CATEGORY 1

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:9808240020 DOC.DATE: 98/08/14 NOTARIZED: NO DOCKET #
FACIL:50-410 Nine Mile Point Nuclear Station, Unit 2, Niagara Moha 05000410
AUTH.NAME AUTHOR AFFILIATION
BOSNIC,D. Niagara Mohawk Power Corp.
DAHLBERG,K.A. Niagara Mohawk Power Corp.
RECIP.NAME RECIPIENT AFFILIATION

SUBJECT: LER 98-002-01:on 980115,violation of TS 6.2.2.b occurred. Caused by inappropriate dehavior of licensed operator who violated TS & procedure requirements.Licensed operator has been removed from all station duties.W/980817 ltr.

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TITLE: 50.73/50.9 Licensee Event Report (LER), Incident Rpt, etc.

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A04

NIAGARA MOHAWK
GENERATION
BUSINESS GROUP

NINE MILE POINT NUCLEAR STATION/LAKE ROAD, P.O. BOX 63, LYCOMING, NEW YORK 13093

August 17, 1998
NMP2L 1816

United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

RE: Docket No. 50-410
LER 98-02, Supplement 1

Gentlemen:

In accordance with 10CFR50.73 (a)(2)(i)(B), we are submitting LER 98-02, Supplement 1, "Violation of Technical Specification 6.2.2.b." There is substantial doubt as to the Licensed Operator's capability to knowingly violate Technical Specifications. Therefore, the cause of this event has been revised.

Very truly yours,

KA Dahlberg

Kim A. Dahlberg
Plant Manager - NMP2

IE22

KAD/GJG/lmc
Attachment

xc: Mr. H. J. Miller, Regional Administrator, Region I
Mr. B. S. Norris, Senior Resident Inspector
Records Management

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Nine Mile Point Unit 2	05000410	1 OF 3

TITLE (4)
Violation of Technical Specification 6.2.2.b

EVENT DATE (5)			LER NUMBER (6)					REPORT DATE(7)			OTHER FACILITIES INVLVED (8)	
MONTH	DAY	YEAR	YEAR		SEQUENTIAL NUMBER		REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
01	15	98	98		02		01	08	14	98	N/A	05000
											N/A	05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check one or more of the following)* (11)

POWER LEVEL (10)					
095	☐ 20.402(b)	☐ 20.405(c)	☐ 50.73(a)(2)(iv)	☐ 73.71(b)
	☐ 20.405(a)(1)(i)	☐ 50.36(c)(1)	☐ 50.73(a)(2)(v)	☐ 73.71(c)
	☐ 20.405(a)(1)(ii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(vii)	☐ OTHER
	☐ 20.405(a)(1)(iii)	☒ 50.73(a)(2)(i)	☐ 50.73(a)(2)(viii)(A)	*(Specify in Abstract below and in Text, NRC Form 366A)*
	☐ 20.405(a)(1)(iv)	☐ 50.73(a)(2)(ii)	☐ 50.73(a)(2)(viii)(B)	
	☐ 20.405(a)(1)(v)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Don Bosnic - Manager Operations NMP2	(315) 349-7952

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
☐ YES *(If yes, complete EXPECTED SUBMISSION DATE)*	☒ NO				

ABSTRACT *(Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines)* (16)

On January 15, 1998, Niagara Mohawk Power Corporation (NMPC) discovered that on December 24, 1997, for approximately six minutes, a Licensed Operator was not "at the controls" of Nine Mile Point Unit 2 (NMP2) as required by Technical Specification (TS) 6.2.2.b. This violation was discovered by NMPC during an investigation into missing Operations personnel files. A Licensed Senior Operator and the Licensed Operator were in the control room and both could have immediately responded to plant transients. At the time, the plant was operating with all Emergency Core Cooling Systems available for automatic response to a plant transient.

The apparent cause of the event is the inappropriate behavior of the Licensed Operator who violated the TS and procedure requirements. Based on the nature of the behavior of the individual, NMPC Employee Assistance Program professionals have concluded that Operations Management had no substantial behavioral observation information that could have been used to predict or prevent this event.

The licensed operator has been removed from all station duties.

I. DESCRIPTION OF EVENT

On January 15, 1998, Niagara Mohawk Power Corporation (NMPC) discovered that on December 24, 1997 for approximately six minutes, a Licensed Operator was not "at the controls" of Nine Mile Point Unit 2 (NMP2). Technical Specification (TS) 6.2.2.b requires "at least one Licensed Operator shall be in the control room when fuel is in the reactor. In OPERATIONAL CONDITIONS 1, 2 or 3, at least one Licensed Senior Operator or Licensed Operator shall be at the controls of the unit." Contrary to this requirement, the Licensed Operator, who was assigned to the "at the controls" area, left the controls area. The "at the controls" area is defined by Figure 13.5-1 of the NMP2 Updated Safety Analysis Report.

As required by TS 6.2.2.e, a Licensed Senior Operator (Assistant Station Shift Supervisor (ASSS)) was in the control room during this period. However, the Licensed Senior Operator was in the area of the control room back panels (not in the view of the "at the controls" area) and was thus unaware of this TS violation. The Station Shift Supervisor (SSS) was performing tasks outside the control room.

NMPC discovered this violation while performing an investigation into missing Operations personnel files. In the course of the investigation, it became evident that the Licensed Operator left the controls area to remove the personnel files. The Licensed Operator entered the glass enclosed SSS office and an area behind a control panel. Both areas are in the control room, but outside the "at the controls" area.

II. CAUSE OF EVENT

The apparent cause of the event is the inappropriate behavior of the Licensed Operator who violated the TS and procedure requirements. Based on the nature of the behavior of the individual, NMPC Employee Assistance Program professionals have concluded that Operations Management had no substantial behavioral observation information that could have been used to predict or prevent this event.

NMPC has performed an investigation and concluded that this violation was isolated to the Licensed Operator on this one occasion. Other licensed personnel were interviewed, and all interviewed knew the "at the controls" requirements and assured that they met those requirements.

III. ANALYSIS OF EVENT

The event is reportable in accordance with 10CFR50.73 (a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications," since a Licensed Operator was not "at the controls".

III. ANALYSIS OF EVENT (cont'd)

As noted above, the Licensed Senior Operator (ASSS), and the Licensed Operator were in the control room and both could have immediately responded to plant transients. At the time, the plant was operating with all Emergency Core Cooling Systems available for automatic response to a plant transient. Therefore, this event did not pose a threat to the health and safety of the public or plant personnel.

IV. CORRECTIVE ACTIONS

1. The Licensed Operator has been removed from all station duties. Prior to the discovery of this event, the individual had his unescorted access removed for medical reasons on January 2, 1998.

2. An investigation was performed and concluded that this was an isolated incident involving this Licensed Operator on this one occasion. Other licensed personnel were interviewed, and all interviewed knew the "at the controls" requirements and assured that they met those requirements.

3. A sampling of surveillances involving the Licensed Operator within the last six months were compared against Security records. The available records indicated that the Operator was in the area needed to perform the surveillances. Additionally, surveillance procedures are reviewed by two operations management staff personnel prior to closing out the procedures.

4. A sampling of rounds performed by the Licensed Operator in the last six months were reviewed against Security records. It was determined that on July 21, 1997, one required area was not entered. This was a general area requiring entry on shiftly rounds. Subsequent rounds verified that there were no anomalies in that area. Therefore, there are no adverse consequence of the missed rounds. An additional sampling was performed with no further discrepancies and thus, the single instance is considered an anomaly.

V. ADDITIONAL INFORMATION

A. Failed components: none.

B. Previous similar events: none.

C. Identification of components referred to in this LER: none.