Nine Mile Point 1
4Q/2011 Plant Inspection Findings

Initiating Events

Significance: G Dec 31, 2011
Identified By: NRC
Item Type: FIN Finding
Failure to Meet Fleet Standards for Preventive Maintenance Templates
The inspectors identified a Green finding for the failure of NMPNS to meet the fleet standard for establishing and implementing preventive maintenance (PM) templates. Specifically, in 2009, NMPNS failed to implement PM templates for critical non-safety related molded case circuit breakers in accordance with the guidance in the new fleet standard. NMPNS entered this issue into their corrective action program as CR-2011-011000 and CR-2011-011045 to evaluate corrective actions needed to address this issue.

The inspectors determined that the finding was more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, continued failure to perform the “clean and inspect” PM on critical NSR MCCBs could lead to a failure that could cause a plant transient. The inspectors determined that the finding was of very low safety significance (Green) since the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available. This finding had a cross-cutting aspect in the human performance area, work practices component, in that NMPNS did not implement procedures for conducing preventive maintenance on electrical breakers [H.4.(b)].
Inspection Report# : 2011005 *(pdf)*

Significance: G Jun 30, 2011
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Procedural Guidance for Main Turbine and Generator Maintenance Activities
A Green self revealing finding for inadequate procedural guidance was identified. The inadequate procedural guidance resulted in a May 2, 2011 Nine Mile Unit 1 scram due to a turbine trip. NMPNS determined that the turbine tripped when the main turbine master trip solenoid (MTS) actuated due to pressure fluctuations caused by a combination of leaking oil supply fittings to the MTS; binding of the secondary speed relay linkages, and main shaft lube oil discharge pressure fluctuations. These degraded conditions occurred because the governing work control documents and procedures that were implemented during the spring 2011 refuel outage contained inadequate detail and guidance. NMPNS corrective actions included repairing the degraded components and initiating actions to revise the procedures.

This finding is more than minor because it affected the procedure quality attribute of the Initiating Events Cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was of very low safety significance 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. This finding has a cross-cutting aspect in the area of human performance in that NMPNS did not ensure that complete and accurate and up-to-date design documentation and procedures were available to implement turbine maintenance during the spring 2011 refuel outage.

Inspection Report# : 2011003 *(pdf)*

Mitigating Systems

Significance: G Dec 09, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Vital Bus Degraded Voltage Time Delay Not Maintained Within LOCA Analysis Assumptions
The inspector identified a finding of very low safety significance (Green) irwotving a non-cited violation (NCV) of 10 CFR 50, Appendix B, Criterion lll "Design Control," in that station personnel did not implement appropriate measures to ensure design basis and regulatory requirements for the vital bus degraded voltage protection time delay were coriectly translated into specifications, procedures, and instructions. Specifically, station personnel implemented the vital bus degraded voltage protection design modification which established a protection relay time delay that resulted in the Emergency Core Cooling System (ECCS) injection times exceeding the times assumed in the Updited Final Safety Analysis Report (UFSAR) Loss-of-Coolant Accident (LOCA) analysis. Constellation performed an operability determination and entered this issue into iheir corrective action program as condition report (CR) 201 1-10339 to track resolution of this issue.
The performance deficiency was determined to be more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely atfected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspector evaluated the finding in accordance with Inspection Manuai Chapter (lMC) 0609, Significance Determination Process, Attachment 0609.04, "Phase 1-lnitial Screening and Characterization of Findings." The finding was determined to be of very low safety significance because the issue was a design deficiency confirmed not to result in loss of operability. The principle underlying cause of this performance deficiency did not reflect current performance and, therefore, no crosscutting aspect was assigned to this finding. (Section 4OA2)
Enclosure
Inspection Report# : 2011011 *(pdf)*

Barrier Integrity

Significance: G Mar 31, 2011
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Corrective Actions to Correct Motor Control Center Spring Clip Engagement Issues
The inspectors identified a finding of very low safety significance associated with a non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Action,” for Nine Mile Point Nuclear Station’s (NMPNS) failure to take adequate corrective actions for a condition adverse to quality. Specifically, between January 26, 2009, and November 29, 2010, NMPNS did not implement adequate corrective actions to address a lack of spring clip engagement for 600 volt General Electric 7700 line motor control centers (MCCs). As a result, the breaker for the control room emergency ventilation system fan failed to correctly operate when required. NMPNS entered this issue into its corrective action program (CAP) and implemented a physical verification of spring clip engagement.

The finding was more than minor because it was associated with the structure, system, and component (SSC), and barrier performance attribute of the Barrier Integrity cornerstone, and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. The finding was determined to be of very low safety significance, because the finding did not represent a degradation of the radiological barrier function of the control room, and the finding did not represent a degradation of the barrier function of the control room against smoke or a toxic atmosphere. This finding had a cross-cutting aspect in the area of problem identification and resolution, corrective action program component, because NMPNS did not thoroughly evaluate the initial component failures such that the resolutions addressed the causes and extent of conditions. Specifically, NMPNS did not properly

prioritize and evaluate spring clip engagement issues over 22 months.

Inspection Report# : 2011002 *(pdf)*

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 21, 2011
Identified By: NRC
Item Type: FIN Finding
PI&R Team Repoirt Summary
The inspectors concluded that Constellation was generally effective in identifying, evaluating, and resolving problems. Constellation personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. In most cases, Constellation appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Constellation typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner.

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

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 employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : 2011008 *(pdf)*

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