

Nine Mile Point 2

3Q/2006 Plant Inspection Findings

Initiating Events

Significance:  Jun 30, 2006

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate use of human performance tools during maintenance results in an equipment failure that causes a reactor scram.

A self-revealing finding of very low safety significance occurred on March 9, 2006, when Nine Mile Point Unit 2 automatically scrambled due to a main turbine trip caused by low condenser vacuum. The loss of condenser vacuum occurred when the normal turbine gland seal supply isolated due to high water level and the emergency gland seal steam supply (non-safety related) failed. The emergency gland seal steam supply failed because a maintenance technician improperly assembled a pressure indicating controller for the system following maintenance in April 2004. Maintenance repaired the pressure indicating controller and Operations restored the plant to full power on March 13, 2006. Nine Mile Point Nuclear Station (NMPNS) entered the issue into its corrective action program (CAP) as CR 2006-0993.

The finding is greater than minor because it was associated with the human performance attribute of the Initiating Event cornerstone and adversely affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during power operations. The inspectors determined the finding to be of very low safety significance using the Phase 1 SDP screening worksheet for at power situations. The finding screened to Green because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, and was not potentially risk significant due to external events.

Inspection Report# : [2006003\(pdf\)](#)

Mitigating Systems

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

RCIC Alignment During Maintenance Not Consistent With Design Bases.

An NRC-identified NCV of 10 CFR 50, Appendix B, Criterion III, "Design Control," was identified on February 8, 2006, when the reactor core isolation cooling (RCIC) system was operated in an unanalyzed configuration that degraded plant safety. Specifically, steam exhaust line vacuum breaker isolation valve 2ICS*MOV148 was shut while RCIC remained aligned for automatic operation. This configuration would have prevented the vacuum breakers from mitigating the water hammer event that occurs following system shutdown, which can produce stresses in the RCIC steam exhaust line that exceed code-allowable values during certain accident scenarios. Operations revised the operating procedure to direct operators to inhibit RCIC automatic initiation if the steam exhaust line vacuum breakers were isolated. NMPNS entered the issue into its CAP as CR 2006-0545.

The finding is greater than minor because it is associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The Region I SRA conducted a Phase 3 risk assessment and determined the finding to be of very low safety significance. The only accident conditions that could cause the suppression pool to pressurize and RCIC to automatically start were medium and large break loss of coolant accidents (LOCAs). The SRA conservatively assumed, based on NMPNS data, that RCIC was in the degraded condition for 3 hours. Using the annual initiating event frequencies from the NMP2 SPAR model for medium and large break LOCAs, the SRA determined that the delta-CDF could not be greater than the low E-8 range, because even if RCIC caused the failure of all injection sources, the increase in the probability of core damage could not be greater than the initiating event frequency adjusted for the exposure time.

Inspection Report# : [2006003\(pdf\)](#)

Significance:  Nov 04, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Incomplete and Untimely Corrective Actions for Fire Brigade Performance Issues

The NRC identified a Green non-cited violation (NCV) of 10 CFR 50.54(a)(1) for failure to take complete and timely corrective actions for fire brigade drill failures in May 2004. The inspectors found that a proposed corrective action to develop qualification standards for fire brigade leaders and brigade members had not been completed, and a corrective action to develop performance based assessment tools was not completed until September 16, 2005. These corrective actions would have addressed some of the identified causes for a drill failure in September 2005. The inspectors also identified that effective corrective actions had not been taken for fire brigade performance issues that resulted in a drill failure in 2003. The actions taken were limited to reinforcing existing assembly practices and did not address brigade member concerns about lack of familiarity with plant access and egress routes. Corrective actions are planned to develop objective standards for fire brigade performance and to revise the drill assessment tools to reflect those standards. The failure to take complete and timely corrective actions to address fire brigade performance issues was more than minor because it affected the protection against external factors attribute of the Mitigating Systems Cornerstone in that it adversely impacted manual fire suppression capability. The finding is not suitable for SDP evaluation, but has been reviewed by NRC management and is determined to be a finding of very low safety significance (Green). Although the lack of fire brigade performance standards and evaluation criteria contributed to several drill failures, the finding was of very low safety significance because fire brigade performance has been satisfactory during the majority of drills. The cause of this finding was related to the cross-cutting element of problem identification and resolution in that it was related to incomplete and untimely corrective actions.

Inspection Report# : [2005007\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Significance: N/A Nov 04, 2005

Identified By: NRC

Item Type: FIN Finding

Identification and Resolution of Problems

The team determined that Constellation's Nine Mile Point (NMP) Nuclear Power Station was effective at identifying problems and entering them into the corrective action program (CAP). Relatively few deficiencies were identified by external organizations (including NRC) that had not been previously identified by the licensee. Audits and self-assessments were generally thorough; however, the inspectors did identify a few missed opportunities to identify issues during internal assessments. Once entered into the CAP, issues were screened and prioritized in a timely manner using established criteria. Items entered into the CAP were properly evaluated commensurate with their safety significance. The causal evaluations for equipment and performance issues were complete, and proposed corrective actions addressed the identified causes. Corrective actions were generally effective and typically implemented in a timely manner. However, corrective actions for previous fire brigade drill failures were incomplete and untimely.

Inspection Report# : [2005007\(pdf\)](#)

Last modified : December 21, 2006