Nine Mile Point 1
2Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Procedure for Cold Weather Operation of the Circulating Water System.
A self-revealing Green non-cited violation (NCV) of Technical Specification (TS) 6.4, "Procedures," was identified concerning an inadequate procedure for cold weather operation of the circulating water system which resulted in a transient intake forebay water level decrease and prompted an emergency power reduction to 90 percent at Unit 1. The performance deficiency associated with this finding is procedural inadequacy, in that the procedure for operation of the circulating water system did not provide adequate direction for management of the lake water intake and discharge flow paths during periods of cold weather. The finding is greater than minor because it could reasonably be viewed as a precursor to a significant event; in this case, a reactor scram precipitated by a loss of the circulating water system. The finding is of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident, 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 increase the likelihood of a fire or internal/external flood.

Inspection Report# : 2004002*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Follow ERV Maintenance Procedure Leads to ERV Failure to Close and Subsequent Scram.
A self-revealing non-cited violation (NCV) of Unit 1 Technical Specification 6.4, "Procedures," was identified concerning inadequate use of procedures, in that an extra gasket was installed in an electromatic relief valve (ERV) pilot valve assembly, contrary to the maintenance procedure instructions. The procedure did not direct installing a second gasket; however, a second gasket was installed which caused the ERV to fail to close during post-maintenance testing at power. The performance deficiency associated with this finding is the failure to follow procedures. The finding is greater than minor because it is associated with the human performance attribute of the Initiating Event Cornerstone and adversely affects the cornerstone objective to limit the likelihood of those events that upset plant stability during power operations. The finding is of very low safety significance as determined by Phase 2 of the significance determination process. The failure to follow procedures is an example of a cross-cutting issue in the area of human performance.
Inspection Report# : 2004003*(pdf)*

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Barrier Breach Permits Cleared while Associated Fire Doors were Still Inoperable
The inspectors identified a Green non-cited violation (NCV) of Facility Operating License DPR-63, 2.D(7), "Fire Protection," concerning two degraded fire doors in fire barriers that separate the two Unit 1 emergency diesel generators (EDG) and the two associated power board rooms. The performance deficiency associated with this finding is inadequate control of activities that affect the operability of fire barriers. 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 either degraded fire door to the other side of the barrier. The failure to maintain barrier breach permits while the two fire doors were degraded is an example of a cross-cutting issue in the area of human performance.

Inspection Report# : 2004002*(pdf)*

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Adequate Precautions in Surveillance Procedure N1-ST-V19.

A self-revealing Green non-cited violation (NCV) of Unit 1 TS 6.4, "Procedures," was identified concerning the specification of limitations on the parameters being controlled by procedure N1-ST-V19, "Emergency Cooling System Heat Removal Capability Test at High Power." The procedure did not provide operators with comprehensive and appropriate limitations concerning reactor response upon initiation of the emergency condenser (EC) system with the reactor at high power. The performance deficiency associated with this finding is a failure to provide adequate precautions and limitations to the operator performing the tasks in surveillance procedure N1-ST-V19. The finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of procedure quality and affects the associated cornerstone objective of ensuring the capability of the emergency condenser system, a core decay heat removal system, 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 emergency condenser system safety function.

Inspection Report# : 2004002*(pdf)*

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)*

Barrier Integrity

Significance: G Jun 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Ineffective Corrective Action to Prevent Recurrence of Plant Equipment Obstruction by Scaffolding.
A self-revealing non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified at Unit 1 for a repeat occurrence of a scaffold installation that interfered with operation of one of the reactor building to pressure suppression chamber vacuum breakers. The performance deficiency associated with this finding is that scaffolding was installed such that it would have restricted the vacuum breaker from fully opening, thereby rendering the vacuum breaker valve inoperable. A contributing cause is ineffective corrective action since a previous occurrence of a vacuum breaker being blocked by scaffolding was identified by the NRC in 2003. The finding is greater than minor because it is associated with the Barrier Integrity Cornerstone attribute of barrier performance, and adversely affects the associated cornerstone objective of providing reasonable assurance that the primary containment protect the public from radionuclide releases caused by accidents or events. The finding is of very low safety significance in accordance with Table 6.2 of the Containment Integrity SDP because it relates to failure of a component critical to suppression pool integrity/scrubbing, and because the condition existed for less than three days. The inadequate corrective action taken to prevent operational interferences due to scaffolding installations is an example of a cross-cutting issue in problem identification and resolution.

Inspection Report# : 2004003*(pdf)*

Emergency Preparedness

Significance: G Mar 31, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Untimely Declaration of an Unusual Event Caused by Low Water Level in the Intake Forebay.
A self-revealing Green non-cited violation (NCV) of 10 CFR 50.54(q), 50.47(b)(4), and Section 6.2 of the Nine Mile Point Site Emergency Plan, was identified concerning a failure to promptly classify an Unusual Event (UE) at Unit 1 in accordance with emergency procedures. The performance deficiency associated with this finding is failure to implement the emergency classification and action level scheme in a timely manner. The finding is greater than minor because it is associated with the emergency response organization performance attribute of the Emergency Preparedness Cornerstone and affects the cornerstone objective of implementing adequate measures to protect the health and safety of the public in the event of a radiological

emergency. The finding is of very low safety significance because Unit 1 failed to implement a risk significant planning standard (RSPS) during an actual UE. The failure to promptly classify a UE is an example of a cross-cutting issue in the area of human performance.

Inspection Report# : 2004002*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

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 : September 08, 2004