

September 9, 1987

MEMORANDUM FOR: Robert M. Gallo, Chief
Operations Branch, DRS

FROM: Larry J. Wink, Operations Engineer, BWR Section,
Operations Branch, DRS

SUBJECT: NIAGARA MOHAWK, NINE MILE POINT 2,
ASSESSMENT OF LICENSEE PERFORMANCE (TEST CONDITION 1)

Attached please find the DRS Interim Assessment for Niagara Mohawk, Nine Mile Point-2. The assessment period is from July 20, 1987, through August 12, 1987. A DRS inspection is currently planned for the week September 14, 1987, and additional assessment or observation will be provided to you as soon as possible after the inspection. If you need more information regarding this assessment or have questions, please call me on extension 5184.

Larry J. Wink, Operations Engineer
BWR Section, Operations Branch, DRS

cc:
W. Johnston, DRS
D. Lange, DRS
W. Kane, DRP
E. Wenzinger, DRP
J. Johnson, DRP
W. Cook, SRI

RI:DRS
Wink/djh
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Lange *[Signature]*
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ASSESSMENT OF LICENSEE PERFORMANCE

NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT NUCLEAR STATION, UNIT 2

PERIOD: JULY 20, 1987 - AUGUST 12, 1987

(TEST CONDITION 1)

INSPECTION ACTIVITIES

The Test Programs Section conducted two inspections during the period July 20, 1987, through August 12, 1987. The inspections involved 94 direct inspection hours by two region-based inspectors. The period covered activities from the completion of the test results evaluation for Test Condition Heatup through the completion of testing in Test Condition 1. No violations were identified.

PERFORMANCE ASSESSMENT

1. MANAGEMENT CONTROL

Management oversight and control of activities has continued to be adequate and effective with improvement noted from the initial low power testing phase. Increased management monitoring of control room activities has been observed during major plant evolutions and tests. Strong management attention continues to be focused on the safety implications of technical problems but engineering support for the resolution of problems has been less than adequate and has significantly hampered the progress of the overall power ascension program.

The effectiveness of the daily management meetings has generally improved. One significant improvement was achieved by changing the time of this meeting from 8:30 a.m. to 9:30 a.m. This allowed the Work Status meeting to be held prior to the management meeting and has improved the quality of information available to plant management. Instances continue to be noted, however, in which poor communications have hampered effective management of daily activities. In one case, following the initial turbine roll, the GE LSTG engineers were allowed to leave the site without an effective turnover of information concerning required actions to support additional turbine testing planned for later that day.

2. PLANT OPERATIONS

Overall plant operations continue to be conducted in a consistently conservative and safety conscious manner. Performance of Operations personnel during testing has been excellent. The station shift superintendents have maintained good control over testing activities and have made significant contributions to the effective performance of major testing evolutions.

Control Room access has been adequately controlled and, even during periods requiring heavy man-loading in the Control Room, the activities were well coordinated. One weakness noted involved the timeliness of operator's response to annunciators. Operators have been noted to allow relatively long (greater than 30 seconds) periods of time to elapse between the audible annunciator alarm and their scanning of the visual annunciator panels to determine the nature of the problem. A possible factor contributing to this casual response is the number of repetitive, " nuisance" annunciators received from certain BOP systems.

3. POWER ASCENSION TEST PROGRAM

The Power Ascension Test Program continues to be well implemented. The working interface between test and operations personnel is now fully developed and is extremely effective. The quality and timeliness of engineering support provided to the Power Ascension Test program has declined significantly during the current period.

Three major power ascension tests were witnessed during Test Condition 1. All testing was conducted in a very well organized and controlled manner. Shift briefings prior to testing continue to be comprehensive and effective. Coordination during tests was excellent and all personnel demonstrate that adequate training had been provided on their individual assignments and responsibilities.

Power ascension test results packages reviewed during the current assessment period included the balance of the Test Condition Heatup results and most results from Test Condition 1. All packages reviewed were complete and clearly documented. Test exceptions have been pursued aggressively for resolution and few open exceptions were carried forward to Test Condition 1. All testing deferred from Test Condition Heatup was reviewed for safety significance by SORC and approved by the General Superintendent.

4. ENGINEERING SUPPORT

The quality and timeliness of engineering support provided for operations and testing has declined significantly during the current assessment period. The root cause of the poor engineering support is not known. The most likely possibility is that the number of problems currently requiring attention is straining the available resources. Effective communication does not exist between site personnel and the engineering support group. The Power Ascension Test Program Group has requested that engineering assign a permanent on-site liaison to work with them on the expeditious resolution of identified problems.

The lack of adequate engineering support was clearly evident during the problems experienced with the Offgas System. Senior operations personnel were assigned to resolve design and installation deficiencies in this system. Engineering was aware of many of these problems but did not become actively involved in their resolution for almost two weeks. Engineering failed to assume the lead roll and allowed operations personnel to identify the problems and propose resolutions. Engineering support was confined, almost exclusively, to the generation of mod packages to implement fixes identified by operations personnel.

5. QUALITY ASSURANCE PROGRAM IMPLEMENTATION

The QA surveillance program for power ascension test activities continues to be effectively implemented.

6. ORGANIZATIONAL INTERFACES

There has been an overall improvement in the interfaces among the various groups involved in the operations and testing of the unit. However, instances continue to be noted where poor interfaces have hampered the effective management of the unit and have contributed to the delays experienced. The problem is particularly noticeable when multiple groups are involved in problem resolution and the lead responsibility has not been clearly assigned or has been assigned inappropriately.

For example, during the initial attempts to place the Offgas System in service, Operations was tasked with lead responsibility. As it became apparent that the problems included design and installation deficiencies, Operations retained the lead and attempted to resolve these engineering problems. During the first coordination meeting to assess progress and obtain engineering support, numerous disagreements were noted among the various participants in the troubleshooting efforts. These disagreements arose because of the anecdotal nature of the observations with an apparent lack of documentation of the troubleshooting actions taken and the results achieved.

7. ENFORCEMENT HISTORY

No violations of NRC requirements were identified during the current assessment period.

CONCLUSION

The licensee continues to conduct a deliberately paced testing program with a good perspective on nuclear safety. Management oversight and control has improved from the previous assessment period.

Strengths noted during this period included professional and highly competent operators, a well coordinated and smoothly functioning test program organization and increased management monitoring of control room activities during major evolutions.

Areas which require improvement include: Engineering support for operations and testing, intergroup communications and overall coordination between groups involved in troubleshooting efforts.

INSPECTION ACTIVITIES

<u>REPORT</u>	<u>DATES</u>	<u>INSPECTOR(S)</u>	<u>HOURS</u>
87-28	7/20-24/87	Wink	34
87-27	8/3-12/87	Wink/Florek	60

D. Holody

AMP-2 ENFORCEMENT CONFERENCE BRIEFING

Summary

Surveillance testing of Standby Gas Treatment (SBGT) System train A was not performed due to lack of cumulative run time data. Concurrently, the diesel generator for SBGT train B was removed for maintenance. These actions rendered both trains of SBGT inoperable or without emergency power and violated the TS LCO.

Events and Corrective Actions:

- June 1 - 11 - Operational Readiness Team Inspection identified that tracking of SBGT run times was inadequate.
- Sept. 1 - Review of SBGT run time data showed that through July 1987 train A had accumulated 785 hours compared to 900 hour limit for charcoal adsorber testing. The control room was not informed.
 - The Division II diesel generator which supplies SBGT train B was removed from service for planned maintenance.
- Sept. 2 - Review of SBGT train A run time data was completed and showed 1120 hours; SBGT train A was declared inoperable. The control room and management were informed.
 - TS required reactor shutdown commenced at 5:35 p.m. due to both trains of SBGT being inoperable or without emergency power.
- Sept. 4 - Charcoal absorber was sampled and passed the iodine testing.
- Later - OP's data sheets revised; tracking responsibility changed to Ops personnel; and cumulative SBGT hours published weekly.

Consequences:

The charcoal adsorbers on train A may not have been able to remove iodine during a potential accident and offsite release. Subsequent testing showed that the charcoal was acceptable and that the technical consequences of the event are negligible.

Major Problems:

1. The corrective action for the NRC identified concern on SBGT run time tracking was inadequate, and TS 4.6.5.3.c was violated.
2. The control room was not informed of the potential inoperability of SBGT train A on Sept. 1 when it was found to be questionable. Combined with the removal of the Div II diesel, this violated TS LCO 3.8.1.1.e.
3. A licensing engineer gave a TS interpretation on whether the 25% band applied to the 720 hours run time limit, although correctly judged to apply, to the control room with practically no management review.

Enclosed References:

1. Special Inspection (IR 50-410/87-32)
2. Operational Readiness Team Inspection (IR 50-410/87-16) excerpt
3. TS 3.8.1.1.e & 4.6.5.3.c

Recommendation: Severity Level III Violation with no Civil Penalty.

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ENFORCEMENT CONFERENCE

OCTOBER 8, 1987

AGENDA

INTRODUCTION -- TEL

CHRONOLOGY -- RBA

MANAGEMENT INVOLVEMENT -- TEL

EVALUATION OF ISSUES

A. MISSED SURVEILLANCE AND UNKNOWN TOTAL RUN TIME -- RBA

B. FAILURE TO INFORM SSS -- RBA

C. PROMPT AND EFFECTIVE ACTION OF IDENTIFIED CONCERNS -- CVM

CONCLUSION -- CVM

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OCTOBER 8, 1987

CHRONOLOGY

EVENTS (INCLUDING TECH. SPEC. SHUTDOWN)

AGREE WITH NRC PRESENTATION OF CHRONOLOGY IN INSPECTION REPORT

MANAGEMENT INVOLVEMENT

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OCTOBER 8, 1987

MANAGEMENT INVOLVEMENT

NOTIFICATION

DECISION TO CONTINUE SHUTDOWN

- INADEQUATE UNDERSTANDING OF CAUSE
- TRAIN "B" STATUS VAGUE (SUBSEQUENTLY RESOLVED)
- PREVIOUS NRC IDENTIFIED CONCERN

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OCTOBER 8, 1987

MISSED SURVEILLANCE AND UNKNOWN TOTAL RUN TIME

CAUSE

INADEQUATE PROCEDURES

TIMELINESS OF ADDING HOURS

INADEQUATE CLERK TRAINING

MANAGEMENT FAILURES

- FAILURE TO ASSURE TIMELY AND ACCURATE CALCULATION OF RUN TIMES

- FAILURE TO HAVE ADEQUATE SYSTEM TO KEEP APPRISED OF RUN TIMES

CORRECTIVE ACTION

PROCEDURE REVISIONS

PLANT MODIFICATIONS

IMPROVED TIMELINESS OF COUNTING

CALCULATIONS PERFORMED BY OPERATING SHIFT KEEPS SSS APPRISED OF
RUN TIMES

LOG SHEETS INCORPORATED IN OPERATING PROCEDURES AND USED TO

DOUBLE CHECK RUN TIME METERS

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OCTOBER 8, 1987

FAILURE TO INFORM SSS

CAUSE

UNCERTAINTY REGARDING DATA VALIDITY

FAILURE TO PROMPTLY FOLLOW-UP DATA ANALYSIS

CONCLUSION THAT 720 HOURS WAS EXCEEDED ONLY SLIGHTLY WITH A
SMALL NUMBER YET TO ADD

CORRECTIVE ACTION

PROCEDURAL CHANGES WILL PREVENT REOCCURRENCE OF PARTICULAR EVENT

WILL REINFORCE THROUGH TRAINING NECESSITY OF TIMELY RESOLUTION
OF POTENTIAL PROBLEMS

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OCTOBER 8, 1987

LACK OF PROMPT AND EFFECTIVE ACTION

CAUSE

SYSTEMS IN PLACE INADEQUATE (NOT INITIATED AT NRC EXIT)

SYSTEMS IN PLACE INFORMAL/FRAGMENTED

SUFFICIENT RESOURCES AND PRIORITY NOT APPLIED

CORRECTIVE ACTION

RE-IMPLEMENT SYSTEM USED DURING UNIT 2 CONSTRUCTION

R. B. ABBOTT TRACK NRC ACTION ITEMS ON SITE COMPUTER SYSTEM

R. B. ABBOTT CONTINUE WEEKLY MEETING WITH RESIDENT INSPECTORS,
WITH LICENSING IN ATTENDANCE

October 19, 1987

Thomas T. Martin, Director
Division of Radiation Safety and Safeguards
U. S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

RE: Nine Mile Point Nuclear Station
Docket No. 50-220, DPR-63
Docket No. 50-410, NPF-54

Dear Mr. Martin:

The attached update is being submitted in accordance with our commitment contained in our response to Combined Inspection Report Nos. 50-220/86-23, and 50-410/86-89, dated September 17, 1987.

In accordance with the provisions of 10 CFR 2.790(d), we hereby request that the material submitted with this letter be withheld from public disclosure.

Sincerely,

Joseph P. Beratta
Joseph P. Beratta
Manager, Nuclear Security

Enclosure

cc: Senior Site Resident Inspector

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NINE MILE POINT NUCLEAR STATION
DOCKET NO. 50-220, DPR-63
DOCKET NO. 50-410, NPF-54

Subject: Combined Inspection Report No. 50-220/86-23 and
50-410/86-39

In reference to our response, to the subject Inspection Report, dated September 17, 1987, I wish to inform you that we have formed a Study Team, composed of representatives from Operations, Security, Training, and Emergency Planning. The purpose of the study team is to address the Safety/Safeguards issue, increasing the effectiveness of our program.

A meeting has been held, and NUREG/CR-4093, "Safety/Safeguards Interactions During Safety-Related Emergencies at Nuclear Power Reactor Facilities," is being studied and evaluated for possible use as a baseline for our program.

This satisfies the first milestone on the submitted schedule of implementation. We will continue to keep you informed of our progress.


DOCKET NO. 50-220, DPR-63
DOCKET NO. 50-410, NPF-54