

Nine Mile Point 2

4Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2015

Identified By: Self-Revealing

Item Type: FIN Finding

Use of Incorrect Grounding Cart Results in Loss of Electrical Bus

The inspectors identified a self-revealing Green finding (FIN) for Exelon Generation Company, LLC (Exelon) personnel's failure to stop when met with unexpected conditions as required by procedure HU-AA-101, "Human Performance Tools and Verification Practices." On August 21, 2015, a Unit 2 division of normal switchgear was unintentionally deenergized which required an unplanned down power to 90 percent and special operating procedure entry. The loss of the switchgear was the result of installation of an incorrect sized grounding cart in the electric fire pump breaker cubicle during breaker maintenance. Use of the correct sized grounding cart was discussed during the pre-job brief. This resulted in the loss of the electric fire pump, half of the drywell coolers, a heater drain pump, and unplanned reactivity change. Exelon entered this issue into their corrective action program for resolution and developed corrective actions which included developing procedures for the use of grounding carts and evaluating where other "skill of the craft" work may pose the same risk.

This finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. In accordance with Inspection Manual Chapter (IMC) 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," the inspectors determined that this finding is of very low safety significance (Green). The finding has a cross-cutting aspect in the area of Human Performance - Challenge the Unknown, because Exelon personnel failed to stop when faced with uncertain conditions. Specifically, after having been briefed on the different stab sizes for 1200 amp and 2000 amp grounding carts, Exelon personnel failed to stop and notify supervision when faced with unlabeled grounding carts stored in the same location, Exelon personnel failed to notify supervision or compare stab sizes to ensure the correct grounding cart was used.

Inspection Report# : [2015003](#) (*pdf*)

Significance: G Mar 31, 2015

Identified By: NRC

Item Type: FIN Finding

Failure to Perform an Adequate Review of Planned Work Activities Results in a Manual Reactor Scram

The inspectors documented a self-revealing Green finding (FIN) for Exelon's failure to properly review a work package associated with the replacement of a reactor vessel level recorder as required by MA-AA-716-234, "FIN Team Process," Revision 8. Specifically, on February 18, 2015, control room operators manually scrambled Unit 2 when reactor vessel water level unexpectedly rose above desired limits during a planned replacement of Unit 2 reactor vessel level recorder 2ISC-LR1608. The unplanned rise in reactor water level occurred when daisy chained leads associated with the level recorder were lifted, which caused an interruption in the feedwater level control circuit.

The inspector's determined that Exelon's failure to ensure measures were in place to address the impact on reactor

vessel level prior to level recorder replacement in accordance MA AA 716 234 was a performance deficiency that was reasonably within Exelon's ability to foresee and correct and should have been prevented. This finding is more than minor because it is associated with the human performance attribute of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Specifically, Exelon did not ensure measures were in place to prevent an adverse impact on the feedwater level control system during level recorder replacement. This resulted in a rapid rise in reactor water level and subsequent manual reactor scram.

In accordance with IMC 0609.04, "Initial Characterization of Findings," and Exhibit 1 of IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," issued June 19, 2012, the inspectors determined that this finding is of very low safety significance (Green) because while the performance deficiency caused a reactor scram, it did not result in the loss of mitigation equipment relied upon to transition the plant from the onset of the trip to a stable shutdown condition. The finding has a cross-cutting aspect in the area of Human Performance, Avoid Complacency, because Exelon failed to recognize and plan for the possibility of mistakes, latent issues, and inherent risk even while expecting successful outcomes. Specifically, Exelon did not ensure measures were in place to address the impact of the level recorder replacement on the feedwater level control system [H.12].

Inspection Report# : [2015001](#) (pdf)

Mitigating Systems

Barrier Integrity

Significance:  Aug 28, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Identify and Correct a Condition Adverse to Quality Associated with Secondary Containment Leakage

The inspectors identified a Green non-cited violation of Title 10 of the Code of Federal Regulations (10 CFR) 50, Appendix B, Criterion XVI, "Corrective Actions," because between 2007 and 2015, Exelon staff did not promptly identify and correct a deficiency associated with Unit 2 reactor building service water pipe penetration W-3177-C. Specifically, on August 20, 2015, during Exelon staff's investigation of an inspector concern associated with the service water pipe penetration into secondary containment, a leakage path into secondary containment was discovered and was not previously identified and evaluated for impact on operability of Unit 2 secondary containment. Exelon generated issue report (IR) 2544831 to document the newly identified condition. The assessment included a review of previously identified leakage paths that were being tracked in accordance with procedure, previously performed secondary containment drawdown leakage testing, and a comparison to the maximum allowable flow rate leakage area. The assessment concluded that based on the gap that was identified at secondary containment penetration W-3177-C, there was a new total of 1.783 square inches of surface area allowing leakage into the Unit 2 secondary containment. Exelon determined this to be acceptable because calculations for secondary containment drawdown testing allows for up to 33.6 square inches of surface area causing in-leakage into secondary containment. Given 1.783 square inches of total identified leakage being less than the allowable 33.6 square inches, there was reasonable assurance that standby gas treatment system will be able to perform its drawdown function and maintain secondary containment vacuum greater or equal to 0.25 inches of vacuum water gauge in accordance with Technical Specification (TS) 3.6.4.1, "Secondary Containment."

This performance deficiency was more than minor because it impacted the design control attribute of the Barrier Integrity cornerstone objective to provide reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, Exelon’s staff failed to identify the degraded penetration seal that impacted the reasonable assurance of Unit 2 secondary containment operability. In accordance with Inspection Manual Chapter (IMC) 0609.04, “Initial Characterization of Findings,” and Exhibit 3 of IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” issued June 19, 2012, the inspectors determined this finding was of very low safety significance (Green) because the finding only represented a degradation of the radiological barrier function provided for the control room, or auxiliary, spent fuel pool, or standby gas treatment system (i.e., secondary containment). This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because Exelon staff failed to properly evaluate the condition identified in multiple IRs to determine the extent of condition associated with secondary containment water in-leakage. Specifically, between 2007 and 2015, three IRs were generated and a 2012 structural monitoring review documented the service water penetration water in-leakage and the issue was not appropriately evaluated for the potential for a service water pipe through-wall leak or the potential impact on secondary containment. [P.2]

Inspection Report# : [2015009](#) (*pdf*)

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Sep 15, 2015

Identified By: NRC

Item Type: FIN Finding

Biennial PI&R Assessment

The inspectors concluded that Exelon Generating Company, LLC (Exelon) was generally effective in identifying, evaluating, and resolving problems. Exelon personnel identified problems, entered them into the corrective action program at a low threshold, and prioritized issues commensurate with their safety significance. Exelon 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 Exelon typically implemented corrective actions to address the problems identified in the corrective action program in a timely manner. However, the inspectors identified two violations of NRC requirements in the area of evaluation of problems.

The inspectors concluded that, in general, Exelon adequately identified, reviewed, and applied relevant industry operating experience to NMPNS operations. In addition, based on those items selected for review, the inspectors determined that Exelon'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# : [2015009](#) (*pdf*)

Significance: N/A Apr 10, 2015

Identified By: Licensee

Item Type: VIO Violation

Incomplete/Inaccurate Medical Information Resulted in Issuance of Multiple Operator Licenses without Required Medical Restrictions and Failure to Report Permanent Changes in Medical Status

On April 10, 2015, the U.S. Nuclear Regulator Commission (NRC) issued a Severity Level (SL) III Notice of Violation (NOV) to Exelon Generation Company, LLC (Exelon) for an issue involving two related violations identified during an inspection at Nine Mile Point Nuclear Station (ML15100A341). The first violation involved Exelon's failure, on multiple occasions, to notify the NRC within 30 days as required by Title 10 of the Code of Federal Regulations (10 CFR) 50.74 (c) of medical conditions of licensed reactor operators and senior reactor operators involving permanent disabilities/illnesses. The second violation involved the submittal by Exelon of information to the NRC that was not complete and accurate in all material respects as required by 10 CFR 50.9. Subsequently, the NRC, based, in part, on this inaccurate information, issued reactor operator licenses without the required restricting license conditions. The NRC concluded that both violations resulted from Exelon's failure to oversee the licensed operator medical examination process and to train the medical staff involved with the process on the requirements of American National Standards Institute/American Nuclear Society 3.4-1983, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants," and 10 CFR Part 55. Accordingly, these violations were categorized collectively as one SL III problem to emphasize the importance of providing suitable training, oversight, and focus on licensed operator medical requirements. In December 2015, an Inspection Procedure 92702 follow-up inspection was conducted closing the NOV in the fourth quarter inspection report.

Inspection Report# : [2015004](#) (*pdf*)

Inspection Report# : [2015008](#) (*pdf*)

Last modified : March 01, 2016