

Nine Mile Point 1

3Q/2006 Plant Inspection Findings

Initiating Events

Significance:  Oct 03, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Manage Risk Associated With Maintenance on Power Board 11 Breaker Resulted in a Reactor Scram.

The inspectors identified an NCV of 10 CFR 50.65(a)(4) for the failure to assess and manage the increase in risk associated with power board maintenance which resulted in an unplanned reactor scram. The performance deficiency associated with this event was the failure to assess and manage the risk and recognize the plant impact associated with power board 11 breaker maintenance coincident with reactor protection system testing on the other channel. A contributing cause of the finding is related to the cross-cutting element of human performance.

The finding is greater than minor because it is associated with the Initiating Events Cornerstone attribute of human performance and affects the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. In addition, the finding relates to the maintenance risk assessment and risk management issue of the failure of the licensee's risk assessment to consider maintenance activities that could increase the likelihood of initiating events. The finding is also associated with the Mitigating Systems Cornerstone because the loss of power board 11 caused a loss of one train of feedwater coolant injection. The finding was determined to be of very low safety significance in accordance with Phase 3 of the Reactor Safety SDP.

Inspection Report# : [2005004\(pdf\)](#)

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\(pdf\)](#)

Barrier Integrity

Significance:  Oct 03, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

Unacceptable Preconditioning of Torus-to-Drywell Vacuum Relief Valves During Surveillance Testing.

The inspectors identified an NCV of 10 CFR 50 Appendix B, Criterion XI, "Test Control," for failure to conduct testing to determine torus-to-drywell vacuum relief check valve's opening force under actual in-service conditions. Specifically, four vacuum relief check valves were being cycled open and closed prior to measurement of their opening force. The performance deficiency associated with this issue is an inadequate surveillance procedure, in that the licensee failed to recognize that cycling all of the torus-to-drywell vacuum relief valves prior to measurement of their opening force was unnecessary and constituted unacceptable preconditioning. (i.e. potentially altering the amount of force required to open the valves during the actual test)

The finding is greater than minor because it is associated with the Barrier Integrity Cornerstone attribute of the procedure quality of a risk important surveillance and affects the cornerstone objective of providing reasonable assurance that physical design barriers (specifically, the primary containment) protect the public from radionuclide releases caused by accidents or events. The finding is determined to be of very low safety significance (Green) in accordance with Phase I of the Reactor Safety Significance Determination Process (SDP) because it did not represent a degradation of the radiological barrier function provided for the control room, spent fuel pool, or standby gas treatment system, did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere, and did not represent an actual open pathway in the physical integrity of reactor containment or involve an actual reduction in defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment.

Inspection Report# : [2005004\(pdf\)](#)

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