

Nine Mile Point 2

3Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Mar 31, 2005

Identified By: NRC

Item Type: FIN Finding

Improper Installation of HPCS Suction Line Flexible Coupling Due To Inadequate Procedure

The inspectors identified a finding regarding an improperly installed flexible coupling in the Unit 2 high pressure core spray (HPCS) system suction line from the condensate storage tank (CST). The tie rods were not properly adjusted, thereby increasing its probability of failure during a seismic event. The performance deficiency is that an inadequate maintenance procedure had been prepared and used to install the HPCS CST suction line flexible coupling. As a result, the tie rods had not been adjusted in accordance with the vendor's specifications.

The finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance in accordance with phase 1 of the SDP because it was not a design or qualification deficiency, did not represent a loss of the HPCS system safety function, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event.

Inspection Report# : [2005002\(pdf\)](#)

Significance:  Mar 31, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Adequately Manage Risk Associated with Maintenance to Jumper a Vital 125 VDC Battery Cell

The inspectors identified a NCV of 10 CFR 50.65(a)(4) for the failure to adequately manage the increase in risk that resulted from maintenance on the Unit 2, Division 2, 125 VDC battery (2BYS*BAT2B). Specifically, the sizing of fasteners was not adequately determined prior to installing a jumper around one of the battery cells, which resulted in the plant being maintained in a high risk configuration for approximately twice as long as would otherwise have been necessary. The performance deficiency associated with this event is failure to adequately plan the jumper installation for battery 2BYS*BAT2B cell 21, such that the time spent in a high risk plant configuration would be minimized.

The finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was determined to be of very low safety significance in accordance with phase 1 of the SDP because it was not a design or qualification deficiency, did not represent actual loss of safety function of a single train for greater than its Technical Specification (TS) allowed outage time, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event.

The failure to adequately manage the increase in risk that resulted from the battery maintenance is an example of a cross-cutting issue in human performance at the organizational level. Specifically, the Engineering Department did not apply rigor commensurate with the sensitivity of the maintenance activity when they failed to determine the precise length of the required fasteners in developing the temporary change package (TCP); and, Maintenance personnel inappropriately excluded parts that were specified in the TCP when preparing for the activity, based on unavailability rather than technical justification.

Inspection Report# : [2005002\(pdf\)](#)

Significance:  Dec 31, 2004

Identified By: NRC

Item Type: FIN Finding

Crew Failure Rate on the Dynamic Simulator Portion of the Facility-Administered Annual Operating Examinations

A finding of very low safety significance was identified at Unit 2. The finding was associated with crew performance on the simulator during facility-administered requalification examinations. Of the nine crews evaluated, three failed to pass their simulator examinations.

The finding is more than minor because it reflected the potential inability of the crews to take appropriate safety-related actions in response to actual abnormal or emergency conditions. The finding is of very low safety significance because the failures occurred during annual testing of the operators on the simulator, because there were no actual consequences to the failures, and because the crews were removed from watch standing duties, retrained and re-evaluated before they were authorized to return to control room watches.

Inspection Report# : [2004005\(pdf\)](#)

G

Significance: Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure of the Nine Mile Point Unit 1 & 2 Plant-Referenced Simulator to Demonstrate Expected Plant Response to Operator Input and to Transient Conditions

An NRC identified finding for failure of the NMP Unit 1 and Unit 2 simulators to comply with 10 CFR 55.46(c)(1), "Plant-referenced simulators." The NCV involved two examples of the failure of Nine Mile Point simulators to correctly demonstrate the expected plant response to two separate events, one at each NMP unit.

This finding is more than minor because it affects the human performance (human error) attribute of the Mitigating Systems Cornerstone. The finding is of very low safety significance (Green) because the simulators' uncorrected model discrepancies did not have an adverse impact on operator actions such that safety-related equipment was made inoperable during normal operations or in response to a plant transient.

Inspection Report# : [2004005\(pdf\)](#)

G

Significance: Dec 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Take Prompt Corrective Action for a Condition that Affected the Ability to Perform a TS Surveillance

An NRC identified non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," was identified for failure to take prompt action to correct a condition adverse to quality. A graph of predicted jet pump loop flow versus flow control valve position, used to perform a daily Technical Specification (TS) surveillance to verify jet pump operability, had not been updated as required after the 2004 refueling outage (April 2004) and the deficiency was not corrected until October 26, 2004. The performance deficiency associated with this finding is the failure to take prompt action to correct a condition that affected the ability of operators to verify the operability of safety-significant reactor vessel internal components (the jet pumps).

The finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and affects the cornerstone attribute of ensuring the availability, reliability, and capability of systems that 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 that had been confirmed to result in a loss of function per Generic Letter 91-18, did not represent a loss of safety function, did not represent actual loss of safety function of a single train for greater than its TS allowed outage time, did not represent an actual loss of safety function of one or more non-TS trains of equipment designated as risk-significant per 10 CFR 50.65 for greater than 24 hours, and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The failure to promptly inform operators when a problem was identified that affected performance of the daily jet pump surveillance is an example of a cross-cutting issue in problem identification and resolution

Inspection Report# : [2004005\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

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