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 AUTH. NAME AUTHOR AFFILIATION
 SYLVIA, B.R. Niagara Mohawk Power Corp.
 RECIP. NAME RECIPIENT AFFILIATION
 HODGES, M.W. Region 1 (Post 820201)

SUBJECT: Suppls 920511 response to NRC request for util perspectives on findings & conclusions contained in NUREG-1455 re transformer failure on 910813 & NRC comments raised during Insp Rept 50-410/92-27. Deviation/event rept initiated.

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B. Ralph Sylvia
Executive Vice President
Nuclear

October 27, 1992
NMP2L 1360

Mr. Marvin W. Hodges
Director, Division of Reactor Safety, Region I
U. S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406

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

Dear Mr. Hodges:

SUBJECT: INFORMATION AND CORRECTIVE ACTIONS RELATED TO AUGUST 13, 1991
INCIDENT AT NINE MILE POINT UNIT 2

Niagara Mohawk Power Corporation (NMPC) submitted letter NMP2L1345 dated May 11, 1992 in response to the NRC's request for NMPC perspectives on the findings and conclusions contained in NUREG-1455, "Transformer Failure and Common-Mode Loss of Instrument Power at Nine Mile Point Unit 2 on August 13, 1991." In that letter, we discussed actions taken by the damage control team with respect to restoration of the Uninterruptible Power Supplies (UPS's). That discussion is contained in the section entitled "Adequacy of Plant Specific Operation and Recovery Procedures." Subsequent review by the NRC staff and discussion with Niagara Mohawk personnel during the course of inspection 50-410/92-27 led to indications at the exit meeting that a portion of the response may be unclear or misleading. The purpose of this letter is to address that comment.

The portion of our response in question is as follows:

"The team worked expeditiously on one unit at a time in accordance with the procedure for restoring UPS power from the maintenance feed. Additional precautions were taken based on their special knowledge of the UPS units and the conditions at the time".

After further evaluation, we agree that this wording is subject to misinterpretation and should be clarified.

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The discussion in section 5.6.5 of NUREG-1455 correctly characterizes the concern of the Emergency Director with respect to the power supply for the UPS loads via the unfiltered maintenance supply, and his desire to establish the most reliable configuration possible. Niagara Mohawk's response reaffirmed this as the basis for the Emergency Director's decision to direct the damage control team's restoration actions. We remain convinced that this was the most prudent course of action.

The NUREG discussion regarding the restoration activities of the damage control team is also basically correct. However, Niagara Mohawk had offered comments in its response to clarify a possible misperception in this discussion that the tasks carried out by the team were in no way addressed by procedures. While it is correct the team had concluded that the available procedural guidance was not adequate, they had not concluded that the procedure did not apply at all. In fact, with the exception of the added precautions, their actions were consistent with the procedure steps. The additional precautions referred to in NMPC's response were precisely precautions to avoid the possibility of further challenges to the plant and staff. Specifically, the motor operator was lifted off the circuit breaker (CB-4) before the logic was reset. The step of lifting the motor operator was not included in the procedure, but was considered prudent in case the logic did not reset properly.

We agree that the situation at the time was such that restoration was not necessary on an emergency basis. In fact, restoration actions were well thought out and planned. When the damage control team determined that they needed to take the additional precautions noted, prior to performing any actions they notified and sought verbal permission of a Control Room Senior Reactor Operator to carry out the additional precautions in conjunction with the procedure. When they began implementation, the team started with the least significant UPS unit in terms of plant impact, so that should another unit failure occur, there would have been minimal impact on the station.

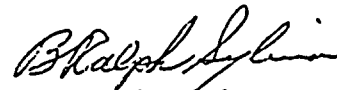
All actions taken were appropriate and technically correct. However, the step that was overlooked for this evolution was an administrative procedure revision before proceeding with the additional precautions. Emergency Plan Implementing Procedure EPIP-EPP-22 (formerly S-EPP-22), "Damage Control", was being used during the event, and it provides for the modification of existing procedures when necessary in conjunction with development of a damage control team and mission. A form of the additional precautions referred to in this instance was subsequently incorporated into appropriate sections of OP-71, "13.8KV/4160V/600V A.C. Power Distribution". Therefore, the additional precautions taken would have been approved had the procedure revisions been developed in conjunction with damage control team activities.



A Deviation/Event Report (DER) has been initiated to address this issue. As noted, the specific corrective action to address the precautions has been accomplished. We will develop appropriate corrective actions to address the issue of procedure changes for damage control team activities.

If you have any additional questions, please contact us.

Very truly yours,



B. Ralph Sylvia
Exec. Vice President

WDB/sek
003017LL

xc: Regional Administrator, Region I
Mr. W. L. Schmidt, Senior Resident Inspector
Mr. R. A. Capra, Director, Project Directorate I-1, NRR
Mr. J. E. Menning, Project Manager, NRR
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