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April 15, 2009

U.S. Nuclear Regulatory Commission
Washington, D.C. 20555-0001

ATTENTION: Document Control Desk

SUBJECT: Nine Mile Point Nuclear Station
Unit No. 1; Docket No. 50-220
NRC Investigation Report No. 1-2008-018
Reply to a Notice of Violation: EA-09-005

REFERENCE: Letter from Mr. D. C. Lew (NRC) to Mr. K. J. Polson (NMPNS) dated March 16, 2009, Notice of Violation - NRC Investigation Report No. 1-2008-018

This letter provides the Nine Mile Point Nuclear Station, LLC (NMPNS) response to the referenced letter, which identified a Notice of Violation associated with the reactor overpower event of January 5, 2008. This violation involved misconduct by two licensed operators in making reactivity changes without proper approval and oversight, and a subsequent delay in reporting the event to control room supervision. NMPNS agrees with the violation and has taken corrective steps to prevent further violations.

The attachment to this letter provides the NMPNS detailed response to the violation. In accordance with 10 CFR 2.201, this response describes the reason for the violation, the corrective steps that have been taken and results achieved, the corrective steps that will be taken to avoid further violations, and the date when full compliance was achieved.

Should you have any questions regarding this matter, please contact T. F. Syrell, Licensing Director, at (315) 349-5219.

Very truly yours,

Sub for Keith Polson

KJP/JJD

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JED
NRR

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cc: NRC Regional Administrator, Region I
NRC Resident Inspector
NRR Project Manager

ATTACHMENT

REPLY TO A NOTICE OF VIOLATION:

EA-09-005

NRC INVESTIGATION REPORT NO. 1-2008-018

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REPLY TO A NOTICE OF VIOLATION: EA-09-005
NRC INVESTIGATION REPORT NO. 1-2008-018

I. NOTICE OF VIOLATION

Technical Specification 6.4.1(a) requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Sections 5.1 and 5.3 of ANSI N18.7-1972 and cover the described activities in Regulatory Guide 1.33, Appendix A, November 3, 1972 (Safety Guide 33). Safety Guide 33, Appendix A, Part A.2, requires procedures for authorities and responsibilities for safe operation and shutdown.

Nine Mile Point Operations Administrative Procedure S-ODP-OPS-0001, Revision 06, "Conduct of Operations," states in section 3.1.6.a, that planned reactivity and power changes are only performed with Shift Manager (SM) permission and shall be supervised by a Senior Reactor Operator (SRO).

Constellation Nuclear Generation Fleet Administrative Procedure CNG-OP-3.01-1000, "Reactivity Management," Revision 00100, states in Attachment 4, Section 1.d, that control room operators shall take conservative action when any unexpected situation occurs with respect to core reactivity and shall notify Operations management and Reactor Engineering as soon as possible.

Contrary to the above, on January 5, 2008: (1) a Reactor Operator (RO) increased power without SM permission or supervision by an SRO, and, after power exceeded the megawatt-thermal license limit, a CRO and the RO decreased power without SM permission or supervision by an SRO; and, (2) the CRO and the RO failed to notify Operations management and Reactor Engineering as soon as possible after the unexpected situation occurred with respect to core reactivity. Specifically, control room management was not notified until the following day that the over-power and down-power events had occurred.

II. REASON FOR THE VIOLATION

As listed above, an NRC Notice of Violation was issued to Nine Mile Point Nuclear Station, LLC (NMPNS) for the failure of two licensed operators to follow administrative procedures concerning roles and responsibilities of control room personnel. Specifically, on January 5, 2008: (1) licensed operators increased and decreased reactor power without SM permission and senior reactor operator oversight; and (2) the licensed operators did not notify Operations management as soon as possible after the unexpected situation occurred with respect to core reactivity. The root cause investigation conducted to address this event identified the following causes:

- Operations management did not ensure that high standards and expectations of performance were being implemented on shift. This resulted from a flawed mental model associated with compliance with standards and inadequate monitoring.
- Less than clear standards, expectations, and practices for maintaining power at or below the licensed core thermal power limit existed at the time of the event.

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III. CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND THE RESULTS ACHIEVED

Immediate and compensatory actions taken included:

1. A stand down was conducted with operations management to share lessons learned.
2. Shift Managers briefed each operating crew on the event.
3. The expectations/requirements for the function of the operator at the controls were clarified.
4. Interim reactor power maintenance guidelines were established to ensure that power is maintained at or below rated core thermal power.

In addition, the following corrective actions were taken as a result of the investigation:

1. A case study of the event was developed and presented to plant operators, initial license candidates, Training department SRO instructors, and Operations management. The case study discussed how erosion of the following standards led to the event: formal communications protocol during day-to-day activities, the control room command function, reactivity maneuvers/adjustments and SRO oversight expectations, and roles and responsibilities of control room personnel.
2. Dynamic learning activities were developed and completed for Operations management, SMs, and licensed operators for reinforcing and evaluating operator fundamentals associated with typical at power, steady state operational activities, including power maintenance, that focused on operational standards such as formal communications protocol, the control room command function, reactivity maneuvers/adjustments and SRO oversight expectations, roles and responsibilities of control room personnel, and critical parameter monitoring.
3. Operating procedures were revised with clear written standards for conduct of power maintenance including initiation and approval of verbal requests to conduct power maintenance, parameter monitoring and verification of intended response, and SRO oversight.
4. An operating band, designed to stay below the licensed thermal power limit, was developed and placed in appropriate procedures and communicated to operating crews via briefings.
5. The NMP steady-state power maintenance guidelines were revised to provide guidance in the event power exceeds the licensed thermal power limit, including making notifications as required by administrative procedures.
6. Disciplinary action was taken against the two operators described in the violation. Neither operator is currently employed by NMPNS.

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IV. CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

NMPNS is confident that the actions described above provide reasonable assurance that future similar events will not occur.

V. DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on August 29, 2008, when the last of the corrective actions described above was completed.