

Indian Point 3 4Q/2014 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2014

Identified By: NRC

Item Type: FIN Finding

Licensed Operator Requalification Remedial Exam Standard Adherence

The inspectors identified a Green finding (FIN) because Entergy did not adhere to their procedural standards for generating remedial written exams. Entergy failed to follow the guidance as stated in their procedure EN-TQ-201-03, "Systematic Approach to Training," Section 5.4, regarding remedial exam construction when an operator was retested on April 25, 2013.

The inspectors determined that Entergy's failure to adhere to their remedial examination standards in EN-TQ-201-03 was a performance deficiency. The inspectors determined that the finding was more than minor because it was associated with the human performance 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. Specifically, the finding affected the quality and level of difficulty of the remedial quiz which potentially impacted Entergy's ability to appropriately evaluate the licensed operator. The inspectors determined that this issue had a cross-cutting aspect in Human Performance, Procedure Adherence, because Entergy did not follow their procedural standards for generating remedial written exams.

Inspection Report# : [2014005](#) (*pdf*)

Significance: TBD Dec 31, 2014

Identified By: Licensee

Item Type: AV Apparent Violation

Incomplete and Inaccurate Medical Information Provided by the Licensee Which Impacted an Operator's License Renewal

Entergy identified two AVs of NRC requirements related to Entergy not notifying the NRC within 30 days of a change in a licensed reactor operator's (RO's) medical condition and to providing information to the NRC pertaining to renewing a RO license that was not complete and accurate in all material respects. Specifically, Entergy identified an AV of Title 10 of the Code of Federal Regulations (10 CFR) 50.74, "Notification of Change in Operator or Senior Operator Status," for Entergy's failure to notify the NRC within 30 days after learning, on October 25, 2012, that a Unit 3 RO had a permanent disability or illness (sleep apnea). Entergy also did not request an amended license with a condition to account for the medical issue, resulting in the RO performing licensed duties without a properly restricted license. Additionally, Entergy identified an AV of 10 CFR 50.9, "Completeness and Accuracy of Information," pertaining to Entergy's failure to provide information to the NRC in the RO's license renewal application in that it did not specify that the RO had a medical condition (sleep apnea) that required a restriction [for use of a continuous positive airway pressure (CPAP)]. The NRC, in turn, issued a license renewal that did not contain the necessary restriction. Compliance was restored on July 7, 2014, when Entergy submitted a letter to the NRC with a Form 396

indicating the new restriction for the use of a CPAP machine. On August 14, 2014, the NRC issued a license amendment with the new restriction. These issues were entered into Entergy's corrective action program (CAP) as condition report (CR)-IP3-2014-1416 and CR-IP2-2014-4202.

The inspectors determined that Entergy's failure to report a change in a licensed operator's permanent medical condition to the NRC and subsequently provide complete and accurate information to the NRC was a performance deficiency that was within their ability to foresee and correct and should have been prevented. The inspectors determined that traditional enforcement applies, as the issue impacted the NRC's ability to perform its regulatory function. The inspectors screened the issue using Section 6.4.c.4(b) of the NRC Enforcement Policy and preliminarily determined that these AVs meet the definition of a Severity Level III violation because Entergy failed to report a condition that would have required the addition of a license restriction within the required timeframe and, again, for the RO's license renewal. No associated Reactor Oversight Process finding was identified and no cross-cutting aspect was assigned. These issues constitute AVs in accordance with the NRC's Enforcement Policy, and the final significance will be dispositioned in future correspondence. Because the significance determination of this issue is not complete, it is identified as TBD.

Inspection Report# : [2014005](#) (*pdf*)

Significance:  Jun 20, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Deficient Design Control Results in Non-Qualified Component Installed in Harsh Environment for Unit 3 BFD-FCV-406B Actuator

The team identified a Green non-cited violation of Title 10 Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion III, Design Control, because Entergy did not ensure the control air pressure regulator (IA-PCV-1548) for Unit 3 auxiliary boiler feedwater (ABFW) flow control valve BFD-FCV-406B was suited and designed to perform its safety-related function. Specifically, IA-PCV-1548 was not designed or qualified for use in the harsh environment area where it was located. Immediate corrective actions included evaluation of IA-PCV-1582 and BFD-FCV-406B to verify component operability. The issue was entered into the corrective action program as condition report IP3-2014-1364, to further evaluate both the extent-of-condition and the station's processes for maintaining configuration control over mechanical components installed in harsh environment areas.

The finding was more than minor because the finding was associated with the Design Control attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of assuring the reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Additionally, the issue was similar to example 3.j in Appendix E of Inspection Manual Chapter 0612, in that the design control issue resulted in a reasonable doubt of operability. The team determined the finding was of very low safety significance (Green) because it was a design or qualification deficiency confirmed not to result in a loss of operability.

The finding had a cross-cutting aspect in the area of Human Performance, Design Margin (H.6), because Entergy did not maintain the operational temperature design margin for the control air pressure regulator to the ABFW flow control valve. The margin between the ABFW pump room peak environmental temperature and the design/qualified temperature of IA-PCV-1582 was not carefully guarded and changed only through a systematic and rigorous process. (Section 1R17.1)

Inspection Report# : [2014007](#) (*pdf*)

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Operability Evaluation of Spalled Concrete in the Service Water Pit Structure

The inspectors identified an NCV of Title 10 of the Code of Federal Regulations (10 CFR) Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," when Indian Point Energy Center (IPEC) staff did not evaluate spalled concrete in the Unit 3 service water pit ceiling slab to the extent required by Entergy procedures. Specifically, IPEC staff referenced an operability screening for a less significant spalled condition at this location that occurred in 2012, characterized spalls that exposed load carrying rebar as "cosmetic," and did not consider the ongoing spalling. When identified by the inspectors to licensee staff, the licensee walked down the area, initiated condition report (CR) IP3 2014 00405, and subsequently developed an operability determination and finite element analysis that determined the service water pit ceiling slab remained operable but degraded.

The failure of licensee staff to adequately perform an operability review of concrete degradation in the Unit 3 service water pit ceiling was contrary to self-imposed procedural standards and was within the licensee ability to foresee and correct and was a performance deficiency. The performance deficiency was determined to be more than minor because, if left uncorrected, it would have the potential to become a more significant safety concern. Specifically, the failure to evaluate the spalling and exposed rebar in the operability screen resulted in IPEC staff not identifying the causes of ongoing spalling and scheduling corrective actions in a timeframe shown to be effective to maintain structural capability. The inspectors determined the finding could be evaluated using IMC 0609, Attachment 0609.04, and "Initial Characterization of Findings." The inspectors screened the finding through IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," using Exhibit 2, "Mitigating Systems Screening Questions." The finding screened as of very low safety significance (Green) because it did not result in the loss of operability or functionality. The inspectors assigned a cross-cutting aspect in the area of Problem Identification and Resolution, Evaluation, because the licensee did not thoroughly evaluate the spalled condition and in completing the operability screening process, IPEC staff did not consider the additional spalled material that exposed rebar or causes of ongoing degradation when applying a prior operability screening for a previous less significant condition.

Inspection Report# : [2014002](#) (*pdf*)

Significance:  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:  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

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