino, President, New York State Energy Research and Development Authority .
- J. Spath, Program Director, New York State Energy Research and Development Authority



John H. Mueller

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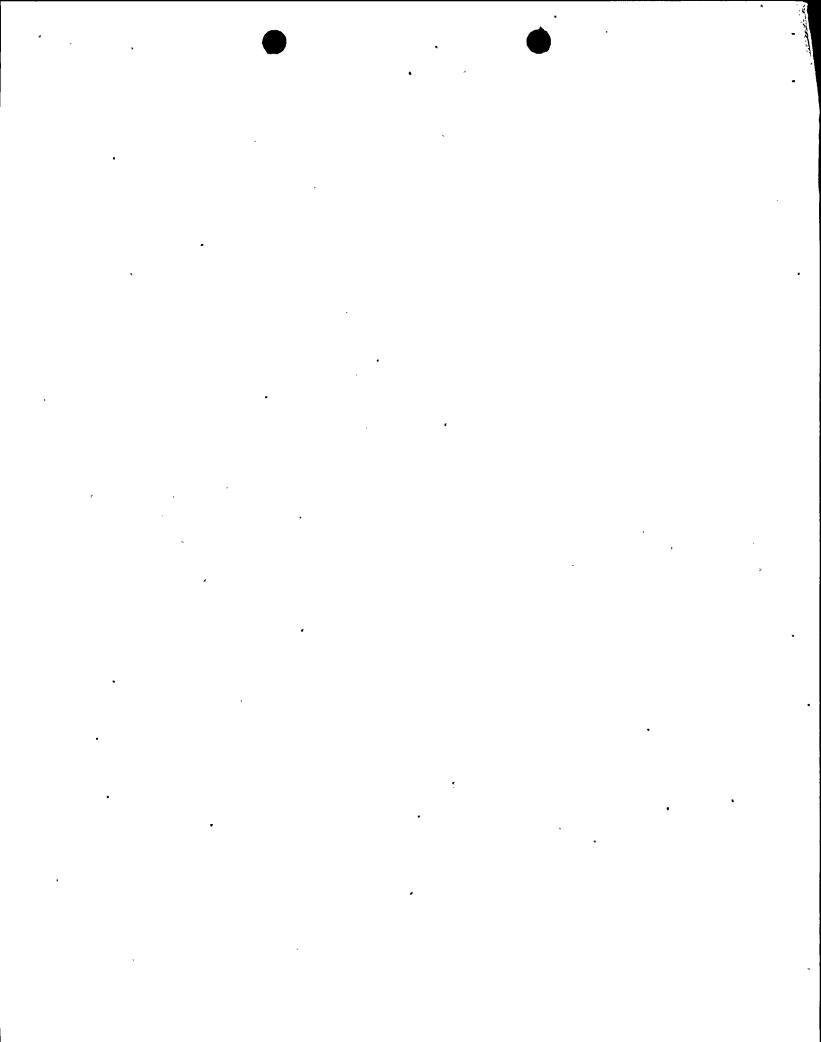


NINE MILE 1 & 2 PLANT ISSUES MATRIX

Date	Турв	Source	ID	SFA	Code	Item Description
2/14/98 713	Negative	IR 98-01 ·	N	1-OPS	2B 5A	The quarterly reviews of extended markups at Unit 1 were weak in that the reviewers failed to identify numerous markup discrepancies that were later identified by the inspectors. Unit 1 management was aware of the weaknesses, and proposed corrective actions appeared appropriate.
2/14/98 712	NCV Negative	IR 98-01 NCV 98-01-02	N	1-OPS	5A 1C	Most catch containments installed in Unit 1 were adequately installed and maintained. However, many designated as "permanent" did not have an engineering evaluation to determine if a plant change or modification was required. The most recent semi-annual catch containment review lacked depth, in that NMPC failed to fully evaluate whether catch containments should be removed or that those designated as "permanent" had the required engineering evaluation. This minor procedure violation was not cited.
2/14/98 711	NCV Negat <u>i</u> ve	IR 98-01 NCV 98-01-01	N	1-OPS	3A 5A	During an inspection in the Unit 2 residual heat removal pump rooms, the inspectors identified inadequate separation between conduits for safety-related temperature elements of different divisions. A breakdown in communications between an Assistant Station Shift Supervisor and a system engineer resulted in a one week delay in recognizing the impact that inadequate conduit separation had on the operability of safety-related plant equipment. This minor 10 CFR 50, Appendix B, violation was not cited.
2/14/98 710	Positive .	IR 98-01	N	1-OPS	4B 5A	Routine monitoring of the Unit 2 refuel reliability index allowed NMPC to identify a reactor fuel leak early, before it degraded any further. The flux tilting and power suppression evolution was methodical and well-controlled due, in part, to good communication and coordination among all involved organizations. NMPC took aggressive actions to prevent further leak degradation.
2/14/98 709 •	Positive	IR 98-01 LER 98-01	N	1-OPS	<sup>-</sup> 1A	Unit 2 operators responded appropriately to the failure of the Division II containment atmosphere gaseous/particulate radiation monitor that occurred while the Division I monitor was inoperable for maintenance. Station Operations Review Committee members maintained the proper safety focus during the meeting to discuss the basis for requesting enforcement discretion. A Notice of Enforcement Discretion (NOED) was issued to preclude a unit shutdown while working to restore the Division I radiation monitor to an operable status.
1/23/98 696	NCV Positive	IR 97-12 LER 97-11 NCV 97-12-03	L	1-OPS	1A 3B	The Unit 1 operations and reactor engineering staffs' initiative to perform a procedure review prior to an infrequently performed evolution, (reactor shutdown by full control rod insertion), was appropriate. This review was good in that it identified the need for some procedural enhancements. The review also identified that, in the past, on several occasions the mode switch was placed in REFUEL contrary to the TS. This licensee identified and corrected violation was not cited.



Date	Туре	Source	ID	SFA	Code	Item Description
1/23/98 695	NCV Negative	IR 97-12 NCV 97-12-02	N ,	1-OPS	3A 1A 1C	Unit 2 licensed control room operators were not aware that the posted surveillance test data for standby liquid control was out of date and that the surveillance was potentially overdue. A chemistry technician failed to post the surveillance summary sheet after completion of the surveillance, as required by procedure.
1/23/98 694 -	Positive	IR 97-12	N	1-OPS	2B 3A 1A	The Unit 1 shutdown safety verification procedure was considered a valuable aid for the control room operators to assist in monitoring plant conditions and assuring that safety functions were sufficiently available during shutdown conditions. Periodic briefings of safety function status during work control meetings and shift turnover was good, in that, it ensured personnel awareness of system status and allowed for feedback of any current or potential deviations.
1/23/98 693	Negative	IR 97-12	N	1-OPS	2A 4A 3C	Following the inspectors' identification of the Unit 1 hydrogen/oxygen analyzer cabinet doors being improperly secured, the licensee completed a technically sound and extensive analysis to determine that operation in this condition did not adversely impact the equipment operability. However, past operations with the cabinet doors improperly secured indicated a poor questioning attitude on part of the Unit 1 operators, in that they failed to recognize the potential safety concern associated with the condition.
1/23/98 692	Negative	IR 97-12	N	1-OPS	5C 4B	Upon identification that the SRV position indication at the Unit 2 remote shutdown panel (RSP) was unreliable during a control room fire due to a portion of the cabling and components being contained with the control room fire-zone, NMPC engineering staff recommended the incorporation of a caution in the RSP procedure regarding the potential unavailability of the indication. Since the loss of SRV position indication could have been confusing to the operators during a plant shutdown from the RSP, the inspectors considered the time to the scheduled procedure revision date to be excessive, and the licensee promptly incorporated the caution statement.
1/23/98 691 •	NCV Positive	IR 97-12 • NCV 97-12-01	L	1-OPS	4A 5B	NMPC identified that the Unit 2 condensate storage tank building temperatures were not being maintained in accordance with the UFSAR, and took appropriate corrective action to change the temperature control switches to the proper set point. Additionally, NMPC identified that the capacity of the building heaters needed upgrading to maintain desired temperature; this was appropriately evaluated and adequate compensatory actions were established. This licensee identified and corrected violation was not cited.



Date	Туре	Source	ID	SFA	Code	Item Description
1/23/98 690	Positive	IR 97-12	N	1-OPS	1A 3A	The shift brief for the newly-installed emergency cooling condenser keepfull modification was synergistic and provided sufficient detail on the system hardware and operation. The conduct of control room activities during the Unit 1 plant startup following repairs to the condensers was good and improved compared to previous startups. The overall reactor startup appeared to run smoother than previous startups due to the improvement in control rod drive performance.
1/23/98 689	Positive	IR 98-03 ·	. N	1-OPS	- 3B	The inspectors determined the Unit 1 applicants were well prepared for the examination and met all regulatory eligibility requirements.
1/23/98 688	Negative	· IR 98-03	N	· 1-OPS	3B 3C	NRC IR 97-08(OL) documented significant areas of difficulty identified by NRC of an NMP-2 initial license written examination. There was apparent ineffective corrective actions to improve the quality of subsequent initial examination submittals.
1/23/98 687	Negative -	IR 98-03	N	1-OPS	3B 3C	An assessment of the initial examination submittal consisting of the written, job performance measures and operating tests found that the submittal was inadequate. A revised examination did not require additional modification.
11/8/97 679	Negative	IR 97-11	L	1-OPS	5B 4B	NMP1 operations staff operability evaluation for the channel 12 GEMAC, though reasonable, did not probe deep enough into all potential reference leg leakage paths.
11/8/97 677	Positive .	IR 97-11	L	1-OPS	2A 3C	An NMP2 SSS's oversight & questioning attitude was good & identified improper APRM gain setting adjustments.
11/8/97 661	Positive	IR 97-11	N	1-OPS	1A 3C	Control room activities during an NMP2 shutdown were well-coordinated, with good supervisory command & control.
10/4/97 628	Positive	IR 97-07	N	1-OPS	2A 3A	System walkdowns & performance history reviews indicated that the material condition of NMP2 SLCS was good, and that the system has demonstrated a high level of reliability. The knowledge level of the technicians and operators observed during the performance of a test was good. Some minor poor work practices were observed.
10/4/97 627	Positive	IR 97-07	N -	1-OPS	1A 3B 3A	Special simulator training resulted in good operating crew performance during the 9/15/97 manual reactor shutdown at NMP1. During the unit shudown, CROs' use of alarm response procedures, 3-part communications, & self/peer checking were noticeably improved.

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Date	Туре	Source	ID	SFA	Code	Item Description
2/14/98 715	VIO	IR 98-01 VIO 98-01-03	N	2- MAINT	. 2B 5A	Based upon the NRC inspector's questions, NMPC management declared the Unit 1 liquid poison system inoperable. Portions of the system piping had not been periodically flow tested and NMPC was unable to readily ascertain whether the piping from the liquid poison tank to the pump suction valves was obstructed. NMPC's decision to declare the liquid poison system inoperable and commence a shutdown was conservative, and the actions taken to test the system were appropriate. The special evolution brief was thorough. Although the previous Unit 1 liquid poison system surveillance testing met TS, the testing was inadequate to verify system operability. This was a violation of 10CFR50, App B, Crit XI.
2/14/98 714	Positive	IR 98-01	N	2- MAINT	5B	NMPC appropriately evaluated the impact of a leaking fuel delivery valve on the operability of the Unit 2 emergency diesel generator.
1/23/98 700 •	Positive	IR 97-12 LER 97-14	N	2- MAINT	5B	Licensee's actions were appropriate in response to an unexpected isolation of the Unit 1 vent and purge system that occurred during radiation monitor troubleshooting. The licensee's root cause of the event was reasonable and the Station Operating Review Committee's review of the event maintained the proper safety focus.
1/23/98 699	Negative	IR 97-12	S	2- MAINT	3A 2B	Due to inattention during a surveillance test, a Unit 2 technician inadvertently inserted a circuit card extender upside down, causing a reactor protection system half-scram signal. In addition, the surveillance test procedure did not contain a precautionary note which could have warned the technician of the potential plant impact if the card were incorrectly inserted.
1/23/98 698	Positive .	IR 97-12	N	2- MAINT	3A 1C	Pre-evolution briefs for the Unit 1 emergency cooling condenser capacity test were detailed and safety-focused. Operators demonstrated a questioning attitude and the briefs were synergistic. The control room environment was very good and clear and formal three-part communications were consistently used.
1/23/98 697	Positive	IR 97-12	N	2- MAINT	2B 3A 1C	A Unit 1 emergency cooling condenser hydrostatic test pre-evolution brief was adequate. Communications during the test were good, in that formal three-way communications were consistently used. Operations and inservice testing supervision provided good oversight and assistance, which resulted in a well-coordinated evolution.
11/8/97 673	Negative	IR 97-11 IR 97-06 VIO 97-06-01	N	2- MAINT	3A 3C 2B 5C	An I&C technician incorrectly performed a step in a calibration procedure and this was not identified during supervisory review. A 1995 NMP1 main steam break instrument trip channel calibration procedure change was in error and received an inadequate review. In addition, the wrong APRM was adjusted during an NMP2 reactor shutdown. These violations were additional examples of the violations cited in IR 97-06.

FROM: 10/1/97 TO: 4/30/98

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11/8/97 670	Positive .	IR 97-11	N	2- MAINT	3C 2A	NMP2 SW system surveillance tests were performed in a controlled manner. ASSS effectively coordinated testing activities & provided a detailed brief. Operators & technicians used clear three-part communications & adhered to the test procedures.
11/8/97 669	Positive .	IR 97-11	N	2- MAINT	2B 3C	NMP1 forced outage work scope was adequately managed & appropriately safety-focused.
11/8/97 662	Positive	IR 97-11	N	2- MAINT	2A	Material condition of the NMP1 CRD housing support & MSL flow restrictor piping and instrumentation was very good.
10/4/97 640	VIO	IR 97-07 VIO 97-07-03 LER 97-07	L	2- MAINT	2B * 3A	The discovery by the NMP2 I&C technician of the missed calibration of NMP2 H2 recombiner system components was good, however, the failure to perform TS 4.6.6.1.b.1 was a violation.
10/4/97 634	Negative	IR 97-07	N	2- MAINT	1C	During a NMP1 EC condenser pipe cutting evolution, a poor safety & radiological work practice was identified, in that, maintenance personnel were using a rubber-gloved hand to remove metal shavings.
10/4/97 633	Positive	IR 97-07	N	. 2- MAINT	3A 5A 2B 2A	During NMP1 EC condenser repair activities, maintenance personnel adhered to work order requirements & all associated procedures & documentation were readily available & the revision current. QA oversight of activities was appropriate. FME controls were appropriately maintained. Material accountability & system cleanliness were well controlled.
2/14/98 722	Positive · .	IR 98-01 Part 21	N	3-ENG	4B 3C	NMPC responded quickly and appropriately to a vendor notification related to a possible failure of spring-return switches used in the emergency cooling and containment spray systems at Unit 1. Control room operators were aware of the potential failure mode; however, the associated operating procedures were not revised to include a precautionary note related to the concern.
2/14/98 721	Positive .	IR 98-01	N	3-ENG	5A 4B 3A	The licensee's actions at both units to address an industry concern with potentially defective emergency diesel generator air start solenoid valves was timely and technically sound.

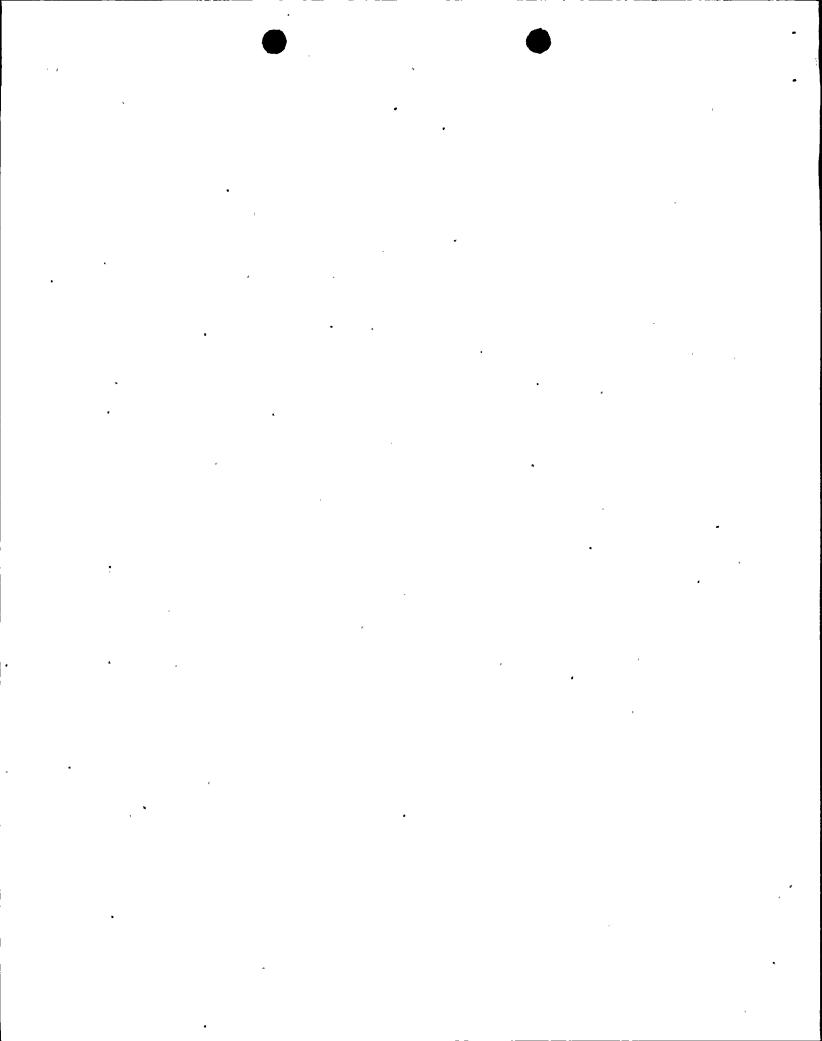


Date	Туре	Source	ID	SFA	Code	Item Description
2/14/98 720	NCV Negative	IR 98-01 NCV 08-01-09 LER 97-16	Ļ	3-ENG	2B	NMPC identified that a portion of the Unit 2 testing for the recirculation pump trip in response to an ATWS was not completed in accordance with the TS. Specifically, the logic system functional testing failed to include the high reactor pressure trip of the low frequency motor generator. In addition, the failure to specify an acceptability range for the lower frequency motor generator time delay in the subsequent procedure change procedure indicated weaknesses in the procedure and in the review of the associated procedure change. Furthermore, in December 1996, NMPC missed an opportunity to identify the inadequate surveillance test due to a non-conservative interpretation of the UFSAR. This licensee identified and corrected violation was not cited.
2/14/98 719	NCV Negative	IR 98-01 NCV 98-01-07 NCV 98-01-08 LER 97-13	L	3-ENG	5B 3C	Prior to April 30, 1992, Unit 2 operated with circuit breakers in the racked out position, and failed to recognize the adverse impact on switchgear seismic qualification and, therefore, switchgear operability. Although NMPC took appropriate actions in 1992 to preclude future operations with breakers in the racked out position, they failed to recognize that they were in an unanalyzed condition, and that the condition was reportable. This licensee identified and corrected violation was not cited.
2/14/98 718	VIO	IR 98-01 VIO 98-01-06	N	3-ENG	5B 3C 2A	The inspectors identified that the temperature control valve for the Unit 1 control room emergency ventilation system had been inoperable since 1983. The administrative controls to disposition the failed valve had not been properly implemented; i.e., the controlled drawings did not indicate the inoperable valve, nor was an engineering evaluation performed, as required by procedures, to determine if continued operation with the degraded condition was acceptable. This was a violation of TS 6.8.1.
1/23/98 717	NCV Negative	IR 98-01 NCV 98-01-05	N	3-ENG	5A 3C	The inspectors identified that NMPC failed to perform a design change for permanently installed scaffolding. This minor procedural violation was not cited.
2/14/98 716	NCV Positive	IR 98-01 NCV 98-01-04	L	3-ENG	3A 2B 4B	As a result of a good questioning attitude by a system engineer, NMPC identified that maintenance on the Unit 1 SW drag valve in the reactor building violated secondary containment integrity. Past maintenance on the valve exceeded the allowable LCO outage time, and a reactor shutdown had not been initiated in accordance with TS. This licensee identified and corrected violation was not cited.
1/23/98 706	Positive .	IR 97-12 Part 21 Notification	N	3-ENG	4B 5B	The licensee's review of an industry concern regarding possible communication between the drywell and the wetwell was appropriate, and their evaluation of other possible evolutions which created a drywell-to-wetwell flow path was good. Actions taken at both units to address identified discrepancies were adequate.

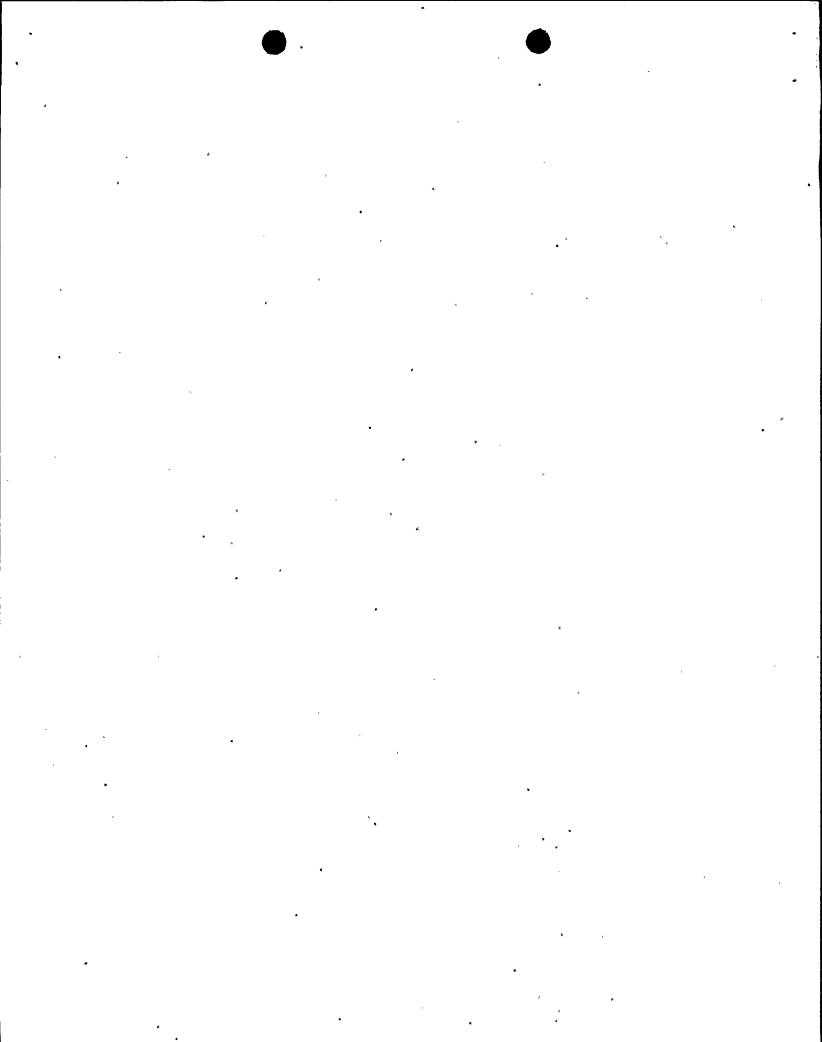


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1/23/98 705	VIO	IR 97-12 VIO 97-12-07 LER 97-12 .	L	3-ENG	4B 5A	The 1997 engineering review of the Unit 1 Safe Shutdown Analysis and Fire Protection Engineering Evaluation documents was good, in that it disclosed previous engineering deficiencies, particularly that emergency lighting required to support alternate shutdown of the plant was missing. However, earlier reviews of these documents were weak in that they failed to identify these deficiencies. This was a violation of 10CFR50, Appendix R.
1/23/98 704	NCV Negative	IR 97-12 LER 97-12 NCV 97-12-06	L	3-ENG	5A 4B 5B	Prior to September 1996, NMPC failed to monitor the Unit 2 relay room temperature, as required by TS. Furthermore, when the licensee identified this issue in 1996, they incorrectly dispositioned it, resulting in a failure to recognize that the condition was reportable, and missed an opportunity to identify other subsequently identified concerns related to the UFSAR description of the control room envelope. This licensee identified and corrected violation was not cited.
1/23/98 703	VIO `	IR 97-12 VIO 97-12-05 LER 97-14	L	3-ENG	3A 4B 5A	A Unit 2 reactor operator demonstrated a good questioning attitude in identifying that a TS required surveillance test for the rod sequence control system was inadequate. This was a violation of TS4.1.4.2.b.1.
1/23/98 702	NCV Negative	IR 97-12 LER 97-15 NCV 97-12-04	Ĺ	3-ENG	5A 5C 4B	At Unit 2, NMPC's identification of a breach between an equipment qualification classified harsh environment area and a mild environment area, an original construction deficiency, was considered good. Particularly noteworthy was the recognition that in the event of a high energy line break, the breach could result in the potential loss of several safety-related systems. Once identified, the licensee took appropriate actions to repair the breach and to verify no other similar openings. This licensee identified and corrected violation was not cited.
1/23/98 701	Positive	IR 97-12	N	3-ENG	4A 4B	The Unit 1 modification of the EC keepfull system was well designed. The modification was installed according to the drawings, and adequately tested.
11/8/97 680	Positive	IR 97-11	L	3-ENG	4B	An engineering safety analysis identified a NMP1 GEMAC level instrument reference leg leakage path which was appropriately resolved within the TS allowed outage time.
11/8/97 678	NCV	IR 97-11 NCV 97-11-05	L	3-ENG	4A 2B	APRM gain setting adjustments at both units were not performed in accordance with the respective TSs. This licensee identified violation of TS was not cited.
11/8/97 676	VIO	IR 97-11 VIO 97-11-04	L	3-ENG	2B 4A	A design review team identified that the positive pressure surveillance test for the NMP2 control room envelope did not include the relay room. This was a violation of TS 4.7.3.e.2.
11/8/97 675	VIO	IR 97-11 VIO 97-11-05 LER 97-11	L	3-ENG	4B 2B	The discovery by NMP2 system engineers of missed surviellance testing of APRMs indicated a good questioning attitude; however, the failure to perform these surveillance tests was a cited violation of TS 4.3.1.2.

FROM: 10/1/97 TO: 4/30/98

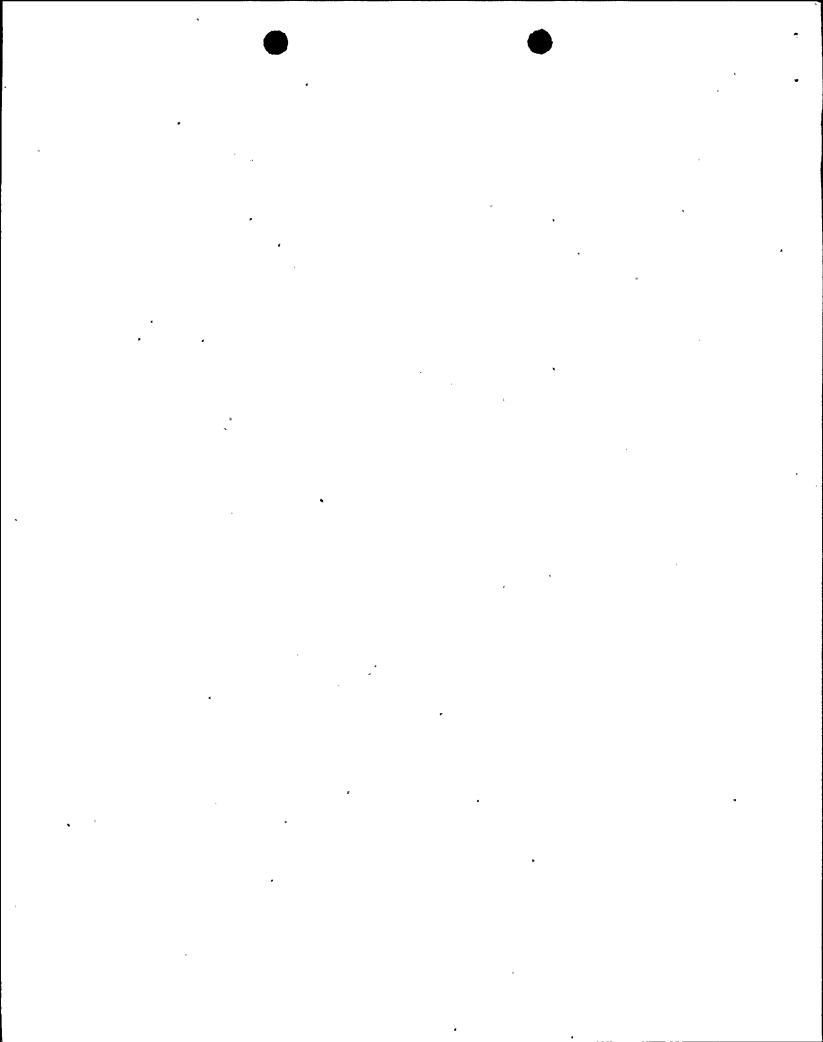


Date	Туре	Source	ID	SFA	Code	Item Description	
.11/8/97 674	Positive	IR 97-11	N	3-ENG	5A	NMPC's self-assessment of procurement activities was critical & in-depth.	
10/4/97 643	NCV	IR 97-07 NCV 97-07-05 LER 97-07	L	3-ENG	2B 4A 5A 2A	The interface between NMP1 smoke purge system and CREVS was inadequately evaluated during modifications in the early 1980s. NMP1 operator's questioning attitude of the control room smoke purge system was very good & resulted in an engineering operability evaluation of the impact on control room emergency ventilation system operability.	
10/4/97 641 •	NCV Negative	IR 97-07 NCV 97-07-04	N	3-ENG	4C '	Review in 1996 of the calculations to support the modification to bring the NMP1 blowout panels within the design basis identified minor calculational errors & corrective actions in early 1996 related to the NMP1 blowout panels design control concern had not been fully effective. This violation of 10CFR50, Appendix B, Criterion III was not cited.	
10/4/97 638	Positive	IR 97-07	N	3-ENG	4B	NMP2 PRA associated with de-energizing one of the two offsite 115 kV supplies for planned maintenance accurately accounted for all equip out of service at the time of maint, & provided a thorough evaluation justifying the conclusion.	
10/4/97 631.	NCV Negative	IR 97-07 NCV 97-07-01	N٠	3-ENG	2B 3A	NMP2 ops considered a catch containment used to collect oil leaking from a RCIC pump gear box to be a permanent installation; however, contrary to NMPC procedure, a plant change request had not been initiated. This minor procedural violation was not cited.	
4/21/98 731	Positive	IR 98-08	N	4-PS	1C 2A		
4/21/98 . 730	Positive	IR 98-08	N	4-PS	2A 2B	The licensee's security facilities and equipment in the areas of protected area assessment aids and personnel search equipment were determined to be well maintained and reliable and were able to meet the licensee's commitments and NRC requirements.	
4/21/98 729	Positive	IR 98-08	N	4-PS	3A 3B		
4/21/98 728	Positive	IR 98-08	N	4-PS	1A 1C	The level of management support, in general, was adequate to ensure effective implementation of the security program, and was evidenced by adequate staffing levels and the allocations of resources to support programmatic needs.	



Date	Туре	Source	ID	SFA	Code	· Item Description
4/21/98 727	EEI	IR 98-08 EEI 98-08-01 EEI 98-08-02	N	4-PS	5A 5C	The effectiveness of licensee management controls relative to the administration of the security program was a weakness. Management's less than aggressive actions to address and resolve the issues associated with the improper control and storage of SGI resulted in two apparent violations of NRC requirements. The first apparent violation was as a result of the licensee's failure to properly control, store, and classify safeguards information (SGI) and the second apparent violation was as a result of the licensee's failure to properly report the violation in accordance with the requirements of 10 CFR 73.21.
4/21/98 726	NCV Negative	IR 98-08 NCV 98-08-03	N	4-PS	1C 5A	In 1996 and 1997, the licensee failed to conduct unannounced drug and alcohol testing at an annual rate equal to at least 50% of the work force as required by 10 CFR 26.24(a)(2). However, the NRC has determined to exercise discretion and refrain from issuing a violation but will issue an NCV.
3/13/98 725	VIO	IR 98-04 VIO 98-04-02	s '	4-PS	1C 3C	One violation of transportation regulations (10CFR71.5) was identified involving the release of vehicle (flat-bed trailer) for unrestricted use, that exceeded the radiation limits specified in 49CFR173.443.
3/13/98 724	Positive	IR 98-04	N	4-PS	1C	A generally effective program for the collection, processing and return to the plant of liquid wastes, and for the collection, processing, storage and transportation of radwaste was established.
1/23/98 723	Negative .	IR 98-01	N	4-PS	1C 3A 5A	Control room and fire brigade personnel appropriately responsed to numerous Unit 1 fire alarm actuations, and the investigation efforts appeared adequately coordinated. However, the failure to fully investigate and resolve previous similar false fire protection system actuations was a weakness and likely contributed to the recent event. Although Unit 1 fire suppression system operability did not appear to be affected by degraded components, the impact of the deficiencies could hinder plant personnel responding to an in-plant fire due to potential multiple false alarms.
1/23/98 708	VIO	IR 97-12 VIO 97-12-09 LER 97-13	S	4-PS	3A 1C	An inadvertent automatic isolation of the Unit 1 drywell vent and purge lines, occurred due to personnel inattention-to-detail, particularly a failure to follow procedure. This was a violation of TS 6.8.1.
1/23/98 707	Positive	IR 97-12	N	4-PS	2A 1C	An inspection of normally inaccessible areas of the Unit 2 reactor water cleanup system found the material condition of the equipment to be satisfactory, with the condition of the equipment in the valve aisle to be particularly good. Housekeeping in the areas inspected was acceptable, and appropriate radiological controls were established.

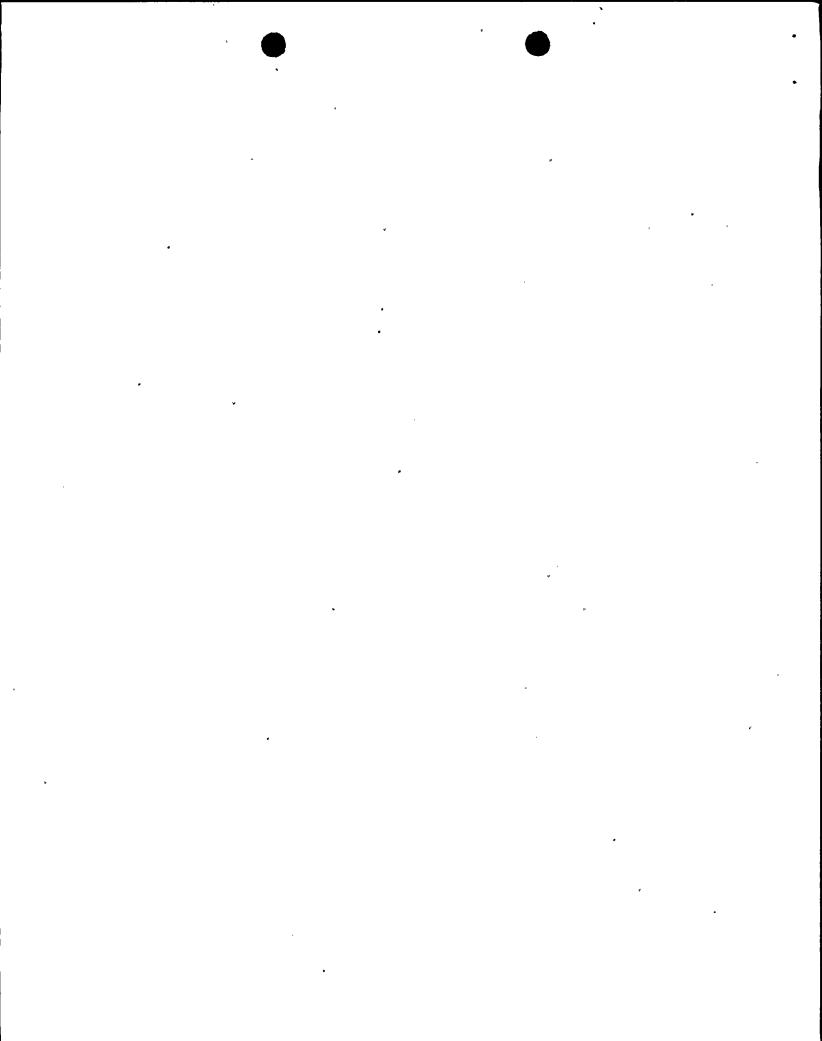
FROM: 10/1/97 TO: 4/30/98 Page 9 of 14 28 May 1998



Date	Туре	Source	ID	SFA	Code	Item Description	
11/8/97 685	Negative	IR 97-11 URI 97-11-08	N -	4-PS	2A 4C	NMP2 radwaste facility fire-door removed for over 3 years without being evaluated as a permanent modification. This was considered a weakness in the licensee's breach permit program to have allowed this permit to remain open. This issue was left unresolved pending further NRC review.	
11/8/97 684	Positíve	IR 97-11	N	4-PS	1C	A QA audit of the security program was comprehensive in scope & depth. NMPC security & safeguards programs were effective & received management support.	
11/8/97 681	NCV Negative	IR 97-11 NCV 97-11-07	L	4-PS	3A 1C	Inattentiveness to postings within the RCA resulted in an NMP2 employee & three visitors entering a posted HRA without authorization. This licensee identified and corrected violation was not cited.	
11/8/97 666	Positive	IR 97-11	N	4-PS	3A	NMP2 operator performance during examinations was generally good, although communications & command/control were noted weaknesses.	
11/8/97 663	Positive	IR 97-11	N	4-PS	3B 3C	NMP2 licensed operator requalification training program was effective & the remedial training program remained strong. During NMP2 LORT event recognition & diagnosis, understanding & interpreting alarms, board manipulations, TS usage, event classification performance were good. Facility evaluator's assessments were objective & thorough.	
10/4/97 658	Positive	IR 97-07	N	4-PS	1C 3C	Plant personnel were trained & equipped to combat a control room fire.	
10/4/97 656	Positive .	IR 97-07	N	4-PS	1C 1B	NMP security personnel response to a "suspicious looking" package was acceptable.  Declaration of an UE by the NMP2 SSS was appropriate & in accordance with the NMP2 Emergency Plan.	
10/4/97 655	SL-III	IR 97-07 EA 97-530	S	4-PS	5A 3A 3C	On three different occasions, NMPC inadequately controlled shipments of radiological material to facilities offsite. 1) shipment shifted during transport & caused radiation levels in occupied space of truck to exceed limits; 2) a wrong liner of low-level radwaste was shipped offsite for disposal; 3) a sample was shipped to an unlicensed facility - a similar occurrence happened in 1995. All of the examples appeared to be due to a lack of procedures describing radwaste operator activities, inattention-to-detail, & a lack of supervisory oversight. (Escalated Enforcement docketed per NRC letter dated 1/22/98, Violations 97-530-1013, 1023, 1033, and 1034 issued. EEIs 97-07-07, 09, and 10 closed.)	
10/4/97 654	Negative	IR 97-07 EA 97-530	N	4-PS	5A	A number of required audits of vendors providing shipping casks were not performed, indicative of a lack of attention by management oversight. (EEIs 97-07-12 and 13 withdrawn, 1/22/97)	

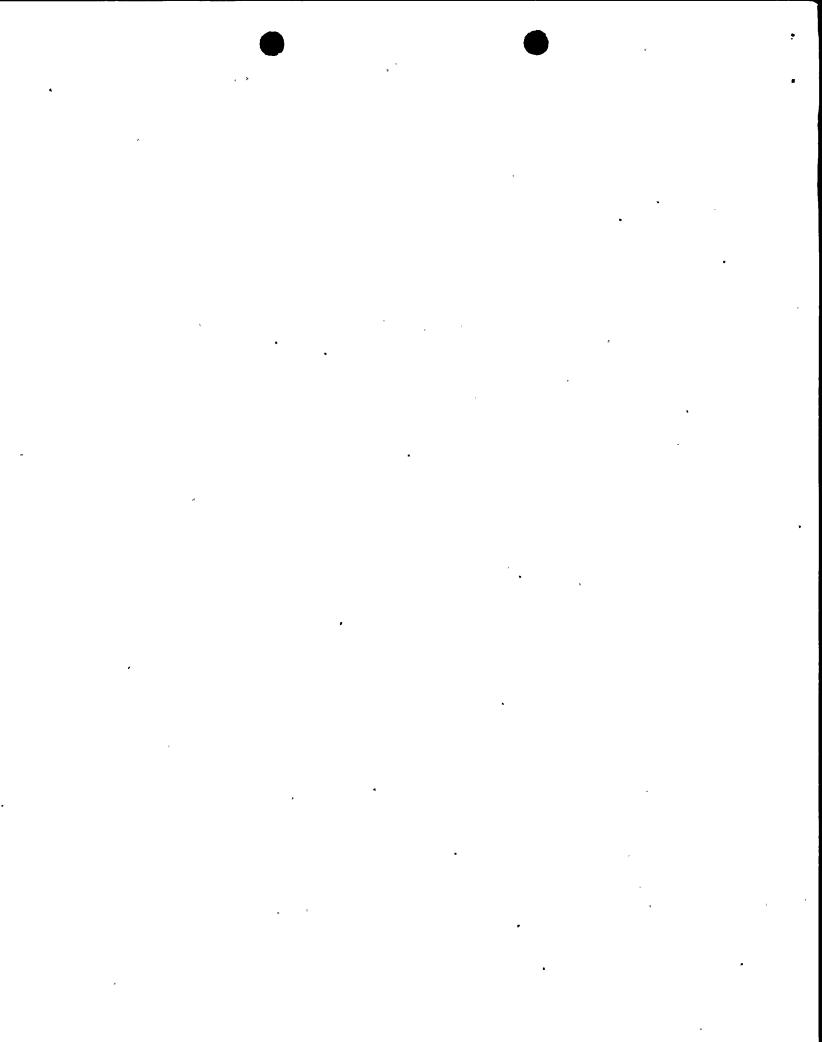


Date	Туре	Source	ID	SFA	Code	Item Description
10/4/97 653	Negative	IR 97-07 EA 97-530	N	4-PS	5C 1C	QA program failed to identify the defects within the unit specific PCPs, & in one instance failed to ensure that corrective actions were taken to address an identified defect, indicative of a lack of attention by management. (EEI 97-07-11 withdrawn, 1/22/97)
10/4/97 652	Positive	IR 97-07	N	4-PS	2A	At NMP2, plant conditions were generally very good relative to radiological housekeeping in radwaste.
10/4/97 651	Negative	IR 97-07	N	4-PS	3C 2A	The lay-up of the NMP1 #11 waste concentrates tank was questionable. Indicative of lack of attention by management.
10/4/97 650	Negative	IR 97-07 EA 97-530	N	4-PS	5A 3A 3C	The Process Control Programs and associated procedures have not been properly maintained. Indicative of a lack of attention by management. (EEI 97-07-06 withdrawn, 1/22/97)
10/4/97 649	Positive	IR 97-07	N	4-PS	1C	At both units, good programs have been established for the processing of liquid & solid radwaste.
10/4/97 648	Positive	IR 97-07	N	4-PS	5A	QA oversight of the RP, ALARA, contamination control, & external dosimetry programs was well implemented; audits & self-assessments were of appropriate scope & technical depth.
10/4/97 644	Positive	IR 97-07	N	4-PS	1C	RP program area was being well-implemented at both units.
10/4/97 637	VIO	IR 97-07 VIO 97-07-02	L	· 4-PS	ЗА	NMP1 RP staff inattention-to-detail & failure to self-check a completed surveillance test data sheet resulted in the failure to perform a ventilation radiation monitor instrument channel calibration within the required frequency. This was a violation of TS 4.6.2.a.
10/4/97 635	Positive	IR 97-07	N	4-PS	1C	Radiological controls during NMP1 EC condenser repair activities were satisfactory.
10/4/97 625	Positive .	IR 97-07	N	4-PS	1C 5A	Questioning attitude of NMP1 chemistry tech & heightened sensitivity of NMP1 staff to the possibility of an EC condenser tube leak were good.



#### ABBREVIATIONS USED IN PIM TABLE

<del></del>	
ALARA	As Low as Reasonably Achievable
APRM	Average Power Range Monitor
CFR ·	Code of Federal Regulations
CRD	Control Rod Drive
CREVS	Control Room Emergency Ventilation System
EC	Emergency Cooling
FME	Foreign Material Exclusion
H2	Hydrogen
HRA	High Radiation Area
I&C	Instrumentation & Control
NMPC	Nine Mile Power Corporation
NRC	Nuclear Regulatory Commission . •
PRA	Probabalistic Risk Assessment
QA	Quality Assurance -
SLCS .	Standby Liquid Control System .
sss	Şenior Shift Supervisor
UE	Unusual Event .
ATWS *	Anticipated transient without scram
TS	Technical Specifications
LCO	Limiting Condition for Operation . ,
sw	Service Water .
SRV	Safety Relief Valve



RSP	Remote Shutdown Panel	
CST ·	Condensate Storage Tank	*
CRO	Control Room Operator	
UFSAR	Updated Final Safety Analysis Report	



#### **GENERAL DESCRIPTION OF PIM TABLE COLUMNS**

Date .	The actual date of an event or significant issue for those items that have a clear date of occurrence (mainly LERs), the date the source of the information was issued (such as for EALs), or the last date of the inspection period (for IRs).
Туре	The categorization of the item or finding - see the Type / Findings Type Code table, below.
Source	The document that describes the findings: LER for Licensee Event Reports, EAL for Enforcement Action Letters, or IR for NRC Inspection Reports.
ID	Identification of who discovered issue: N for NRC; L for Licensee; or \$ for Self Identifying (events).
SFA	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
Code	Template Code - see table below.
Item Description	Details of NRC findings on LERs that have safety significance (as stated in IRs), findings described in IR Executive Summaries, and amplifying information contained in EALs.

#### TYPE / FINDINGS CODES

ED .	Enforcement Discretion - No Civil Penalty				
Strength	Overall Strong Licensee Performance				
Weakness	Overall Weak Licensee Performance				
EEI *	Escalated Enforcement Item - Waiting Final NRC Action				
VIO	Violation Level I, II, III, or IV				
NCV .	Non-Cited Violation				
DEV	Deviation from Licensee Commitment to NRC				
Positive	Individual Good Inspection Finding				
Negative	Individual Poor Inspection Finding				
LER	Licensee Event Report to the NRC .				
URI **	Unresolved Item from Inspection Report				
Licensing	Licensing Issue from NRR				
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc. The type of all MISC findings are to be put in the Item Description column.				

#### **TEMPLATE CODES**

1	Operational Performance: A - Normal Operations; B - Operations During Transients; and C - Programs and Processes
2	Material Condition: A - Equipment Condition or B - Programs and Processes
3	Human Performance: A - Work Performance; B - Knowledge, Skills, and Abilities / Training; C - Work Environment
4	Engineering/Design: A - Design; B - Engineering Support; C - Programs and Processes
5	Problem Identification and Resolution: A - Identification; B - Analysis; and C - Resolution

#### NOTES:

- EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.
- URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.



#### Enclosure 2

### Nine Mile Point Planned NRC Inspections

May 25, 1998 - December 31, 1998

IP-Inspection Procedure
Core-minimum NRC Inspection Program (mandatory all plants)
Core Resident Activities Not Included

INSPECTION PROCEDURE	TITLE/PROGRAM AREA	PLANNED DATES	INSPECTION COMMENTS
		•	
IP 84750	Effluent Monitoring	6/1/98	Core
IP 92903	Followup - Engineering	6/8/98	Regional Initiative
IP 73753	Inservice Inspection	6/8/98	Core
IP 62706	Maintenance Rule Program	6/15/98	OA
IP 92903	Followup - Engineering	6/29/98	Regional Initiative
IP 93802	Operational Safety Team Inspection	7/20/98	Regional Initiative
IP 37550	Engineering ·	8/3/98	Regional Initiative
IP 93809	Safety System Engineering Inspection	8/3/98	Regional Initiative
TI 2515/137	Medium Voltage and Low Voltage Power Circuit Breakers	9/21/98	Safety Issue Inspection
IP 81810	Followup - SGI Control	9/28/98	Regional Initiative
IP 83750	Occupational Radiation Exposure	10/12/98	Core
IP 82701	Emergency Preparedness Program	11/2/98	Core

