

Indian Point 3

3Q/2004 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE IMPLEMENTATION OF FIRE PROTECTION PROCEDURES

The inspectors identified a Green NCV involving the failure to perform a transient combustibles evaluation (TCE) for combustible materials in an area of the Primary Auxiliary Building (a Level II combustible fire zone). Procedure ENN-DC-161, Transient Combustibles Program," Section 5.2 requires that a TCE be performed when more than five gallons of combustible liquids are introduced into a Level II combustible control zone. Contrary to the above, between April 7, 2003, and February 24, 2004, approximately 200 gallons of combustible oil was stored inside the radiological drumming station in the Primary Auxiliary Building without a TCE.

This finding is greater than minor because it represents conditions similar to those described in Example 4.k. of Appendix E to IMC 0612, in that the combustible material exceeded the maximum fire loading by 24%. The finding is of very low safety significance because no credible fire scenario was identified due to the design and integrity of the oil storage containers and no credible fire ignition source was present.

Inspection Report# : [2004002\(pdf\)](#)

Significance: G Nov 07, 2003

Identified By: NRC

Item Type: FIN Finding

POOR WORKMANSHIP, IMPROPERLY PERFORMED CORRECTIVE MAINTENANCE, AND INADEQUATE CONTRACTOR OVERSIGHT CONTRIBUTED TO THE FAILURE OF 345 KV BREAKER NO. 3 ON TWO SEPARATE OCCASIONS

Poor maintenance work practices (failure to follow vendor manual instructions) and insufficient contractor oversight (monitoring, quality verification, and knowledge of work activity) contributed to this self-revealing finding involving the failure of the 345 kV circuit breaker No. 3 on November 15, 2002 and June 22, 2003.

This finding is greater than minor because it is associated with improperly performed maintenance which directly impacted the Initiating Events Cornerstone. The June 22, 2003, breaker failure resulted in the Unplanned Scrams in 7000 Critical Hours Performance Indicator exceeding the Green to White threshold. This finding is of very low safety significance because, even though both breaker failures resulted in reactor trips, the inadequately performed maintenance did not contribute to the likelihood of LOCA initiator; did not contribute to the combination of both a reactor trip and the unavailability of accident mitigation equipment; and did not increase the likelihood of a fire or flood.

Inspection Report# : [2003010\(pdf\)](#)

Mitigating Systems

Significance: G Sep 30, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE ADEQUATE MAINTENANCE PROCEDURE FOR WORK ON BREAKER 52/GT5

A self-revealing, non-cited violation of TS 5.4.1 was identified involving Entergy's failure to develop a maintenance procedure appropriate for work on 6.9 KV breaker 52\GT5. An unexpected actuation of the 6.9 KV bus transfer block relay occurred when workers attempted to repair a bent cell switch and this rendered the 138 KV source of offsite electrical power temporarily unavailable.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of procedure quality and adversely affected the mitigating systems cornerstone objective of availability of systems that respond to initiating events to prevent undesirable consequences. Actuation of the 6.9 KV bus transfer block relay prevents a fast-transfer of the power supply to 6.9 KV buses 1 and 2 from the unit auxiliary transformer to the station auxiliary transformer during a turbine trip event and would have left the 31 emergency diesel generator as the only source of power to safety-related 480 V buses 2A and 3A. The finding is of very low safety significance because of the short duration (several seconds) that the 138 KV offsite electrical power system was unavailable.

Inspection Report# : [2004006\(pdf\)](#)

G**Significance:** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to operate the safety-related 32 Central Control Room Air Conditioning Unit in accordance with station procedures.

Green. The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, for a failure to operate the safety-related 32 Central Control Room Air Conditioning Unit in accordance with station procedures. This violation involved the failure to perform a required step in the procedure for operation of the 32 Central Control Room Air Conditioning Unit and leaving the discharge damper shut.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of configuration control and adversely affected the Mitigating Systems Cornerstone objective of availability of systems that respond to initiating events to prevent undesirable consequences. Leaving the discharge damper from the 32 Central Control Room Air Conditioning Unit shut left one of two safety-related trains of Control Room Ventilation and Air Conditioning inoperable. The finding is of very low safety significance because the remaining train of Central Control Room Air Conditioning was operable and the duration of the inoperability of the effected train was short. (Section 1R19)

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to promptly identify and correct repetitive failures of the 31 Central Control Room Air Conditioning Unit.

Green. The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, for a failure to promptly identify and correct repetitive failures of the 31 Central Control Room Air Conditioning Unit. This violation is related to not identifying and correcting a material deficiency with the compressor belt on the 31 Central Control Room Air Conditioning Unit which caused the air conditioning unit to trip and required operator action to restart.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the objective of availability of systems that respond to initiating events to prevent undesirable consequences. The particular failure of the 31 Central Control Room Air Conditioning Unit required operator actions to restore one of the two safety-related trains of Control Room Ventilation and Air Conditioning to service. The finding is of very low safety significance because the remaining train of Central Control Room Air Conditioning was operable and the short duration of the effected train's unavailability. (Section 1R15)

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 30, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to identify and correct the 34 Auxiliary Boiler Feedwater flow indicator displaying a value greater than actual flow and the Technical Specification Surveillance Requirement (SR) 3.3.3.2.

Green. The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, for a failure to identify and correct the 34 Auxiliary Boiler Feedwater flow indicator displaying a value greater than actual flow and the Technical Specification Surveillance Requirement (SR) 3.3.3.2. This violation involved a material deficiency with the 34 Auxiliary Boiler Feedwater flow indicator which caused the indicator to intermittently display a value greater than actual flow. If left uncorrected, this condition could have caused operators to reduce flow below the actual value required during a reactor trip response per emergency operating procedures.

This finding is greater than minor because it is associated with the Mitigating Systems Cornerstone attribute of equipment performance and adversely affected the objective of capability of systems that respond to initiating events to prevent undesirable consequences. The 34 Auxiliary Boiler Feedwater flow indication displaying a flow value greater than actual flow could have caused operators to reduce auxiliary feedwater flow below the required value during accident conditions. The finding is of very low safety significance because steam generator level indication remained operable and would have allowed operators to recognize an abnormal auxiliary feedwater flow condition. (Section 1R15)

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Oct 05, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

A Green NCV was identified for a failure to implement appropriate design controls for the field modification of plant components and systems.

The licensee failed to implement design controls during the field modification of safety-related equipment. The modification occurred when scaffolding was mechanically anchored to EDG and RHR pipe supports, and a CS pump pedestal, without prior engineering evaluation or approval. This finding is greater than minor because it was similar to Example 4.a. of Appendix E to IMC 0612, in that the licensee routinely failed to perform engineering evaluations of scaffolds attached to safety-related equipment. The finding is of very low safety significance (Green) because no equipment was rendered inoperable due to the attached scaffolding, and the scaffolding would not have caused the loss of any safety function following a seismic event.

Inspection Report# : [2003009\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance:  Nov 07, 2003

Identified By: NRC

Item Type: FIN Finding

FAILURE OF THE EOF UPSs ON AUGUST 14, 2003 - FAILURE TO IMPLEMENT NON-RISK SIGNIFICANT PLANNING STANDARD PROGRAM ELEMENT

This team-identified finding involves the August 14, 2003, loss of off-site power event which revealed that Entergy did not have a preventive maintenance program in place to ensure the continued functionality of the numerous un-interruptible power supplies in the Emergency Operations Facility (EOF) which provide back-up power to emergency response equipment.

This finding is considered greater than minor because a significant amount of the Unit 2 and Unit 3 emergency response organization communications equipment was non-functional on August 14 until off-site power was restored. However, this finding is of very low safety significance because key members of the ERO were able to implement established compensatory measures to effectively perform their emergency response functions from the EOF, TSC/OSC, and Unit 2 and 3 central control rooms, using back-up telephone communications. Inspection Report# : [2003010\(pdf\)](#)

Significance:  Nov 07, 2003

Identified By: NRC

Item Type: FIN Finding

FAILURE OF THE UNIT 3 TSC DIESEL ON AUGUST 14, 2003 - FAILURE TO IMPLEMENT NON-RISK SIGNIFICANT PLANNING STANDARD PROGRAM ELEMENT

This team-identified finding involves the failure of the Unit 3 Technical Support Center back-up diesel generators to function on August 14, 2003. The conditions which caused the diesel generators to fail to function were previously identified by Entergy on April 18, 2003, as a result of a failed periodic load test and inadequate retest. This condition was not resolved in a timely manner.

This finding is considered more than minor because a significant amount of the Unit 3 TSC/OSC emergency response equipment was without AC power because the diesel was non-functional. On August 14, Entergy elected to de-energized all of the remaining emergency response equipment and plant information computer systems. The Unit 3 TSC/OSC functions were all transferred to the Unit 2 TSC/OSC under one site Technical Support Center Manager. This finding is of very low safety significance because key members of the Unit 3 ERO were able to implement established compensatory measures to effectively perform their emergency response functions from the Unit 2 TSC/OSC. Inspection Report# : [2003010\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

Last modified : December 29, 2004