Indian Point 3
2Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Jun 28, 2003
Identified By: Self Disclosing
Item Type: FIN Finding
MAIN TURBINE FIRE AND NOTICE OF UNUSUAL EVENT (NUE)
On April 29, 2003, a self-revealing Green finding was identified involving poor maintenance practices and inadequate work controls during main turbine bearing inspections which contributed to the improper reinstallation of the No. 2 bearing casing and an oil leak which caused a fire. Operators initiated a manual turbine and reactor trip and declared an Unusual Event based upon the duration of the fire. This finding was greater than minor since it was associated with the protection against external factors (fire) and the human performance attributes that affect the Initiating Events cornerstone objective; and since maintenance work control inadequacies resulted in a perturbation in plant stability by causing a reactor trip. The finding is of very low safety significance (Green) as determined using the SDP Phase 1 worksheet. Specifically, the event did not increase the likelihood of a primary or secondary system loss of coolant accident initiator, did not contribute to a loss of mitigation equipment functions, and did not increase the likelihood of an internal/external flood.
Inspection Report# : 2003006*(pdf)*

Significance: G Mar 29, 2003
Identified By: Self Disclosing
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: G Jun 28, 2003
Identified By: Self Disclosing
Item Type: FIN Finding

LOSS OF PRIMARY SPENT FUEL POOL COOLING
A self-revealing finding occurred involving a configuration control error which resulted in the inadvertant loss of primary spent fuel pool cooling for approximately 15 minutes. This finding is greater than minor since it is associated with the Configuration Control and Human Performance attributes that affect the Mitigating System cornerstone objective. This finding is of very low safety significance since the loss of normal cooling was of short duration, there was no appreciable increase in spent fuel pool temperature, and the back-up spent fuel pool cooling system was in service at the time..
Inspection Report# : 2003006*(pdf)*

Significance: G Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
OPERATION OF THE 32 SI PUMP AT ZERO FLOW FOR LONGER THAN THE MANUFACTURER'S LIMIT TO PREVENT DAMAGE
The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, involving inadequate configuration controls that led to the unintended operation of the 32 Safety Injection (SI) pump with zero flow for greater than the maximum time limit established by the pump manufacturer. This finding is greater than minor because it is associated with the Human Performance and Configuration Control attributes that effect the Mitigating System cornerstone objective; and since the operators did not properly implement configuration controls required by the procedures that govern SI pump operation. The finding is of low safety significance since pump damage did not occur as a result of this human performance error. This issue is being treated as a non-cited violation.
Inspection Report# : 2003006*(pdf)*

Significance: G Mar 29, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE DEDICATION OF COMMERCIALLY 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: G 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)*

Barrier Integrity

Significance: 

Jun 28, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
LOSS OF REACTOR COOLANT SYSTEM INVENTORY DURING FUEL TRANSFER DUE TO INADEQUATE PROCEDURE IMPLEMENTATION TO INSTALL A STEAM GENERATOR BOWL DRAIN PLUG
The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, involving an inadequate procedure and porr maintenance practices which contributed to the ejection of a barrier plug in a steam generator nozzle. The consequence of these inadequacies was the draining of approximately 5000 gallons of reactor coolant system inventory due to the containment sump. This finding is greater than minor since it is associated with the procedure quality attribute of the barrier integrity cornerstone objective. The failure to perform an adequate verification that the bowl drain plug was properly installed was of a very low safety significance since RCS inventory control was maintained and there was no rise in RCS temperature. Accordingly, this issue is treated as a non-cited violation.
Inspection Report# : 2003006*(pdf)*

Emergency Preparedness

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 : September 04, 2003