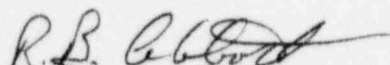
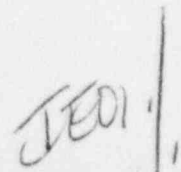


RICHARD F. ABBOTT  
Vice President  
Nuclear GenerationDecember 21, 1995  
NMP1L 1017U. S. Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555RE: Nine Mile Point Unit 1  
Docket No. 50-220  
DPR-63**Subject: RESPONSE TO NOTICE OF VIOLATION**  
**NRC Inspection Report No. 50-220/95-23 and 50-410/95-23**

Gentlemen:

Niagara Mohawk Power Corporation's response to the Notice of Violation contained in the subject Inspection Report dated November 22, 1995 is enclosed as Attachment A. Attachment B addresses the NRC's concern about the effectiveness of the NMPC periodic review program also expressed in the Inspection Report.

Very truly yours,

R. B. Abbott  
Vice President - Nuclear GenerationRBA/TWR/lmc  
Attachmentxc: Regional Administrator, Region I  
Mr. B. S. Norris, Senior Resident Inspector  
Mr. L. B. Marsh, Director, Project Directorate I-1, NRR  
Mr. G. E. Edison, Senior Project Manager, NRR  
Records Management**290005**9512290024 951221  
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ATTACHMENT A

NIAGARA MOHAWK POWER CORPORATION  
NINE MILE POINT UNIT 1  
DOCKET NO. 50-220  
DPR-63

"RESPONSE TO NOTICE OF VIOLATION," AS CONTAINED IN  
INSPECTION REPORT 50-220/95-23 AND 50-410/95-23

VIOLATION 50-220/95-23-01

During an NRC inspection conducted from September 3 through October 14, 1995, a violation of NRC requirements was identified. In accordance with the NRC "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG 1600, (60 FR 34381; June 30, 1995), the violation is listed below:

The Nine Mile Point Nuclear Power Station Technical Specifications Section 6.8.1, requires procedures to be established and implemented.

Procedure N1-PM-V16, "Reactor Startup and Shutdown Prerequisite Verifications," requires the service water primary containment outside isolation valve be locked closed.

Contrary to the above:

On October 13, 1995, a Unit 1 service water containment outside isolation valve (72-479) locking chain was not locked. (This resulted in the valve being closed but not locked.)

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

*I. THE REASON FOR THE VIOLATION*

Niagara Mohawk admits to the violation as stated in Inspection Report 50-220/95-23.

An apparent cause analysis was performed in accordance with Nuclear Interface Procedure NIP-ECA-01, "Deviation/Event Report." The cause for the valve being inadequately secured with a locking device was determined to be poor work practice.

On April 2, 1995, valve 72-479 was lined up in accordance with N1-OP-18, "Service Water System," and independently verified closed. The procedure did not specify this valve as having to be locked which was consistent with the Piping and Instrumentation drawing (P&ID). On April 3, 1995, Form III of Procedure N1-PM-V16, "Reactor Startup and Shutdown Prerequisite Verification," was completed. Step 6.0 of this procedure required verification that valve 72-479 was locked closed. The Operator that performed the step

verified the valve was closed and placed a locking device on the valve. However, the locking device did not engage the valve in a manner to secure it. Specifically, the cable was not looped through the valve yoke and only went through the handwheel. On April 11, 1995, Form III of Procedure N1-PM-V16 was performed again. A different Operator performed the verification that valve 72-479 was locked closed. The Operator performing this verification determined the valve was closed and that a lock was on the valve. The Operator, however, did not detect that the lock was not securing the valve, because by casual visual observation, it appeared to be locked.

The cause for the discrepancy between procedure N1-PM-V16, procedure N1-OP-18, and the P&ID is ineffective procedure development. A review of the licensing and design bases reveals there are no requirements that valve 72-479 be locked; locking of the valve was a management decision implemented in the early 1980's as a prudent measure above and beyond regulatory requirements.

N1-PM-V16 currently consists of plant startup checks which had previously been included in plant startup procedure N1-OP-43. In 1993, N1-PM-V16 was developed to remove the checks from the startup procedure; this change was administrative in nature and included reformatting to standards of the procedure writers manual. Because the relocation of the startup checks to another procedure was primarily an administrative change, a review of the technical content of the procedures was not adequately performed.

While operating procedure N1-OP-18 was reconciled against the design bases to eliminate the requirement to lock the valve, an opportunity was missed to similarly reconcile N1-PM-V16 at the time that procedure was developed. At the time of discovery of the inadequate securing of the valve, N1-PM-V16 was at the revision 00 level and had not yet undergone the technical review associated with the periodic review process.

Procedure N1-PM-V16 is used as a prerequisite verification for plant startup or shutdown. Although procedure N1-PM-V16, Form III, did not require an independent verification for valve 72-479, Form II of this procedure required verification of system valve/electrical lineups per the applicable Operating Procedures, including N1-OP-18. N1-OP-18 specified independent verification for valve 72-479 which had been reconciled with the P&IDs. Procedure N1-PM-V16 was not reconciled in the same manner when it was developed in November of 1993.

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

A Deviation/Event Report (DER) was initiated to identify and document corrective actions for this event. These actions include:

1. Operations personnel immediately properly locked closed valve 72-479.
2. To ensure that the inadequate work practices associated with improper locking of valves was not a generic concern, accessible manual primary containment valves required to be locked closed were verified to be properly secured in accordance with applicable procedures. No other valves were found to be improperly secured.

## ATTACHMENT B

### *Supplemental Information*

In addition to the specific violation, the NRC expressed the following concern:

"As a result of those findings, we are concerned about the effectiveness of your procedure periodic review program and how well personnel provide input for procedure problems."

### *Effectiveness of the Periodic Review Process*

The periodic review process encompasses three basic areas; 1) future Procedure Change Evaluations (PCEs), 2) immediate PCEs, and 3) source documents for changes or performance of a technical review as specified in "Preparation and Review of Technical Procedures" (NIP-PRO-03). Future PCEs are evaluated for impact and if determined to significantly enhance the procedure, they are incorporated at the time of periodic review. Immediate PCEs (already incorporated) are reviewed for human factors and accuracy. Source documents are reviewed to determine if changes that would affect the procedure have occurred since the last review or revision.

At Nine Mile Point few problems have been experienced with the periodic review process related to the technical correctness of the procedures. This performance has led to the submittal of a Proposed Change to the Quality Assurance Topical Report which would replace the biennial review process with an alternative commitment to review procedures upon identification of new or revised source material that could affect procedures.

### *Personnel Input to Procedures*

Typically, many immediate, future, and editorial procedure changes, on the order of several thousand per year are written against both units' procedures. Whether self-identified or identified by others, this indicates considerable personnel input when problems or areas to improve are identified. NMPC recognizes that user input into the procedure review and revision process is vital to the success of the program and continues to encourage station personnel to identify worthwhile changes to procedures. Specifically, our procedures are developed by user department personnel.

The need for procedure changes may be identified through a number of sources and at various intervals. The current procedure review process at Nine Mile Point Unit 1 and Nine Mile Point Unit 2 is dynamic, based on internal identification and external receipt of new or revised source material. The DER program also provides a method for personnel to report and correct items adverse to quality. Corrective actions may include procedural changes deemed necessary to preclude recurrence as well as recommendations for procedural enhancements.

Existing administrative controls specify responsibilities for proper use of procedures. If a procedure cannot be performed safely, cannot or should not be performed as written, is technically incorrect, or unexpected results or conditions occur, users are directed to stop the activity, notify supervision, and initiate a change or revision to the procedure, as appropriate. In addition, mechanisms exist for procedure users to recommend enhancements to improve procedures/processes based on experience.

### *Specific Issues in Inspection Report 95-23*

With regard to the concern pertaining to the periodic review of procedure N1-PM-V16, the current revision at the time of this event was Rev. 0. The procedure was not due for periodic review until late October 1995, which was after the event. Therefore, NMPC does not consider the periodic review process to be a contributing factor.

The trip of both Reactor Recirculation Pumps at Unit 2 (DER 2-95-2571) was determined not to be due to procedural inadequacy, but rather an unanticipated interaction of systems or components by the persons performing the work. That is, personnel failed to understand the plant impact when troubleshooting this circuit. The RRCS was being de-energized in accordance with procedure (N2-OP-30B) as had been done successfully many times previous to this event. The trip of the Recirculation Pumps occurred because the procedure did not anticipate the system response with one channel in a tripped condition. Additionally, the procedure source documents did not identify the susceptibility of the system to spuriously tripping under these conditions. When the event occurred, Operations personnel immediately revised the procedure to preclude similar conditions from causing a trip in the future.

The failure to reopen a Unit 2 suppression pool spray valve after a test (DER 2-95-1854) was determined to be caused by a failure to follow procedure in that the Operator initialed the restoration step but failed to properly verify the step had actually been performed. Contributing causes were difficulties due to multiple procedure implementation and substandard procedural guidance for component position verification. That is, the Operators involved were performing too many tasks simultaneously and the interaction of performing several procedures resulted in not having sufficiently clear guidance to restore the system appropriately.

While opportunities exist to improve procedures, these instances do not demonstrate an inherent inadequacy of the periodic review process or personnel input to procedures.

### *Conclusion*

Niagara Mohawk has concluded that the periodic review process is effective. Input to procedures is received from many sources to correct deficiencies. Through review and analysis of the three specific examples discussed in Inspection Report 95-23, it is concluded that poor personnel performance was the primary cause of these events rather than an ineffective periodic review process or inadequate personnel input to resolve procedural problems.

3. While no regulatory requirements exist to require locking 72-479, a management decision has been made to incorporate locking of the valve into appropriate documents; as a result, the P&ID and Operating Procedure N1-OP-18 have been revised to require valve 72-479 to be locked closed. Similarly, the P&ID and N1-OP-18 have been revised to require the inside containment valve 72-480 to be locked closed.

### **III. ACTIONS TAKEN TO PREVENT RECURRENCE**

1. Operations Department personnel have been coached on the proper techniques for locking and verifying valves locked.
2. Procedure N1-PM-V16 will be reviewed and revised by February 28, 1996, to ensure:
  - compliance to the procedure writers manual for component positioning and verification standards
  - compliance to the licensing and design bases.

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

Full compliance with procedure N1-PM-V16, "Reactor Startup and Shutdown Prerequisite Verifications" was achieved on October 13, 1995 when Operations personnel immediately locked valve 72-479.