

## United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I  
 INDIAN POINT 3

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/31/2000	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Procedure For Venting CCW HX</b> The licensee's procedure for venting component problems cooling water (CCW) at the excess letdown heat exchanger was inadequate. This resulted in a lifted relief valve and a loss of more than 200 gallons of CCW when the licensee attempted to place the heat exchanger in service for excess letdown.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b> 4B	<b>Transition to Year 2000</b> The inspector observed that there were no plant events or significant equipment failures that occurred during the year 2000 transition. None of the minor computer anomalies with meteorological (met) tower data or main generator temperature that occurred after the transition were apparently attributable to the year 2000 transition. Both problems were quickly rectified, and did not have any operational or safety consequences.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Safety Review Committee Performance</b> The offsite Safety Review Committee quarterly meeting was conducted in accordance with technical specification requirements, and the members provided good insights during discussions of plant issues related to safety.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	URI	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b> 5C	<b>Control Room Supervisor Inattentive</b> A control room supervisor was inattentive to his duties during a period of direct observation, and did not fulfill his obligations at the controls of an operating nuclear power plant. He also did not meet NYPA's management expectations for operator demeanor in the control room. The licensee's short term actions were adequate to correct this situation and to evaluate the extent-of-condition; however, this item is unresolved pending further NRC review.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010-02	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 5A	<b>Procedures Not Effective For Configuration Controls</b> The licensee's administrative procedures, check-off lists, and protective tagging orders were not effective in assuring adequate configuration controls, and these administrative controls were not properly implemented during system and component alignments following the last refueling outage. The failure to implement adequate configuration controls for the RHR and CVCS systems is a violation of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawing." This licensee identified deficiency was entered into the corrective action system, and will be treated as a Non-Cited Violation in accordance with Section VII.B.1.a of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010-05	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b> 5A	<b>Unevaluated EDG Configuration Impact</b> Except for the 33 Emergency Diesel Generator (EDG), the inspector assessed the general plant equipment condition to be acceptable during routine inspection tours. Inadequate work control for a post-maintenance test of the EDG room exhaust fan resulted in an unevaluated configuration of an EDG ventilation system. The impact on operability was not properly assessed when the work activity was scheduled or performed. (NCV 05000286/1999010-03). The inspector also observed instances of unofficial and uncontrolled information in the plant that had been used by auxiliary operators.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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12/13/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 3A <b>Sec:</b> 1C <b>Ter:</b> 1A	<b>High Trend in Out-of-Position Components</b> The NRC noted that you independently began trending an increasing number of out-of-position valves and breakers in December which we regarded as a good initiative. While this initial effort was good, the screening criteria used to identify configuration control issues was initially somewhat narrow to identify all instances for evaluation.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 3A	<b>Good Shift Turnover Performance</b> The operations staff demonstrated good overall performance and good procedural adherence during shift and position turnovers. The inspectors considered the licensee's shift turnover process to be an organizational strength. During a plant tour, the inspector observed that operators demonstrated good knowledge of the status of plant equipment
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> 5C <b>Ter:</b> 1C	<b>Adequate Response to GL 98-02</b> NYPA's overall response to GL 98-02, "Loss of Reactor Coolant Inventory and Associated Loss of Emergency Mitigation Functions While in a Shutdown Condition," was acceptable. This included precautions added to heatup and cooldown procedures to prevent inadvertent opening of isolation valves that could result in an alignment comparable to the Wolf Creek event. However, initial actions taken in late 1998 were not comprehensive, such as a lack of consideration of human factors to ensure positive configuration control of the RCS boundary. NYPA issued appropriate Deviation/Event Reports to correct this weakness and to meet the intent of the requested actions in GL 98-02
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 3A	<b>Licensee's policy for excess overtime</b> The licensee's policy for excess overtime was appropriately managed and restricted for operators during the refueling outage. The excess overtime authorized during the last two weeks of the outage was appropriately justified and controlled by station management prior to operations personnel exceeding the normal overtime limits
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1B <b>Sec:</b> 1C <b>Ter:</b> 3A	<b>High Pressure Leak in a failed RCS Flow Transmitter</b> Operator response was well focused and effective in diagnosing and isolating a high pressure leak in a failed reactor coolant system flow transmitter inside containment. They also made timely entries into the appropriate response procedures and recognized the correct conditions for classifying an Unusual Event. Emergency Plan responders made the required local, state, and NRC notifications properly and on time. Operators promptly diagnosed control room indications and directed auxiliary operators inside containment to isolate the leak before a significant volume of RCS inventory was lost. The resulting consequences to personnel and equipment inside containment were minimized, and the subsequent analysis by the post-transient review group was timely and comprehensive
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b> 5B	<b>Establishment of good program for performing outage risk assessments</b> The licensee established a good program for performing outage risk assessments. The pre-outage schedule review was thorough and resulted in the incorporation of numerous schedule modifications to reduce risk. Appropriate contingency planning was performed for conditions where system redundancies would be reduced. In one instance, the operations department did not perform a daily risk assessment following a significant plant condition change, as recommended by the procedure
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
10/24/1999	1999008-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 1B <b>Sec:</b> 3A <b>Ter:</b> 5B	<b>Inadequate Test Controls Resulted in a Loss of Reactor Coolant Inventory During Residual Heat Removal Ope</b> Operators correctly diagnosed and stopped an uncontrolled loss of approximately 1100 gallons of reactor coolant system (RCS) inventory, recovered the normal RCS level, and prevented a rise in the bulk RCS temperature. The failure to implement adequate system test and configuration controls while the residual heat removal system was in operation is a violation of 10 CFR 50, Appendix B, Criterion XI, "Test Control" (NCV 50-286/99-08-01)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> <b>Sec:</b> <b>Ter:</b>	<b>Unnecessary Secondary Equipment Challenges Following Plant Transient</b> The licensee was unnecessarily challenged by safety-related and nonsafety-related secondary equipment during the plant transient on August 12. A third incident of degraded auxiliary boiler feed pump packing was observed during the reactor trip transient. Also, a carbon dioxide discharge onto the main boiler feedwater pumps and a failure of a secondary steam supply valve provided minor distractions to the operations crew coping with the transient
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1B <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Reactor Trip Following Instrument Bus Failure</b> The plant responded as designed following the failure of the 34 instrument bus on August 12, 1999. However, the plant transient following the reactor trip was complicated, and operator performance in response to the trip was mixed. There were important equipment losses/responses following loss of the 34 instrument bus that were undetected for a period of time, and that operators were not alerted to by the existing procedures. Also, the operators did not appear to be fully cognizant of the circuitry of the high pressure steam dump valves which in this scenario rendered them inoperable due to a loss of signal to the controller. Further, although operations management considered that operator performance was acceptable, very little information was available from interviews to support this conclusion
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09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 1B <b>Ter:</b> 3A	<b>Insufficient Procedure Guidance Complicated Operator Response Following Plant Transient</b> The off-normal operating procedure for the loss of the 34 instrument bus did not provide sufficient guidance to the reactor operators for how to manage secondary pressure control when this instrument bus is lost. As a result, some challenges to the operators and to plant equipment were noted that complicated a transient on August 12, 1999. In order to disseminate the lessons learned, the operations manger issued a shift order that contained specific actions for operators, even though the licensee's operations administrative procedure did not allow this practice.
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09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 5A <b>Ter:</b> 5B	<b>Poor Post-Transient Review Group Performance</b> The PTRG's initial response to this event was poor with respect to NYPA's administrative guidance for post-transient evaluations. The PTRG was slow to organize, to develop a plan with team member assignments, and to initiate effective data gathering. The PTRG also did not effectively coordinate assignments for operations or engineering to assist in developing a comprehensive timeline, or to evaluate plant and operator responses. Aggressive management direction and oversight was necessary for the PTRG to develop a final end product with sufficient analysis and recommendations to afford site management with a sound safety-basis for restarting the plant.
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09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3B <b>Ter:</b>	<b>Good Operator Performance During Reactor Startup</b> The plant startup on August 13, 1999, was well controlled and had a good level of management oversight. The operators performed well, and maintained a strong emphasis on reactivity management with good command and control during the reactor startup
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09/13/1999	1999007	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b>	<b>Good Risk Assessment for Refueling Outage (RO-10)</b> A detailed and thorough licensee-performed risk assessment of the RO-10 refueling outage schedule resulted in a number of improvements to the schedule, thereby increasing equipment redundancy for key safety functions.
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09/13/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Poor Operator Awareness</b> Operations identification and awareness of degraded service water flow instruments was poor. The failure to initiate a problem identification tag for a degraded instruments demonstrated a lapse in operator performance in identifying problems. Also, the operators did not physically post the PID tags near the degraded instruments which led to an inconsistent awareness by operators regarding the status of those flow indicators. Specifically, some operators were not aware that the indicators were in a degraded condition and may not be relied on during accident conditions.
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09/13/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 3C <b>Ter:</b> 3B	<b>Poor Operator Attention-to-detail</b> Operations personnel performance while removing a heater drain pump from service was ineffective. Poor attention to detail caused an inadvertent trip of the 32 heater drain pump (HDP) while attempting to remove the 31 heater drain pump from service. In addition, the licensee did not initiate a deviation event report on this issue, and therefore did not identify a potential human performance error regarding the inadvertent HDP trip. Also, weaknesses in interdepartmental communications, engineering support and work control coordination led to a condition that could have created a potentially significant secondary plant transient. Specifically, precautions were not communicated to the operators regarding a degraded HDP check valve prior to removing its respective pump from service.
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09/13/1999	1999005	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Routine Operator Performance</b> Operator performance during routine operations was adequate and in accordance with licensee management expectations. Good command and control practices were observed.
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08/09/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Operability Determinations</b> In general, operators properly assessed and documented the operability determination for degraded plant equipment. However, the team identified several examples where operators did not properly document the bases for operability, or made an operability determination without appropriate engineering involvement. The licensee planned to address these issues by clarifying expectations for operability determinations, and by expanding the role of the plant deficiency review team to independently review operability determinations.
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08/09/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Routine Operations</b> Operations were conducted in a safe and controlled manner in accordance with plant procedures. Operators adhered to management standards and expectations regarding communications, overhead annunciator response, and control board awareness. Peer-checking and self-checking were routinely used by the operators during control board manipulations. Shift turnovers were professional and effective in ensuring that the operators were well-informed of plant conditions, and that important plant status information was conveyed to the on-coming shift. Shift supervision provided effective oversight of control room and plant activities.
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08/19/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Control of Maintenance</b> Operators maintained appropriate control of maintenance activities. The licensee responded appropriately to a self-identified tagging deficiency.
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08/09/1999	1999006	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 5B <b>Ter:</b>	<b>Equipment Condition</b> The material condition of plant equipment was adequate to support continued safe operation. The licensee was generally responsive in identifying and evaluating deficient conditions. The age and number of some identified material deficiencies did not meet the licensee's performance goals and remained a challenge to the plant staff. Deficiencies were identified involving the classification of operator work-around items and control room deficiencies, and in the evaluation of a long term boric acid build-up on the spent fuel pool heat exchanger inlet and outlet flanges.
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06/16/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 1C <b>Sec:</b> 1C <b>Ter:</b> 3A	<b>Failure to Identify LCO Entry</b> The licensee's instrument and controls procedure for calibration of a weld channel and penetration pressurization system transmitter did not identify a potential entry into a technical specification limiting condition for operations. Although, the weld channel zone pressure remained above the technical specification limit, the system was isolated in a manner that was inconsistent with the technical specification bases. Neither the Instrumentation & Control calibration procedure nor the work package planners identified the impact of the work on technical specifications.
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06/16/1999	1999003	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b> 1C	<b>Good Operator Communications</b> Information provided during turnover meetings was accurate and detailed. Control room communications were appropriate and consistent with operational directive expectations. The nuclear plant operators were knowledgeable of their watch responsibilities and used good self-checking techniques while operating plant equipment. (NRC; 1999003)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Inadequate Tagout Corrective Actions</b> Corrective actions to address an inadequate protective tagout for an atmospheric steam relief valve were narrowly focused and did not identify the root cause of the event. Specifically, the licensee failed to identify and correct an inadequate piping diagram and poor human performance which had the potential to challenge personnel and plant safety. The failure to identify the root cause of this event is a violation of 10 CFR 50 Appendix B, section 16, "Corrective Actions." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This issue is in the licensee's corrective process as deviation event report 99-00839.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
05/05/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b>	<b>Degraded Louver</b> The licensee's evaluation of a degraded louver in the emergency diesel generator ventilation system was insufficient. There was no engineering basis to justify the ability of the exhaust system to maintain the emergency diesel generator (EDG) room at its design basis temperature during single fan operation when a degraded louver on the redundant fan was identified.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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05/05/1999	1999002	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b>	<b>Equipment Deficiencies</b> Overall, equipment deficiencies were appropriately identified in the field and did not impact equipment operability. However, the impact of a containment spray flow indication deficiency on the implementation of emergency operating procedures (EOPs) was not documented and communicated effectively to the operators. In addition, engineering support to operations was insufficient as no technical evaluation was performed to assure operators that the degraded flow indicator would provide reliable information while executing the EOPs. The potential impact was subsequently evaluated and appropriate guidance was provided to operators.
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03/24/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 3A <b>Ter:</b>	<b>Secondary Plant Equipment Challenges</b> The approach to resolving secondary equipment challenges was not thorough and the overall materiel condition of secondary equipment challenged the operators during the power ascension following a unit trip on March 9, 1999. The work to resolve deficiencies associated with the main boiler feed pump discharge valve was not well coordinated and resulted in multiple entries into and exits from limiting conditions for operation. Troubleshooting efforts on secondary plant oscillations in February 1999 did not thoroughly address the problem as evidenced by several heater drain pump trips during power ascension in March 1999.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 3A <b>Ter:</b>	<b>Routine Operations</b> Operator performance during this inspection period was adequate. Overall operator response to a reactor trip and implementation of emergency operating procedures was appropriate. Reactor start up activities were performed well. Specifically, the use of peer reviews for reactivity manipulations was a noteworthy initiative.
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03/24/1999	1999001	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 4B <b>Ter:</b>	<b>EDG Fuel Oil System</b> The emergency diesel fuel oil storage system was properly maintained to assure that it would perform its intended functions. The testing and maintenance of important components and procedures for controlling system configuration were appropriately established. The calculations for minimum fuel storage requirements were thorough.
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03/24/1999	1999001-01	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 1C <b>Sec:</b> 5C <b>Ter:</b>	<b>Incorrect Valve Position</b> The licensee's formal root cause evaluation for the mis-positioning of the isolation valve to a service water monitoring box was not thorough. The licensee did not consider the potential for the valve to be closed during preventive maintenance and did not review the effectiveness of configuration control processes for valves within a tagout boundary. Further, the licensee did not consider an extent of condition review concerning the resolution of deviations identified during the performance of the checkoff list. The licensee failed to promptly identify and correct mis-positioned valve SWN-111-1. This failure is a Severity Level IV violation of 10 CFR 50 Appendix B, Criterion XVI, "Corrective Actions," and is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
02/10/1999	1998010	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Weak PM Work Package Planning</b>  The work planning associated with the 120 volt AC distribution panel No. 32 preventive maintenance package was weak because it did not identify the full impact the associated electrical loads would have on the facility. Following a second NYPA review, the work performed with this package still resulted in unexpected equipment responses as evidenced by an inadvertent containment isolation signal and additional challenges to operations. The quality standards and expectations of several personnel associated with the preparation of this work appeared inconsistent with those of senior plant management.
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02/10/1999	1998010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Weak Licensee Response</b>  The licensee's immediate response to the identification of the depleted nitrogen bottle to the control room ventilation system was weak. The licensee did not consider potential implications of the rapid reduction in the pressure on the leak tight integrity of the air operation damper actuators and associated piping. This reflected a lack of questioning by personnel screening the deviation event report (DER). Subsequent planned and completed actions by the licensee were appropriate.
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02/10/1999	1998010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Weak Corrective Actions</b>  The licensee's corrective actions were weak in response to a licensee identified deficiency in 1996, in which the minimum nitrogen bottle pressure for the isolation valve seal water system was not maintained during normal standby conditions. The licensee inappropriately revised procedures to change out nitrogen bottles at 1200 psig during both post accident and normal standby conditions rather than during normal standby conditions only, and did not consider whether additional bottles needed to be staged.
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02/10/1999	1998010	<b>Pri:</b> OPS <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> <b>Ter:</b>	<b>Routine Operator Performance</b>  Operator performance during routine activities, including control room alarm responses, communications and shift turnovers, was good. During an observed plant tour and a walk through of an abnormal procedure by plant operators, the operators demonstrated good knowledge of plant equipment and identified several equipment deficiencies.
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02/10/1999	1998010-01	<b>Pri:</b> OPS <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>Backup Nitrogen</b>  A nuclear plant operator (NPO) failed to notify his supervision of the significant drop in backup nitrogen pressure. As a result, the licensee failed to promptly identify and correct this condition adverse to quality. Although adequate, the licensee's corrective action in response to this failure was weak due to oversights in documenting the NPO performance issue in deviation event report 99-0015. This oversight resulted in the loss of human performance error data point and reduced the reliability of performance trends, which the licensee monitors. The failure to promptly identify and correct a condition adverse to quality is a violation of 10 CFR Part 50 Appendix B, Criterion XVI, "Corrective Actions." However, the violation is considered non-cited because the issues were licensee identified and the corrective actions taken were adequate, consistent with Section VII.B.1 of the NRC Enforcement Policy. (NCV 98010-01)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 1C <b>Ter:</b>	<b>Preventive Maintenance Critique</b> The licensee's critique of the 33 Emergency Diesel Generator two-year preventive maintenance was not very self critical, and contained very little discussion about the deficiencies that were identified or areas for improvements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>Maintenance Performance</b> The licensee satisfactorily completed observed maintenance activities and successfully performed post-maintenance testing for operability. The inspector observed several minor human performance discrepancies associated with error reduction techniques and poor work coordination of a safety-related component under a protective tagging order.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>Surveillance Tests</b> Routine surveillance tests were conducted satisfactorily and in accordance with procedural and administrative requirements. Test instrumentation was observed to be within the required calibration periods and all test acceptance criteria for operability were met, or subsequently evaluated for acceptable performance.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>Functional Capability of 120 Vac and 125 Vdc Systems</b> Following a walkdown of the 120 VAC Instrument Buses and 125 VDC buses, the inspector concluded that the system was capable of performing its design function. The inspector also found several canceled problem identification tags inappropriately hanging on equipment in the plant.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>Battery Surveillance Testing</b> Based on a review of documented surveillance tests, the inspector concluded that the licensee satisfactorily accomplished technical specification requirements for battery testing, and adequately demonstrated station battery operability.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						



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12/13/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1A <b>Sec:</b> 2A <b>Ter:</b> 2B	<b>Weak Work Control</b> The recurring problem with Problem Identification Description tags remaining in the plant and control room after work has been completed, rejected, or canceled represented a weakness in the licensee's work control process and caused unnecessary actions by operators to troubleshoot abnormal equipment conditions
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Satisfactory Conduct of Maintenance</b> Maintenance activities observed were conducted satisfactorily and in accordance with applicable maintenance and administrative procedures. The corrective maintenance performed was satisfactory to resolve the deficient conditions and the post maintenance testing was adequate to determine the effectiveness of the repairs. The licensee appropriately monitored performance of equipment within the scope of the maintenance rule and re-evaluated preventive maintenance frequencies based on equipment performance
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Satisfactory Conduct of Surveillance Testing</b> Routine surveillance tests were conducted appropriately and in accordance with procedural and administrative requirements. Test and performance monitoring personnel maintained a good level of communication and coordination with control room operators during observed surveillance tests. Test instrumentation was within the required calibration periods and all test acceptance criteria for operability were met
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009-07	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	URI	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 4B	<b>No Formal Basis for Use of Plant Computer for TS Compliance</b> Independent calculations by the inspectors confirmed that the licensee's core thermal power calculations were technically accurate based on the data inputs that were used. However, the licensee did not provide a formal basis for the use of a non-qualified instrument (i.e., plant computer) in order to verify compliance with the Technical Specification limit on core thermal power. This item will remain unresolved pending further NRC review of the licensee's basis for its use in meeting Technical Specification requirements
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2A <b>Sec:</b> 4B <b>Ter:</b>	<b>Walkdown Inspections of plant equipment</b> The inspector identified several discrepancies during walkdown inspections of plant equipment during the refueling outage. The discrepancies appeared to be minor in nature, but were referred to the licensee for evaluation and resolution prior to the end of the outage
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1A <b>Sec:</b> 1C <b>Ter:</b> 3A	<b>Safety Injection/Station Blackout Integrated Functional Test</b> The pre-job briefing for the Safety Injection/Station Blackout integrated functional test was thorough, addressed industry events, and emphasized self-checking and peer checking techniques. Performance of the test had the appropriate level of management oversight. The test coordinator made a good configuration control effort during the pre-job briefing by ensuring that an isolation boundary was maintained between the reactor coolant system and the refueling water storage tank to preclude a potential leak path
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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10/24/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 2B <b>Ter:</b> 4B	<b>In-service Inspection Program</b> The second ten-year interval in-service inspection program was satisfactorily completed in accordance with the American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Section XI. No indications of structural defects were found during visual inspection of the reactor vessel and removable internals. Three steam generator tubes inspected revealed indications due to loose parts wear, but the indications were considered arrested at their current acceptable depth, without a potential for further growth
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Routine surveillance tests conducted</b> Routine surveillance tests were conducted appropriately and in accordance with procedural and administrative requirements. Test and performance monitoring personnel maintained a good level of communication and coordination with control room operators during observed surveillance tests. Test instrumentation was observed to be within the required calibration periods and all test acceptance criteria for operability were met
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008-02	<b>Pri:</b> MAINT <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b> 4B	<b>Prressurizer Safety Valves Inoperable, Condition Prohibited by Technical Specifications</b> Poor communications and inadequate work control guidance led to a condition prohibited by the plant technical specifications. In loosening the pressurizer safety relief valve body-to-bonnet bolts, the licensee compromised the operability of all three valves prior to establishing a suitable pressure relief path as required by technical specification 3.1.A.2. This failure to comply with the technical specification is a violation of NRC requirements (NCV 50-286/99-08-02)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	LIC	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b>	<b>Maintenance Activities Observed</b> Maintenance activities observed were conducted satisfactorily and in accordance with applicable maintenance and administrative procedures. The licensee appropriately monitored performance of equipment within the scope of the maintenance rule
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 5B <b>Ter:</b> 4B	<b>Insufficient Post-Maintenance Test for Auxiliary Feedwater Pump</b> The licensee's preventive maintenance did not include a sufficient post-maintenance test to provide an adequate basis for operability of the 31 auxiliary boiler feedwater pump. The pump was later declared inoperable due to motor vibration data that was above administrative limits. The licensee's maintenance and test procedures were revised to require appropriate evaluation and testing.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 3B	<b>Satisfactory Maintenance Performance</b> Maintenance activities observed were conducted satisfactorily and in accordance with applicable maintenance and administrative procedures. The licensee appropriately monitored performance of equipment within the scope of the maintenance rule.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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09/13/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 3B	<b>Good Surveillance Test Performance</b> Surveillance tests were conducted appropriately and in accordance with procedural and administrative requirements. Good coordination and communication with the control room were maintained during performance of the observed surveillances. Test instrumentation was within calibration and the test acceptance criteria were achieved.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 2B <b>Ter:</b> 3B	<b>Good Appendix R Diesel Test Performance, but Problem Identification Tags Not Properly Dispositioned</b> The performance of the Appendix R diesel generator monthly surveillance test was good. Procedures and self checking techniques by the test performers were used effectively and in accordance with licensee procedures. However, neither the test or operating procedure verified the correct speed setting on the engine mechanical governor. The configuration control verification for the diesel was not thorough and may not have prevented inadvertent tripping of the Appendix R diesel when called upon for service if the governor's speed setting had been inadvertently altered. The licensee appropriately planned to revise the system prerequisite check-off list to verify the speed setting. Some poor communication between system engineering, planning, and operations was noted as problem identification tags remained on the engine control panel even though the problems had been reviewed and deemed acceptable by both planning and engineering.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007-01	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 2A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Ineffective Corrective Actions for Water Intrusion in the 32 Emergency Diesel Generator Fuel Oil Storage Tank</b> The licensee did not take adequate corrective actions to identify the root cause or to prevent a significant accumulation of water in the bottom of the 32 emergency diesel generator (EDG) fuel oil storage tank. Three prior instances of water accumulation were identified by the licensee and were entered into their corrective action system. However, the corrective actions in the licensee's October 1998 action plan were not complete and did not prevent the recurrence of a significant condition adverse to quality. That condition could have resulted in a common mode failure for all three EDGs due to a fuel transfer system design that could have transferred the water to each diesel generator day tank. This is considered to be a severity level IV violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action;" however, it will be regarded as a non-cited violation in accordance with Appendix C of the NRC Enforcement Policy
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Maintenance Surveillances</b> Surveillances were conducted appropriately and in accordance with procedural and administrative requirements. Good coordination and communication with the control room was observed during performance of observed surveillances. Test instrumentation was within calibration, and the test acceptance criteria were achieved.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3C <b>Sec:</b> <b>Ter:</b>	<b>Maintenance Observations</b> Maintenance activities observed were conducted satisfactorily and in accordance with applicable maintenance and administrative procedures. The licensee appropriately monitored performance of equipment within the scope of the Maintenance Rule.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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06/16/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 1C <b>Sec:</b> 3C <b>Ter:</b> 5C	<b>Station Work Control</b> Overall, some improvements have occurred in station work control during the past six months; however, significant challenges remain in the area of material availability. Also, some problem identification tags on risk significant systems were not being corrected in a timely manner. The schedule adherence meeting observed was not effective in determining the causes and possible corrective actions for schedule non-adherence. Work control performance indicators focused mainly on work performance rather than work planning performance.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 2A <b>Ter:</b>	<b>EDG Preventative Maintenance</b> Preventive maintenance on the 33 emergency diesel generator (EDG) was adequate and maintenance procedures were of good quality. Some minor discrepancies with work control implementation were observed as evidenced by unclear guidance for venting of components, leakage from a lube oil cooler flange and incorrect gasket material which extended the unavailability of the emergency diesel generator.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
05/05/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 1A <b>Ter:</b>	<b>Good Questioning Attitude</b> Nuclear plant operators exhibited questioning attitudes when they identified a discrepancy in a surveillance test procedure. The surveillance test to implement a containment integrity requirement contained ambiguous step sequences that had the potential to change the boundary of the pressure test.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
05/05/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>Failed EDG Fuel Pump Linkage</b> The licensee's immediate response to and corrective actions for a failed fuel pump linkage on a cylinder of 33 emergency diesel generator were prompt and thorough. An extent of condition review was conducted for the other two emergency diesel generators and the Appendix R diesel generator. No additional problems were identified. Corrective measures were adequate.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
05/05/1999	1999002	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3B <b>Ter:</b>	<b>MSIV Steam Leak</b> The licensee took appropriate action to repair a steam leak on a main steam isolation valve. The nuclear safety evaluation and temporary modification package appropriately bounded the required system injection pressure for the leak repair. In addition, the pre-job planning was thorough and accounted for potential trip risks to the plant.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Containment Spray Test</b> The licensee appropriately implemented a quarterly surveillance requirement for the containment spray pumps. However, the re-calibration of the ultrasonic flow measurement device and its impact on the flow rate acceptance criteria was not communicated to the operations shift and resulted in a two-hour delay in declaring the pump operable.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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03/24/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Control Room Ventilation</b> The licensee's planning and implementation of a preventive maintenance (PM) package did not effectively minimize out-of-service time for the control room ventilation system. The planning of the work package did not verify the availability and staging of parts needed for the ventilation booster fan prior to commencing work. Also, difficulties with completing the post maintenance test were not effectively communicated and led to unnecessary use of limiting condition for operation time. The licensee's critique did not capture the material and communication problems that occurred during the PM.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 3B <b>Ter:</b>	<b>AFW Flow Rate</b> The licensee's performance of a feedwater flow transmitter calibration was adequate. However, the management expectations with regard to venting transmitters were not clearly understood by the technicians, and procedural guidance for venting transmitters was inconsistent. NYPA acknowledged the inspector's observation and initiated deviation event report 99-0563 to address the need to clarify expectations on venting.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4C <b>Sec:</b> <b>Ter:</b>	<b>CVCS Drain Valve</b> The repair of a socket weld in April 1998 was weak in that it did not capture an engineering design change to install a new shim design which may have precluded a second failure of the same socket weld in December 1998. The licensee missed several opportunities to identify this weakness during the review of the completed work package after the first failure.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> <b>Ter:</b>	<b>Well Written Test Procedure</b> Test procedure 3PT-Q100, Turbine First Stage Pressure Analog Channel, was well written and its acceptance criteria appropriately ensured that technical specifications requirements were met. The calculation, which supported the test acceptance criteria, was of high quality and was thorough in considering all potential instrument loop inaccuracies. The technicians' performance of the test was good.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Maintenance Activities</b> Maintenance activities observed were conducted satisfactorily and in accordance with applicable maintenance and administrative procedures. The licensee was appropriately monitoring performance for equipment within the scope of the maintenance rule. Surveillances were conducted appropriately and in accordance with procedural and administrative requirements. As applicable, good coordination and communication with the control room was observed during performance of the surveillance. The test instrumentation was within calibration, and the acceptance criteria were achieved.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>Maintenance Work Packages</b> Maintenance work packages and procedures used to perform the quarterly preventive maintenance (PM) work on the 32 emergency diesel generator and its associated auxiliary equipment were appropriate to the circumstance. In addition, discrepancies that arose during the implementation of the PM were appropriately dispositioned by maintenance personnel. Lastly, the post maintenance critique identified several areas for improvement and addressed lessons learned from the activity.
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02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2B <b>Sec:</b> 3A <b>Ter:</b>	<b>PASS Temporary Modification</b> The licensee effectively implemented a temporary modification on a post-accident sample line that was a part of the containment boundary. The planning and preparation, pre-job briefing, and work coordination and support were excellent, and resulted in minimizing the time in which the plant was in a one-hour limiting condition for operation for containment integrity. The nuclear safety evaluation for installing the temporary modification was appropriate and used risk insights to limit the time that the temporary modification could be installed.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> MAINT <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Erosion/Corosion in Service Water Piping</b> The performance of radiography to determine the extent of erosion/corrosion in the service water piping was appropriate. Minor discrepancies with the quality assurance of the weld picture and the numerical designations on the radiographs were identified; however, the information derived from the radiographs was acceptable.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 2A <b>Ter:</b>	<b>Pump Repair Methodology</b> Engineering completed an adequate analysis of the 31 charging pump failure, and pursued a good initiative to prevent similar failures by proposing a revision to the manufacturer's approved methodology for replacing internal check valves.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Untimely Updates to Reactivity Tables and Graphs</b> Reactor engineering was slow to update reactivity tables in operating procedures and the full power zero axial offset detector currents in the plant computer after the plant achieved full power following the last refueling outage. The use of outdated tables and incorrect detector currents resulted in unanticipated core temperature responses following blended boron additions to the reactor coolant system, and during a plant power reduction. Operators took appropriate actions in response to minor Tave increases and the unexpected core responses. No power or significant temperature transients resulted and the operators were able to maintain maximum Tave below the Technical Specification limit
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5A <b>Ter:</b> 5C	<b>Good Overall Material Condition of Emergency Diesel Generators</b> The overall material condition of the emergency diesel generators (EDGs) was good. The EDG equipment appeared to be properly maintained and in adequate working condition. The system engineer was knowledgeable of the equipment condition, problems, and maintenance associated with the EDGs.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 5B <b>Ter:</b> 4A	<b>Acceptable Analysis and Actions Following Indian Point 2 Reactor Trip</b> The licensee conducted an acceptable review of the August 31, 1999, Indian Point 2 reactor trip complications for the purpose of assessing what actions, if any, should be taken to prevent a similar at Indian Point 3 (IP3); and had initiated appropriate actions to ensure that IP3 would not be vulnerable to a similar event
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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12/13/1999	1999009-10	<b>Pri:</b> ENG <b>Sec:</b>	NRC	URI	<b>Pri:</b> 4B <b>Sec:</b> 5A <b>Ter:</b> 5B	<b>Inadequate Review of Contractor Prepared Calculations for Degraded Voltage</b>  The licensee justified the operability of the electrical system under normal operating conditions. However, several opportunities were missed in the past to verify the adequacy of and correct the Technical Specification-defined minimum voltage at the 480 Volt buses. The missed opportunities were the result of inadequate review of licensee or contractor-prepared calculations. The issues regarding the minimum required voltage at the 480 Volt buses and the required relay settings are unresolved pending the licensee's calculations to address the voltage drop from the motor control center to the motor starter coils and the accuracy of the voltage sensing circuit
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008-03	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b> 5B	<b>Inadequate Commercial Dedication of Purchased Material, Equipment, and Services</b>  The licensee did not verify that a reactor coolant system flow transmitter procured as commercial-grade material could satisfactorily perform the pressure boundary safety function. The flow transmitter subsequently failed at high system pressure and caused an RCS leak that required operators to declare an Unusual Event. This is a Severity Level IV Violation of 10 CFR 50, Appendix B, Criterion VII, "Control of Purchased Material, Equipment, and Services." (NCV 50-286/99-08-03)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 4B	<b>Good Engineering Response to 10 CFR 21 Notification</b>  NYP&A reactor engineering demonstrated a proactive response to a 10 CFR Part 21 Notification by Rochester Gas & Electric by evaluating its potential impact on IP3, and by identifying errors and initiating corrections through Westinghouse to the existing design basis analysis of record for a main steam line break inside containment. (See LER 99-008)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999007-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b> 5A	<b>Failure to incorporate service water flow requirements into a design basis calculation and system test proced</b>  Engineering evaluation of the flow requirements described in the licensee's emergency operating procedures was not translated into the acceptance criteria of a service water flow performance test. Specifically, the back pressure resulting from the addition of a service water pump onto the non-essential header was not accounted for in the acceptance criteria nor the design basis calculation for the system
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005-06	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>Inadequate Test Control</b>  The licensee's development and implementation of a test connection modification to the isolation valve seal water system was poor in that it did not address significant issues associated with plant and personnel safety. Specifically, the modification did not identify the potential for a containment release path after a portion of the modification was installed. The failure to properly test the function of the tubing modification prior to placing it in the containment isolation boundary is a violation of 10 CFR Part 50, Appendix B, Section XI, "Test Control." However, this Severity Level IV Violation is being treated as a Non-Cited Violation because the issues were licensee identified and the corrective actions taken were adequate, consistent with Appendix C of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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09/13/1999	1999005-07	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4A <b>Ter:</b>	<b>RHR Operability Determination</b> The operability determination for an anomalous reading for a residual heat removal system flow transmitter was flawed and reflected weak engineering support to operations. As a result, corrective action to address this deficiency, such as venting the transmitter, was not performed and no additional actions planned until the issue was raised by the NRC. The failure to promptly correct a condition adverse to quality is a violation of 10 CFR Part 50, Appendix B, Section XVI, "Corrective Actions." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Digital Design Package</b> One design package did not contain a documented evaluation of all of the potential impacts of replacing a main generator protective relay with a microprocessor based digital model. Although this relay is not a safety-related component, it is important because a malfunction could result in a turbine and reactor trip. The licensee initiated DER-99-01019 to further evaluate this issue.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>DER Process</b> Although personnel are using the DER process to identify station deficiencies, the team identified several discrepancies related to an inconsistent understanding of management's expectations for the DER process. Specifically, personnel did not always initiate a DER to report low-level human performance deficiencies, and many did not understand the use of DER trend codes.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Corrective Action Program</b> Discrepancies were noted involving administration of the corrective action program. Examples include: deficiency tags in the field were not removed after repair work was completed, effectiveness reviews were not always completed, and a large backlog of DERs needed evaluation by the operations review group. As a result, evaluation of current and historical trends is difficult.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Design Modifications</b> In general, the design packages for plant modifications scheduled for implementation in the next refueling outage that were reviewed contained appropriate technical bases to support the change to be implemented. The safety evaluations associated with the modifications were thorough and provided appropriate bases for the conclusions reached in the evaluations.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Management Support for Open Work</b> The licensee management of the open engineering work on the systems reviewed was adequate to ensure system operability was not affected and engineering had developed appropriate action plans to resolve the significant issues affecting system reliability or availability.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						



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08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>System Engineering</b> The team found that system engineering was cognizant of and appropriately engaged with several equipment challenges which took place during the inspection. The technical adequacy of the support provided to the operations and maintenance departments was acceptable.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5C <b>Sec:</b> <b>Ter:</b>	<b>Engineering Support</b> Engineering provided appropriate support to the resolution of issues affecting component and system reliability and availability.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006-07	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 1C <b>Ter:</b>	<b>Temporary Modifications</b> The temporary modifications (TMs) reviewed were generally technically adequate. The team found a large number (77) of TMs, and some existed since 1990. Several TM implementation deficiencies were identified where procedures and drawings were not properly updated. In addition, a violation of 10 CFR 50, Appendix B, "Design Control" was identified for a failure to translate design basis requirements into a surveillance procedure. (NCV 99-06-01) The team did not identify any TMs that adversely affected system operability.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006-11	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 4B <b>Ter:</b>	<b>Assumption Errors</b> The inspectors identified three examples of engineering support to operations which contained technical or assumption errors, or where the design requirements were not properly translated into written procedures or calculations. None of the identified deficiencies resulted in an incorrect operability determination, but indicated engineering performance in this area could be improved. These are additional examples of violations of 10 CFR 50, Appendix B, "Design Control". (NCV 99-06-01) In addition to the corrective actions for each of the individual examples, the licensee has an ongoing project to validate the system design basis requirements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
08/09/1999	1999006-13	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>RWST Level Switch</b> The root cause evaluation and corrective action programs were generally effective. However, the team noted that timely and effective corrective actions had not been implemented for a degraded RWST level indicating switch. This is a violation of 10 CFR 50, Appendix B, "Corrective Actions". (NCV 99-06-02)
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
06/16/1999	1999003-02	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 5A <b>Sec:</b> 5B <b>Ter:</b>	<b>Inadequate Emergency Power Test</b> Licensee Event Report 50-286/99005: Incomplete testing of emergency power supply tie-breaker interlocks. On May 18, 1999, the licensee determined that a technical specification surveillance requirement for emergency power system testing was not met. While reviewing the emergency power supply breaker configuration for planning preventive maintenance, the license identified a condition where the emergency power supply breakers were in an untested condition due to a failure to properly test their associated tie-breaker interlocks. Specifically, two parallel contacts which provided permissive signals to the emergency diesel supply breakers were not tested independently. The inspector noted excellent performance on the part of the licensee's independent safety engineering group (ISEG) that identified this issue. This licensee identified and corrected violation of technical specification 4.6.A is being treated as a Non-Cited Violation, consistent with section VII.B.1 of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
05/05/1999	1999002-01	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Thermal Overloads</b> The licensee inadvertently installed undersized thermal overloads for the 32 boric acid transfer pump (BATP), when an engineer provided the work planners the incorrect overload specifications. As a result, the 32 BATP tripped prematurely during operation and, coupled with the 33 emergency diesel generator being out of service, placed the plant outside technical specifications. During preventive maintenance on the previous day, maintenance workers had identified that the overloads to be installed differed from those already installed, and initiated a deviation event report. However, the licensee did not aggressively pursue the deviation and did not raise concerns with operability until the pump tripped. This self-revealing deficiency was determined to be a Severity Level IV violation of 10 CFR 50, Appendix B, Section III, "Design Control." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001-02	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 4A <b>Sec:</b> <b>Ter:</b>	<b>Containment Vent Design Deficiency</b> NYPA took appropriate actions in response to a containment vent design deficiency, which resulted in the potential for a single failure vulnerability. The deficiency was determined to be non-risk significant. Although the licensee missed an opportunity to identify this deficiency in 1994 during the development of the design basis document for the containment system, this opportunity was deemed to be small. This NRC identified deficiency was determined to be a Severity Level IV violation of 10 CFR 50, Appendix B, Criterion 3, "Design Control." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This issue is in the licensee's corrective action process as deviation event report 99-0130.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001-03	<b>Pri:</b> ENG <b>Sec:</b>	NRC	NCV	<b>Pri:</b> 5B <b>Sec:</b> 4B <b>Ter:</b>	<b>Missing Shims on Chemical and Volume Control System Supports</b> The licensee did not perform a thorough extent of condition review to identify missing shims on the chemical and volume control system as evidenced by the NRC's identification of several additional missing shims. This NRC identified deficiency was determined to be a Severity Level IV violation of 10 CFR 50, Appendix B, Criterion 16, "Corrective Action." This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This issue is in the licensee's corrective action process as deviation event report 99-0320.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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02/10/1999	1998010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> <b>Ter:</b>	<b>Seismic Grating</b> The reasonable expectation of operability performed by engineering in response to a seismic qualification concern of grating in the diesel generator room was appropriate. The assumptions used in the evaluation were appropriate to the expected seismic conditions specified in the plant design.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> ENG <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Service Water Action Plan</b> The scope of the licensee's service water action plan was extensive and appropriately addressed equipment performance issues associated with the service water system. Based on the service water system improvements made by the licensee, the circumstances surrounding need for the notice of enforcement discretion was determined not to be a violation of NRC requirements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010-02	<b>Pri:</b> ENG <b>Sec:</b>	Licensee	NCV	<b>Pri:</b> 4B <b>Sec:</b> 4C <b>Ter:</b>	<b>Containment Vent Design Deficiency</b> The identification and resolution of a containment isolation valve testing deficiency due to a 75 pound spring loaded check valve, which may have invalidated the differential pressure conditions of a containment isolation valve leak test, was good. The corrective actions and extent of condition review for this test deficiency were appropriate. Notwithstanding, the original containment isolation valve leak test was inadequate and is a violation of 10 CFR Appendix B, Criterion V. However, because this issue was identified by the licensee, and adequate corrective actions were promptly taken upon discovery, this violation is being treated as a Non-Cited Violation.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
01/31/2000	1999010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> 5B <b>Ter:</b>	<b>Chemistry Sample</b> The inspector concluded that a watch chemist accurately analyzed and documented a routine primary coolant sample and analysis for boron in accordance with procedures.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
12/13/1999	1999009	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> 4A <b>Ter:</b> 5C	<b>Satisfactory Resolution of Large Water In-leakage to the Primary Auxiliary Building</b> The licensee's actions were effective in removing a large volume of rain water that leaked into the primary auxiliary building (PAB), and to cleanup the resulting spread of contamination into an uncontrolled area. The causes of the storm drain blockage were satisfactorily addressed by establishing a regular scheduled activity to inspect and cleanout storm drains outside the PAB
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	NEG	<b>Pri:</b> 3A <b>Sec:</b> 5B <b>Ter:</b> 5C	<b>Radiation Protection Plan</b> In response to unanticipated reactor containment building conditions, the radiation protection department did not provide effective guidance to preclude excessive personnel facial contaminations. Emergent issues associated with the reactor coolant temperature and the unavailability of a containment fan cooling unit were not well integrated in the radiation protection plan or the ongoing outage radiation protection work
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10/24/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Radiological Controls Effectively Implemented</b>  The licensee effectively implemented radiological controls during the current refueling outage. Access controls to radiologically controlled areas were applied effectively, and appropriate occupational exposure monitoring devices were provided and used. Personnel occupational exposure was maintained within applicable regulatory limits and as-low-as-is-reasonably-achievable. Also, the radiation work permit program was properly implemented
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Effective Implementation of surveys, monitoring, and control of radioactive materials</b>  Overall, the licensee implemented effective surveys, monitoring, and control of radioactive materials and contamination. Occupational exposure was maintained as-low-as-is-reasonably-achievable, self-assessment and corrective action processes in the area of radiation protection were effective
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
10/24/1999	1999008	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4C <b>Sec:</b> 3A <b>Ter:</b> 3C	<b>Security and Safeguards Activities</b>  Security and safeguards activities with respect to alarm station controls, communications, and protected area access controls were effectively implemented and met licensee commitments and NRC requirements. The level of management support was adequate to ensure implementation of the security program, and the security audit and self assessments were effectively implemented
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>EP Drill Performance</b>  Overall, the conduct of the emergency preparedness drill was good and the self assessment was thorough in identifying discrepancies and providing for program enhancements. The licensee's partial participation emergency exercise drill was developed and implemented in accordance with NYPA's emergency response procedures and the NRC guidelines for emergency preparedness.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Radwaste Program</b>  The solid radioactive waste management program continued to be effective based on proper implementation of the program by knowledgeable personnel, the existence of appropriate procedures and controls, and the acceptable condition of facilities and equipment. The Process Control Program documentation provided a complete and detailed description of the waste types generated, waste stream sampling and analyses performed, and waste processing methods used.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Radwaste Transportation</b>  The program to transport low level radioactive waste and other radioactive materials was effective. Overall, shipping manifests and supporting documentation were properly prepared, radiation and contamination limits were met, waste was properly classified, and shipments were properly typed as to their DOT class.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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09/13/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Radwaste Training</b> The NRC and DOT training and retraining requirements for radioactive waste group personnel were met. The training program for personnel involved with solid radioactive waste activities and with the transportation of radioactive materials remained well organized, fully implemented, and well documented.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
09/13/1999	1999005	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Plant Support Self-Assessments</b> Surveillances, self-assessments, and other methods used for problem identification and resolution were being performed in an effective manner. Surveillance reports identified items for corrective action. The two most recent self-assessments were detailed and identified numerous recommendations for improvement. Problems were being identified and put into the corrective action program, and appropriate and timely corrective actions were being instituted.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 4B <b>Ter:</b> 3A	<b>Calibration of Effluent Monitoring Systems</b> The licensee maintained an effective program for effluent RMS calibration. The System Engineer effectively monitored the system for operability and reliability problems and assured adequate maintenance of the system and supporting components. The licensee had no Y2K issues with respect to the effluent RMS.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 4B <b>Ter:</b> 3B	<b>Charcoal Adsorber Surveillance</b> The licensee established, implemented, and maintained an effective ventilation system surveillance program with respect to charcoal adsorption surveillance tests, high efficiency particulate (HEPA) and charcoal filter mechanical efficiency tests, and air flow rate tests.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 4B <b>Sec:</b> 3A <b>Ter:</b>	<b>Liquid and Gaseous Effluent Programs</b> The licensee maintained effective radioactive liquid and gaseous effluent control programs. The Offsite Dose Calculation Manual (ODCM) contained sufficient specification and instruction to acceptably implement and maintain the radioactive liquid and gaseous effluent control programs. The licensee established an effective program to comply with Inspection & Enforcement Bulletin (IE) 80-10 and 10 CFR 50.57(g) requirements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
06/16/1999	1999003	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Quality Assurance in RP&amp;C Activities</b> The licensee's QA program for effluent control was effectively implemented. The licensee's QC program to validate analytical results for the radioactive liquid and gaseous effluent control program was effective.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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05/05/1999	1999002	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 2A <b>Sec:</b> <b>Ter:</b>	<b>Radiological Controls</b>  Overall, radiological controls remained good. Routine walk downs revealed that radiological postings and barriers were appropriately implemented. Good contamination controls were observed, particularly after maintenance activities.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Sample Collection Activities</b>  The licensee effectively performed sample collection activities according to the MOU with Con Edison and according to the REMP procedures, conducted the land use, and maintained and calibrated the automatic sampling equipment. The licensee together with Con Edison effectively conducted a line by line comparison of both environmental TS. The licensee effectively provided program oversight and met the reporting requirements in the TS. The radiological environmental monitoring program was effectively implemented in accordance with regulatory requirements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3A <b>Sec:</b> <b>Ter:</b>	<b>REMP Evaluation</b>  The implementation of the REMP, relative to program oversight; sample collection methodology; material condition, operation, and calibration of automatic sampling equipment; Land Use Census; and reporting requirements, was evaluated for the period between January 1998 and January 1999.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 3B <b>Sec:</b> <b>Ter:</b>	<b>Memorandum of Understanding</b>  The licensee shares REMP responsibilities with Con Edison (Unit 2) through a memorandum of understanding. REMP samples were collected from the locations described in the TS by Con Edison. Sampling was performed according to the procedures and the schedule agreed upon by both stations. The automatic air sampling equipment were operable and calibrated. The automatic water compositors were operable. The heat trace on the compositors showed early signs of corrosion, which could lead to freezing of the sampling lines and missed samples. The land use census for 1998 was performed as required in the TS. The licensee prepared the annual Radiological Environmental Operating Report. The report provided a comprehensive summary of the results of the REMP for 1997 and met the TS reporting requirements.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
03/24/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> <b>Ter:</b>	<b>Sampling Technician Oversight</b>  The licensee provided program oversight by performing periodic reviews of sampling technicians and contract personnel, and periodic reviews of the sample data to ensure the program is implemented effectively. This was evident in one of the two self assessments performed by the licensee. The other self assessment was an independent review, performed by the radiological engineer, corporate. This assessment focused on laboratory practices, including quality control instrument calibration, and quality assurance. Both assessments were thorough and of appropriate technical depth to identify areas for improvement. Any areas for improvement that required action were assigned to the responsible personnel and were resolved.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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03/24/1999	1999001	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5B <b>Sec:</b> <b>Ter:</b>	<b>Quarterly Meetings</b> The licensee demonstrated improvement regarding communication with Con Ed through quarterly meetings. During each meeting, the licensee, together with Con Ed discussed self identified areas for improvement and audit findings, assigned action item to the responsible personnel for resolution. For example, as part of a response to an QA audit finding, the licensee's radiological engineer, radiological and environmental services and Con Ed's senior radiation specialist, nuclear environmental monitoring conducted a line by line comparison of both environmental TS. Minor differences were identified, addressed, and corrected.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Internal and External Radiological Exposure</b> The licensee implemented effective applied radiological controls. Access controls to radiologically controlled areas were effective, and appropriate occupational exposure monitoring devices were provided and used. Personnel occupational exposure was maintained within applicable regulatory limits and as low as is reasonably achievable (ALARA). The radiation work permit program was properly implemented.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> <b>Ter:</b>	<b>Radiological Controls - ALARA</b> The licensee implemented a very effective program to maintain occupational radiation exposure as low as is reasonably achievable (ALARA) and the ALARA efforts and results for 1998 were exceptionally good, including the management of radiologically significant work and a station record for lowest annual person-rem.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 1C <b>Sec:</b> 3A <b>Ter:</b>	<b>Radiological Controls</b> The licensee implemented overall effective surveys, monitoring, and control of radioactive materials and contamination. Health Physics technicians performed proper surveys and properly documented survey results. Radiological housekeeping conditions were noted to be good. The personnel contamination rate was tracked and trended. The radiological surveys, monitoring, and controls were implemented with calibrated and properly used devices.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						
02/10/1999	1998010	<b>Pri:</b> PLTSUP <b>Sec:</b>	NRC	POS	<b>Pri:</b> 5A <b>Sec:</b> 5C <b>Ter:</b>	<b>RP&amp;C Quality Assurance</b> The licensee's self identification and corrective action processes in the area of radiation protection were effective. A Quality Assurance audit, self-assessments, and the corrective action program continued to be effective in identifying, at a low threshold, deficiencies and improvement opportunities. Effective corrective actions were implemented for findings.
<b>Dockets Discussed:</b> 05000286 Indian Point 3						

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## Legend

### Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

### Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

### Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.