

Indian Point 3 2Q/2013 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Assess and Manage Risk Associated with Reactor Testing Below Normal Operating Conditions

The inspectors identified an NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65(a)(4), requirements for monitoring the effectiveness of maintenance, when Entergy did not assess and manage the risk associated with reactor protection testing with Unit 3 below normal operating pressure. Specifically, on March 27, 2013, with Unit 3 just having entered Mode 3 and while raising reactor coolant system (RCS) temperature, required risk management actions were not taken regarding a reactor protection system test, and due to a problem with the test equipment, a low pressure safety injection (SI) actuated. Entergy operators took action to mitigate the SI, and the event was entered into the corrective action program (CAP) as CR IP3 2013 2115. A root cause evaluation was initiated to determine the acceptability of conducting this test with the plant at low pressure in Mode 3 and address extent of condition.

The finding was more than minor because it was associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. In addition, in accordance with IMC 0612, Appendix E, Example 7.f, had the risk assessment for the testing been done using Entergy's risk procedure, the assessment would have determined the impairment of the low pressure SI interlocks and would have placed the plant in an administrative higher risk condition (Orange). The finding was evaluated using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," and determined to be of very low safety significance (Green) when the risk assessment was performed correctly with the resulting actual incremental core damage frequency deficit determined to be very small, less than $1E-6$. The inspectors determined this finding had a cross-cutting aspect in Human Performance, Work Control, when Entergy personnel did not take risk insights, job site conditions such as the plant pressure, technical specification requirements, and an inaccurate pressurizer level indication into consideration when preparing for testing along with the need for contingencies. Inspection Report# : [2013003](#) (*pdf*)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a Condition Adverse to Quality Affecting Pressurizer Safety Valves

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," when Entergy failed to correct a condition adverse to quality associated with the Unit 3 pressurizer safety valves (PSVs). Specifically, following valve lift setpoint failures in 2005 and 2008, Entergy did not complete a cause determination and establish corrective actions. As a result, a PSV (PCV-468) removed from Unit 3 in 2011, lifted at higher than its setpoint pressure due to spring fatigue. Following the 2011 failure, Entergy performed a cause investigation and

initiated a corrective action to include spring rate testing in the inspection of the safety valves.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, the finding screened to be of very low safety significance (Green), when all screening questions were answered "no." The inspectors determined that no cross-cutting aspect was applicable to this performance deficiency because this finding was not indicative of current licensee performance.

Inspection Report# : [2013003](#) (pdf)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Appropriate Procedures for Response to Safety Injection Actuation at Low Temperature

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Procedures," when Entergy did not maintain appropriate written procedures for responding to an inadvertent SI on Unit 3 when below the normal operating RCS temperature. As a result, operators did not comply with procedure requirements when responding to an inadvertent SI event on March 27, 2013. During a review of the event by the inspectors, procedure deficiencies were identified which have the potential to lead to a more significant safety concern. Entergy personnel documented the March 27 event in their CAP as CR IP3-2013-2115 and initiated a root cause evaluation.

The finding was more than minor because, if left uncorrected, the procedure deficiencies have the potential to lead to a more significant safety concern related to exceeding vessel integrity pressure limitations if a charging pump was started in solid conditions below 380°F. In accordance with IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, the finding screened to be of very low safety significance (Green), when all screening questions were answered "no." The finding was assigned a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not ensure that design documentation and procedures were adequate to assure nuclear safety.

Inspection Report# : [2013003](#) (pdf)

Significance: G Nov 09, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Turbine Building HELB Evaluation for Effect on Safety Related Equipment

The team identified a finding of very low safety significance (Green) involving a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, Design Control, because Entergy had not verified the adequacy of their design with respect to the potential impact on safety-related electrical equipment in response to postulated turbine building high energy line breaks (HELBs). Specifically, the potential impact on safety-related equipment contained in the adjacent control building cable spreading room and 480V switchgear room had not been adequately evaluated. Entergy entered the issue into their corrective action program to perform an operability evaluation and correct the design deficiency and to determine the need for additional analyses or plant changes to address the HELB issue and conformance with equipment qualification design considerations.

The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and

adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, The Significance Determination Process (SDP) for Findings at Power, Exhibit 2 - Mitigating Systems Screening Questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. Specifically, the deficiency was associated with an analysis performed in 1973 and was not identified in a subsequent review of operating experience performed in 2000.

Inspection Report# : [2012007](#) (*pdf*)

Significance: G Nov 09, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Verification of Design Analyses for Recirculation Pump NPSH

The team identified a finding of very low safety significance (Green) involving a non-cited violation of 10 CFR.Part 50, Appendix B, Criterion III, Design Control, because Entergy had not verified the adequacy of the existing design analyses for internal recirculation pump net-positive-suction-head (NPSH) margin and vapor containment strainer allowable head loss determinations. Specifically, the recirculation pump flow system hydraulic modeling assumption relative to zero leakage through an idle recirculation pump check valve was not verified or consistent with the existing test method which could allow significant backflow with the established pump and check valve test acceptance criteria. Entergy entered the issue into their corrective action program to evaluate and resolve the design deficiency, and performed an operability evaluation to ensure there was adequate NPSH margin.

The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, The Significance Determination Process (SDP) for Findings at Power, Exhibit 2 - Mitigating Systems Screening Questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance.

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equipment contained in the adjacent control building cable spreading room and 480V switchgear room had not been adequately evaluated. Entergy entered the issue into their corrective action program to perform an operability evaluation and correct the design deficiency and to determine the need for additional analyses or plant changes to address the HELB issue and conformance with equipment qualification design considerations.

The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, The Significance Determination Process (SDP) for Findings at Power, Exhibit 2 - Mitigating Systems Screening Questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance. Specifically, the deficiency was associated with an analysis performed in 1973 and was not identified in a subsequent review of operating experience performed in 2000.

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The performance deficiency was determined to be more than minor because it was associated with the design control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The team evaluated the finding in accordance with IMC 0609, Appendix A, The Significance Determination Process (SDP) for Findings at Power, Exhibit 2 - Mitigating Systems Screening Questions. The finding was determined to be of very low safety significance because it was a design deficiency confirmed not to result in a loss of operability. This finding was not assigned a cross-cutting aspect because it was a historical design issue not indicative of current performance.

Inspection Report# : [2012007](#) (*pdf*)

Significance: G Jul 20, 2012

Identified By: NRC

Item Type: VIO Violation

Failure to Protect Safe Shutdown Equipment from the Effects of Fire

The inspectors identified a finding of very low safety significance (Green), involving a cited violation of Indian Point Unit 3 Operating License Condition 2.H to implement and maintain all aspects of the approved fire protection program. Specifically, ENO failed to protect required post-fire safe shutdown components and cabling to ensure one of the redundant trains of equipment remained free from fire damage as required by 10 CFR Part 50, Appendix R, Section III.G.2. In lieu of protecting a redundant safe shutdown train, ENO utilized unapproved operator manual actions to mitigate component malfunctions or spurious operations caused by postulated single fire-induced circuit faults. ENO submitted an exemption request (M1090760993) on March 6, 2009, in which it sought exemption from requirements of Paragraph III.G.2, to permit the use of OMAs upon which it had been relying for safe-shutdown in a number of fire areas. However, several OMAs within the exemption request were denied because ENO failed to demonstrate that the OMAs were feasible and reliable, or to appropriately evaluate fire protection defense-in-depth. ENO's performance deficiency delayed achieving full compliance with fire protection regulations and adversely affected post-fire safe shutdown. ENO has entered this issue into the corrective program for resolution. The inspectors found the manual actions in addition to roving fire watches in all affected areas to be reasonable interim compensatory measures pending final resolution by ENO.

ENO's failure to protect components credited for post-fire safe shutdown from fire damage caused by single spurious actuation is considered a performance deficiency. The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to an external event to prevent undesirable consequences in the event of a fire. Specifically, the use of operator manual actions during postfire safe shutdown is not as reliable as normal systems operation which could be utilized had the requirements of 10 CFR 50, Appendix R, Section III.G.2 been met and, therefore, prevented fire damage to credited components and/or cables. The inspectors used IMC 0609, Appendix F, Fire Protection Significance Determination Process, Phase 1 and a Senior Reactor Analyst conducted a Phase 3 evaluation, to determine that this finding was of very low safety significance (Green). This finding does not have a cross cutting aspect because the performance deficiency occurred greater than three years ago when the exemption request was submitted to the NRC on March 6, 2009, and is not indicative of current licensee performance.

Inspection Report# : [2012008](#) (*pdf*)

Significance: G Jul 20, 2012

Identified By: NRC

Item Type: VIO Violation

Failure to Protect Safe Shutdown Equipment from the Effects of Fire

The inspectors identified a finding of very low safety significance (Green), involving a cited violation of Indian Point Unit 2 Operating License Condition 2.K to implement and maintain all aspects of the approved fire protection program. Specifically, ENO failed to protect required post-fire safe shutdown components and cabling to ensure one of the redundant trains of equipment remained free from fire damage as required by 10 CFR Part 50, Appendix R, Section III.G.2. In lieu of protecting a redundant safe shutdown train, ENO utilized unapproved operator manual actions to mitigate component malfunctions or spurious operations caused by postulated single fire-induced circuit faults. ENO submitted an exemption request (M1090770151) on March 6, 2009, in which it sought exemption from requirements of Paragraph III.G.2, to permit the use of OMAs upon which it had been relying for safe-shutdown in a number of fire areas. However, several OMAs within the exemption request were denied because ENO failed to demonstrate that the OMAs were feasible and reliable, or to appropriately evaluate fire protection defense-in-depth. ENO's performance deficiency delayed achieving full compliance with fire protection regulations and adversely affected post-fire safe shutdown. ENO has entered this issue into the corrective program for resolution.

The inspectors found the manual actions in addition to roving fire watches in all affected areas to be reasonable interim compensatory measures pending final resolution by ENO.

ENO's failure to protect components credited for post-fire safe shutdown from fire damage caused by single spurious actuation is considered a performance deficiency. The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to an external event to prevent undesirable consequences in the event of a fire. Specifically, the use of operator manual actions during post-fire safe shutdown is not as reliable as normal systems operation which could be utilized had the requirements of 10 CFR Part 50, Appendix R, Section III.G.2 been met and, therefore, prevented fire damage to credited components and/or cables. The inspectors used IMC 0609, Appendix F, Fire Protection Significance Determination Process, Phase 1 and a Senior Reactor Analyst conducted a Phase 3 evaluation, to determine that this finding was of very low safety significance (Green). This finding does not have a cross cutting aspect because the performance deficiency was not considered indicative of current licensee performance.

Inspection Report# : [2012009](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : September 03, 2013