Nine Mile Point 2
2Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Aug 23, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to implement corrective actions for valve packing leaks inside the drywell
A violation of 10 CFR 50, Appendix B, Criterion XVI, (measures be established to assure that conditions adverse to quality are promptly identified and corrected) dispositioned as a non-cited violation was identified for failure to implement corrective actions for valve packing leaks inside the drywell which caused several plant shutdowns. Specifically, the failure to take effective corrective actions in a timely manner to address packing leakage from valve 2RCS*MOV18A that was observed in September 2000 and March 2001 led to the December 15, 2001, reactor scram which was a self-revealing event. This finding is more than minor because it could reasonably be viewed as a precursor to a more significant event, which in this case was a 6 gpm reactor coolant system (RCS) leak that necessitated a manual reactor scram (an initiating event) on December 15, 2001. This issue was evaluated using Phase 1 of the reactor safety significance determination process (SDP) and determined to be of very low safety significance (green). Although the issue increased the transient initiator contributor, it did not contribute to the likelihood of a loss-of-coolant accident, it did not contribute to the likelihood mitigating equipment or functions would be unavailable and it did not increase the likelihood of an external event.
Inspection Report# : 2002009*(pdf)*

Mitigating Systems

Significance: G 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: G 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)*

Significance: G Aug 02, 2002
Identified By: NRC
Item Type: FIN Finding
Lack of adequate corrective action to address longstanding problems with the Unit 2 instrument air (IA) system
The inspection team identified a lack of adequate corrective action to address longstanding problems with the Unit 2 instrument air (IA) system. Following an IA system modification in 1993, problems were identified with IA compressor cooling water pump trips and cycling, as well as the need for operator action to restart the IA compressors after a loss of offsite power which could affect the reliability of the IA system. Although the problems were entered in the corrective action program, there was a history of cancelled deviation event reports (DERs) and longstanding operator work-arounds associated with the IA system. The finding was considered to be of very low safety significance (Green) based on a Phase 3 risk evaluation because cycling of the cooling water pumps and the loss of offsite power were infrequent events, cooling water flow to the air compressors could be restored by restarting the redundant cooling water pump, it was very unlikely that both pumps would fail at the same time, procedures existed for manually restarting the compressors following a loss of power, and there were several additional failures that must also occur for a loss of instrument air to result in core damage. There was no violation of NRC regulations since the IA system was not safety-related.
Inspection Report# : 2002010*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: FIN Finding

During the Spring 2002 refueling outage, hydraulic control unit (HCU) valve maintenance resulted in 6.91 person-rem of collective exposure based on an exposure estimate of 1.8 person-rem
During the Spring 2002 Unit 2 refueling outage, hydraulic control unit (HCU) valve maintenance resulted in 6.91 person-rem of collective exposure based on an exposure estimate of 1.8 person-rem. This work activity was 283 percent above the estimate. The occupational radiation safety significance determination process screening criteria for work activity exposure greater than 5 person-rem and greater than 50 percent above estimated were exceeded. There were two performance deficiencies that were attributed to this exposure overrun. There was an 83 percent increase in work-hours and exposure due to the improper installation of 139 solenoid operated valve spring clips and air supply hoses that required rework. In addition, after the scram at the start of the outage, rather than isolating and draining the scram discharge volume (SDV) piping immediately after the scram, as is typically done, the licensee left the SDV connected and pressurized to the reactor coolant system in preparation for a outage in-service test. Although leaving the SDV connected to the reactor coolant system was a planned evolution, radiation protection personnel were not involved in the planning activities. This resulted in 73 percent higher dose rates during HCU maintenance due to an outage crud burst spreading into the SDV piping. Constellation Nuclear's three-year rolling average (99-01) is 179 person-rem, which is below the SDP criteria of 240 person-rem for Boiling Water Reactors (BWRs), therefore, overall ALARA performance has been effective and this finding is of very low safety significance.
Inspection Report# : 2002006*(pdf)*

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: FIN Finding
During the Spring 2002 refueling outage, under-vessel work activities resulted in collective exposures of 47.2 person-rem based on 18 person-rem estimated for the work activities
During the Spring 2002 Unit 2 refueling outage, under-vessel work activities resulted in collective exposures of 47.2 person-rem based on 18 person-rem estimated for the work activities. After giving credit for higher dose rates than expected (9.5 person-rem), this work activity was 72 percent above a 27.5 person-rem adjusted estimate. The occupational radiation safety significance determination process screening criteria for work activity exposure greater than 5 person-rem and greater than 50 percent above estimated were exceeded. The performance deficiency that resulted in the exposure overrun was due to inexperienced and poorly trained personnel, and vendor equipment problems. Constellation Nuclear's three-year rolling average (99-01) is 179 person-rem, which is below the SDP criteria of 240 person-rem for Boiling Water Reactors (BWRs), therefore, overall ALARA performance has been effective and this finding is of very low safety significance.
Inspection Report# : 2002006*(pdf)*

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : September 04, 2003