

Nine Mile Point 2

4Q/2009 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Implement the Operator Workaround Program During 2009

An NRC-identified finding was identified on November 19, 2009, when inspectors determined the NMPNS Operator Workaround program had not been implemented at Unit 1 and Unit 2 in accordance with Nuclear Administration Instruction NAI-REL-02, "Control of Operator Workarounds, Burdens and Interests," Revision 07, during the year 2009. As a result, determinations of operational encumbrances that constituted workarounds, burdens, and interests, had not been made by the Unit Workaround Coordinators, lists of these items had not been maintained, and quarterly aggregate reviews of their impact on the ability of operators to perform their duties had not been performed during that period. As corrective action, NMPNS performed a review of work orders that were opened during 2009, and were coded as being operator workarounds or burdens, to identify existing operator workarounds and burdens. An evaluation of that information was performed, which concluded that the station had not been in an unrecognized increased risk condition as a result of the cumulative effects of all workarounds and burdens. The issue was entered into the corrective action program (CAP) as condition report (CR) 2009-8395.

The finding was more than minor because the NRC considers licensee identification of operator workaround problems at an appropriate threshold, and implementation of follow-on actions that focus and progress corrective actions to completion, to be an important aspect of problem identification and resolution, as discussed in IP 71152, "Identification and Resolution of Problems." The failure to implement the operator workaround program, if left uncorrected, had the potential to increase the likelihood of operator errors during normal and off-normal conditions and lead to a more significant safety concern. The finding had a cross-cutting aspect in the area of human performance, decision-making, because the roles and authorities of the Operator Workaround Coordinators for Units 1 and 2 were not effectively communicated during the personnel turnover that occurred at the beginning of 2009, and therefore were not implemented as designed during the year 2009.

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Oct 16, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify procedural inadequacies and non-compliances that contributed to the November 4, 2008 SW pumps foreign material intrusion events.

The NRC identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," involving two examples of conditions adverse to quality not properly identified and corrected. For the first example, Constellation failed to identify that responsible station personnel did not adhere to the governing procedures for diving operations and foreign material intrusion for the C service water (SW) pump fouling event, and as a consequence, this led to the fouling of the F SW pump on November 4, 2008. For the second example, Constellation failed to identify that inadequate work controls and procedural guidance contributed to the November 4, 2008, SW pump foreign material intrusion events. The failure of Constellation to have identified these procedural non-compliance and adequacy issues is considered a significant weakness in Constellation's causal analysis and associated corrective actions for the White PI. This NRC-identified finding supports the basis for a parallel White finding. Constellation

entered this finding into their Corrective Action Program (Condition Report No. 2008-08430).

This corrective action finding is more than minor because it adversely impacted the equipment performance attribute and the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors evaluated the significance of this finding using IMC 0609, Attachment 4, "Phase 1 – Initial Screening and Characterization of Findings." The finding screened as very low safety significance (Green) because the failure of the C and F SW pumps did not represent an actual loss of safety function of a single train of SW system for greater than its Technical Specification Allowed Outage Time. This finding has a cross-cutting aspect of P.1(c), referring to the area of Problem Identification and Resolution – Corrective Action Program, involving the thoroughness and effectiveness of evaluations.

Inspection Report# : [2009009](#) (pdf)

Significance: **W** Oct 16, 2009

Identified By: NRC

Item Type: FIN Finding

Parallel Performance Indicator White Finding

The NRC identified a parallel White Performance Indicator (PI) inspection finding involving significant weaknesses identified in Constellation's causal evaluation and corrective actions for a White Cooling Water Systems PI.

The inspectors identified significant weaknesses in Constellation's causal evaluation and corrective actions associated with the White Performance Indicator (PI) change. Specifically, the inspectors identified that the initial work controls put in place for the service water (SW) fore bay diving evolutions, and the changes made to the diving work scope on November 4, 2008, were inadequate and directly contributed to the C SW pump foreign material intrusion event. In addition, the inspectors identified that the Constellation staff failed to follow the governing dive procedure and foreign material exclusion guidance after the C SW pump was fouled on November 4, 2008. This failure to follow procedures directly contributed to the F SW pump fouling one hour later. These performance deficiencies were not identified and corrected by Constellation.

In accordance with Inspection Procedure 95001 and NRC Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," a parallel PI inspection finding is assigned the same safety significance as the initiating PI. This parallel PI inspection finding provides for additional NRC review of Constellation's actions to address the weaknesses identified in this report and to demonstrate appropriate progress in reversing the adverse trend in cooling water systems performance as evidenced by the White PI. This finding takes the color (White) of the PI. Constellation entered this parallel finding into its Corrective Action Program (Condition Report No. 2009-007201).

Inspection Report# : [2009009](#) (pdf)

Significance: **G** Sep 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Unqualified HPCS Pump Power Cables Used in Submerged Conditions

An NRC-identified non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified, in that Nine Mile Point Nuclear Station (NMPNS) failed to maintain the Unit 2 high pressure core spray (HPCS) pump power cables in an environment for which they were designed. Although NMPNS had indications that these cables were periodically submerged in water, they could not demonstrate that the cables were designed for submerged conditions. As immediate corrective action, NMPNS dewatered and inspected the HPCS cable run, and changed the frequency of dewatering to monthly. Based on the inspection results, along with the cable design specifications and most recent test results, NMPNS concluded that the HPCS pump power cables would remain operable while they conduct a design change evaluation to examine methods to reduce cable exposure to submerged conditions. The issue was entered into the corrective action program (CAP) as condition report (CR) 2009-2901.

The finding was more than minor because, if left uncorrected, it had the potential to lead to a more significant safety concern. The finding affected the equipment performance attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was of very low safety significance because it was a qualification deficiency that did not result in loss of operability. The finding had a cross-cutting aspect in the area of problem identification and resolution,

operating experience, because NMPNS did not use operating experience, such as Generic Letter (GL) 2007-01, "Inaccessible or Underground Power Cable Failures That Disable Accident Mitigation Systems or Cause Plant Transients," to evaluate possible adverse effects of periodic submergence of the HPCS pump power cables (P.2.a per IMC 0305).

Inspection Report# : [2009004](#) (pdf)

Significance:  Jun 19, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Fire Brigade Training Program Procedure

The team identified a finding of very low safety significance (Green) involving a non-cited violation of Unit 1 Technical Specifications, section 6.4.1 and Unit 2 Technical Specifications, section 5.4.1., for NMPNS's failure to correctly implement the fire brigade training program procedure to ensure that fire brigade members met the fire drill requirements to be qualified. Specifically, NMPNS failed to correctly assess the acceptance criteria required for a successful drill per their implementing procedure. Further review of fire brigade qualifications by the licensee determined that a number of fire brigade members were not qualified. The licensee removed the appropriate individuals from shift for remediation and placed the issue into their corrective action program for further review.

The finding is greater than minor because the Mitigating Systems cornerstone objective to provide protection against external factors (fires) was affected. Specifically, the reliability and capability of the fire brigade's ability to respond to a fire was challenged. In accordance with Manual Chapter 0609, Appendix M, the safety significance of this finding was determined to be of very low safety significance (Green) because the fire brigades were able to meet the required times for fire extinguishment for the fire drill scenarios, and the issue did not significantly affect the ability of the fire brigades to respond to a fire. The finding had a cross-cutting aspect in the area of human performance because Nine Mile Point Nuclear Station failed to follow their fire brigade training program procedure.

Inspection Report# : [2009006](#) (pdf)

Significance:  Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Inadequate Maintenance Instructions Result in Residual Heat Removal System Voiding

A self-revealing non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified when inadequate instructions for maintenance that had previously been performed on the Unit 2 residual heat removal (RHR) system were found to have allowed the accumulation of voids in the 'C' RHR pump suction line, the combined volume of which could have potentially affected the operability of the pump. As immediate corrective action, the 'C' RHR pump suction line was filled and vented. After the void volume had been sufficiently reduced to allow pump operation, the 'C' RHR pump quarterly surveillance was performed to sweep out the remaining voids. This issue was entered into the corrective action program (CAP) as condition report (CR) 2009-457.

The finding was more than minor because it was similar to example 3.k in Appendix E of Inspection Manual Chapter (IMC) 0612, in that there was a reasonable doubt on the operability of the 'C' RHR system because the as-found condition exceeded the industry standard limit for operability. The finding was associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The finding was evaluated in accordance with IMC 0609, Attachment 4, and determined to be of very low safety significance because the finding was not a design or qualification deficiency, did not represent a loss of a system/train safety function, and did not screen as potentially risk significant due to external events. This finding had a cross-cutting aspect in the area of problem identification and resolution because the susceptibility of the RHR pump discharge lines to voiding was identified in 1999 and reflected in plant procedures, but this internal operating experience was not incorporated into the 2008 maintenance procedure (P.2.b per IMC 0305).

Inspection Report# : [2009002](#) (pdf)

Significance: **G** Mar 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Failure to Properly Perform Standby Liquid Control System Surveillance

A self-revealing non-cited violation (NCV) of Technical Specification (TS) 5.4, "Procedures," was identified on January 30, 2009, when operators did not align the Unit 2 Division 2 Standby Liquid Control (SLC) system in accordance with the surveillance procedure and establish a pump discharge flow path. As a result, following pump start, the pump discharge relief valve lifted due to high system pressure and the valve subsequently required replacement due to excessive seat leakage. As immediate corrective action for this event, the SLC pump was secured and the system was returned to its normal standby alignment to support further testing. The issue was entered into the corrective action program (CAP) as condition report (CR) 2009-548.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and adversely affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because the finding was not a design or qualification deficiency, did not represent a loss of a system/train safety function, and did not screen as potentially risk significant due to external events. This finding had a cross-cutting aspect in the area of human performance because the operators did not effectively use human error prevention techniques such as pre-job briefing, self and peer checking, and proper documentation of activities (H.4.a per IMC 0305).

Inspection Report# : [2009002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Oct 22, 2009

Identified By: NRC

Item Type: FIN Finding

PI&R Team Report Summary

The inspectors concluded that Constellation, in general, adequately identified, evaluated, and resolved problems; however, several weaknesses were noted related to the quality of evaluations. In general, Constellation personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with the safety significance. For most cases, Constellation screened issues for operability and reportability and performed causal analyses that adequately considered extent of condition, generic issues, and previous occurrences. However, weaknesses were noted in this area related to the quality of evaluations, and for one issue reviewed, the inspectors identified that the Plant Process Computer's Safety Parameter Display System (SPDS) was not appropriately scoped into the maintenance rule, resulting in an NRC identified NCV. Corrective actions taken to address the problems identified in Constellation's corrective action process were typically implemented in a timely manner. However, for one issue reviewed, Constellation did not conduct an appropriate extent of condition review for a 2008 NCV related to work hours and repeated the same performance deficiency during the 2009 Unit 1 refueling outage, resulting in an NRC identified NCV.

The inspectors also concluded that, in general, Constellation adequately identified, reviewed, and applied relevant industry operating experience to Nine Mile Point Nuclear Station operations. In addition, based on those items selected for review by the inspectors, Constellation's audits and self-assessments were thorough and probing.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities, and reviews of individual corrective action program and employees concerns program issues, the inspectors did not identify any concerns that site personnel were not willing to raise safety issues nor did they identify conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2009010](#) (*pdf*)

Last modified : March 01, 2010