

Three Mile Island 1 2Q/2003 Plant Inspection Findings

Initiating Events

Significance:  Oct 25, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Control of Transient Combustibles

AmerGen Energy Company failed to control transient combustibles in the relay room in accordance with the limits established in the Fire Hazard Analysis Report and Administrative Procedures 1035, "Control of Transient Combustible Materials." The failure to properly control transient combustible materials can result in an increase in the ignition frequency for a fire area. This finding was determined to be greater than minor significance based on the example provided in Section 4.k of NRC Manual Chapter 0612, Appendix E, "Power Reactor Inspection Reports."

Inspection Report# : [2002011\(pdf\)](#)

Mitigating Systems

Significance: N/A Jun 28, 2003

Identified By: NRC

Item Type: FIN Finding

Failure to Document a Temporary Modification to a Floor Drain Flood Barrier in the River Water Pump House

AmerGen failed to evaluate the adequacy of, and ensure proper administrative controls were in place for, a temporary inflatable plug installed in a river water pump house floor drain flood barrier. The inflatable plug was later found deflated and unable to function as a flood protection barrier. The temporary plug was needed because the floor drain standpipe, which serves as the permanent flood barrier, was broken off during maintenance activities. The finding is greater than minor because, in the event of a maximum probable flood, the operability of safety related equipment in the river water pump house would have been challenged. The finding, which is under the mitigating systems cornerstone, is of very low safety significance because, the nonexistent flood protection barrier would not have resulted in a plant trip or a complete safety system failure.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Report Changes in Medical Status of Licensed Operators as Required by 10 CFR 50.74

Three instances were identified in which the licensee had identified potentially disqualifying medical conditions in regard to licensed operators, but did not report these conditions to the NRC within 30 days because of lack of understanding of the reporting requirement. This is a violation of 10 CFR 50.74. The violation is of very low safety significance because no license restrictions were found necessary when the conditions were reported and reviewed by the NRC medical review officer.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Follow Test Procedure Results in Inadvertent Emergency Diesel Generator Start and Increased Unavailability

A human performance related procedure error resulted in an unexpected start of the 'B' emergency diesel generator (EDG) during emergency safeguards actuation system (ESAS) surveillance testing. The procedure error occurred when an auxiliary operator manipulated keyed test switches on the 'A' EDG instead of the desired 'B' EDG. A self-revealing non-cited violation of technical specification 6.8, "Procedures and Programs," was identified. This finding is more than minor because the procedure error resulted in unplanned unavailability to the 'B' EDG, a mitigating system important to safety. The finding is of very low safety significance, because the redundant 'A' EDG was not affected, and the increased unavailability was less than the technical specification allowed outage time for a single EDG.

Inspection Report# : [2002007\(pdf\)](#)

Significance:  Oct 12, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Assure a Leaking EDG Governor Oil Fitting was Promptly Evaluated and Repaired

Operators failed to promptly evaluate an oil leak on the 'A' emergency diesel generator (EDG) mechanical governor that was of sufficient magnitude to render the diesel inoperable. The delay in assessing the significance of the degraded condition resulted in the diesel being inoperable for over five hours with no compensatory actions in place. The safety significance of AmerGen's failure to promptly evaluate and correct an oil leak on the 'A' EDG that rendered the diesel inoperable was very low (Green), because the time period the diesel was inoperable was less than the technical specification allowed outage time for a single EDG and the redundant 'B' EDG was not affected. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Actions," requires in part that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. Contrary to this requirement, plant operators failed to assure that an oil leak that affected the operability of the 'A' EDG, was promptly identified and repaired.

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

Barrier Integrity

Significance:  Oct 12, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement Adequate Procedures for Process Radiation Monitoring System Operation

Control room operators secured an inoperable reactor coolant drain tank (RCDT) vent radiation monitor and placed its associated interlock defeat switch in defeat for several weeks without adequate compensatory actions. The defeat position disabled a high radiation isolation signal for two normally open reactor building isolation valves on the RCDT vent line in the auxiliary building. The operators' oversight caused by inadequate procedure guidance was determined to be of very low safety significance (Green). Only the radiological barrier function of the reactor building containment to the auxiliary building was degraded. Engineered safeguards isolation capability was maintained operable to the isolation valves for the duration. Technical specification 6.8.1.a. requires in part that written procedures shall be established, implemented and maintained covering the applicable procedures recommended in Appendix "A" of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33, Revision 2, February 1978 recommends

written procedures for process radiation monitoring system operation. Contrary to this requirement, on May 1, 2002, to August 4, 2002, control room operators secured the RCDT vent line radiation monitor and disabled associated high radiation signals without adequate procedure instruction.

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

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : September 04, 2003