

Nine Mile Point 1

4Q/2007 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 29, 2007

Identified By: NRC


Item Type: NCV NonCited Violation

Failure To Take Action Per Operating Experience Results In Two Inoperable IRM Channels During Reactor Startup

A self-revealing Green NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," occurred when NMPNS failed to identify and correct a condition adverse to quality, associated with two of the four Unit 1 intermediate range monitor (IRM) instrument channels, when they failed to perform vendor recommended testing during refueling outage (RFO) 19. As a result, operators identified two of the four IRM instrument channels, associated with the 12 reactor protection system (RPS) trip, inoperable during the startup on April 14, 2007. Operators immediately halted the startup and maintenance repaired the signal cable connections. NMPNS entered the issue into its corrective action program (CAP) as condition report (CR) 2007-2359.

The finding is greater than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding to be of very low safety significance because the finding is not a design or qualification deficiency, does not represent a loss of a system safety function or safety function of a single train, and does not screen as potentially risk significant due to external events. This finding has a cross-cutting aspect in the area of human performance because NMPNS management failed to use conservative assumptions in decision making and inappropriately deleted vendor recommended testing designed to detect degraded IRM system cable connections (H.1.b.) (Section 1R20.1)

Inspection Report# : [2007003](#) (*pdf*)

Significance:  Jan 18, 2007

Identified By: NRC

Item Type: VIO Violation

Failure to Ensure Integrity of Unit 1 Examinations and Tests

White. A violation of 10 CFR 55.49, "Integrity of Examinations and Tests," was identified, concerning an apparent compromise of the 2005 and the 2006 annual operating exams at Unit 1. NRC inspectors identified practices that collectively had the impact of compromising, albeit unintentionally, the examinations; these practices included: 1) a lack of simulator exam scenario diversity (i.e., The scenarios were substantially the same including: critical tasks; major transients; Emergency Operating Procedure flow paths; and emergency classifications); 2) an overuse of a single emergency operating procedure strategy (i.e., full core Anticipated Transient Without Scram); and 3) a pattern of crews validating scenarios substantially similar to their exam scenario sets. Constellation had not identified and compensated for the compromise prior to completing the 2005 exam and returning the operators to normal control room duties. Following NRC identification of the compromise in 2006, Constellation took immediate and substantive corrective actions prior to completion of the annual operating exam cycle. Based on the Licensed Operator Requalification Significance Determination Process (SDP) this finding was determined to be of low to moderate safety significance (White). The licensee initiated Condition Report CR-NM-2006-4808, dated October 19, 2006, that documented this issue and later initiated a Category I Root Cause Analysis (CR-NM-2006-4808), "Annual Licensed Operator Requalification Exam Compromise."

This finding was more than minor because it was associated with the Human Performance attribute of the Initiating Events, Mitigation Systems, and Barrier Integrity cornerstones and affected the combined objective of: limiting the likelihood of; ensuring the availability and reliability of mitigating systems to respond to; and providing reasonable assurance that physical barriers protect the public from radio-nuclide releases caused by, initiating events. The finding has a cross-cutting aspect in the area of problem identification and resolution because Constellation did not effectively collect, evaluate, and communicate applicable external operating experience to affected internal stakeholders nor did they conduct self-assessments that were comprehensive, appropriately objective, and self-critical such that either Unit 1 2005 exam compromise issues were avoided altogether or identified and corrected prior to the end of the 2005 annual operating exam cycle.

A supplemental inspection was conducted in accordance with Inspection Procedure 95001 to assess Constellation's root cause analysis, extent of cause and condition review, and corrective actions. The inspectors concluded that Constellation completed a comprehensive root cause evaluation of the exam compromise performance deficiency associated with this White finding. Additionally, the inspectors concluded that the completed corrective actions appropriately addressed the related causes. (ML080150151)

Inspection Report# : [2006011](#) (*pdf*)

Inspection Report# : [2007007](#) (*pdf*)

Significance:  Jan 18, 2007

Identified By: NRC

Item Type: FIN Finding

Unit 1 Crew Failure Rate on the Dynamic Simulator Portion of the Annual Operating Examinations

A finding of very low safety significance (Green) was identified at Unit 1. The finding was associated with crew performance on the simulator during the 2006 facility-administered requalification examinations. Of the six crews evaluated, two failed to pass their simulator examinations when the newly developed more comprehensive exams were re-administered in response to the above noted preliminary White finding. The failures are documented in licensee-initiated Condition Report CR 2006-5797, which resulted in Constellation conducting a Category I Root Cause Analysis.

This finding was more than minor because it was associated with the Human Performance attribute of the Initiating Events, Mitigation Systems, and Barrier Integrity cornerstones and affected the combined objective of: limiting the likelihood of; ensuring the availability and reliability of mitigating systems to respond to; and providing reasonable assurance that physical barriers protect the public from radio nuclide releases caused by, initiating events. The finding was assessed as having very low safety significance because: 1) the failures occurred during annual testing of the operators on the simulator; 2) there were no actual consequences to the failures; 3) the crews were removed from watch standing duties, retrained and re-evaluated before they were authorized to return to control room watches; and, 4) because the crew failure rate for the 2005 Unit 1 Annual Operating Exams was less than 20%.

Inspection Report# : [2006011](#) (*pdf*)

Barrier Integrity

Significance:  Jun 29, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

Procedural Noncompliance Resulted In Failure to Establish Primary Containment Prior to Reactor Startup.

A self-revealing Green NCV of Unit 1 TS 6.4, "Procedures," occurred on April 2, 2007, when operators failed to resolve a position discrepancy identified with respect to the emergency cooling system (EC) vent line isolation valves prior to reactor startup following RFO 19. This resulted in the EC vent line isolation valves being left open, which represented an open pathway in the physical integrity of the reactor coolant and primary containment system boundaries. Upon discovery of the degraded barrier, operators immediately halted the startup and closed the valves. NMPNS entered the issue into its CAP as CR 2007-2380.

The finding is greater than minor because it is associated with the human performance attribute of the Barrier Integrity

cornerstone and adversely affects the cornerstone objective to provide reasonable assurance that reactor coolant and containment system physical design barriers protect the public from radionuclide releases caused by accidents or events. The inspectors determined the finding to be of very low safety significance because even though the open valves were associated with the integrity of the reactor coolant system and containment they did not contribute to large early release frequency because the EC steam line vent to the reactor building (RB) equipment drain tank is less than two inches in diameter. This finding has a cross-cutting aspect in the area of human performance because operators failed to follow procedures (H.4.b.) (Section 1R20.2)
Inspection Report# : [2007003](#) (*pdf*)

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

Significance: N/A Jun 28, 2007

Identified By: NRC

Item Type: FIN Finding

Problem Identification & Resolution

Overall, the inspection team determined that the Corrective Action Program (CAP) at Constellation's NMPNS was generally effective in the identification, evaluation, and resolution of problems. The inspection team determined that NMPNS typically identified problems and placed them in the CAP. The inspection team identified that operating experience was utilized and considered at NMPNS, although certain issues at Unit 1 were not fully assessed in all aspects. The inspection team noted that NMPNS was effective in conducting root cause and apparent cause evaluations and effectively resolved most problems categorized as more significant. Based on interviews, observations of plant activities, reviews of the CAP and the Employees Concerns Program, the inspection team determined that site personnel were willing to raise safety issues.

Inspection Report# : [2007006](#) (*pdf*)

Last modified : February 04, 2008