

# CATEGORY 1

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SUBJECT: Responds to NRC 961125 ltr re violations noted in insp repts  
50-220/96-10 & 50-410/96-10. Corrective actions:  
N2-IPM-SWP-R109 has been verified to be correct.

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NIAGARA MOHAWK

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RICHARD B. ABBOTT  
Vice President and  
General Manager - Nuclear

December 26, 1996  
NMP1L 1169

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

RE: Nine Mile Point Unit 1  
Docket No. 50-220  
DPR-63

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

*Subject: Notice of Violation dated November 25, 1996*  
*NRC Inspection Report 50-220/96-10 and 50-410/96-10*

Gentlemen:

Niagara Mohawk Power Corporation's (NMPC) reply to the Notice of Violation is enclosed as Attachment A to this letter. We have admitted to the two violations which are cited.

Very truly yours,

R. B. Abbott  
Vice President and General Manager - Nuclear

RBA/GJG/mc 101  
Attachment

xc: Regional Administrator, Region I  
Mr. S. S. Bajwa, Acting Director, Project Directorate I-1, NRR  
Mr. B. S. Norris, Senior Resident Inspector  
Mr. D. S. Hood, Senior Project Manager, NRR  
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ATTACHMENT A

NIAGARA MOHAWK POWER CORPORATION  
NINE MILE POINT UNIT 1 AND UNIT 2  
DOCKET NO. 50-220/50-410  
DPR-63/NPF-69

**"RESPONSE TO NOTICE OF VIOLATION," AS CONTAINED IN  
INSPECTION REPORT 50-220/96-10 AND 50-410/96-10**

A. VIOLATION 50-410/96-10-03

The Unit 2 Technical Specifications, Section 6.8.3, requires temporary changes to procedures listed in Technical Specification Section 6.8.1 be approved by two members of the unit management staff at least one of whom holds a Senior Operator license on the affected unit.

Contrary to the above, on August 14, 1996, a procedure change evaluation (NMPC's terminology for temporary changes) form was approved to revise a setpoint to procedure N2-IPM-SWP-R109, "Calibration of the Control Building Service Water Flow Instrumentation Channels." The approval included one member of the Unit 2 management staff, but did not include the approval of a Unit 2 Senior Reactor Operator.

This is a Severity Level IV violation (Supplement 1).

I. THE REASON FOR THE VIOLATION

The cause of this event was that Nuclear Division Interfacing Procedure (NIP) NIP-PRO-04, "Procedure Change Evaluation," Revision 4, permitted single approval by the Responsible Procedure Owner (RPO) for editorial changes which included certain design changes (Criterion 3 of Attachment 2 to NIP-PRO-04). The intent of that editorial change criterion was to allow for procedure changes based upon fully approved design changes, such as setpoints, which had already gone through the engineering review and approval process, including 10CFR50.59 requirements. The rationale was that the Applicability Reviews performed in accordance with NIP-SEV-01, "Applicability Reviews and Safety Evaluations," during the design change process satisfied the required reviews for procedure changes. NMPC has since concluded that this type of change should not have been classified as an editorial change.



## **II. CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED**

On November 1, 1996, NIP-PRO-04, was revised to eliminate the provision that allowed implementation of certain design changes such as setpoints as editorial. The change to N2-IPM-SWP-R109 has been verified to be correct.

## **III. ACTIONS THAT WILL BE TAKEN TO PREVENT RECURRENCE**

NMPC acknowledges that this is the second occurrence where the NRC has identified that the requirements of the operating license were not adequately translated into approved procedures (see IR 50-220/96-01 and 50-410/96-01). However, it is noted that the NMPC Quality Assurance Department was performing an audit of operations at the time this event occurred. The audit plan included the specific intent to audit the procedure change process. Since the NRC identified this deviation early in the audit, NMPC cannot state with certainty that it would have otherwise been discovered during the audit. In any event, Deviation/Event Report (DER) C-96-1942 was written during the audit to document inconsistencies between NDD-PRO and NIP-PRO-04 regarding editorial changes to procedures.

As stated in our response to Notice of Violation 96-01-05, the following corrective actions have been taken with regard to the event described in that violation.

- A review of the controls described in NDD-PRO, "Procedures and Orders" and NIP-PRO-02, "Preparation and Review of Administrative Procedures" has been completed.
- A review of higher tier Nuclear Division Procedures (Nuclear Division Directives (NDDs)) for compliance with the license bases has been completed.

These corrective actions were expanded by NMPC to include selected Nuclear Interface Procedures (NIPs) and Generation Administrative Procedures (GAPs). Based upon that review, NMPC plans to completely review the remaining NIPs and GAPs by December 31, 1997. This review will include the use of enhanced computer search capabilities which have recently been developed for use by procedure writers and benchmarking of other licensees' procedure programs. Any significant discrepancies identified during these review activities will be documented in our corrective action program for evaluation and correction.

During the review of NDDs, NIPs, and GAPs, Niagara Mohawk has determined that our review and approval process for administrative procedures is not as rigorous as the process for technical procedures. Therefore, we will revise as necessary the administrative procedure review and approval process by April 30, 1997.

## **IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED**

NMPC achieved full compliance on November 1, 1996, when NIP-PRO-04, Revision 5, was made effective.





B. VIOLATION 50-220/96-10-04 and 50-410/96-07-04

Unit 1 Technical Specifications, Section 6.8.1, requires that written procedures be established and implemented. The Unit 2 Technical Specifications, Section 6.8.1, also requires that written procedures shall be established and implemented that meet the requirements and recommendations of ANSI N18.1-1972 and Appendix "A" of Regulatory Guide 1.33, which covers maintenance and surveillance activities.

1. Nine Mile Point Unit 1 surveillance test N1-ST-Q1B, "Core Spray Loop 12 Pumps and Valve Operability," Revision 5, requires that data from step 8.3.21.d to be carried forward to step 8.3.21.f for determining core spray topping pump 121 differential pressure.

Contrary to the above, on June 6, 1996, during the performance of N1-ST-Q1B, data from steps 8.3.21.d was not properly carried forward to step 8.3.21.f, resulting in NMPC being unaware until July 17, 1996, that core spray topping pump 121 exceeded the surveillance test acceptance criteria for high differential pressure.

2. NMPC procedure GAP-OPS-02, "Control of Hazardous Energy and Configuration Tagging," Revision 6, required that during the application of a markup, the assigned operator placed all necessary devices in the required position and applied a completed tag.

Contrary to the above, on July 26, 1996, during the application of a Unit 1 markup for hydraulic unit (HCU) 18-31, the assigned operator removed the fuses from HCU 38-18, causing control rod 38-18 to scram.

3. NMPC procedure GAP-PSH-01, "Work Control," Revision 15, Section 3.11.1, states that for changes that adversely affect the scope or plant impact statement of a work order (WO) in progress, work shall not continue until the WO has been updated or another WO generated.

Contrary to the above, on July 25, 1996, changes were made to a Unit 2 work order (WO 96-10638-00) related to the Division II hydrogen/oxygen (H<sub>2</sub>O<sub>2</sub>) monitor. This adversely affected the plant impact statement, and work proceeded without the WO being updated or another WO generated. This resulted in I&C technicians working on the wrong division of the H<sub>2</sub>O<sub>2</sub> monitoring system.

In aggregate, this is a Severity Level IV violation (Supplement 1).



## **I. THE REASON FOR THE VIOLATION**

The three events described in the violation had previously been identified in NMPC's corrective action program (NIP-ECA-01, Deviation/Event Report).

The primary cause of the three cited examples is personnel error in that appropriate self-checking was not applied prior to the initiation of an action.

In the first example, the failure to carry forward data from steps 8.3.21.d to step 8.3.21.f of N1-ST-Q1B, was caused by the operator who performed the calculation and omitted the pressure correction for the evaluation of a pressure gauge. Subsequently, the Station Shift Supervisor (SSS) discovered the initial error and corrected a portion of the calculation. However, the SSS failed to correct the subsequent calculations required in the procedure after having discovered the error.

In the second example, the inadvertent scram of control rod 38-31, the operator marking up the hydraulic control unit for maintenance failed to self verify that he was pulling the correct fuses. That is he failed to assure that the correct action was to be taken prior to removing the fuse. Further, he failed to ensure that a peer verification was performed in accordance with management expectations.

In the third example, the supervisor who prepared a change to WO 96-10638-00 failed to perform adequate self-checking when the change was made to ensure that it was on the proper division.

## **II. CORRECTIVE ACTIONS TAKEN AND RESULTS ACHIEVED**

Following are the corrective actions which have been taken as documented in the associated DERs.

### **Error in Calculation in Procedure N1-ST-Q1B**

Licensee Event Report 96-06 documents this event and as noted in Inspection Report 96-10 has been closed by the NRC. The corrective actions for LER 96-06 encompass the corrective action necessary to respond to this violation of Technical Specifications and are as follows.

1. On July 17, 1996, surveillance procedure N1-ST-Q1B was re-performed for the core spray topping pump 121 with acceptable results and the pump was declared operable.
2. The Manager of Operations counseled the individuals involved in the event regarding the importance of attention to detail and self-checking.
3. The Manager of Operations discussed the event with each operating shift, focusing on self-checking techniques and the necessity to ensure calculations are performed correctly. Also, the expectations for supervisory review of testing activities were reaffirmed.



4. The Procedure Writer's Guide governing Operation's Surveillance Procedures has been revised to enhance the format of independent verification steps for calculations.

#### Inadvertent Scram of Control Rod 38-31

1. Immediate corrective actions were to replace the fuses on HCU 38-31 and to complete the markup on HCU 18-31.
2. Reactor Engineering evaluated and approved restoration of control rod 38-31 to the fullout position 48 position.
3. On July 26, 1996, instructions were issued directing Shift Supervisors to review the Operations Reference Manual regarding verification actions prior to marking up CRD HCUs for maintenance. Particular emphasis was placed on expectations for concurrent (peer) verifications. The Shift Supervisors were directed to communicate and enforce these expectations.
4. Job performance counseling was completed for the operator who performed the markup.
5. Shift management performed a self-assessment of the responsible operator's use of self-verification techniques. The Manager of Operations reviewed this event with each operating shift, discussing the different self-checking techniques and when each is appropriate.

#### Leads Lifted on Wrong Division of H<sub>2</sub>O<sub>2</sub> Monitor

1. The lifted leads were immediately relanded and verified.
2. The supervisor involved was counseled by maintenance management.
3. The Unit 2 Maintenance Manager lead a standdown of Maintenance supervisors in which he covered poor performance by maintenance with regard to personnel errors. He emphasized accountability for individual performance.

### **III. CORRECTIVE ACTIONS THAT WILL BE TAKEN TO PREVENT RECURRENCE**

Niagara Mohawk continually monitors performance with regard to personnel errors. The Quarterly DER Program Trend Report Summary is utilized to monitor trends on a broad basis. Each Branch Manager is responsible to evaluate negative performance trends and take appropriate action to reverse the trend. In response to the specific examples cited, Niagara Mohawk management counseled the individuals involved and reviewed details of the specific events with expectations to the supervisory personnel in the involved branches. (Operations Unit 1 and Maintenance Unit 2)



To further heighten the awareness of the impact of personnel errors in the Operations and Maintenance branches at both units, the Branch Managers will review this violation with their personnel by February 28, 1997.

Several actions have been added to the 1997-2000 SBU Business Plan to facilitate continued improvement regarding human performance at Nine Mile Point. Objective 4, Strategy E specifically addresses human errors and improvement in personnel performance. The strategy addresses monitoring human performance, monitoring the self-assessment process, improving radiation worker practices, and standardizing the cause determination process.

***IV. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED***

Full compliance was achieved as follows.

1. Procedure N1-ST-Q1B was reperformed on July 17, 1996, with fully satisfactory results.
2. On July 26, 1996, the fuses were replaced on control rod HCU 38-31.
3. On July 25, 1996, the subject lifted leads were relanded and verified.

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