NIAGARA MOHAWK

NIAGARA MOHAWK POWER CORPORATION/NINE MILE POINT, P.O. BOX 63, LYCOMING, NY 13093/TELEPHONE (315) 349-2882

B. Ralph Sylvia
Executive Vice President
Nuclear

July 29, 1994
NMP1L 0844

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

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

Gentlemen:

Subject: Reply to Notice of Violation - NRC Inspection Report 50-220/94-07

Enclosed is Niagara Mohawk Power Corporation's reply to the Notice of Violation contained in the subject Inspection Report dated June 24, 1994. We believe that the reply appropriately addresses the causes of this violation and presents specific corrective actions which will prevent recurrence. In accordance with a telephone discussion between Mr. M. McCormick, Vice President Safety Assessment and Support and Mr. C. Cowgill of the NRC, Region I staff, this response is being submitted within 30 days of receipt.

Within the subject Inspection Report, there is further discussion of the circumstances associated with this Notice of Violation. The Inspection Report notes the action to review the PM/ST database, taken subsequent to the event described in Licensee Event Report (LER) 50-220/94-01, should have identified the surveillance database discrepancy that was a factor in the missed leak rate surveillance test addressed in LER 50-220/94-03. Niagara Mohawk agrees with this Notice of Violation that an effective database review should have identified the missed surveillance test described in LER 50-220/94-03.

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If you have any questions regarding this matter, please contact me.

Very truly yours,

B. Ralph Sylvia
Executive Vice President Nuclear

BRS/AFZ/ksj

Enclosures

xc: Mr. T. T. Martin, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Mr. M. L. Boyle, Acting Director, Project Directorate I-1, NRR
Mr. D. S. Brinkman, Senior Project Manager, NRR
Records Management

ENCLOSURE 1

NIAGARA MOHAWK POWER CORPORATION

NINE MILE POINT UNIT 1
DOCKET NO. 50-220
"REPLY TO NOTICE OF VIOLATION," AS CONTAINED IN
INSPECTION REPORT 50-220/94-07

VIOLATION 50-220/94-07-01

10CFR50, Appendix B, Criterion XVI, Corrective Action, requires that measures be established to assure that conditions adverse to quality are promptly identified and corrected, and that the cause of the condition is determined and corrective action taken to prevent repetition.

Contrary to the above, corrective actions taken for a missed Technical Specification surveillance were inadequate. A review of the surveillance test program was completed on March 1, 1994, to validate the accuracy of the program with respect to required surveillances. On April 6, 1994, it was identified that the semi-annual drywell airlock surveillance, due on October 16, 1993, had not been performed. It was determined that the frequency for the surveillance was incorrectly entered into the program's database to produce the desired results.

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

1. THE REASONS FOR THE VIOLATION

During the evaluation of the circumstances associated with a missed Technical Specification surveillance of the Intermediate Range Monitors (IRMs), it was discovered that the preventive maintenance/surveillance test (PM/ST) database was not properly updated to reflect a change made to the IRM surveillance procedure as described in Licensee Event Report (LER) 50-220/94-01. The PM/ST database issue was not discussed in the LER 50-220/94-01 as it was not material to the cause of the missed IRM surveillance. The Plant Manager consequently directed his Branch Managers to review the PM/ST database for completeness and accuracy. Deviation/Event Report (DER) 1-94-0182 was issued on January 26, 1994 and assigned to the Outage Management/Work Control (OM/WC) Branch for disposition and overall coordination of the review.

The disposition of this DER contained multiple required actions, among which were to perform a 100% verification of the PM/ST database to ensure that all information is present and accurate, and to validate the accuracy of the frequency field for Technical Specification required surveillances.

These and other actions in the DER disposition were ostensibly completed by March 1, 1994, however, on April 6, 1994 Maintenance Branch personnel, while performing a routine review of procedures, determined that Technical Specification required leak tests of the containment personnel and emergency airlocks had not been performed within the required frequency. The root cause of this event, as reported in LER 50-220/94-03, was inadequate change management. Although an effective PM/ST database review in response to DER 1-94-0182 would have identified the missed surveillance earlier, it would not have prevented the Technical Specification violation.

A root cause analysis was performed of the Maintenance Branch failure to detect the incorrect frequency code entry for the drywell air lock surveillance. This analysis concluded that the team of individuals tasked with reviewing the Maintenance Branch portion of the PM/ST database were not totally knowledgeable of the PM/ST Program database, specifically with respect to the various frequency codes that are used to trigger surveillance test schedules. Hence, the Maintenance team did not recognize the database discrepancy for the drywell airlock surveillance between the "REFERENCES" field (which prescribed a semi-annual frequency that they did confirm) and the "FREQUENCY CODE" field which did not contain the required "SAX" code that would have triggered the appropriate six-month frequency.

Based upon further management review of this issue, a second and no less significant cause was identified. As stated earlier, the DER that was generated to implement the PM/ST database review was dispositioned by the Outage Management/Work Control Branch, and accurately stated the actions required to perform a comprehensive review of the PM/ST database and program administration previously directed by the Plant Manager. However, the disposition section of the DER was not completed, nor distributed to the other Branch Managers for their use prior to their assigning individuals to perform the required tasks. Rather, a memo was distributed by the OM/WC Branch Manager to the other Branch Managers (and copied to the Plant Manager) which gave a more general direction for performing the review, and requested feedback as to scope, results, and completion date. The disposition section of the DER was completed concurrent with the ongoing Branch reviews and, therefore, was not available for use by the Branch Managers to ascertain whether their actions satisfied the disposition requirements.

This mismanagement of the DER and inadequate coordination of the reviews resulted in a lack of clear direction as to what actions were required of the Branches. Consequently, a comprehensive review of the PM/ST database was not performed as expected, nor was there an adequate management review of completed actions that should have identified this shortcoming. This is further evidenced by the feedback received from the Branches with respect to the scopes of reviews actually performed, and by the numerous errors found during the subsequent PM/ST database review that was conducted as a result of discovering the frequency code error in April, 1994. Overall, management involvement and control of the work effort was therefore inadequate, and is determined to be an equally significant cause for this violation.

2. CORRECTIVE ACTIONS TAKEN AND THE RESULTS ACHIEVED

The corrective actions for identifying and correcting the PM/ST database errors which could impact Technical Specification requirements are delineated in LER 50-220/94-03. These actions included a comprehensive review of the PM/ST database, training of appropriate personnel charged with updating and ensuring accuracy of the database, and strengthening of the process for making changes to the database. These actions were completed by June 30, 1994.

3. CORRECTIVE ACTIONS TAKEN TO AVOID FURTHER VIOLATIONS

In addition to the actions described in LER 50-220/94-03, the following actions have been taken to prevent further violations:

The Plant Manager has reinforced the fundamental requirements for disposition and implementation of DERs with Branch management, specifically with regard to the mismanagement aspects of the subject DER.

Coaching of personnel in the proper use of the DER process as an effective tool for identifying and correcting adverse conditions is an ongoing effort.

4. DATE WHEN FULL COMPLIANCE WAS ACHIEVED

Full compliance was achieved on April 11, 1994, when leak rate surveillance tests were performed for the personnel airlock and the emergency airlock.