# **Initiating Events**

# **Mitigating Systems**



Identified By: Self Disclosing Item Type: NCV NonCited Violation

**Inadequate procedural adherance and incorrect valve line-up of the CVC system results in boration induced power transient.** 10 CFR 50, Appendix B, Criterion V, requires in part that activities affecting quality shall be accomplished in accordance with documented instructions, procedures, or drawings. Contrary to Criterion V, on March 14, 2002, operators did not properly configure the chemical and volume control system (CVCS) prior to a resin discharge evolution in accordance with the instructions in standard operating procedure SOP-CVCS-009A, "Resin Replacement - CVCS Demineralizers." The improper CVCS configuration resulted in a momentary automatic injection of diluted make-up water to the reactor coolant system (RCS) and a small increase in average RCS temperature, which required an immediate response by control room operators to heavily borate the RCS make-up water. This event of on low safey significance (Green) due to the minor change in reactor power (<0.5%).

Inspection Report# : 2002004(pdf)



Significance: Mar 30, 2002 Identified By: NRC

Item Type: FIN Finding IDENTIFICATION OF AN INADEQUATE RISK ASSESSMENT TO SCHEDULE A SAFETY INJECTION PUMP SURVEILLANCE TEST CONCURRENT WITH A SAFETY INJECTION ACTUATION LOGIC TEST

The inspectors identified an inadequate risk assessment that the licensee used to schedule a safety injection (SI) pump surveillance test concurrent with a safety injection actuation logic test. Simultaneous performance of these tests would have reduced the licensee's accident mitigation capability since it would have resulted in the unavailability of two SI trains Inspection Report# : 2002002(pdf)



Significance: Feb 21, 2002

Identified By: NRC Item Type: NCV NonCited Violation

INADEQUATE PROCEDURE FOR TRANSITION TO COLD SHUTDOWN DURING SHUTDOWN FROM OUTSIDE THE CONTROL ROOM

The team identified a non-cited violation of 10 CFR 50, Appendix R for failure to have adequate procedures to achieve cold shutdown conditions within 72 hours following a fire. The team found that the procedures for shutdown from outside of the control room did not provide sufficient direction to assure that pressurizer pressure could be reduced to allow initiation of the residual heat removal system for decay heat removal in sufficient time to ensure that cold shutdown could be achieved within 72 hours of plant shutdown. A delay in achieving cold shutdown following a fire that required shutdown from outside of the control room was considered a credible impact on safety. This finding was of very low safety significance because the likelihood of a fire that could necessitate a shutdown from outside of the control room and cause a loss of reactor coolant system letdown capability was small.

Inspection Report# : <u>2001012</u>(*pdf*)

# **Barrier Integrity**

**Emergency Preparedness** 

4Q/2002 Inspection Findings - Indian Point 3

**Significance:** N/A May 18, 2002 Identified By: NRC Item Type: NCV NonCited Violation

No Color. On March 6, 2002, the licensee implemented changes to the accountability process that decreased the effectiveness of the Emergency Plan (E-Plan). This finding was considered more than minor because, if left uncorrected, it could become a more significant safety concern. Changing commitments in the E-Plan without prior approval potentially impacts the NRC's ability to perform its regulatory function, and potentially creates an ineffective response to a radiological emergency. The consequences of this change were minimal because, although delayed, it did not preclude the function of accountability from being performed. The licensee has entered this deficiency into the corrective action system as condition report CR-IP3-2002-00773, has implemented corrective actions, and has since met the timeliness goals. However, the change in the accountability process, which decreased the effectiveness of the E-Plan, was determined to be a violation of 10 CFR 50.54(q), and is being treated as a Non-cited Violation consistent with Section VI.A.1 of the Enforcement Policy, issued May 1, 2000 (65 FR 25388). Inspection Report# : 2002003(*pdf*)

### **Occupational Radiation Safety**

### **Public Radiation Safety**

### **Physical Protection**

### Miscellaneous

Significance: N/A Oct 03, 2002
Identified By: NRC
Item Type: FIN Finding
Overall implementation of the corrective action program at Indian Point 3 was adequate.
The NRC inspection team concluded that the overall implementation of the corrective action program at Indian Point 3 was adequate. In general, the threshold for problem identification was appropriate and problems were properly identified, evaluated and corrected. Problem

general, the threshold for problem identification was appropriate and problems were properly identified, evaluated and corrected. Problems were entered into the corrective action program at an appropriate threshold. The licensee adequately prioritized and evaluated issues, and their evaluations were of adequate depth to identify the causes and appropriately broad in considering the extent of condition. The corrective actions were reasonable and adequately implemented.

Inspection Report# : <u>2002006</u>(*pdf*)

Last modified : March 25, 2003