U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket/Report Nos.:	50-220/98-13 50-410/98-13
License Nos.:	DPR-63 NPF-69
Licensee:	Niagara Mohawk Power Corporation P. O. Box 63 Lycoming, NY 13093
Facility:	Nine Mile Point, Units 1 and 2
Location:	Scriba, New York
Dates:	July 20-24, 1998
Inspectors:	J. Trapp, Group Leader S. Dennis, Operations Engineer C. Osterholtz, Resident Inspector - Ginna
Approved by:	Richard J. Conte, Chief Operator Licensing and Human Performance Branch Division of Reactor Safety

EXECUTIVE SUMMARY

Nine Mile Point Unit 1
50-220/98-13
July 20-24, 1998

- The management standards and expectations for plant operators were appropriate and clearly documented in the Operations Manual. Operations personnel consistently adhered to expectations regarding communications, control room access, control board awareness, and shift turnovers. Log keeping and annunciator response were acceptable. Operations personnel were effectively tracking technical specification equipment status but operators were unclear as to management expectations on the equipment status log entries.

- The administrative guidance governing safety and configuration tagging was appropriate to protect workers and the integrity of safety-related systems. The implementation of the safety and configuration tagging administrative requirements by plant operators was effective.

- Plant operators were effective in identifying deficient plant equipment and had established appropriate thresholds for including deficiencies in the corrective action program. However, the inspectors noted that a poor interface existed between operations and the work planning organization in identifying and resolving deficient or incomplete work packages.

- The administrative guidance for temporary modifications, control room deficiencies, and operator work-arounds was appropriate. However, the effectiveness of the implementation of the programs could not be determined, as operators were still in the process of developing a comprehensive list of deficiencies and work-arounds.

- Appropriate procedure guidance was available for the risk significant operator actions reviewed. The procedures were walked down in the field with licensed operators and the operators were found to have a thorough understanding of the procedure guidance. The surveillance procedures used for the tests observed were of good quality.

- Operators implementing several surveillance tests exhibited good procedure adherence skills. Operators interviewed were fully aware of management's expectations for verbatim procedure compliance.

- Control room and plant operators demonstrated appropriate knowledge of plant systems and administrative requirements necessary to safely operate the plant. All operations and testing evolutions observed were conducted in a safe and controlled manner.

- The shift supervisor provided appropriate oversight of shift activities and pre-evolution briefs were well managed. Operations management was observed providing appropriate oversight of control room activities.

- Operations department management was proactive in initiating quality assurance surveillances and establishing the mentoring program. The self-assessment and quality assurance audits were effective in identifying the recent decline in operations performance. The assessment of DER trends, the mentoring program, and quality assurance's 1997 audit of operations and recent surveillance collectively provided a thorough assessment of the operations organization performance.

- The licensee appropriately resolved past inspection findings and appropriately identified and acted on violations dealing with senior reactor operator duties in the control room. **(NCV 50-222/98-13-01,02)**

Report Details

Background

Nine Mile Unit 1 remained at rated power throughout the duration of this inspection. The inspectors directly observed approximately 50 hours of operator performance during routine plant operations and scheduled surveillance testing. The objective of this inspection was to verify the licensee was aware of the recent decline in Unit 1 operations performance and was taking appropriate corrective actions to address the root causes. Inspection Procedure (IP) 93802 was considered in the scope of review for each section of this report and the staffing for this inspection was at a reduced level.

I. Operations

O1 Conduct of Operations

O1.1 Control Room Observations

a. Inspection Scope

The team verified that operators were meeting management expectations in the areas of communications, control room access, control board awareness, annunciator response, shift turnovers and operator log-keeping.

b. Observations and Findings

General Comments

The inspectors found that plant management was cognizant of the decline in performance and has taken corrective actions to address the causes. A new operations management team was recently established. The new management team had established an Operations Manual (common to both Units 1 and 2) that clearly established standards and expectations for the operations staff. This inspection verified overall that the operators were appropriately implementing the standards and expectations provided in the Operations Manual.

Communications and Control Room Access

The inspectors observed that the operator's consistently used 3-way communications during routine evolutions, shift turnovers, and system surveillance tests. Control room decorum and professionalism was consistently maintained during the team's observations. Control room operators appropriately controlled the access of non-operating personnel in the at-the-controls area of the control room. Additionally, non-technical reading material, and other material not required for station operation were not observed in the control room.

Control Board Awareness and Annunciator Response

The inspectors reviewed the expectations contained in the Operations Manual pertaining to control board awareness and verified that the operators were alert and attentive to control board indications during steady state conditions and surveillance testing.

The inspectors observed that the control room operators properly responded to alarms in accordance with the guidance in the Operations Manual with one minor exception. The Operations Manual recommends that the alarm response procedure be referenced for the first alarm occurrence each shift. The inspectors noted one example where the alarm response procedure was not referenced as recommended by the Operations Manual. Operation's management had identified other examples where this expectation was not satisfied and had reemphasized the need to reference the alarm response procedure during the shift briefings.

Effectiveness of Shift Turnovers

The inspectors observed eight shift turnovers and found them to be consistent with Nine Mile Point Unit 1 (NMP1) administrative requirements. The responsible control room and/or plant operators were knowledgeable of tagged equipment, unusual or abnormal conditions, upcoming tests, and ongoing work in the plant. The Senior Shift Supervisor (SSS) and Assistant Senior Shift Supervisor (ASSS) elicited participation from all crew members and reinforced safety and communication standards adherence as part of each turnover. On several occasions, due to background noise, some crew members had difficulty hearing information provided during the turnover and in most cases requested the information to be repeated.

Log Keeping

The inspectors reviewed the previous month of ASSS and Chief Shift Operator (CSO) narrative logs and the shift control room equipment status log. While the inspectors found the ASSS logs to be consistent with established standards, the CSO log entries were less consistent with those standards.

c. Conclusions

The management standards and expectations for plant operators were appropriate and clearly documented in the Operations Manual. Operations personnel consistently adhered to expectations regarding communications, control room access, control board awareness, and shift turnovers. Log keeping and annunciator response were acceptable.

02 Operational Status of Facilities and Equipment

02.1 Safety Tagging and Equipment Control

a. Inspection Scope

The inspectors reviewed the guidance and implementation of the safety tagging and equipment control processes for protecting workers and the integrity of safety-related systems; general administrative procedure GAP-OPS-02, "Control of Hazardous Energy and Configuration Tagging;" and additional guidance in the Operations Manual pertaining to safety tagging to verify proper implementation and that appropriate tagging requirements had been established.

b. Observations and Findings

The inspectors reviewed markups associated with the fuel pool cooling system and the instrument air compressor, and found them in compliance with administrative procedure requirements. Valves and control switches for the 102 emergency diesel generator were properly aligned. Labeling of some switches on panels located outside the control room were occasionally different than the description in the procedures. A preventive maintenance procedure had been recently implemented to formally check the control room valve and switch positions every shift. This was an appropriate corrective action for a recent failure to properly align a containment spray valve in the control room. However, the inspectors identified that there was no similar expectation to periodically verify switches and valves located outside of the control room. In response, license management agreed to review this specific area.

c. Conclusions

The administrative guidance governing safety and configuration tagging was appropriate to protect workers and the integrity of safety-related systems. The implementation of the safety and configuration tagging administrative requirements by plant operators was effective.

The corrective actions for a valve alignment problem in the control room only encompassed control room operated equipment.

02.2 Corrective Actions and Work Controls

a. Inspection Scope

The inspectors assessed operator's threshold for including plant equipment deficiencies into the corrective action program and also reviewed the interactions between operations and planning and scheduling organization.

b. Observations and Findings

The inspectors conducted plant tours with auxiliary operators and found they were knowledgeable of plant equipment deficiencies. During the tours, the inspectors noted several minor deficiencies nearly all of which had been previously identified by the auxiliary operators and included in the corrective action program. The items that were not in the corrective action program were added. The material condition of the reactor building was good in that plant operators were cognizant of the importance of maintaining good housekeeping efforts.

Operators were not always aware of projected start and finish times for work scheduled for safety-related equipment. This may place an additional burden on operators to assess the plant risk associated with simultaneous work activities. The inspectors noted that the recently implemented daily management meeting to review maintenance activities was helpful in establishing maintenance priorities.

The inspectors conducted interviews with operations personnel and reviewed several deviation/event reports (DERs). Based on the interviews, the inspectors found that several operators were not confident with the quality of support provided by the work planning organization. The team noted two DERs (1-98-1740 and 1-98-1972) had recently been written by operations in response to work packages that contained deficiencies that were not identified until final review by the operating shift for establishing safety markups. DER 1-98-1740 was written due to a work package for preventive maintenance on a power supply that did not identify that relay replacements were required as part of the maintenance, and subsequently did not contain the necessary parts. DER 1-98-1972 was written due to a work package for preventive maintenance on a diesel generator heat exchanger that did not contain plans or parts in the event of a failure while performing the maintenance. Both work packages had been closed out, but neither of them indicated that a DER had been generated in response to the noted deficiencies. It appeared that the work planning personnel responsible for closing the work packages were unaware that operations had generated the DERs.

c. Conclusions

Plant operators were effective in identifying deficient plant equipment and had established appropriate thresholds for including deficiencies in the corrective action program. However, the inspectors noted that a poor interface existed between operations and the work planning organization in identifying and resolving deficient or incomplete work packages.

02.3 Operability Status of Safety-Related Components

a. Inspection Scope

The inspectors reviewed the processes for tracking plant status and the operability of safety-related equipment.

b. Observations and Findings

The guidance for maintaining safety system configuration control was documented in an Equipment Status Log (ESL). The inspectors interviewed operations personnel regarding what the threshold was for equipment to be included in the log. Some operators indicated that only Technical Specification (TS) and maintenance rule equipment needed to be included in the log, while others indicated that all plant equipment out-of-service be included in the log. The ESL was not being appropriately maintained at the start of the inspection due to a computer program failure that occurred the week prior to the inspection. However, actions to update the log were completed during the inspection.

The inspectors noted that a status board was being maintained in the control room to track TS limiting condition for operations (LCOs) as well as safety-related equipment out of service. The inspectors found that the status board was being appropriately updated.

c. Conclusions

Operations personnel were effectively tracking TS equipment status but operators were unclear as to management's expectations on ESL entries.

02.4 Temporary Modifications, Control Room Deficiencies, and Operator Work-arounds

a. Inspection Scope

The inspectors reviewed the licensee's programs for temporary modifications (TMs), control room deficiencies, and operator work-arounds to verify that operator responsibilities for these programs were properly implemented.

b. Observations and Findings

There were a total of 11 TMs installed, none of which affected safety-related equipment. The operators log, tagging, and approval of the TMs were all in accordance with the administrative requirements. The inspectors did not identify any problems with operations implementation of the TM or annunciator processes.

The programs for tracking control room deficiencies and identifying and tracking operator work-arounds had recently been incorporated into the Operations Manual. There were 32 identified control room deficiencies and a computer database was used to track the status of each deficiency. The program guidance for tracking operator work-arounds was added to the Operations Manual one week before this inspection. The identification of operator work-arounds was discussed during shift briefings and the SSS encouraged operators to evaluate current deficiencies for inclusion into the program.

c. Conclusions

The administrative guidance for temporary modifications, control room deficiencies, and operator work-arounds was appropriate. However, the effectiveness of the implementation of the programs could not be determined, as operators were still in the process of developing a comprehensive list of deficiencies and work-arounds.

03 Operations Procedures and Documentation

03.1 General Observations

a. Inspection Scope

The inspectors assessed the quality of selected operating procedures and also verified that risk significant operator actions, identified in the Individual Plant Examination, were included as procedure instructions. The inspectors verified that operators appropriately complied with procedure requirements during plant evolutions.

b. Observations and Findings

The sections of the procedures reviewed were consistent with the licensee procedure writers guide and the instructions were appropriate for conducting the intended task. The licensee was in the process of improving the shutdown from outside the control room procedure by identifying steps that were described in the licensing basis analysis for fires and those that were not credited for safe shutdown of the plant. The delineation between required and optional steps was important to inform operators that optional operations performed may not have the benefit of emergency area lighting and would only be performed provided that sufficient time was available to complete required actions. The inspectors determined that the operations support staff was taking appropriate steps to include these procedure enhancements. The risk significant operator actions for station blackout, recovery of offsite power, and evacuation of the control room were all properly incorporated into the procedures.

Operators were aware of management expectations for procedure compliance and they appropriately conducted operation and surveillance test procedures in compliance with the approved procedure instructions.

c. Conclusions

Appropriate procedure guidance was available for the risk significant operator actions reviewed. The procedures were walked down in the field with licensed operators and the operators were found to have a thorough understanding of the procedure guidance. The surveillance procedures used for the tests observed were of good quality.

Operators implementing several surveillance tests exhibited good procedure adherence skills. Operators interviewed were fully aware of management's expectations for verbatim procedure compliance.

04 Operator Knowledge and Performance

04.1 General Observations

a. Inspection Scope

The inspectors observed operations personnel performing routine tasks and surveillance testing to assess operator knowledge of procedures, systems, and administrative requirements. The control room observations also provided the inspectors a basis for assessing the quality of shift supervision and assure that plant management was providing clear expectations, setting proper standards, and conducting effective oversight of operations activities

b. Observations and Findings

The inspectors conducted operator interviews and determined that operators have a good understanding of plant system operation, equipment status and administrative requirements. The inspectors accompanied plant operators on four sets of rounds in the reactor building and found all operators to be knowledgeable of systems and familiar with the bases for the log readings they recorded.

The inspectors observed the SSS and ASSS conduct several shift turnover meetings and pre-evolution briefings for surveillance tests. The supervision and direction giving to plant operators during the shift turnover and pre-evolution test briefings was appropriate. The shift supervisors were observed to discuss safety considerations and plant contingencies prior to performing testing evolutions. The shift supervisors effectively controlled work activities to minimize distractions for the reactor operators.

The inspectors found that management standards were clearly defined in the recently issued Operations Manual. However, differing opinions exist among operations personnel concerning whether the standards were requirements or guidelines. Operations management was frequently observed in the control room discussing expectations and standards with the shift operators.

c. Conclusions

Control room and plant operators demonstrated appropriate knowledge of plant systems and administrative requirements necessary to safely operate the plant. All operations and testing evolutions observed were conducted in a safe and controlled manner.

The shift supervisor provided appropriate oversight of shift activities and pre-evolution briefs were well organized. Operations management was observed providing appropriate oversight of control room activities. Management expectations were clearly articulated in the newly developed Operations Manual.

07 Quality Assurance in Operations

07.01 General Observations

a. Inspection Scope

The inspectors assessed the quality of the self assessment and independent oversight of the operations organization.

b. Findings and Observations

At the request of the Operations Manager, the quality assurance organization conducted a surveillance of the operations in June 1998. The quality assurance staff used the NRC inspection procedure (93802) to conduct this review. The scope of the surveillance was similar to this inspection. The conclusion of the surveillance report stated that "overall, conduct of operations meets expectations." The licensee's surveillance team found opportunities for improvement in the area of operator log keeping, implementation of the Shift Technical Advisor (STA) function and a lowering of the threshold for writing DERs. The surveillance findings were generally consistent with those noted during this inspection.

The licensee had initiated a control room mentoring program in June of 1998 to provide feedback to the operators regarding performance expectations. The inspectors reviewed a select sample of the mentor's observation reports and found that they were candid assessments and met the program expectations. Several operators stated that they believed the mentoring program would assist in understanding and complying with management expectations.

An August 1997 Quality Assurance annual audit of operations identified a "...general decline in Conduct of Operations." The audit reviewed the conduct of operators, management performance, administrative controls and procedures.

The inspectors reviewed the licensee's self assessment program for operations. The administrative controls for the program provided explicit observation area objectives and standards. Performance records were maintained for each performance objective. The 1998 performance records indicated that observations were frequently conducted and were self critical. The operations department also assesses performance by trending DERs. The DER trend reports indicated that the 1998 personnel error rate for operations was slightly higher than the business plan goal and the trend was not declining. The information in the trend report provided operations management with a good basis for assessing performance. Operations department management reviewed the quarterly trend reports and documented an assessment of the data.

c. Conclusions

Operations department management was proactive in initiating a quality assurance surveillance and establishing the mentoring program. The self-assessment and quality assurance audits were effective in identifying the recent decline in operations performance. The assessment of DER trends, the mentoring program, and quality assurance's 1997 audit of operations and recent surveillance collectively provided a thorough assessment of the operations organization performance.

O8 Miscellaneous Operations Issues

O8.1 (Closed) Violation 50-220 & 50-410/96-10-04: Multiple examples of failure to follow procedures

This violation cited three separate examples of failure to follow procedures. The failures occurred during a surveillance test on the core spray topping pump (Unit 1), during the installation of a markup on a hydraulic control unit (Unit 1) and during maintenance by I&C on the hydrogen/oxygen monitors (Unit 2). The inspectors verified the completion of selected corrective actions provided in Niagara Mohawk's, December 26, 1996, Notice of Violation response letter to the NRC.

The inspectors verified that Procedure Writer's Guide was revised and included enhanced guidance regarding independent verification of calculations. Also, surveillance test procedure (U1-ST-Q1B) was revised to be consistent with the guidance provided in the writer's guide.

The inspectors reviewed the Operations Manual to verify that appropriate guidance was provided for independent verification during application and clearing of markups. Operations Manual, Section 3.10.3 recommends that when applying and clearing markups on safety-related systems that independent verification is required. The inspectors observed markups being applied and cleared and noted that the operator's were conducting independent verifications in accordance with the Operations Manual. The inspectors observed the operators applying self checking techniques provided in the Operations Manual which was instituted as an enhancement to reduce human errors.

The licensee has recently set new standards for self checking and verification to improve the personnel error rate and reduce the incidence of failure to follow procedures. The licensee monitors the personnel error rate on a quarterly basis and has established a business plan goal for personnel errors. The inspectors determined that the licensee's corrective actions to reduce personnel errors and the trending and goal setting for reducing the personnel error rate provides an appropriate basis for closure of this violation.

O8.2 (Closed) Violation 50-220 & 50-410/97-06-01: Multiple examples of failure to follow procedures

The corrective actions implemented by the licensee in 1996 to reduce the instances of failure to follow procedures were not completely successful. In 1997, a second NRC violation was written for additional examples of failure to follow procedures. The 1997 violation cited four examples of failure to follow procedures that occurred during the month of July. The examples included inadvertently operating the wrong valve during a containment spray surveillance test, opening the wrong breaker during an isolation of a motor generator set, not following test procedure steps during fire system testing, and the failure to properly restore a radiological waste system to service. The inspectors verified the completion of selected corrective actions described in the Niagara Mohawk's, October 15, 1997, Notice of Violation response letter to the NRC.

The inspectors conducted extensive observations of operators conducting surveillance tests and the implementation of markups. The operators were found to be implementing good self checking and verification practices. Management expectations regarding self checking and verifications were clearly articulated in the Operations Manual. Pre-job briefings for these activities were thorough. The labels on the normal and maintenance supply breakers for the process computer were appropriately revised.

The licensee now monitors the personnel error rate and has established goals for personnel errors. Closure of this violation is based on the current inspection results of strict adherence to procedures, on the licensee's corrective actions to reduce personnel errors, and on the trend of personnel error rate which appears to be holding steady.

O8.3 (Closed) VIO 50-220/EA96-541-1013: Failure to control reactor pressure vessel water level following a scram resulting in water entering the main steam lines.

On November 5, 1996, following a reactor scram, a reactor vessel overfill occurred which resulted in filling the main steam lines with approximately 30,000 gallons of water. The details associated with this issue are documented in NRC Inspection Report 50-220/96-13. As a result, a notice of violation and proposed imposition of civil penalties letter was issued by the NRC to Niagara Mohawk Power Corporation (NMPC), dated April 10, 1997. NMPC provided their response to the violation in their letter dated May 12, 1997, to the NRC.

The inspectors conducted an on-site review to assess and verify corrective and preventive actions stated in the response by NMPC in the areas of design change, procedure, training, and organizational enhancement. Specifically, the inspectors conducted document reviews and interviewed the responsible engineer and general supervisor of operations (GSO) and assessed and verified the following:

- New training scenarios which were developed and are currently in use to test overfill events and the modification made to the high pressure coolant injection (HPCI) and feedwater (FW) trip system.
- Post trip reviews which were used to verify consistency between simulator and plant response to events.
- Plant operating procedures which were revised and now provide more explicit direction for vessel level control and reflect the modification made to the HPCI/FW trip system.
- Technical specifications which were amended to reflect the reinstatement of the GSO position to provide additional operations oversight.

Additionally, the inspectors reviewed five subsequent plant shutdown post-trip reviews and found no instances of level control problems. The licensee's root cause and analysis and related corrective and preventive actions were acceptable. This violation is closed.

08.4 Licensee Event Reports (LER) 50-220/98-07 and LER 50-220/98-14:

(Closed) On duty SRO temporarily leaves the control room (LER 98-07)

On April 24, 1998, with NMP1 at full power, the on duty ASSS left the control room to discuss ongoing maintenance with an electrical technician; the SSS was out of the control room attending to other business. This resulted in no SRO in the control room as required by TS 6.2.2.e. After about two minutes, the ASSS realized the error, returned to the control room, and immediately notified the SSS. The ASSS was subsequently removed from licensed duties following a NMP1 management investigation. NMP1 management initiated DER 1-98-0983 and subsequent LER 50-220/98-07 to document the event and initiate a root cause analysis.

The inspectors conducted an on-site review of the root cause analysis and associated corrective actions for this event. The event was licensee identified. Additionally, through review of past NMP1 and NMP2 LERs and interviews with plant management, the inspectors found that the event was an isolated case and non-repetitive. The inspectors concurred with the licensee's determination of root cause as inadequate managerial methods and a contributing factor of inadequate verbal communications. The inspectors selected associated corrective actions for review which included verification of physical barriers put in place to remind operators of the control room envelope boundaries, review of an event notification

to all operating staff, and verification through training records that the individual involved received additional training and developed a lessons learned memo. The team determined the corrective actions to be acceptable and this LER met the requirements of 10CFR50.73. The inspectors concluded that LER 98-07 is closed and the event was a violation of NMP1 TS 6.2.2.e. **(NCV 50-220/98-13-01)**

(Open) On duty SRO fails to satisfy training requirement (LER 98-14)

On June 16, 1998, with NMP1 at full power, an unqualified SRO assumed the position of ASSS for approximately four hours and was the only SRO in the control room for approximately 45 minutes during that time. The SRO was not qualified because on the previous day, June 15, 1998, the SRO had failed an evaluated requalification simulator exam and per NMPC training procedure NTP-TQS-102, "Licensed Operator Requalification Training," Section 3.5.7.b.3, completion of remediation is required prior to an individual resuming licensed duties following a failure. The required remediation was not completed when the SRO assumed the position of ASSS for 4-hours. Therefore, the TS 6.6.2.e. requirement for having a qualified SRO in the control room during power operation was not satisfied during the 45 minute period when the SSS was out of the control room to attend the morning meeting. Also, the NRC identified that the "unqualified" ASSS did not meet the requirement of TS 6.6.2.a.

The SRO was assigned to the ASSS position by the GSO to allow the normally scheduled ASSS to attend an offsite meeting. Additionally, the GSO and SRO were aware of the failure when the assignment was made, but did not realize at the time that the failure should preclude the SRO from assuming the position of ASSS until remediation was complete. The event was brought to the attention of NMPC management on June 17,1998, by a trainer who had been observing the shift on June 16,1998, as part of the operations mentoring program. NMPC initiated DER 1-98-1882 and subsequent LER 50-220/98-14 to document the event, initiate a root cause analysis, and develop corrective actions.

The inspectors conducted an on-site review of the root cause analysis and associated corrective actions for the event described in LER 50-220/98-14 and DER 1-98-1882. The team noted the event was licensee identified. The inspectors concurred with the licensee's determination of inadequate managerial methods. However, the inspectors determined that an additional root cause was inadequate verbal communications which the licensee had stated in their LER was a contributing factor to the event. The inspectors reviewed selected corrective actions to assure that both root causes were addressed. The inspectors verified that: a crew remediation and successful reevaluation were performed, a lessons learned memo was distributed to all operations staff, and training procedure NTP-TQS-102 "Licensed Operator Requal Training" was revised to provide more explicit and formal direction regarding the communication and notification process for crew and individual failures. Due to the complexity of this event, additional review will be conducted by the NRC to verify that all root causes are identified and corrected. LER 98-014 will remain open pending that review.

Conclusion for Followup of LERS 50-220/98-07 and 98-14

The inspectors determined that both events occurred under distinctly different circumstances and causes. For both events, the same NMP1 requirements for control room SRO staffing as specified in TS 6.2.2.a and e applied.

V. Management Meetings

X1 Exit Meeting Summary

On July 24, 1998, a meeting was held to discuss the findings of this inspection. NMPC management at the exit meeting did not dispute any of the team's findings or conclusions. Based on the NRC Region I review of this report, and discussions with NMPC representatives, it was determined that this report does not contain safeguards or proprietary information.

PARTIAL LIST OF PERSONS CONTACTED

B. Booth	General Supervisor of Operations, Unit 1
J. Conway	Vice President, Nuclear Generation
J. Dreyfuss	Operations Support
D. Topley	Operations Manager

INSPECTION PROCEDURES USED

IP 93802	Operational Safety Team Inspection

PROCEDURES REVIEWED

Administrative Procedures

GAP-OPS-01, Rev. 9	Administration of Operations
GAP-OPS-02, Rev. 9	Control of Hazardous Energy and Configuration Tagging
GAP-OPS-03, Rev. 3	Control of Operator Aids
GAP-DES-03, Rev. 7	Control of Temporary Modifications
GAP-PHS-03, Rev. 2	Control of On-line Work Activities
GAP-PSH-01, Rev. 18	Work Control
GAP-PSH-03, Rev 2	Control of On-line Work Activities
S-400-NDD-CON	Configuration Management
S-500-NDD-OPS	Operations
NIP-ECA-01	Deviation Event Report
NIP-OUT-01	Shutdown Safety
N1-PM-S5	Control Room System Lineup Verification

Operations Department Procedures

N1-ODP-OPS-0101, Rev.10	Shift Turnover and Brief
Operations Manual	Effective Date 4/17/98

Operating Procedures

N1-OP-13, Rev. 29	Emergency Cooling System
N1-OP-45, Rev. 23	Emergency Diesel Generators
N1-OP-38C, Rev. 15	LPRM/APRM
N1-OP-40, Rev. 12	Reactor Protection & ATWS Systems
N1-OP-43B, Rev. 0	Balance of Plant Startup & Shutdown
N1-OP-43A, Rev. 4	Reactivity Control

Special Operating Procedures

N1-SOP-18, Rev. 5	Station Blackout
N1-SOP-9.1, Rev. 4	Control Room Evacuation
N1-SOP-5, Rev. 9	Loss of 115 KV
N1-SOP-7, Rev. 4	Service Water Failure/Low Intake Level
N1-SOP-1, Rev. 9	Reactor Scram

Deviation/Event Reports

1-98-0983	SRO left the control room
1-98-1882	Failure to comply with NRP-TQS-102
1-98-0632	Avoidable loss of EDG availability hours
1-98-0008	Inappropriate Operator Action
1-98-0708	Trending DER for EDG 103 fuel oil tank level
1-98-0143	Procedure inadequacy
1-98-0204	FSAR discrepancy - Manual spray initiation does not agree with EOP
1-98-0323	Procedure inconsistency N1-SOP-9.1 (Control Room Evacuation)
1-98-0965	Failure to implement TS action statement
1-98-1094	Procedure violation - failure to follow n1-OP-43A
1-98-0919	Unrecognized violations of secondary containment
1-98-2006	Incomplete procedure change review

Quality Oversight

Audit Report 97009, Operations, Surveillance and Test
Surveillance Report 98-0066-1, Unit 1 Operations Branch Assessment
Deviation Event Report Program - Trend Summary Report Second Quarter 1998
Deviation Event Report Program - Trend Summary Report First Quarter 1998
NMP1 Operations - Evaluation of DER Trend Report First Quarter 1998
Unit One Operations - Performance Observation Report
Control Room Mentoring Program

ITEMS OPENED, CLOSED, AND UPDATED

Closed

50-220 & 410/96-010-04	VIO	Multiple examples of failure to follow procedures
50-220 & 410/97-06-01	VIO	Multiple examples of failure to follow procedures
50-220/EA96-541-1013	EEI	Vessel overfill event
50-220/97-03-01,50-220/98-07	NCV/LER	On duty SRO temporarily leaves control room

Updated

50-220/98-14	LER	On duty SRO fails to satisfy training requirements

LIST OF ACRONYMS USED

APRM	Average Power Range Monitor
ASSS	Assistant Station Shift Supervisor
CFR	Code of Federal Regulations
CSO	Chief Shift Operator
DER	Deviation/Event Report
ESL	Equipment Status Log
FW	Feedwater System
GSO	General Supervisor of Operations
LCO	Limiting Condition for Operation
HPCI	High Pressure Coolant Injection
LER	Licensee Event Report
NMPC	Niagara Mohawk Power Corporation
NMP1	Nine Mile Point Unit 1
NMP2	Nine Mile Point Unit 2
NRC	Nuclear Regulatory Commission
OSTI	Operational Safety Team Inspection
SSS	Station Shift Supervisor
SAT	Shift Technical Advisor
TM	Temporary Modification