

# Nine Mile Point 1

## 3Q/2009 Plant Inspection Findings

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### Initiating Events

**Significance:** **G** Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Failure to Follow Startup Procedure for Second Stage Reheaters Leads to Turbine Trip**

A self-revealing non-cited violation (NCV) of Technical Specification (TS) 6.4, "Procedures," was identified when operators did not follow the operating procedure when placing the Unit 1 second stage main steam reheaters in service during plant power ascension. The resultant uneven turbine heating caused an increase in turbine vibrations that led the control room operators to rapidly reduce power and trip the turbine, which, in turn, cause an automatic initiation of the high pressure coolant injection (HPCI) system. As corrective action, the operating procedure was revised to provide improved guidance on placing the second stage main steam reheaters in service. This issue was entered into the corrective action program (CAP) as condition report (CR) 2009-2238.

The finding was more than minor because it is associated with the procedure quality attribute of the Initiating Events cornerstone and affected the 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 is 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 Human Performance, Work Practices, because the operators did not follow the procedure for placing the second stage main steam reheaters in service (H.4.b per IMC 0305). (Section 1R20)

Inspection Report# : [2009003](#) (*pdf*)

**Significance:** **G** 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*)

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## Mitigating Systems

**Significance:**  Jun 19, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Implement Fire Brigade Training Program Procedure**

The team identified a finding of very low safety significance (Green) involving a non-cited violation of Unit 1 Technical Specifications, section 6.4.1 and Unit 2 Technical Specifications, section 5.4.1., for NMPNS's failure to correctly implement the fire brigade training program procedure to ensure that fire brigade members met the fire drill requirements to be qualified. Specifically, NMPNS failed to correctly assess the acceptance criteria required for a successful drill per their implementing procedure. Further review of fire brigade qualifications by the licensee determined that a number of fire brigade members were not qualified. The licensee removed the appropriate individuals from shift for remediation and placed the issue into their corrective action program for further review.

The finding is greater than minor because the Mitigating Systems cornerstone objective to provide protection against external factors (fires) was affected. Specifically, the reliability and capability of the fire brigade's ability to respond to a fire was challenged. In accordance with Manual Chapter 0609, Appendix M, the safety significance of this finding was determined to be of very low safety significance (Green) because the fire brigades were able to meet the required times for fire extinguishment for the fire drill scenarios, and the issue did not significantly affect the ability of the fire brigades to respond to a fire. The finding had a cross-cutting aspect in the area of human performance because Nine Mile Point Nuclear Station failed to follow their fire brigade training program procedure.

Inspection Report# : [2009006](#) (*pdf*)

**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*)

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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

**Significance:** SL-IV Mar 16, 2009

Identified By: NRC

Item Type: VIO Violation

### **Operator Failure to Obtain Senior Reactor Operator Permission Prior to Changing Reactor Power**

A cited violation (VIO) of Unit 1 Technical Specification (TS) 6.4, "Procedures," was identified when a Reactor Operator (RO) and a Chief Reactor Operator (CRO) failed to notify the Control Room Supervisor (CRS) of an "over power" event and manipulated reactor power without CRS approval or direction. Specifically, the RO deliberately manipulated the controls to increase power without the approval or direction of a senior reactor operator (SRO); the CRO and RO manipulated the controls to decrease power without the approval or direction of an SRO when power exceeded the megawatt-thermal license limit; and, the CRO deliberately failed to immediately report the over power and down power events to Operations management.

The violation, absent willfulness, would be considered a minor violation because it did not impact the safe operation of the reactor, in that, the over power condition was minimal (100.03 percent for approximately one hour). However, the NRC considered the violation to have been more significant than minor because it involved willfulness, and therefore, the NRC has classified the violation at Severity Level (SL) IV, in accordance with the NRC Enforcement Policy.

Inspection Report# : [2009003](#) (*pdf*)

Inspection Report# : [2009004](#) (*pdf*)

Last modified : December 10, 2009