

U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket/Report Nos.: 50-220/98-09
50-410/98-09

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 5 - August 15, 1998

Inspectors: B. S. Norris, Senior Resident Inspector
L. A. Peluso, Radiation Specialist
D. M. Silk, Senior Emergency Preparedness Inspector
R. A. Skokowski, Resident Inspector

9809220045 980910
PDR ADOCK 05000220
Q PDR



EXECUTIVE SUMMARY

**Nine Mile Point Units 1 and 2
50-220/98-09 & 50-410/98-09
July 5 - August 15, 1998**

This NRC inspection report includes reviews of licensee activities in the functional areas of operations, engineering, maintenance, and plant support. The report covers a six-week period of inspections and reviews by the resident staff and regional specialists in the areas of emergency preparedness and environmental monitoring.

OPERATIONS

In general, the conduct of operations was professional and safety conscious. No performance concerns were identified in this area.

MAINTENANCE/SURVEILLANCE

During preparations for maintenance on the Unit 1 containment spray system, the markup for isolation of the system was inadequate, resulting in a breach of the primary containment integrity. This issue remains open pending the NRC inspectors' review of NMPC's completed root cause analysis and determination of corrective actions to prevent recurrence. (EEI 50-220/98-09-01)

ENGINEERING

At Unit 1, an inadequate engineering evaluation of a 1997 configuration change resulted in a non-conformance with the 10CFR50, Appendix R, Safe Shutdown Analysis, by opening the core spray high point vent valves to address GL 96-06 thermal over-pressurization concerns. Upon identification, NMPC took prompt and appropriate corrective actions. This licensee identified and corrected violation of Appendix R was not cited. (NCV 50-220/98-09-02)

During Unit 2 surveillance testing, NMPC identified that both control room air conditioning units were running in parallel, contrary to the intended design. This design vulnerability could have potentially resulted in the system being inoperable, under certain design basis accident scenarios. This licensee identified and corrected violation of 10CFR50, Appendix B, Criterion III, Design Control, was not cited. (NCV 50-410/98-09-03)

PLANT SUPPORT

Overall performance in this area was good. No concerns were identified during the inspectors' in-office review of a number of Emergency Plan implementing procedures.



TABLE OF CONTENTS

	page
EXECUTIVE SUMMARY	ii
TABLE OF CONTENTS	iii
SUMMARY OF ACTIVITIES	1
Niagara Mohawk Power Corporation (NMPC) Activities	1
Nuclear Regulatory Commission (NRC) Staff Activities	1
I. OPERATIONS	2
O1 Conduct of Operations	2
O1.1 General Comments	2
O8 Miscellaneous Operations Issues	2
O8.1 (Closed) VIO 50-220/EA96-079-2024: Failure to Notify NRC of Unit 1 Blowout Panels being in a Condition Outside Design Basis ..	2
O8.2 (Closed) LER 50-410/98-02, Supplement 01: Violation of Technical Specification 6.2.2.b	2
O8.3 Administrative Closure of Inspection Follow Item 50-220/97-04-05	3
O8.4 Administrative Closure of Inspection Follow Items (IFIs)	3
II. MAINTENANCE	3
M1 Conduct of Maintenance	3
M1.1 General Comments	3
M1.2 Inadequate Markup Resulted in a Breach of Unit 1 Primary Containment Integrity	4
M8 Miscellaneous Maintenance Issues	5
M8.1 Administrative Closure of Unit 1 Items Referenced in NRC IR 50-410/98-12	5
III. ENGINEERING	5
E1 Conduct of Engineering	5
E1.1 General Comments	5
E8 Miscellaneous Engineering Issues	6
E8.1 (Closed) VIO 50-410/EA96-474-2033: Debris Found in the Unit 2 Suppression Pool Downcomers - Inadequate Corrective Action	6
E8.2 (Closed) LERs 50-410/97-15, Supplements 01 & 02: Opening Between Reactor Building and Reactor Building Auxiliary Bay	6
E8.3 (Closed) LER 50-220/98-13: Valve Repositioning Caused Non- conformance With Appendix R Safe Shutdown Analysis	7
E8.4 (Closed) LER 50-410/98-17: Control Room Ventilation System Inoperable due to Original Design Deficiency	8

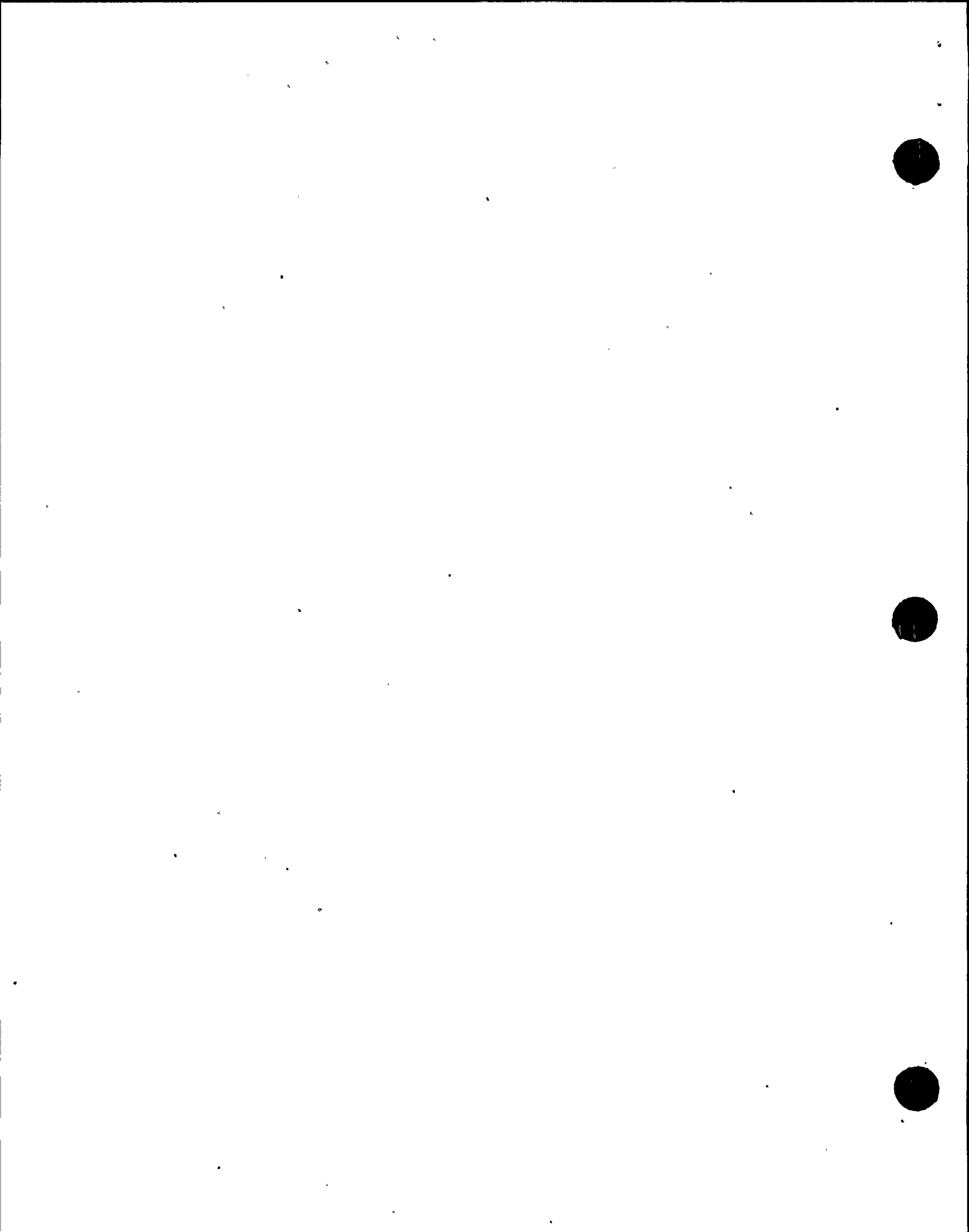


Table of Contents (cont'd)

IV. PLANT SUPPORT	9
R8 Miscellaneous RP&C Issues	10
R8.x (Closed) LER 50-410/98-16: Missed Technical Specification Surveillance Requirement of Meteorological Wind Speed	10
P3 EP Procedures and Documentation	10
P3.1 Review of Emergency Plan and Implementing Procedures	10
F8 Miscellaneous Fire Protection Issues	11
F8.1 (Closed) LER 50-410/98-19: Fire Proofing Missing from Beam ...	11
V. MANAGEMENT MEETINGS	11
X1 Exit Meeting Summary	11

ATTACHMENT

Attachment 1- Partial List of NMPC Persons Contacted

- Inspection Procedures Used
- Items Opened, Closed, and Updated
- List of Acronyms Used



REPORT DETAILS

Nine Mile Point Units 1 and 2
50-220/98-09 & 50-410/98-09
July 5 - August 15, 1998

SUMMARY OF ACTIVITIES

Niagara Mohawk Power Corporation (NMPC) Activities

Unit 1

Nine Mile Point Unit 1 (Unit 1) maintained full power throughout the inspection period.

Unit 2

At the beginning of the inspection period, Nine Mile Point Unit 2 (Unit 2) was conducting power ascension and startup testing following the completion of the sixth refueling outage. Full power was achieved on July 12. On July 19, power was reduced to 55% to allow swapping feed pumps, power was restored to 100% the same day.

Nuclear Regulatory Commission (NRC) Staff Activities

Inspection Activities

The NRC resident inspectors conducted inspection activities during normal, backshift, and deep backshift hours. In addition, specialists from Region I conducted in-office inspections in the areas of emergency preparedness and environmental monitoring. The results of these activities are integrated into this inspection report (IR).

Updated Final Safety Analysis Report Reviews

While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the Updated Final Safety Analysis Report (UFSAR). The inspectors verified that the UFSAR descriptions were consistent with the observed plant practices, procedures, and/or parameters. The only notable exception was discussed in Section E8.4, related to both Unit 2 control room air conditioning units running in parallel.



I. OPERATIONS

O1 Conduct of Operations

O1.1 General Comments (71707)¹

Using NRC Inspection Procedure 71707, the resident inspectors conducted frequent reviews of ongoing plant operations. The reviews included tours of accessible areas of both units, verification of engineered safeguards features (ESF) system operability, verification of adequate control room and shift staffing, verification that the units were operated in conformance with Technical Specifications (TS), and verification that logs and records accurately identified equipment status or deficiencies. In general, the conduct of operations was professional and safety-conscious; specific events and noteworthy observations are detailed in the sections below.

O8 Miscellaneous Operations Issues

O8.1 (Closed) VIO 50-220/EA96-079-2024: Failure to Notify NRC of Unit 1 Blowout Panels being in a Condition Outside Design Basis (92901)

In 1993, the licensee identified that the Unit 1 reactor and turbine building blowout panels would not relieve until a pressure greater than that described in the UFSAR. NMPC failed to promptly report this condition outside the design basis of the plant, as required by 10CFR50.72 and 50.73. The inspectors completed an in-office review of the docketed correspondences between NMPC and NRC regarding this violation, including NMPC's April 27, 1998, final reply to the violation. Based upon the review of docketed material, discussions with the NRC Office of Enforcement, and verification of actions taken by NMPC regarding this issue, this violation is closed.

O8.2 (Closed) LER 50-410/98-02, Supplement 01: Violation of Technical Specification 6.2.2.b (90712)

The technical details associated with this Licensee Event Report (LER) were described in NRC IR 50-410/98-02, Section O8.4. The inspectors completed an in-office review of the additional information provided in Supplement 01 and found it acceptable. LER 50-410/98-02, Supplement 01, is closed.

¹ Topical headings such as O1, M8, etc., are used in accordance with the NRC standardized reactor inspection report outline. Individual reports are not expected to address all outline topics. The NRC inspection manual procedure or temporary instruction that was used as inspection guidance is listed for each applicable report section.



08.3 Administrative Closure of Inspection Follow Item 50-220/97-04-05

During NRC inspection 50-220/98-17, the inspectors reviewed the technical details associated with the inspection follow item (IFI) 50-220/97-04-05, but erroneously referred to item IFI 50-220/97-04-01. Item number 50-220/97-04-01 was a Non-Cited Violation and was opened and closed in NRC IR 50-220/97-04. No additional inspection was required to close IFI 50-220/97-04-05. This item is closed.

08.4 Administrative Closure of Inspection Follow Items (IFIs)

The below listed IFIs were re-examined and determined to have minimal regulatory significance. These IFIs are being administratively closed without additional NRC inspection:

50-410/96-07-15	Long Standing Hardware Problems
50-220/96-13-02	No Trending of Out-of-Tolerance Calibrations
50-220/97-04-01	Low Difficulty Associated with the Written Examination for Licensed Operator Requalification Training
50-410/97-80-02	Engineering Evaluation and Corrective Actions for RHR "B" Full Flow Test Valve

II. MAINTENANCE ²

M1 Conduct of Maintenance

M1.1 General Comments (61726, 62707)

Using NRC Inspection Procedures 61726 and 62707, the resident inspectors periodically observed various maintenance activities and surveillance tests. As part of the observations, the inspectors evaluated the activities with respect to the requirements of the Maintenance Rule, as detailed in 10CFR50.65. In general, maintenance and surveillance activities were conducted professionally, with the work orders (WOs) and necessary procedures in use at the work site, and with the appropriate focus on safety. Specific activities and noteworthy observations are detailed in the inspection report. The inspectors reviewed procedures and observed all or portions of the following maintenance/surveillance activities:

- N1-ST-Q25 Emergency Diesel Generator Cooling Water Quarterly Test
- N1-PM-S1 Operator's Rounds Guide
- N1-ISP-044-005 High Water Level Scram Discharge Volume Instrument Channel Functional Calibration

² Surveillance activities are included under "Maintenance." For example, a section involving surveillance observations might be included as a separate sub-topic under M1, "Conduct of Maintenance."



- N1-ISP-036-008 High Reactor Pressure - Emergency Cooling & Low Reactor Pressure - Core Spray Permissive Instrument Channel Test/Calibration
- WO 98-01949-01 Inspection and Cleaning of Containment Spray #121 In-Line Strainer #80-09
- N1-ST-Q6A Containment Spray System Loop #111 Quarterly Operability Test
- N2-OSP-EGS-M@001 Diesel Generator and Diesel Air Start Valve Operability Test - Division I and II
- N2-OSP-CSL-Q@002 Low Pressure Core Spray Pump & Valve Operability Test and System Integrity Test

M1.2 Inadequate Markup Resulted in a Breach of Unit 1 Primary Containment Integrity

a. Inspection Scope (61726)

During planned maintenance on the Unit 1 containment spray system, a torus low pressure annunciator alerted the control room operators to a breach in primary containment integrity. The condition existed for five (5) hours before it was discovered.

The inspectors reviewed the DER, the markup, the associated work orders, and the procedure that controlled the generation of markups. In addition, the inspectors discussed the event with the individuals involved and Unit 1 management.

b. Observations and Findings

On August 4, 1998, during planned maintenance on the Unit 1 containment spray system, NMPC discovered that primary containment integrity had been inadvertently breached. Specifically, the isolation of containment spray strainer #121 for maintenance was inadequate, in that closure of the heat exchanger vent valves was not included on the markup. This resulted in a leakage path from the torus air space, through the open vent lines to the containment spray system, to the reactor building atmosphere via the disassembled strainer. The leakage path had been open for about five hours, when a torus low pressure alarm was received in the control room. The Station Shift Supervisor (SSS) promptly recognized the cause and directed the vent valves to be closed, which re-established primary containment integrity.

The inspectors reviewed the work order, the associated markup for the planned maintenance, the system prints, and the NMPC implementing procedure for markups (GAP-OPS-02, "Control of Hazardous Energy and Configuration Tagging). The inspectors also discussed the event with Unit 1 Operations management and the licensed operators responsible for the generation and approval of the markup. As of the end of the inspection period, NMPC had not completed the root cause evaluation or determined the corrective actions to prevent recurrence. This issue, which is an apparent violation of NRC requirements, will remain open pending



receipt and review of the associated LER required to be submitted to the NRC, in accordance with 10CFR50.73. (EEI 50-220/98-09-01)

c. Conclusion

During preparations for maintenance on the Unit 1 containment spray system, the markup for isolation of the system was inadequate, resulting in a breach of the primary containment integrity. This issue remains open pending the NRC inspectors' review of NMPC's completed root cause analysis and determination of corrective actions to prevent recurrence. (EEI 50-220/98-09-01)

M8 Miscellaneous Maintenance Issues

M8.1 Administrative Closure of Unit 1 Items Referenced in NRC IR 50-410/98-12

During the NRC inspection of the Unit 2 Maintenance Rule implementation, the inspectors reviewed the technical details of the below listed Unit 1 open items and all were closed. The results of this review were documented in NRC IR 50-410/98-12. However, due an administrative oversight the Unit 1 docket number was not included in the cover letter and inspection report. This serves to administratively close the below listed Unit 1 items:

URI 50-220/96-12-02	Effectiveness of the expert panel, including untimely reviews associated with (a)(1) systems
IFI 50-220/96-12-03	Engineering evaluation to provide a basis for the risk ranking downgrade of the diesel fire pump
IFI 50-220/96-12-04	Review balancing of reliability and unavailability
VIO 50-220/EA-97-007-1013	Failure to include a number of systems, structures, and components within the scope of the rule
VIO 50-220/EA-97-007-1023	Ineffective goals and monitoring for the (a)(1) and (a)(2) systems

III. ENGINEERING

E1 Conduct of Engineering

E1.1 General Comments (37551)

Using NRC Inspection Procedure 37551, the resident inspectors frequently reviewed design and system engineering activities and the support by the engineering organizations to plant activities.



E8 Miscellaneous Engineering Issues**E8.1 (Closed) VIO 50-410/EA96-474-2033: Debris Found in the Unit 2 Suppression Pool Downcomers - Inadequate Corrective Action (92903)**

In 1995 during the fourth refueling outage (RFO4) at Unit 2, NMPC did not adequately clean the suppression pool. Specifically, the cleaning did not include the removal of debris from of the downcomers. [A downcomer is a hollow steel vent pipe which penetrates the drywell floor, and connects the drywell atmosphere to the water in the suppression pool. The suppression pool is filled with water and provides for the rapid condensation and cooling of the steam-water mixture which would result from a loss of coolant accident (LOCA).] This was identified by NMPC during RFO5 in October 1996. NMPC had initiated a deviation/event report (DER) in May 1995, documenting that most of the debris removed in RFO4 was located beneath the downcomers. The NRC determined this was a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action," in that controls were not established to assure that a condition adverse to quality was identified and appropriate corrective action taken.

NMPC identified in their response to the violation that the root cause for the violation was a lack of a questioning attitude with respect to the location of the material in the suppression pool and a lack of sensitivity to the issue of foreign debris potentially clogging the strainers for emergency core cooling system pumps. In addition, NMPC admitted that there were multiple missed opportunities to have determined that a downcomer inspection was warranted. With respect to the overall adequacy of the Nine Mile corrective action program, as defined in procedure NIP-ECA-01, "Deviation/ Event Reports," NMPC stated in their response to the violation that they considered the DER program to be fundamentally sound. However, the program was enhanced, to include: (1) written guidance for dispositioning DERs, (2) categorizing DERs based on significance, and (3) a requirement that formal root causes for Level 1 DERs be performed by qualified personnel. In addition, to prevent recurrence, the practice of an acting branch manager approving the DER disposition was discontinued and, in the absence of a branch manager, the approval was to be escalated to a senior manager.

The inspectors reviewed the Notice of Violation response, dated May 12, 1997, and determined that the root cause and corrective actions were acceptable. The resident inspectors routinely review significant DERs and observe management meetings where DER dispositions are discussed. Generally, the DER disposition and corrective actions have improved since this event and senior NMPC management expectations have been adhered to. This violation is closed.

E8.2 (Closed) LERs 50-410/97-15, Supplements 01 & 02: Opening Between Reactor Building and Reactor Building Auxiliary Bay (90712)

The issues associated with this LER were described in NRC IR 50-410/97-12, Section E8.1. The inspectors completed an in-office review of the additional



information provided in the Supplements and found it acceptable. The LER Supplements are closed.

E8.3 (Closed) LER 50-220/98-13: Valve Repositioning Caused Non-conformance With Appendix R Safe Shutdown Analysis

a. Inspection Scope (92700)

On June 4, 1998, Nine Mile Point engineering personnel discovered that some requirements of the Unit 1 10CFR50, Appendix R, Safe Shutdown Analysis, were not satisfied.

The inspectors assessed the licensee's immediate actions, root cause analysis, and planned corrective actions. With respect to immediate actions, the inspectors discussed the actions with the SSS and reviewed applicable plant drawings. With respect to the root cause and planned corrective actions, the inspectors reviewed the associated DER and LER, applicable licensee procedures, specific engineering documents, the Unit 1 UFSAR and the Unit 1 System Design Basis Document. In addition, the inspectors verified the completion of the LER in accordance with 10CFR50.73.

b. Observations and Findings

As a result of a previous violation associated with the Unit 1 Fire Protection/ Appendix R Program, NMPC performed a design verification review of their Fire Protection Engineering Evaluation (FPEE). During this review, NMPC engineering personnel discovered that some requirements for the Unit 1 10CFR50, Appendix R Safe Shutdown Analysis were not satisfied. Specifically, two 1-inch manual valves (40-26 and 40-27) downstream of the core spray system high point vent lines were opened to preclude post-LOCA thermal over-pressurization concerns, as addressed by Generic Letter (GL) 96-06, "Assurance of Equipment Operability and Containment Integrity during Design-Basis Accident Conditions." The valves had previously been closed to satisfy Appendix R high/low pressure interface/inventory loss pathway concerns.

The specific Appendix R concern is a control room fire which causes a loss of alternating current (AC) power. During this event, the reactor vessel must retain sufficient coolant inventory until power is restored. The Unit 1 Appendix R analysis determined that with the maximum leakage allowed by TS, makeup to the vessel would not be required for the initial eight hours of the event. With valves 40-26 and 40-27 open, and with the spurious operation of two motor-operated valves (MOVs) and one air-operated valve, a leak path could potentially be established from the core spray spargers, within the reactor vessel, through the core spray system to the reactor building equipment drains. This potential pathway could result in leakage that exceeds the amount assumed in the analysis, and adversely impact the ability to maintain coolant inventory (i.e., keep the reactor coolant water level above the top of active fuel) during the eight-hour period that AC power is assumed unavailable.



The licensee's immediate corrective actions were to verify that the MOVs were closed and to tag open the associated circuit breakers. The Unit 1 UFSAR, Appendix 10B, "Appendix R Safe Shutdown Analysis," Section 5.9.4.3, allows electrical isolation of components as a means to resolve potential spurious operation. Therefore, this configuration ensures conformance with the Appendix R, Safe Shutdown Analysis, and satisfactorily addresses the GL 96-06 thermal over-pressurization concern. Based on discussions with the SSS and a review of the applicable plant drawings and UFSAR sections, the inspectors concluded that these immediate actions were acceptable.

NMPC evaluated the consequence of the event and concluded that the probability of multiple hot shorts was very small, and the probability was likewise very small of sufficient leakage through this pathway to cause the core to become uncovered. Therefore, based on the above, this event did not pose a threat to the health and safety of the public or plant personnel. Additionally, NMPC completed a probabilistic assessment of the event that concluded that there was no significant increase in core damage frequency. Nonetheless, the failure to provide adequate protection against possible spurious operation of equipment that could adversely impact the safe shutdown capability is a violation of 10CFR50, Appendix R, Section III G.2. This non-repetitive, licensee-identified and corrected violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1 of the NRC Enforcement Policy. (NCV 50-220/98-09-02)

The inspectors verified that the LER was completed in accordance with the requirements of 10CFR50.73. Specifically, the description and analysis of the event, as contained in the LER, were consistent with the inspectors' understanding of the event. The root cause and corrective and preventive actions as described in the LER were reasonable. This LER is closed.

c. Conclusion

At Unit 1, an inadequate engineering evaluation of a 1997 configuration change resulted in a non-conformance with the 10CFR50, Appendix R, Safe Shutdown Analysis, by opening the core spray high point vent valves to address GL 96-06 thermal over-pressurization concerns. Upon identification, NMPC took prompt and appropriate corrective actions. This licensee identified and corrected violation of Appendix R was not cited. (NCV 50-220/98-09-02)

E8.4 (Closed) LER 50-410/98-17: Control Room Ventilation System Inoperable due to Original Design Deficiency (92700)

a. Inspection Scope, Observations, and Findings

On May 20, 1998, during performance of a surveillance test to verify the loss of offsite power (LOOP) function of the emergency diesel generators, NMPC identified that both control room air conditioning units (ACUs) were running for a short period of time. This was not one of the expected responses to the test, and DER 2-98-1459 was written to evaluate the acceptability of both ACUs operating in



parallel. On June 2, NMPC determined that the parallel operation of these safety-related ACUs could adversely impact their design function. The control room ACUs are designed to cool safety-related equipment in the control room and to maintain control room habitability following a LOCA coincident with a LOOP. Specifically, if both ACUs were to start and run in parallel, one or both of the ACUs could trip due to low flow. The start logic would consequently have to be manually reset, before the tripped ACU(s) would automatically restart. If both ACUs tripped or the operating ACU were to become inoperable, the system would not be able to automatically maintain the control room environment.

Although not designed for parallel operation, NMPC's investigation revealed that the start logic permitted this configuration. The system ducting was designed for single ACU operation only. NMPC determined the root cause to be inadequate verification and independent review of the original design provided by the Architect/Engineer. Unit 2 engineering determined that control room temperature alarms would alert the operators early enough to initiate manual actions to restore at least one ACU to maintain the control room temperature below design limits. Corrective actions included a modification to the control logic for the system, and a review of all other safety-related ventilation systems for similar design vulnerabilities. This original construction design vulnerability resulted in the control room ventilation system being potentially inoperable, which is contrary to 10CFR50, Appendix B, Criterion III, Design Control. However, this licensee identified and corrected violation is being treated as a Non-Cited Violation, consistent with Section VII.B.1 of the NRC Enforcement Policy. (NCV 50-410/98-09-03)

The inspectors verified that the LER was completed in accordance with the requirements of 10CFR50.73. Specifically, the description and analysis of the event, as contained in the LER, were consistent with the inspectors' understanding of the event. The root cause and corrective and preventive actions as described in the LER were reasonable. This LER is closed.

b. Conclusion

During Unit 2 surveillance testing, NMPC identified that both control room air conditioning units were running in parallel, contrary to the intended design. This design vulnerability could have potentially resulted in the system being inoperable, under certain design basis accident scenarios. This licensee identified and corrected violation of 10CFR50, Appendix B, Criterion III, Design Control, was not cited. (NCV 50-410/98-09-03)

IV. PLANT SUPPORT

Using NRC Inspection Procedure 71750, the resident inspectors routinely monitored the performance of activities related to the areas of radiological controls, chemistry, emergency preparedness, security, and fire protection. Minor deficiencies were discussed with the appropriate management, significant observations are detailed below. Specialist inspectors in the same areas used other procedures during their



reviews of plant support activities; these inspection procedures are listed, as applicable, for the respective sections of the inspection report.

R8 Miscellaneous RP&C Issues

R8.x (Closed) LER 50-410/98-16: Missed Technical Specification Surveillance Requirement of Meteorological Wind Speed (90712)

The details associated with this LER were discussed in NRC IR 50-220/98-05, Section R1.2. The inspectors completed an in-office review of the LER and verified that it was completed in accordance with the requirements of 10CFR50.73. Specifically, the description and analysis of the event, as contained in the LER, were consistent with the inspectors' understanding of the event. The root cause and corrective and preventive actions as described in the LER were reasonable. This LER is closed.

P3 EP Procedures and Documentation

P3.1 Review of Emergency Plan and Implementing Procedures (82701)

Based on NMPC's determination that the changes to the Nine Mile Emergency Plan and the below implementing procedures did not decrease the overall effectiveness of the Emergency Plan, and a limited review of the changes, the NRC acknowledges that the changes did not require NRC approval, in accordance with 10CFR50.54(q). The NRC will inspect the implementation of these changes in a future inspection to confirm that they did not decrease the overall effectiveness of the emergency preparedness function.

<u>Procedure</u>	<u>Title</u>	<u>Revision</u>
---	Site Emergency Plan	36
EPIP-EPP-02	Classification of Emergency Conditions at Unit 2	8
EPIP-EPP-03	Search and Rescue	3
EPIP-EPP-05	Station Evacuation	2
EPIP-EPP-06	In-plant Emergency Surveys	3
EPIP-EPP-07	Downwind Radiological Monitoring	4
EPIP-EPP-08	Off-Site Dose Assessment and Protective Action Recommendations	8
EPIP-EPP-09	Determination of Core Damage Under Accident Conditions	2
EPIP-EPP-10	Security Contingency Event	3
EPIP-EPP-11	Hazardous Material Incident Response	3
EPIP-EPP-13	Emergency Response Facilities Activation and Operation	8



<u>Procedure</u>	<u>Title</u>	<u>Revision</u>
EPIP-EPP-15	Emergency Health Physics Procedure	3
EPIP-EPP-16	Environmental Monitoring	3
EPIP-EPP-20	Emergency Notifications	7
EPIP-EPP-22	Damage Control	2,3
EPIP-EPP-23	Emergency Personnel Action Procedures	7
EPIP-EPP-25	Emergency Reclassification and Recovery	4
EPIP-EPP-27	Emergency Public Information Procedure	4
EPIP-EPP-30	Prompt Notification System Problem Response	3
EPMP-EPP-01	Maintenance of Emergency Procedures	8
EPMP-EPP-02	Emergency Equipment Inventories and Checklists	12,13,14
EPMP-EPP-04	Emergency Exercise/Drill Procedure	4
EPMP-EPP-05	Emergency Preparedness Program Self Assessment	1
EPMP-EPP-08	Maintenance, Testing and Operation of the Oswego County Prompt Notification System	4

F8 Miscellaneous Fire Protection Issues

F8.1 (Closed) LER 50-410/98-19: Fire Proofing Missing from Beam (90712)

On June 17, 1998, NMPC identified that a structural beam in the Unit 2, Division II emergency switchgear room was not properly coated with fire proofing. This was identified as a result of a similar deficiency at Unit 1. The beam was subsequently re-coated, and no additional significant deficiencies were identified. This failure to ensure the plant was in a condition consistent with the design basis constitutes a violation of minor significance and is not subject to formal enforcement action.

V. MANAGEMENT MEETINGS

X1 Exit Meeting Summary

At periodic intervals, and at the conclusion of the inspection period, meetings were held with senior station management to discuss the scope and findings of this inspection. The final exit meeting occurred on August 21, 1998. During this meeting, the resident inspectors' findings were presented. NMPC did not dispute any of the inspectors 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.



ATTACHMENT 1

PARTIAL LIST OF NMPC PERSONS CONTACTED

Niagara Mohawk Power Corporation

R. Abbott	Vice President, Nuclear Engineering
D. Barcomb	Manager, Unit 2 Radiation Protection
D. Bosnic	Manager, Unit 2 Operations
J. Burton	Manager, Training
H. Christensen	Manager, Security
J. Conway	Vice President, Nuclear Generation
B. Holloway	Manager, Unit 1 Chemistry (acting)
R. Dean	Manager, Unit 2 Engineering
A. DeGracia	Manager, Unit 1 Work Control
S. Doty	Manager, Unit 1 Maintenance
K. Dahlberg	Plant Manager, Unit 2 (acting)
G. Helker	Manager, Unit 2 Work Control
A. Julka	Director, ISEG
C. Merritt	Manager, Unit 2 Chemistry
P. Mezzafero	Manager, Unit 1 Technical Support
L. Pisano	Manager, Unit 2 Maintenance
N. Rademacher	Manager, Quality Assurance
R. Randall	Manager, Unit 1 Engineering
V. Schuman	Manager, Unit 1 Radiation Protection
R. Smith	Plant Manager, Unit 1
C. Terry	Vice President, Nuclear Safety Assessment & Support
D. Topley	Manager, Unit 1 Operations
K. Ward	Manager, Unit 2 Technical Support
D. Wolniak	Manager, Licensing

INSPECTION PROCEDURES USED

IP 37551	On-Site Engineering
IP 61726	Surveillance Observations
IP 62707	Maintenance Observations
IP 71707	Plant Operations
IP 71750	Plant Support
IP 82701	Operational Status of the Emergency Preparedness Program
IP 90712	In-Office Review of Written Reports of Non-Routine Events at Power Reactor Facilities
IP 92700	Onsite Follow-up of Written Reports of Non-Routine Events at Power Reactor Facilities
IP 92901	Follow-up - Operations
IP 92903	Follow-up - Engineering



ITEMS OPENED, CLOSED, AND UPDATEDOPENED

50-220/98-09-01	EI	Inadequate markup resulted in a breach of primary containment integrity
50-220/98-09-02	NCV	Appendix R safe shutdown analysis not satisfied due to a core spray valve repositioning
50-410/98-09-03	NCV	Control room ventilation inoperable due to design deficiency

CLOSED

50-220/98-09-02	NCV	Appendix R safe shutdown analysis not satisfied due to a core spray valve repositioning
50-410/98-09-03	NCV	Control room ventilation inoperable, due to design deficiency
50-220/97-04-05	IFI	Poor reliability of the Unit 1 simulator full-core display
50-220/96-12-02	URI	Effectiveness of the expert panel, including untimely reviews associated with (a)(1) systems
50-220/96-12-03	IFI	Engineering evaluation to provide a basis for the risk ranking downgrade of the diesel fire pump
50-220/96-12-04	IFI	Review balancing of reliability and unavailability
50-220/EA97-007-1013	VIO	Failure to include a number of systems, structures, and components within the scope of the rule
50-220/EA97-007-1023	VIO	Ineffective goals and monitoring for the (a)(1) and (a)(2) systems
50-220/EA96-079-2024	VIO	Failure to notify NRC of Unit 1 blowout panels being in a condition outside design basis
50-410/96-07-15	IFI	Long standing hardware problems
50-220/96-13-02	IFI	No trending of out-of-tolerance calibrations
50-220/97-04-01	IFI	Low difficulty associated with the written examination for LORT
50-410/97-80-02	IFI	Engineering evaluation and corrective actions for RHR "B" full flow test valve
50-410/EA96-474-2033	VIO	Debris found in the suppression pool downcomers - inadequate corrective action
50-410/98-02-01	LER	Violation of TS 6.2.2.b
50-410/97-15-01	LER	Opening between reactor building and reactor building auxiliary bay



Attachment 1 (cont'd)

50-410/97-15-02	LER	Opening between reactor building and reactor building auxiliary bay
50-220/98-13	LER	Valve repositioning caused non-conformance with Appendix R safe shutdown analysis
50-410/98-17	LER	Control room ventilation system inoperable due to original design deficiency
50-410/98-16	LER	Missed TSSR of meteorological wind speed
50-410/98-19	LER	Fire proofing missing from beam

UPDATED

none

LIST OF ACRONYMS USED

ACU	Air Conditioning Unit
CFR	Code of Federal Regulations
DER	Deviation/Event Report
EA	Enforcement Action
EEI	Escalated Enforcement Item
ESF	Engineered Safeguards Feature
FPEE	Fire Protection Engineering Evaluation
GL	Generic Letter
IR	Inspection Report
LER	Licensee Event Report
LOCA	Loss of Coolant Accident
LOOP	Loss of Offsite Power
MOV	Motor Operated Valve
NCV	Non-Cited Violation
NMPC	Nine Mile Point Corporation
NRC	Nuclear Regulatory Commission
RFO	Refueling Outage
RHR	Residual Heat Removal
SSS	Station Shift Supervisor
TS	Technical Specification
UFSAR	Updated Final Safety Analysis Report
Unit 1	Nine Mile Point Unit 1
Unit 2	Nine Mile Point Unit 2
VIO	Violation
WO	Work Order

