Indian Point 3
4Q/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)*

Mitigating Systems

Significance: G Dec 30, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO COMPLETE THE VOLTAGE CALCULATION AND TO PROPERLY TRANSLATE DESIGN OUTPUT VOLTAGE REQUIREMENTS INTO DESIGN CHANGE PACKAGE
The inspector identified a non-cited violation of 10 CFR 50, Appendix B, Criterion III, Design Control, regarding Entergy's failure to properly translate design requirements into the design change package (DCP) for the replacement of the instrument bus 34/34A alternate supply transformer. Specifically, Entergy replaced the existing safety-related transformer with a non-safety related transformer in April 2003 using a commercial grade dedication process, without performing calculations to verify the minimum output voltage was acceptable considering the wider tolerances of the replacement transformer.

The finding was more than minor because it affected the design control attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of instrument bus 34/34A to prevent undesirable conditions. The issue was a design deficiency that did not result in loss of function per Generic Letter (GL) 91-18, and was determined to be of very low safety significance (Green) because a procedure had been in place to ensure that the instrument bus voltage remained in an acceptable range.
Inspection Report# : 2004009*(pdf)*

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.

This finding is associated with the cross-cutting area of human performance, in that operators and maintenance technicians did not recognize

the potential impact on availability of offsite power sources due to the breaker 52/GT5 cubicle maintenance.
Inspection Report# : 2004006*(pdf)*

Significance: G 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)*

Significance: G 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)*

Significance: G 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)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

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