

Nine Mile Point 2 4Q/2003 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 20, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Correct Fire Protection Deficiency.

The inspectors identified a non-cited violation of 10 CFR 50.54(a)(1) that occurred because the fire protection corrective action requirements of the quality assurance program were not properly implemented to promptly address a problem with the adequacy of fire brigade member familiarity with all areas of the plants.

This finding adversely impacted the manual fire suppression capability and because it affects the reactor safety mitigating systems cornerstone objective, the finding is greater than minor. The finding is of very low safety significance because delays in the fire brigade response during fire drills have not been frequent and the duration of the delay during the observed drill was relatively small with respect to the established response time goal such that equipment required for safe shutdown of the plant would not have been adversely affected. (Section 1R05.6).

Inspection Report# : [2003007\(pdf\)](#)

Significance:  Mar 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Procedural Non-Compliance Resulted in the Incorrect Position for Division 1 Unit Heater Switch.

Green. The inspectors identified a non-cited violation of Technical Specification 5.4.1 at Unit 2 for procedural non-compliance, in that the control switch for one of three area heaters in the Division 1 Emergency Diesel Generator (EDG) room was not in the "auto" position as specified by operating procedure N2-OP-57, "Diesel Generator Building Ventilation System."

This finding is greater than minor because it could reasonably be viewed as a precursor to a significant event, in that incorrect plant equipment configuration could impact system operability. The finding was determined to be of very low safety significance in accordance with Phase 1 of the Reactor Safety SDP because the other two area heater switches were in the correct position, the EDG room temperature was being maintained, and the EDG remained operable. This finding was an example of a cross-cutting issue in human performance. (Section 1R22)

Inspection Report# : [2003002\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Oct 24, 2003

Identified By: NRC

Item Type: FIN Finding

Problem Identification and Resolution Team Assessment

The team determined that, in general, Nine Mile Point Nuclear Station (NMPNS) properly identified, evaluated and corrected problems. Corrective actions, when specified, were generally implemented in a timely manner. Audits and self-assessments were found to be acceptable. Since the last problem identification and resolution (PIR) inspection, weaknesses associated with your corrective action program have been identified as a contributing root cause for an unplanned scram performance indicator that crossed the white threshold and for a white finding associated with degraded reactor building closed loop cooling system piping. These equipment reliability issues contributed to the 2003 NRC Reactor Oversight Program (ROP) mid-cycle performance assessment that a substantive cross-cutting issue existed in the PIR area. Although the long term effectiveness of recent changes to your corrective action program cannot yet be evaluated, the team determined that the recent improvements to the corrective action program appeared appropriate. On the basis of interviews conducted during the inspection, workers at the site felt free to input safety findings into the corrective action program.

Inspection Report# : [2003011\(pdf\)](#)

Last modified : March 02, 2004