

FEB 10 1988

MEMORANDUM FOR: William A. Cook, Senior Resident, NMP-2  
THRU: Jack Strosnider, Chief, M&PS  
FROM: Harry W. Kerch, Senior Reactor Engineer, M&PS  
SUBJECT: CLOSING VIOLATION 50-410/87-25-01

An in house review of the violation associated with weld XI-2MSS-POV-CDA-FW003 was performed by the inspector. This violation involved failure of the licensee to identify a zone of incomplete fusion in the subject weld. This indication would have been rejectable by Section III of the ASME Code which is the governing construction code. The documents reviewed consisted of:

- NRC inspection report 50-410/87-25
- NMP-2 letter NPF-69 response and corrective action
- Nonconformance report 2-87-0084
- NMP-2 letter 3M2.2.M598.99.9
- NMP-2 letter dated July 10, File #9M STQA87.363
- Summary of fracture mechanics analysis
- PSI ultrasonic results

Subsequent to identification of the radiographic indication by the NRC inspector, ultrasonic testing was performed and the subject indication evaluated in accordance with Section XI of the ASME Code which is the applicable code for inservice inspection. This evaluation concluded that the indication was acceptable. In addition, the licensee contracted a more detailed fracture mechanics analysis that further demonstrated acceptability.

The inspector independently reviewed the above information and concurs with the licensee's responses and corrective action. He has no further questions concerning this violation and considers item 50-410/87-25-01 closed.

C. Kerch

*Jack A. Strosnider*  
Harry W. Kerch  
Sr. Reactor Engineer  
M&PS  
*for*

*RI:DRS* 2/9/88  
Kerch/cgl/rw  
*RI:DRS* 2/9/88  
Strosnider

*F/S2*

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### NMP-2 ENFORCEMENT CONFERENCE BRIEFING

#### Summary

During the performance of a monthly Division I Automatic Depressurization System (ADS) functional test, a wiring error was discovered which rendered the ADS Division I Logic circuit inoperable. This wiring error was made prior to initial fuel load on November 2, 1986, and was not identified by the construction quality control program and the Preoperational Testing Program. 5/86  
 Subsequent to Preoperational Testing, there were two separate occasions during the performance of cyclic surveillance Logic System Functional Test (LSFT) when the anomaly was detected, but went unresolved due to inadequate technical and management review.

#### Events and Corrective Actions

- 5/86 - Preoperational Testing of the subject ADS circuitry.
- 7/86 - Surveillance Test containing LSFT requirements for ADS was performed and identified the effects of the wiring error; error was not pursued to resolution.
- 5/88 - The surveillance was performed for the second time and the effects of the error were again found and inadequate technical and management review prevented resolution.
- 12/3/88 - During the monthly surveillance while shutdown, the licensee identified and corrected the wiring error, and initiated a 50.73 report. The licensee began an investigation to determine the effects on operability of the ADS system.
- 12/8/88 - Investigation revealed the error caused Division I ADS circuitry to be inoperable. A four hour 50.72 notification was made to the NRC.

#### Consequences:

The ADS Division I logic was rendered inoperable by the wiring error; however, ADS Division II remained operable. The applicable SRVs could always be opened manually from the control room, as directed by the EOPs. In the event of a small break LOCA, the primary high pressure ECCS is the HPCS and it was available.

#### NRC Concerns

1. One of two redundant divisions of the ADS circuitry was miswired and was unable to automatically perform its safety function. The wiring deficiency caused a violation of Technical Specification 3.3.3 which requires both divisions of ADS logic to be operable for Operational Modes 1,2 and 3.

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2. The Preoperational Test Program failed to identify and correct the wiring error.
3. The refueling cycle surveillance test that contained LSFT requirements for ADS logic identified the effects of the wiring error on two separate occasions, but due to inadequate technical and management review, the anomaly went uncorrected.

Corrective Actions

1. The licensee conducted a review of all Preoperational Tests that used a similar test switch application. This review identified no other discrepancies.
2. A review of all last performed LSFT test results was conducted, and a few discrepancies were found. This prompted further corrective action as identified in Action 3 below.
3. All LSFT procedures will be reviewed for technical adequacy to ensure the entire circuit is tested and proper overlap exists when more than one procedure is utilized. This review is in progress and has identified several mistakes.

Recommended Enforcement Action

Severity level III violation with no civil penalty. The following factors were utilized to make this assessment.

- Escalating Factors: 1. Failure to identify and correct the anomaly at earlier opportunities.
- Mitigating Factors: 1. Identified by the licensee.  
2. Corrective action appears to be very thorough.

Attachments

1. Inspection Report 50-410/88-21
2. Proposed Notice of Violation

*Holody*

NMP-2 ENFORCEMENT CONFERENCE BRIEFING PACKAGE

EA 87-104

March 18, 1988 - 1:00 p.m.

Summary:

In June 1985 Region I formally requested that Niagara Mohawk evaluate alleged problems concerning the installation of neutron monitoring (NM) cables at Nine Mile Point 2 (NMP-2). The resulting Niagara Mohawk review was seriously flawed but was transmitted\* to Region I containing potential material false statements regarding the cable installation.

Technical Significance:

The safety significance of the cable installation problems is negligible. The installed cables were acceptable for use as is based on satisfactory continuity and insulation resistance tests, and subsequent preoperational tests and routine operations have demonstrated acceptable performance.

Chronology:

- 5/23/85 - Anonymous letter alleges that neutron monitoring cables had been installed improperly, in violation of procedures, and without proper quality control (QC) involvement.
- 6/7/85 - Region I requests that Niagara Mohawk review the problem.
- 7/11/85 - Niagara Mohawk transmits review, which states that neutron monitoring cable installation was satisfactory, in accordance with procedures, and with acceptable QC coverage.
- 9/17/85 - Anonymous worker alleges to N.Y. Public Service Commission that review was inadequate and findings were incorrect.
- 10/3/85 - Region I requests OI investigation of the potential material false statements.
- 11/15/85 - Specialist inspector identifies Level V procedure violation but determines the cable installation to be technically acceptable.
- 3/12/87 - OI issues Report 1-85-020, which concludes that the July 1985 Niagara Mohawk response contained false and inaccurate information and constituted careless disregard on their part.
- 5/8/87 - OI transmits OI Report to Dept. of Justice (DOJ).
- 7/1/87 - OI, NRR, and Region I brief Commissioners on investigation.
- 11/6/87 - DOJ notifies OI that no prosecution will result.
- 1/11/88 - Region I transmits OI Synopsis to Niagara Mohawk and requests Enforcement Conference.

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False, Inaccurate Information and Errors in Niagara Mohawk Review:

1. Niagara Mohawk stated that "All personnel confirmed the ... pushing technique of cable installation."

OI found that cables were installed by a combination push/pull technique, that no tension monitoring was used as required for pulling, and that there was no written documentation of the review and approval of the push technique.

2. Niagara Mohawk stated that "No one had knowledge of overtensioning or breaking cables."

OI found that "in several instances either an NMC cable conductor broke during installation or, at the very least, separated or disconnected from the plastic polywater hose that was used to guide the cable.... Further, they (the instances of breaking or disconnection) were alleged by some to have been related to QIP personnel during their investigative effort."

3. Niagara Mohawk stated that "SWEC Quality Control by Interoffice Correspondence to SWEC Engineering stated that cables installed into the undervessel flex conduits were pushed..." and that "the Quality Control Program was adhered to by qualified personnel...."

OI found that "there is no QC inspection program/criteria for cable "pushing" at NMP-2. When questioned as to what criteria was being applied during inspection, QC personnel advised they were visually observing the physical integrity of the cable. They admitted that they were limited to judging how much tension was applied, and one QC inspector indicated that periodically he had to caution the craft personnel to back off on the amount of pull tension being applied."

4. The Niagara Mohawk review listed the five job categories into which the 20 interviewed people belonged. Craft personnel were absent from the list, but it did list "3 Craft Supervision".

The OI Report noted that "QIP's failure to interview craft personnel involved in the installation effort, and to separate some of the individuals from their supervisors and peers during the interviews, as well as interjecting personal opinions into the interview process, are viewed as contributing to their failure to develop accurate information."

Inspection Summaries and Corrective Actions on NM Cables and QIP:

December 1985 - Technical Review of Cable Installation;  
(Specialist Inspector for 5 days - IR 85-42)

The inspector reviewed the NM cable installation and observed a mockup cable installation. The IR issued a violation for failing to follow procedures (lack of pull tension monitoring and excessive bend radii). The inspector concluded that NM cables had been pulled (based on 2-3 breaks reported in cable attachment loops) and that there was no installation procedure for push installations. Based on the demonstration the inspector concluded that using the lubrication guide tube, it was not possible to install NM cable without pulling but that the pull force was acceptable. He found that the NM cable could be installed by pushing alone when there was no lube tube.

January 1986 - Review of QIP;  
(5 Man team for 5 days - IR 86-04)

The team reviewed QIP, its operation, its review of specific concerns, and its perception by workers. The team found numerous positive aspects and numerous weaknesses, including review of potential wrongdoing, qualification of investigators, and documentation. The team concluded that the program was perceived positively by workers. Overall, the team concluded that all 76 cases reviewed by the team had been ultimately dispositioned adequately.

June 1986 - Followup Review of QIP;  
(SRI and Section Chief for 2 days - IR 86-29)

The review focused on the progress toward correcting the previously noted weaknesses. The review noted Niagara Mohawk's responsiveness in making improvements in QIP based on the team's assessment. Particular improvement was noted in the process for handling of potential wrongdoing issues.

September 1986 - Review of QA Program Concerns Being Reviewed by QIP;  
(4 Man team for 5 days - IR 86-52)

Region I had become aware of programmatic quality control (QC) concerns raised by QC inspectors to QIP. Because of the impending licensing of Unit 2, the team reviewed the adequacy of the Quality Assurance Program in parallel with the QIP review. The team concluded that there were no hardware deficiencies and that QA overchecks of QC inspection activities had identified and corrected hardware deficiencies.

Attachments:

1. Region I letter dated 1/11/88 transmitting OI Synopsis
2. Niagara Mohawk letter dated 7/11/85 transmitting review
3. Region I letter dated 6/7/85 requesting Niagara Mohawk review

PRE-INSPECTION COVER SHEET AND INSPECTION PLAN  
(Region I Work Form)

FROM: J. J. Kottan  
(Reporting Inspector)

Report No. BB-14, BB-13

TO: W. J. Pasciak  
(Reporting Inspector's Supervisor)

SUBJECT: INSPECTION OF Nine Mile Pt 1 & 2 ON 4/25-29/85  
(Facility) (Dates)

- List of outstanding items up to date, reviewed and proper items selected.
- Inspection plan completed (attached or summarized below).

Inspection Plan: Closeout of outstanding PASS items

NAMES OF ACCOMPANYING PERSONNEL:

A. Kirkwood

RESIDENT INSPECTOR NOTIFIED: VJK 4/18  
Inspector Initial/Date

PROJECT SECTION CHIEF NOTIFIED: VJK 4/18  
Inspector Initial/Date

ACKNOWLEDGED:

Accompanying Inspector's Supervisor (if applicable)

SUBMITTED: J. J. Kottan  
Reporting Inspector

APPROVED: [Signature]  
Reporting Inspector's Supervisor

Te: \_\_\_\_\_  
Branch Files (Inspector's Branch and Project Branch)

tel: Quality Inn (Fulton, NY)

Phone: ( ) - \_\_\_\_\_

FTS: 8-315-593-2444

Site Contact (Name): Resident Insp  
Bill Cook

Phone: ( ) - \_\_\_\_\_

FTS: 8-315-342-4041

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NMP

~~NYC~~

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PRIORITY ATTENTION REQUIRED

MORNING REPORT - REGION I

APRIL 20, 1988

Licensee/Facility

Nine Mile Point 2  
DN 50-410

Notification/Subject

4/20 SRI PC  
Fitness for Duty

Event

On 4/19 the licensee reported to the resident inspectors and NRC Headquarters Duty Officer that three of the five station employees tested for illegal drug use were tested positive. Site access by these employees had been suspended last week pending drug testing results. Licensee representatives indicated that these employees would be fired. The two employees who tested negative resumed their normal station duties.

In addition, on 4/12, the resident inspectors were informed of the results of local union arbitration of the licensee's Fitness for Duty Policy involving random and annual employee physical examination drug and alcohol testing. The arbitrator ruled against Niagara Mohawk's annual and random drug and alcohol testing policy. This ruling does not prevent the licensee from screening employees if drug or alcohol use/abuse is suspected.

Licensee/Facility

Nine Mile Point Unit 2  
DN 50-410

Notification/Subject

4/19 ENS  
Exceeded Rated Core Flow

Event

At about 9:30 a.m. 4/19, during a routine control panel walkdown, the shift supervisor observed that the recirculation system flow control valves were open more than they should be for 100% core flow. As a result of this observation the licensee initiated a review of the core flow data and determined that the actual core flow exceeded the rated flow by 3%.

The licensee's 'Core flow check' computer run indicated that, while the total core flow as measured by the sum of the jet pump flows was 107 Mlb/hr, the sum of the recirculation loops A and B was 110 Mlb/hr. This discrepancy was apparently caused by erroneous inputs to the program that provides the total core flow values. The erroneous inputs are thought to be caused by 'bad contacts' on the jet pump summer cards. When these cards were pressed in by hand to make better contact the total core flow indicated was found to be 112 Mlb/hr or 103% rated. The licensee reduced core flow until all core flow indications were less than 108.5 Mlb/hr and initiated a work request to correct the problem. Initial licensee review indicates that no Technical Specification limits were violated. The resident inspector has been onsite following the licensee's actions.

Call  
FYE

F/56



*BLT Kane & White*  
*Did you say anything all this is meant to be*



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DEPARTMENT OF LAW  
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(212) 341-2348

cc: J. Gutierrez  
W. Kane  
M. Miller  
~~Ch. Abraham~~  
JMA - 6/7/88

*G. S. Joblan*  
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*R. Henry*

ROBERT ABRAMS  
Attorney General

JOHN W. CORWIN  
Assistant Attorney General in Charge  
Consumer Frauds and Protection Bureau

June 2, 1988

Gary J. Lavine, Esq.  
General Counsel  
Niagara Mohawk Power Corporation  
300 Erie Blvd. West  
Syracuse, N.Y. 13202

Re: Employees trapped in the Nine Mile Two  
Main Steam Tunnel on September 14, 1987

Dear Mr. Lavine:

Information provided to the Attorney General indicates that at about 11:10 A.M. on September 14, 1987, ten Niagara Mohawk employees were trapped in the Main Steam Tunnel at Nine Mile Two because company Security had removed a key needed to open Door R240-6. We understand that requiring a key to exit the Main Steam Tunnel is in violation of federal safety standards, specifically Occupational Safety and Health Administration Standard 1910.36(b)(4). It is also our understanding that on several occasions since September 14, 1987, Niagara Mohawk has taken Nine Mile Two out of service but has not brought Door R240-6 into compliance with applicable federal safety standards. This office has several questions about the event on September 14, 1987 and the status of Door R240-6.

Event On September 14, 1987

Our understanding is that the ten men were trapped in the Nine Mile Two Main Steam Tunnel on September 14, 1987 because Niagara Mohawk Security removed a "2MX" key required to unlock the door (No. R240-6) that the men had to use to leave the Tunnel. Our first questions concern the removal of the essential key. Why did company Security remove the key? Were the company Security personnel who removed the key aware that Niagara Mohawk employees were still in the Main Steam Tunnel? If so, why was the key removed anyway? If not, please explain why the Security personnel who removed the key were not aware that there were company employees in the Tunnel.

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Our second set of questions concern what happened to the men trapped in the Nine Mile Two Main Steam Tunnel. Please indicate how long the ten men were kept in the Tunnel beyond the time they otherwise would have exited, and whether the company has attempted to determine if this delay resulted in additional radiation exposure to the men. If Niagara Mohawk has attempted to determine whether the delay produced additional radiation exposure, please indicate for each individual involved the result of the company's tests. Please identify the affected individuals by name and job description. If the company has not attempted to determine if the delay increased radiation exposure, please explain.

Our third area of concern is the method by which Nine Mile Two management became aware that ten men were trapped in the plant's Main Steam Tunnel. One of our sources indicates that the personnel in the Nine Mile Two Control Room became aware of the men in the Tunnel only when company Security was unable to account for the whereabouts of the men immediately prior to the beginning of the process to take Nine Mile Two critical. Another source indicates that the men in the Tunnel contacted the Nine Mile Two Control Room and made their presence known. Please indicate whether the men in the Tunnel made their presence known by contacting the Nine Mile Two Control Room directly, or whether their presence became known by some other, indirect method. If the method was other than by direct contact between the men in the Tunnel and the Nine Mile Two Control Room, please describe the method.

Our fourth area of inquiry is the status of Nine Mile Two at the time the ten men were trapped in the Main Steam Tunnel. As of the time the presence of the ten men in the Tunnel was made known to the Nine Mile Two Control Room, please indicate when Niagara Mohawk planned to begin pulling rods to return the plant to critical. Further, indicate whether the presence of the men in the Tunnel delayed Nine Mile Two's return to critical.


#### Status of the Problem

Our fifth concern is whether Niagara Mohawk knew before September 14, 1987 that Door R240-6 did not comply with OSHA standards. If so, please indicate when this problem was identified. In any event, explain why the door has not been brought into compliance with the applicable safety standards. Further, indicate whether the company has reviewed all the doors at Nine Mile Two to determine if other doors present the same safety problems as R240-6. If so, please indicate the result of Niagara Mohawk's study. If not, indicate why the company has not conducted such a survey.

Finally, please indicate whether Niagara Mohawk has informed the Nuclear Regulatory Commission or OSHA of the September 14, 1987 incident in the Nine Mile Two Main Steam Tunnel. We understand that the company has discussed modification of Door R240-6 with NRC Security, but it is not clear that that conversation extended beyond the subject of compliance with NRC and OSHA standards. If the company has informed either the NRC or OSHA of the September 14, 1987 incident in writing, please provide a copy of each such document.

Thank you for your early attention and cooperation.

Very truly yours,



RICHARD W. GOLDEN  
Assistant Attorney General

RWG/gt

cc: Mr. James W. Stanley  
Regional Administrator  
OSHA Region 2

Mr. William T. Russell  
Regional Administrator  
NRC Region 1

Jeffrey W. Meyers, Esq.  
LeBoeuf, Lamb, Leiby & MacRae