

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

January 2, 1991
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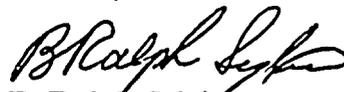
RE: Nine Mile Point Unit 2
Docket No. 50-410
NPF - 69

Gentlemen:

Attached is Niagara Mohawk Power Corporation's response to the Notice of Violation contained in Inspection Report No. 50-410/90-09 dated December 4, 1990.

Very truly yours,

NIAGARA MOHAWK POWER CORPORATION



B. Ralph Sylvia
Executive Vice President - Nuclear

JTP/KBT/tsc

Attachment

xc: Regional Administrator, Region I
Mr. W. A. Cook, Senior Resident Inspector
Records Management

~~12/10/90~~
WAP



NINE MILE POINT UNIT #2
DOCKET NO. 50-410
NPF-69

Response to Notice of Violation Contained in Inspection Report 50-410/90-09-01.

VIOLATION

Nine Mile Point Unit 2, Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained for maintenance and testing. Administrative Procedure (AP) 3.3.2, Radiation Work Permits (RWP), step 5.7.1 states that radiation workers shall comply with the requirements of radiation work permits. AP 5.3.1, Control and Calibration of Measuring and Test Equipment, step 5.4.6.a.4 states that personnel using measuring and test equipment shall do so in compliance with special instructions on special instruction tags.

Contrary to the above, on October 25, 1990, written procedures were not properly implemented during safety related maintenance on hydraulic control unit (HCU) 6-15, in that:

- Maintenance mechanics failed to adhere to Note (1) of RWP 905853-01A which required a full set of anti-contamination clothing be worn for any HCU work performed in a contaminated area; and,
- Maintenance mechanics used torque wrench 22-1035 to torque fasteners on the HCU 6-15 scram inlet valve air diaphragm housing; however, the fastener torque settings were outside the calibrated range of the torque wrench as specified on the special instruction sticker affixed to the torque wrench.

These two examples comprise a Severity Level IV Violation (Supplement 1).

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

Niagara Mohawk Power Corporation admits to the violation as stated.

THE REASON FOR THE VIOLATION

The Manager-Maintenance held an investigative meeting to determine the cause of both procedure violations. Attending were the Manager-Maintenance, Supervisor - Mechanical Maintenance, and Chief Mechanic of the work crew involved. The cause of both procedure violations, i.e. failure to adhere to RWP requirements and use of the wrong torque wrench, was determined to be inattention to detail. The Plant Manager and the Vice President-Nuclear Generation concurred with this conclusion based on the Plant Manager's discussion with the Manager-Maintenance and the NRC Inspector who observed the violations.

The work crew was initially working on hydraulic control units (HCU's) that were not in a contaminated area. A Radiation Protection Technician performed a contamination check on an air diaphragm and found that it was not contaminated.



Radiation Protection advised the mechanics that these components on other HCU's would not be contaminated. When the mechanics came to HCU 6-15, which was in a designated contaminated area, they reached into the contaminated area without donning protective clothing. They were working on a ladder near the border of the contaminated area and mistakenly thought they could work on a clean component, in an area where the floor was contaminated, without protective clothing. However, this was in violation of the RWP requirements, which specified protective clothing for work in the contaminated area.

Two (2) torque wrenches were present at the job site and each wrench was calibrated for a different torque range. The Chief Mechanic selected the wrong wrench for the job and handed it to the work crew. The work crew assumed the correct wrench was selected, and neither questioned the Chief nor looked at the label on the torque wrench.

CORRECTIVE STEPS TAKEN AND RESULTS ACHIEVED

The scram valve housing that was torqued with the incorrect wrench was retorqued to the correct value with the correct wrench. The Radiation Protection Supervisor was notified of the RWP violation, and a Radiological Occurrence Report was initiated to document what happened, the cause, and corrective actions. Additionally, a Radiation Protection Technician performed a contamination survey of the immediate work area and found less than 100 dpm's/100cm sq. beta-gamma smearable contamination.

Mechanical Maintenance Supervisors met with all shifts of Mechanical Maintenance personnel to discuss the specifics of the RWP violation and the use of the incorrect torque wrench. Compliance with RWP requirements, and reading the labels on torque wrenches were covered. The supervisors emphasized the need for increased attention to detail.

The Plant Manager conducted a meeting with departmental Managers to emphasize compliance to station rules and procedures. The departmental Managers were then directed to immediately reinforce the concept of compliance throughout their organizations by holding meetings with their personnel. This reinforcement was accomplished within several days of the Plant Manager's meeting.

The Plant Manager held an accountability meeting with the Supervisor - Mechanical Maintenance, Chief Mechanic, Mechanics in the work crew, labor union representatives and an Employee Relations Department representative. The Vice President-Nuclear Generation also attended. All aspects of the violation were thoroughly discussed. Subsequently, appropriate disciplinary action was taken with the workers involved. Letters documenting this discipline are being prepared for placement in the appropriate company files.



CORRECTIVE STEPS WHICH WILL BE TAKEN TO AVOID FURTHER VIOLATION.

Niagara Mohawk realizes that there is a need to have people "down in our ranks" understand the Nuclear Division Standards of Performance, and to meet those standards. These standards include procedure adherence and accountability/responsibility. Niagara Mohawk needs to ensure that people account for their actions and that corrective action, and discipline if necessary, is administered effectively. In the future, accountability meetings will continue to be used to reinforce these Standards of Performance.

In early December 1990, the Executive Vice President-Nuclear and the Vice President-Nuclear Generation met with all levels of supervisory personnel in staff meetings at the Nine Mile Point Site. The accountability meeting for the RWP and torque wrench violations was discussed. Management's expectations regarding procedure compliance were expressed. Additionally, the Vice President - Nuclear Generation held separate meetings with the maintenance departments at each unit to discuss his expectations and receive feedback on their understanding of the Standards of Performance. Supervisors were informed that procedure compliance is a requirement for employment. Supervisors must ensure that their personnel understand the necessity of following procedures, and that supervisors observe personnel in the field to ensure they are following their procedures.

THE DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Niagara Mohawk is currently in full compliance.

