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                          Document Control Branch (Document Control Desk)

SUBJECT: Responds to violations noted in Insp rept 50-410/91-17 on 910728-0907. Corrective actions: Administrative Procedure AP-4.2 re control of equipment markups revised & reissued & closed svc water valve on 910617 reviewed w/shifts.

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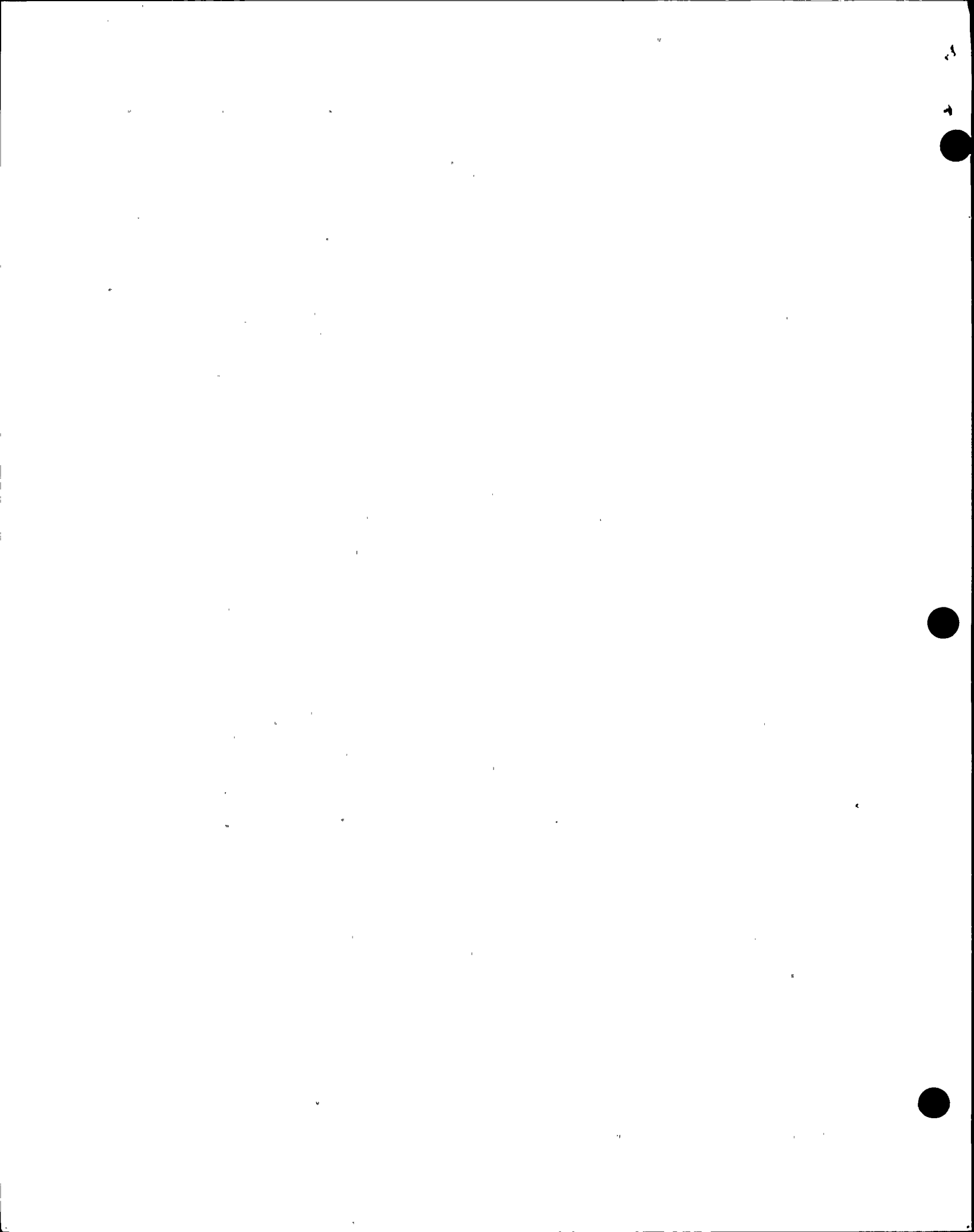
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B. Ralph Sylvia  
Executive Vice President  
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November 22, 1991  
NMP2L 1328

U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, D. C. 20555

Nine Mile Point Unit 2  
Docket No. 50-410  
NPF-69

Gentlemen:

SUBJECT: RESPONSE TO NOTICE OF VIOLATION  
NRC INSPECTION REPORT NO. 50-410/91-17

Attached is Niagara Mohawk Power Corporation's response to the Notice of Violation contained in the subject Inspection Report dated October 23, 1991. If you have any questions concerning this matter, please contact me.

Very truly yours,



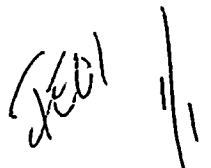
B. Ralph Sylvia  
Exec. Vice President - Nuclear

WDB/sek  
001734LL

Attachment

xc: Regional Administrator, Region I  
Mr. W. L. Schmidt, Senior Resident Inspector  
Mr. R. A. Capra, Project Directorate No. I-1, NRR  
Mr. J. E. Menning, Project Manager, NRR  
Mr. D. R. Haverkamp, Chief, Reactor Projects, Section 1B  
Records Management

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PDR ADOCK 05000410  
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NINE MILE POINT UNIT 2  
DOCKET NO. 50-410  
NPF-69

**Notice of Violation**

Niagara Mohawk Power Corporation  
Nine Mile Point Unit 2

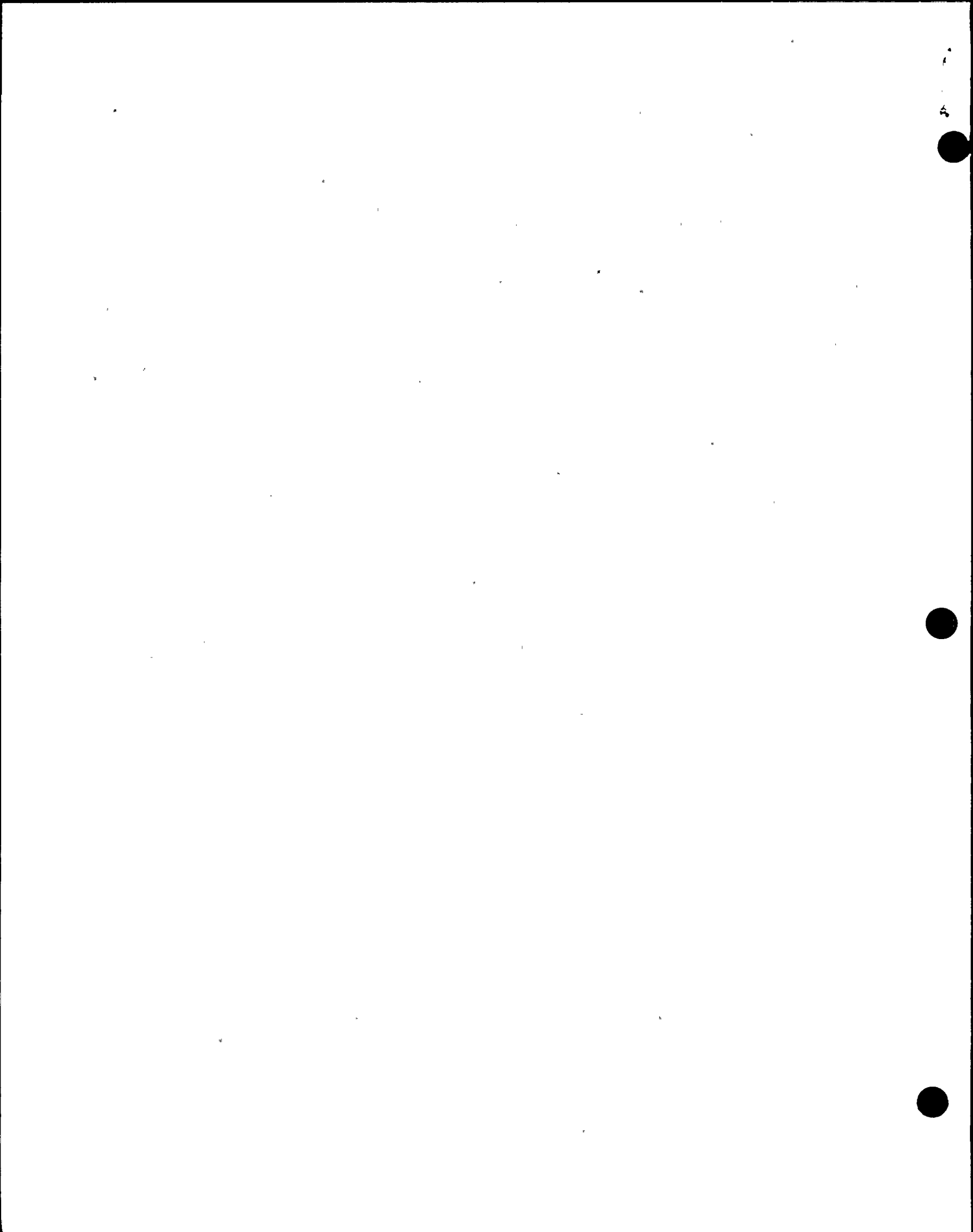
Docket No. 50-410  
License No. NPF-69

During an NRC inspection conducted on July 28 - September 7, 1991, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR 50 Part 2, Appendix C (1991), the violation is listed below:

Nine Mile Point Unit 2 Technical Specification 6.8.1 requires that written procedures be implemented that meet or exceed the requirements of Regulatory Guide 1.33, Appendix A, which includes administrative procedures for equipment control through the use of markups (i.e., tagging). NMPC administrative procedure (AP) 4.2, Control of Equipment Markups, Section 5.5, provides specific requirements for the application of markups, including maintaining configuration control on marked up components.

Contrary to the above, on June 17, 1991, the service water valve 2SWP\*V136D, the inlet supply valve to unit cooler 2HVR\*UC404D, was taken to the closed position during establishment of a markup to support a maintenance activity on the unit cooler, without adequate configuration control of that marked up component. Specifically, further processing of the markup in the field was terminated due to the inability to operate one of the valves specified in the markups, and the markup was subsequently voided and disposed of without control personnel noting the fact that the 2SWP\*V136D was shut. As a result, the valve was left in the abnormal position until July 2, 1991.

This is a Severity Level IV violation (Supplement I).



## Reply to Notice of Violation 50-410/91-17

### 1. THE REASONS FOR THE VIOLATION

Niagara Mohawk Power Corporation admits to the violation as stated. The root cause of this violation is personnel error resulting from inadequate work practices. The operator and supervisors involved exercised poor communications practices, and demonstrated a lack of accountability for their actions by failing to maintain proper control over the component.

A thorough investigation of this event has been conducted and documented in Licensee Event Report (LER) 91-16. Supplement 2 of the LER is being submitted providing the most recent conclusions of the investigation and the results of our analysis.

The plant operator assigned to isolate and markup unit cooler 2HVR\*UC404D successfully closed the cooling water inlet valve (2SWP\*V136D), but was unable to close the outlet valve (2SWP\*V553D). The operator correctly identified the problem to the Station Shift Supervisor (SSS), but failed to advise the SSS of the closed and marked up status of the inlet valve which was on the same markup. The SSS in turn suspended further work on the markup and held the incomplete paperwork until the problem could be addressed. The SSS was not aware of the inlet valve position and failed to verify its status when he assumed responsibility for the markup.

The markup paperwork was transferred to two subsequent SSS's at shift turnovers apparently with only an explanation of the problem encountered on the outlet valve. The closed status of the inlet valve was not documented or communicated during the turnovers. After unsuccessful attempts to resolve the problem with the outlet valve, a decision was made to cancel the unit cooler work. Since the markup had not been completed, the markup hard copy record and tags were collected and destroyed consistent with past practice, and the markup was voided. This process was not proceduralized.

The lack of procedural guidance was determined to be a contributing factor. Administrative Procedure AP-4.2, "Control of Equipment Markups" provided guidance for issuance and restoration, but was silent on voiding markups which are not used or completed. Since the markup had not been formally issued, restoration sheets were not issued when the decision to void the markup was made. Regardless of this factor, the operator and supervisors were accountable for the closed inlet valve and should have known to communicate its status.

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## **2. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED**

Operations Management reviewed this event with all Operating shifts. The importance of maintaining positive component configuration control was emphasized. In addition, accountability for individual actions was stressed. The individuals responsible for the loss of configuration control have been counselled and disciplined.

The Plant Manager held a meeting on July 3, 1991 with the Unit 2 supervisors, followed by an administrative stop work so that supervisors could discuss this and other performance issues with their personnel. These discussions stressed that while complete and accurate procedures are important, less than perfect procedures are not an excuse for lack of individual accountability and responsibility.

Shortly after the discovery of the mispositioned valves and identification of the procedural deficiency, two interim department instructions were issued to provide the missing guidance until the markup Administrative Procedure could be revised. One addressed the standard practice for voiding markups, and the second described the four step processes for hanging and removing markups. These instructions and the loss of configuration control event were also documented and distributed on a Lessons Learned Transmittal (LLT) for personnel awareness. The LLT reemphasized the need for personnel to ensure that the procedures they use are complete.

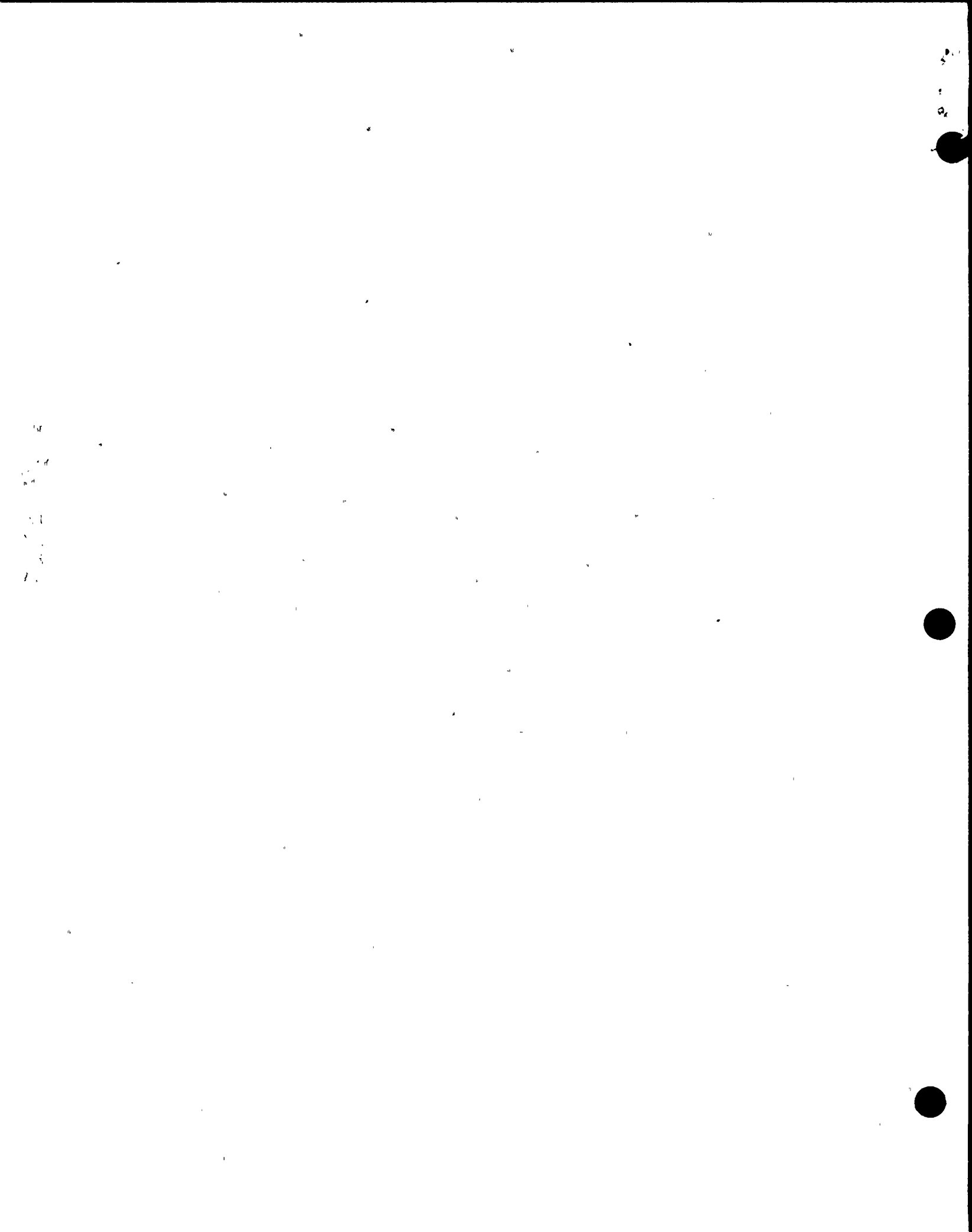
Administrative Procedure AP-4.2, "Control of Equipment Markups" has been revised and reissued as a new Generation Administrative Procedure GAP-OPS-02. Clarifications have been incorporated in the markup application section emphasizing the need to document the markup application after each component manipulation. In addition, a new section has been added to address markup voiding.

Another corrective action completed was a revision to the markup computer program to better track the initiation and disposition of voided markups. Also a review was conducted of standby safe shutdown and engineered safety features systems to determine if any systems may have been affected by other voided markups. No problems were found.

## **3. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS**

Training on the new markup procedure with emphasis on the incorporated changes has been initiated for all affected Operations personnel.

Recently, an investigation was conducted by the Independent Safety Engineering Group (ISEG 91-43 dated September 20, 1991) in response to an adverse trend identified in work practices at Nine Mile Point Unit 2. The issues of this violation were not specifically the subject of the investigation, but many of the findings and



### 3. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

(Continued)

recommendations are directly applicable to the subject violation. Findings relative to Operations' performance in defining and communicating good work practices and policies, motivation to comply, and proper resources were generally very positive. The findings indicate that Operations personnel are clearly aware of good work practices, policies and expectations, including the need for self-verification.

However, the investigation report identified one area of concern applicable to Operations. The report recommended that direct work observation of personnel should become a more significant part of the supervisor's daily routine. Operations supervision, which currently focuses the majority of its work observations on control room activities, needs to more evenly divide this time between field activities and control room activities. In this way supervision can provide more timely and direct feedback to operators in the field encouraging and reinforcing good work practices, and correcting poor practices. Operations management is currently evaluating how best to implement the improvement recommendation.

Niagara Mohawk is also taking steps to strengthen shift management. The Assistant Station Shift Supervisor (ASSS) has been moved into the Control Room to provide Senior Reactor Operator (SRO) presence and to directly oversee Control Room activities. This will permit the SSS to assume more of a shift managerial role. In early 1992 the transition of responsibilities will be completed with full utilization of the Shift Technical advisor in support of the shift, allowing the SSS to perform more effectively in all operating situations.

### 4. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance will be achieved when training on the new equipment markup procedure has been completed. Training is expected to be complete by December 15, 1991.

