Indian Point 3
3Q/2005 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
INADEQUATE WORK INSTRUCTIONS DURING TROUBLESHOOTING LEADS TO MANUAL REACTOR TRIP
A Green self-revealing finding was identified for failure to have adequate work instructions for a maintenance activity performed by Entergy maintenance technicians during the 3R13 refueling outage in April 2005.

This finding is greater than minor because Entergy did not provide adequate work instructions for a maintenance activity on a secondary plant component and this error directly contributed to the occurrence of a reactor trip. The reactor trip adversely impacted the Initiating Events Cornerstone Objective, and was associated with the objective's human performance attribute. The finding was determined to be of very low safety signficance (Green) based on a Phase 1 analysis in accordance with IMC 0609, safety significance (Green) based on a Phase 1 analysis in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." The basis of this determination was that all safety systems were available during the reactor trip. No violation of regulatory requirements occurred.

This finding is associated with the cross cutting area of human performance, in that, the plant staff did not implement appropriate work instructions during a maintenance activity and their technical review of the maintenance activity did not identify the potential for an undesired plant response. These errors negatively impacted the likelihood of an initiating event.
Inspection Report# : 2005004*(pdf)*

Significance: G Jun 30, 2005
Identified By: Self-Revealing
Item Type: FIN Finding
Inadequate Work Controls during Troubleshooting Leads to Automatic Reactor Trip
A Green self-revealing finding was identified involving Entergy's failure to use adequate work instructions during troubleshooting on the condensate polisher system which resulted in an automatic reactor trip on May 6, 2005.

This finding is greater than minor because Entergy did not provide adequate controls for maintenance troubleshooting activities on a secondary plant component and this error directly contributed to the occurrence of a reactor trip. The reactor trip adversely impacted the Initiating Events Cornerstone Objective, and was associated with the objective's human performance attribute. The finding was determined to be of very low safety significance (Green) based on a Phase 1 analysis in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." The basis of this determination was that all safety systems were available during the reactor trip. No violation of regulatory requirements occurred.

This finding is associated with the cross-cutting area of human performance, in that, the plant staff did not implement appropriate work controls for the troubleshooting activities and their technical review of the troubleshooting activities did not identify the potential for an undesired plant response. These errors negatively impacted the likelihood of an initiating event.
Inspection Report# : 2005003*(pdf)*

Mitigating Systems

Significance: G Jun 30, 2005
Identified By: NRC
Item Type: FIN Finding
Inadequate corrective actions associated with training, procedural adequacy and operator knowledge on methods to address degraded grid
The inspectors identified a green finding involving inadequate corrective actions associated with the adequacy of plant procedures to be utilized during degraded grid voltage conditions and the operators' knowledge of these procedures.

This finding was determined to be greater than minor because the issue adversely impacted the Mitigating Systems Cornerstone objective associated with procedure quality. The inspectors conducted a Phase 1 SDP screening and determined that the finding was of very low safety

significance. The 138KV system voltage had been maintained greater than the minimum operating voltage throughout the year and implementation of the procedure was not required, therefore an actual loss of safety function did not exist during the period in question.

This finding is associated with the cross-cutting issue of problem identification and resolution in that it resulted from inadequate corrective actions associated with a previously identified issue.
Inspection Report# : 2005003*(pdf)*

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)*

Barrier Integrity

Significance: G Apr 01, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
CONTROL ROOM VENTILATION SYSTEM INOPERABLE DUE TO HUMAN PERFORMANCE MAINTENANCE ERROR
A Green self-revealing non-cited violation of Technical Specification 3.7.11 was identified involving Entergy's failure to maintain the proper configuration of a damper actuator in the safety-related control room ventilation system. On January 26, 2005, during tracer gas testing, Entergy discovered that control room ventilation system damper B was operating in the reverse direction due to it's actuator and position indicator both being installed backwards. Entergy's investigation determined that the actuator and position indication were installed backwards during maintenance in 2001. As a result of the damper's actuator being reversed, the control room ventilation system would not have protected operators from toxic gases.

This finding is more than minor because Entergy failed to meet Technical Specification 3.7.11, "Control Room Ventilation System," which states that two control room ventilation system (CRVS) trains shall be operable. Contrary to this requirement, due to the improper installation of damper B, the CRVS was considered inoperable since May 5, 2001. Entergy's failure to properly maintain the proper configuration of the CRVS was determined to have very low safety significance (Green) based on a Phase 3 analysis in accordance with IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations." Although the damper misalignment represented a degradation of the barrier function of the control room against smoke and/or toxic gas intrusion, compensatory measures are pre-planned. In addition, the control room dose limits per 10 CFR 50, Appendix A, General Design Criteria (GDC) 19 would not have been exceeded during a design basis event. Because this failure to maintain the CRVS was entered into the licensee's corrective action program (reference CR-IP3-2005-00315), this violation is being treated as an NCV consistent with Section VI.A. of the NRC Enforcement Policy.
Inspection Report# : 2005002*(pdf)*

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Significance: G Apr 01, 2005
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
TRANSFER OF LOW-LEVEL RADIOACTIVE WASTE, BY ENTERGY INDIAN POINT ENERGY CENTER FOR DISPOSAL, THAT DID NOT MEET BARNWELL LOW-LEVEL WASTE DISPOSAL FACILITY LICENSE
A Green self-revealing non-cited violation of 10 CFR 20.2001 was identified associated with the transfer of waste, by Entergy's Indian Point Energy Center, for disposal, that did not meet Barnwell Low-Level Waste Disposal facility license requirements as required by 10 CFR 30.41. Specifically, a shipment (0205-12578) of low-level radioactive waste, from the Indian Point Energy Center, was identified on February 11, 2005, at the Barnwell Low-level Waste Disposal Facility, to have loose radioactive waste material inside the shipping cask (and outside of the waste disposal container) contrary to the disposal facility's site operating license (License No. 097, Amendment 47, Condition 61).

This finding is considered to be more than minor because Entergy failed to meet a waste disposal facility license requirement that was reasonably within its ability to foresee, correct, and prevent. This radioactive material control transportation finding was evaluated against criteria specified in NRC Manual Chapter 0609, Appendix D, and determined to be of very low safety significance (Green) because: 1) no external radiation or contamination limits were exceeded; 2) no package breach was involved; 3) no failure to make a notification was involved; and 4) although a low-level burial ground non-conformance was involved, burial ground access was not denied and no 10 CFR 61.55 waste classification issue was involved. In addition, although the finding did involve a certificate of compliance issue; the finding was a minor contents deficiency with low risk significance relative to causing a radioactive release to the public or public or occupational exposure. The small quantity of waste material was contained within the NRC approved shipping cask. Entergy temporarily suspended this type of shipment from the Indian Point Energy Center and placed the issue in the corrective action program.
Inspection Report# : 2005002*(pdf)*

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Last modified : November 30, 2005