

Nine Mile Point 2

4Q/2005 Plant Inspection Findings

Initiating Events

Mitigating Systems

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\(pdf\)](#)

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\(pdf\)](#)

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\(pdf\)](#)

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