

Indian Point 3

1Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Mar 29, 2003

Identified By: NRC

Item Type: FIN Finding

SELF-REVEALING GREEN FINDING INVOLVING REACTOR TRIP DUE TO POOR MAINTENANCE

A self-revealing finding was identified due to inadequate work controls and procedures that did not properly restore circulating water pump motor electric cables following a previous repair. This resulted in a manual reactor trip after the cables failed when the plant was at full power. This finding is greater than minor because it affected the objective of the Initiating Events Cornerstone in that work controls and procedure inadequacies resulted in a perturbation in plant stability that caused a reactor trip. The finding is of very low safety significance because, although it caused a reactor trip, it did not increase the likelihood of a primary or secondary system loss of coolant accident (LOCA) initiator, did not contribute to a combination of a reactor trip and loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flood.

Inspection Report# : [2003002\(pdf\)](#)

Mitigating Systems

Significance:  Mar 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE DEDICATION OF COMMERCIALY PROCURED EQUIPMENT FOR THE REPLACEMENT OF A VALVE ACTUATOR IN THE EMERGENCY DIESEL GENERATOR FUEL SUPPLY SYSTEM, WHICH IS A SAFETY-RELATED APPLICATION

The inspectors identified a Green Non-cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion III. This violation is related to an inadequate dedication of commercially procured equipment for a safety-related application in that a non-Appendix B certified vendor was inappropriately used to confirm a "like-for-like" replacement of a valve actuator in the emergency diesel generator fuel supply system. Also, the licensee's technical evaluation and dedication package did not specify all of the appropriate critical characteristics to certify the replacement was like-for-like. This resulted in additional engineering analysis for the adequacy of commercially procured material to safety-related service. This finding is greater than minor because the technical evaluation and dedication package lacked sufficient detail to ensure the reliability and availability of mitigating equipment, and affected the availability objective of the Mitigating Systems Cornerstone. The finding is of very low safety significance because the actuator was eventually shown to be acceptable for service in its intended application.

Inspection Report# : [2003002\(pdf\)](#)

Significance:  Mar 29, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

A TEMPORARY ALTERATION OF THE FUEL STORAGE BUILDING VENTILATION SYSTEM WAS IMPLEMENTED WITHOUT CONSIDERATION OF THE EFFECT ON AIR FLOW WITHIN THE VENTILATION SYSTEM

The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, in that a temporary alteration of the fuel storage building ventilation system was implemented without consideration of the effect on air flow within the ventilation system. The effect of removing the system's charcoal bed dampers resulted in use of the charcoal beds that was not accounted for, and required additional system testing to analyze the air flow. Also, the system operating procedure and work order used to install and remove the dampers lacked sufficient detail for a temporary alteration and had to be revised. This finding is more than minor because changes to the plant without a complete analysis of the effects upon a safety system affected the Mitigating Systems Cornerstone objective of equipment reliability. The alteration of the dampers reduced the reliability of the ventilation system, resulted in the unaccounted use of the charcoal beds, and caused a lapse in the required tests for iodine removal efficiency. These tests were not performed as required by the Technical Specifications (TS) every 720 hours for approximately one year between January 2002 and January 2003. The finding is of very low safety significance because subsequent laboratory tests performed in January 2003 confirmed that the iodine removal efficiency did not fall below the TS required minimum of 90%.

Inspection Report# : [2003002\(pdf\)](#)



Significance: Jun 29, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

Inadequate procedural adherence and incorrect valve line-up of the CVC system results in boration induced power transient.

10 CFR 50, Appendix B, Criterion V, requires in part that activities affecting quality shall be accomplished in accordance with documented instructions, procedures, or drawings. Contrary to Criterion V, on March 14, 2002, operators did not properly configure the chemical and volume control system (CVCS) prior to a resin discharge evolution in accordance with the instructions in standard operating procedure SOP-CVCS-009A, "Resin Replacement - CVCS Demineralizers." The improper CVCS configuration resulted in a momentary automatic injection of diluted make-up water to the reactor coolant system (RCS) and a small increase in average RCS temperature, which required an immediate response by control room operators to heavily borate the RCS make-up water. This event of on low safety significance (Green) due to the minor change in reactor power (<0.5%).

Inspection Report# : [2002004\(pdf\)](#)

Barrier Integrity

Emergency Preparedness

Significance: N/A May 18, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

VIOLATION OF 10 CFR 50.54(q) FOR A DECREASE IN THE EFFECTIVENESS OF THE SITE EMERGENCY PLAN

No Color. On March 6, 2002, the licensee implemented changes to the accountability process that decreased the

effectiveness of the Emergency Plan (E-Plan). This finding was considered more than minor because, if left uncorrected, it could become a more significant safety concern. Changing commitments in the E-Plan without prior approval potentially impacts the NRC's ability to perform its regulatory function, and potentially creates an ineffective response to a radiological emergency. The consequences of this change were minimal because, although delayed, it did not preclude the function of accountability from being performed. The licensee has entered this deficiency into the corrective action system as condition report CR-IP3-2002-00773, has implemented corrective actions, and has since met the timeliness goals. However, the change in the accountability process, which decreased the effectiveness of the E-Plan, was determined to be a violation of 10 CFR 50.54(q), and is being treated as a Non-cited Violation consistent with Section VI.A.1 of the Enforcement Policy, issued May 1, 2000 (65 FR 25388).

Inspection Report# : [2002003\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Oct 03, 2002

Identified By: NRC

Item Type: FIN Finding

Overall implementation of the corrective action program at Indian Point 3 was adequate.

The NRC inspection team concluded that the overall implementation of the corrective action program at Indian Point 3 was adequate. In general, the threshold for problem identification was appropriate and problems were properly identified, evaluated and corrected. Problems were entered into the corrective action program at an appropriate threshold. The licensee adequately prioritized and evaluated issues, and their evaluations were of adequate depth to identify the causes and appropriately broad in considering the extent of condition. The corrective actions were reasonable and adequately implemented.

Inspection Report# : [2002006\(pdf\)](#)

Last modified : May 30, 2003