

# Nine Mile Point 1

## 3Q/2008 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Meet TS Oversight Requirement**

A self-revealing non-cited violation (NCV) of Technical Specification (TS) 6.1, "Responsibility," was identified on April 26, 2008, when the Unit 1 shift manager (SM) left the control room without designating another senior reactor operator (SRO) qualified individual to assume the control room command function. When the condition was identified, the SM promptly returned to the control room.

The finding was greater than minor because it could reasonably be viewed as a precursor to a significant event. Specifically, the absence of SRO oversight during licensed control room activities increases the likelihood of human performance errors, which in turn, increases the likelihood of an initiating event and reduces the effectiveness of event mitigation. The finding has been reviewed by NRC management in accordance with IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria," and was determined to be of very low safety significance because of the short period that the SM was not present in the control room, and because no initiating events occurred during that time. The finding had a cross-cutting aspect in the area of human performance because of the ineffective use of human error prevention techniques (H.4.a per IMC 0305).

Inspection Report# : [2008003](#) (*pdf*)

**Significance:**  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Properly Control Operations Staff Overtime**

An NRC-identified non-cited violation (NCV) of Unit 1 Technical Specification (TS) 6.2.2 and Unit 2 TS 5.2.2, "Unit Staff," was identified for not properly implementing and maintaining procedures for controlling plant staff work hours of personnel performing safety-related activities. Specifically, over 400 overtime deviations were approved between July 2007 and April 2008 for Operations personnel to work greater than procedurally established work hour limits for routine outage support activities during outages and other reasons not permitted by TS. Corrective actions were being developed to increase qualified operator levels.

The finding was greater than minor because, if left uncorrected, it would become a more significant safety concern. Specifically, the excessive work hours would increase the likelihood of human errors during plant activities and response to plant events. The finding has been reviewed by NRC management in accordance with IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." Although the increased likelihood of human error would adversely affect the station's defense-in-depth, the violation was determined to be of very low significance because no significant events or human performance issues were directly linked to personnel fatigue as a result of the hours worked. The issue had a cross-cutting aspect in the area of human performance because the licensee did not use conservative assumptions in decision making, in that, the consequences of the high number of overtime deviations were not fully considered and the possible unintended consequences evaluated. (H.1.b per IMC 0305).

Inspection Report# : [2008003](#) (*pdf*)

**Significance:**  Jun 30, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Repetitive Improper Authorization and Evaluation of Overtime Deviations**

A non-cited violation (NCV) of Unit 1 Technical Specification (TS) 6.2.2 and Unit 2 TS 5.2.2, "Unit Staff," was identified by the inspectors for a recurring trend of operations personnel being required to stand 24 hour shifts in order to ensure adequate shift coverage. There were eight occurrences between May 2007 and May 2008. Several of these overtime deviations were not properly authorized or documented in accordance with station procedures as required by TS. Corrective actions were being developed to increase qualified operator levels.

The finding was greater than minor because, if left uncorrected, it would become a more significant safety concern. Specifically, the excessive work hours would increase the likelihood of human errors during plant activities and response to plant events. The finding has been reviewed by NRC management in accordance with IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." Although the increased likelihood of human error would adversely affect the station's defense-in-depth, the violation was determined to be of very low significance because no significant events or human performance issues were directly linked to personnel fatigue as a result of the hours worked. The issue has a cross-cutting aspect in the area of problem identification and resolution because NMPNS failed to periodically trend and assess information from the corrective action program and other assessments in the aggregate to identify programmatic and common cause problems

Inspection Report# : [2008003](#) (*pdf*)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## **Physical Protection**

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## **Miscellaneous**

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