Nine Mile Point 1
1Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Degraded Penetration Fire Seal not Identified in a Timely Manner.
The inspectors identified a Green non-cited violation (NCV) of Facility Operating License DPR-63, 2.D(7), Fire Protection, concerning a degraded fire seal for a 3-hour fire barrier that separates the diesel fire pump from the remainder of the screenhouse at Unit 1. The performance deficiency associated with this finding is failure to promptly identify a degraded fire seal for a pipe penetration. The finding is greater than minor because it is associated with the protection against the external factors attribute, and affects the mitigating systems cornerstone objective of ensuring the availability of systems that respond to initiating events. The finding is of very low safety significance in accordance with Phase 2 of the Fire Protection Significance Determination Process (SDP) because there is no realistic scenario by which a fire on one side of the barrier could propagate through the degraded seal to the other side of the barrier. The failure to identify the degraded fire seal is an example of a cross-cutting issue in problem identification and resolution.

Inspection Report# : 2003006*(pdf)*

Significance: G Dec 31, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Untimely Corrective Action Resulted in the Failure of Control Rods to Meet the Five Percent Scram Insertion Time.
The inspectors identified a Green non-cited violation (NCV) of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Action," for the failure to implement timely corrective actions to replace degraded control rod system components which resulted in several control rods failing to meet the Technical Specification (TS) five percent insertion time requirement. The performance deficiency associated with this finding is that appropriate corrective actions were not performed to replace degraded scram solenoid pilot valve diaphragms in a timely manner. This led to four control rods exceeding their TS five percent insertion time limit in October 2003. The finding is greater than minor, because it is associated with the equipment performance attribute of the mitigation system cornerstone and adversely affected the cornerstone objective of reliability. The finding is of very low safety significance because it is not a design or qualification deficiency, it did not represent a loss of safety function and was not potentially risk significant due to seismic, fire, flooding or weather related initiating events.
The failure to implement timely corrective actions is an example of a cross-cutting issue in the area of problem identification and resolution.
Inspection Report# : 2003006*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: FIN Finding
Operability Determination Not Performed for CS With Keep-Full System Out of Service
The inspectors identified a finding when the number 12 core spray (CS) keep-full system was taken out of service for maintenance without determining the effect of its removal on the operability of the CS train number 12.

The finding is greater than minor because it is associated with the configuration control attribute of the mitigating system cornerstone and adversely affects the cornerstone objective. Specifically, the reliability of the 12 CS train was reduced due to the increased susceptibility for water hammer that would potentially cause piping damage and affect the capability of the 12 CS train to respond to an initiating event. The finding is of very low safety significance, because it is not a design or qualification deficiency and it does not represent an actual loss of the CS safety function or of a single CS train that contributes to internal or external event (e.g., seismic, fire, flooding, or severe weather) core damage accident sequences. Additionally, there was no evidence of significant draining of the number 12 CS train piping during the time period that the keep-full system was removed from service.

A contributing cause of the finding was related to the human performance cross-cutting area. Operators removed a core spray keep-full

subsystem from service without determining the effect of its removal on the core spray system. (Section 1R17)

Inspection Report# : 2003005*(pdf)*

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide for Bypassing the HPCI Interlock in EOP-2
The inspectors identified a non-cited violation of technical specification (TS) 6.4.1.b because the licensee did not develop and validate an emergency operating procedure (EOP) to reflect current plant design. Specifically, EOP-2 "Reactor Pressure Vessel Control Flowchart's" did not direct the operators to bypass the high pressure coolant injection (HPCI) mode feedwater flow control valve low pump discharge pressure interlock to allow the use of the condensate system following a HPCI failure.

The finding is greater than minor because it is associated with the Mitigating Systems cornerstone attribute of procedure quality and affected the associated cornerstone objective of ensuring the capability of the condensate system, a preferred low pressure injection water source, to respond to initiating events to prevent undesirable consequences. The finding is of very low safety significance, because it was not a design or qualification deficiency and it did not represent an actual loss of the low pressure injection safety function or of a single low pressure injection train that contributes to internal or external events (e.g., seismic, fire, flooding, or severe weather) core damage accident sequences. (Section 4OA5)

Inspection Report# : 2003005*(pdf)*

Significance: G Sep 12, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Adequate Procedures for the RBCLC System Oxygen Injection System Temporary Modification
The inspector identified a non-cited violation of Technical Specification 6.8.1, "Procedures." Constellation Energy Group did not develop a procedure to ensure that the temporary oxygen injection system would be secured upon shutdown of the RBCLC system.
The finding is greater than more than minor because the failure to develop this procedure could have complicated recovery of the RBCLC system following initiating events that included loss of the RBCLC system. The inspector determined that this procedural problem would not affect the frequency for loss of RBCLC initiated events. The finding was determined to have very low safety significance (Green) using the Significance Determination of Reactor Inspection Findings for At-Power Situations process because it did not result in any actual loss of safety function of a system (Section 02.04).

Inspection Report# : 2003010*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: FIN Finding
Inadequate Operability Determination for High Pressure Coolant Injection System (Section 1R15)
The inspectors identified a finding for an inadequate operability determination regarding the Unit 1, 11 Feedwater Pump 2-inch minimum flow valve. The operability determination failed to adequately verify the function of the minimum flow valve. The valve subsequently failed which rendered the 11 high pressure coolant injection (HPCI) train inoperable on May 17, 2003.

This finding is greater than minor because it affected the Mitigating System Cornerstone objective of equipment availability, in that an inadequate operability determination led to the conclusion that 11 HPCI train was operable, when in actuality, the 2-inch minimum flow valve failed on the next demand. The finding is of very low safety significance because the finding did not represent an actual loss of safety function of a single train for greater than its Technical Specification allowed outage time. The inadequate operability determination was an example of a cross-cutting issue in human performance. (Section 1R15)
Inspection Report# : 2003004*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: FIN Finding
Inadequate Operability Determination for Reactor Recirculation Pump Erratic System Flow (Section 1R15)
The inspectors identified a finding for an inadequate operability determination regarding intermittent erratic flow indication from Unit 1 reactor recirculation pump (RRP) 12. On May 18, 2003, 12 RRP flow indication was determined to be operable when, in actuality, an intermittent problem had developed which caused the indication to be unreliable. The original operability determination did not address the effect of the condition on the reactor protection system (RPS) because it did not take into account that the RRP flow instruments provided input to the RPS.

When the condition later persisted, the adverse effect on RPS was recognized, and a half scram was manually inserted.

This finding is greater than minor because it affects the Mitigating System Cornerstone objective of equipment reliability, in that if the condition which led to equipment degradation is left uncorrected or not addressed, a more significant safety concern affecting RPS could develop. The finding is of very low safety significance because there was not an actual loss of safety function of the system. The inadequate operability determination was an example of a cross-cutting issue in human performance. (Section 1R15)
Inspection Report# : 2003004*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: FIN Finding
Inadequate Corrective Action Associated With Loss of 115 kV (Section 4OA2)
The inspectors identified a self-revealing finding concerning corrective actions related to the availability of the 115 kV offsite power sources. Administrative controls were not adequately implemented to assure that one 115 kV offsite power source would remain available during planned maintenance of the other offsite power source. Corrective actions implemented following a similar condition in 2001 did not prevent the problem from reoccurring during a November 2002 offsite power line maintenance activity.

The finding is greater than minor because it affects the Mitigating Systems Cornerstone objective of equipment availability in that the operability of offsite power Line 4 was not assured while Line 1 was taken out-of-service. This degraded the reliability of the offsite electrical system. The finding was determined to be of very low safety significance because the accident mitigating systems remained operable, there was no loss of electrical system safety function, and no technical specification limiting conditions for operation were exceeded. The finding was an example of a cross-cutting issue in problem identification and resolution. (Section 4OA2)

Inspection Report# : 2003004*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Post Maintenance Testing for the Control Rod Drive Pump Resulted in it Being Inoperable for Greater than the TS Allowed Outage Time (Section 4OA3)
The inspectors identified a self-revealing non-cited violation for failure to implement a procedure in accordance with Technical Specification 6.8.1, which resulted in a control rod drive (CRD) pump being inoperable for 25 days. The work order for post maintenance testing of the 12 CRD pump breaker did not require performance of the 12 CRD Pump surveillance, as required by the post maintenance testing administrative procedure, and the pump subsequently failed.

The finding is greater than minor because it affects the Mitigating Systems Cornerstone objective of equipment availability in that it had an actual impact of causing the CRD pump to be inoperable for greater than the Technical Specification allowed outage time. The finding is of very low safety significance because the exposure time for this condition was less than 30 days and all other mitigation capabilities described on the SDP Phase 2 worksheet were maintained. The finding was an example of a cross-cutting issue in human performance. (Section 4OA3)
Inspection Report# : 2003004*(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 : May 05, 2004