

Nine Mile Point 1

1Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedure for Main Steam Isolation Valve Troubleshooting

A self-revealing non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when use of an inadequate maintenance procedure resulted in unanticipated partial closure of Unit 1 main steam isolation valve (MSIV) 01-01. The troubleshooting procedure did not identify that the valve would move in the closed direction when power was reapplied to the control circuit. As immediate corrective action, the control circuit was deenergized to stop further closure of the MSIV and power was reduced to 97 percent. The issue was entered into the corrective action program (CAP) as condition report (CR) 2009-442.

The finding was more than minor because it was similar to example 4.b in Inspection Manual Chapter (IMC) 0612, Appendix E, in that it challenged stability of the plant due to closure of the MSIV and resulted in a power reduction to 97 percent. The finding was associated with the procedure quality attribute of the Initiating Events cornerstone and adversely affected the associated cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was evaluated in accordance with IMC 0609, Attachment 4, and determined to be of very low safety significance because the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available, and did not screen as potentially risk significant due to external events. The finding had a cross-cutting aspect in the area of problem identification and resolution because Nine Mile Point Nuclear Station did not implement internal operating experience from 2001, concerning the response of a mid-positioned MSIV to reapplication of control circuit power, in the MSIV troubleshooting procedure (P.2.b per IMC 0305). (Section 1R22)

Inspection Report# : [2009002](#) (*pdf*)

Mitigating Systems

Significance:  Oct 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control for Unit 1 600V MCC Control Circuit Voltage Drop Calculations

The team identified a finding of very low safety significance (Green) involving a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control, in that

Constellation had used non-conservative inputs in voltage drop calculations with respect to evaluating the adequacy of the voltage supplied to Unit 1 safety related motor control center (MCC) contactors. Specifically, Constellation's voltage drop calculation for the MCC control circuits did not recognize additional impacts to overall circuit voltage drops which resulted in reduced margin. Constellation entered the issue into their corrective action program and performed a review of the effect on the circuits with the lowest voltage margin. The calculated voltage at the contactor coil for the main steam isolation valve (MSIV), 01-01, was determined to be less than the 90 Vac minimum acceptance criterion and was therefore tested during the inspection at a lower voltage to ensure it remained operable.

The finding is more than minor because the deficiency was associated with the design control attribute of the Mitigating Systems Cornerstone and affected the cornerstone objective of ensuring the availability, reliability and

capability of systems that respond to initiating events to prevent undesirable consequences. The team determined the finding was of very low safety significance (Green) because it was a design deficiency confirmed not to result in the loss of equipment operability.

Inspection Report# : [2008008](#) (*pdf*)

G

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*)

G

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*)

G

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*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

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.

Miscellaneous

Last modified : May 28, 2009