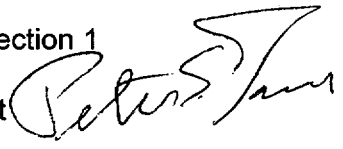




UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

January 21, 2000

MEMORANDUM FOR: File Center

FROM: Peter S. Tam, Senior Project Manager, Section 1  
Project Directorate I  
Division of Licensing Project Management  
Office of Nuclear Reactor Regulation 

SUBJECT: NINE MILE POINT NUCLEAR STATION, UNIT 1 --  
FACSIMILE TRANSMISSION DATED 3/2/99 (TAC MA4388)

The attached two pages were apparently transmitted by fax to Nine Mile Point personnel D. Wolniak and S. Leonard on March 2, 1999, by the former NRC project manager, Darl Hood. There is no indication that the two pages were made available to the public. This memorandum retroactively makes the two pages publicly available. This memorandum or the attachment does not convey a formal request for information or an official NRC staff position.

Docket No. 50-220

Attachment: As stated

Distribution

PUBLIC

M. Gamberoni

**NRC FILE CENTER COPY**

DF01



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555-0001

FACSIMILE TRANSMISSION

DATE: 3-2-99

TO: Denise Wolniak / S. Leonard

FAX NO: 315-349-1400

TEL NO: -4246

FROM: Dan Hood

U.S. NUCLEAR REGULATORY COMMISSION  
OFFICE OF NUCLEAR REACTOR REGULATION

FAX NO.: (301) 415-2102

TEL NO: 301-415-3049

PAGE 1 OF PAGES 2

REMARKS:

Results of Acceptance Review of CR Habitability  
Amendment Request.

Let me know if you wish to discuss these  
by phone / meeting before I send you a letter stating  
it is insufficient to initiate staff review.

## Nine Mile Unit 1 CONTROL ROOM HABITABILITY Assessment

I have reviewed the December 18, 1998 submittal which proposed to delete the licensee condition associated with reliance upon KI tablets for control room habitability. As a result of this review, the staff has determined that the submittal is deficient in the following manner.

1. The analyses presented do not address the impact of Unit 2 and the Fitzpatrick operation on control room habitability.
2. It appears from the analysis presented that the licensee limits their evaluation to the consequences associated with a LOCA. Other accidents, including a SBLOCA, should have been assessed to determine whether they might be more limiting.
3. The licensees provided an insufficient amount of information in their dose assessment to allow the staff to perform an adequate review.
4. It is not clear as to whether the licensee incorporated MSIV leakage into their analysis. Exclusion of this pathway would be inappropriate. If it is included it appears to be a value of 1 scfh per valve. It is unclear as to whether this degree of integrity has ever been achieved.
5. The licensee had identified numerous discrepancies in the project team assessment. The licensee has never informed the staff of these discrepancies and the modifications which the licensee performed to address them.