

August 9, 2001

Mr. A. Alan Blind
Vice President - Nuclear Power
Consolidated Edison Company of
New York, Inc.
Indian Point 2 Station
Broadway and Bleakley Avenue
Buchanan, NY 10511

SUBJECT: INDIAN POINT 2 NUCLEAR POWER PLANT - NRC SUPPLEMENTAL
INSPECTION REPORT NO. 05000247/2001-007

Dear Mr. Blind:

On June 25, 2001, the NRC completed a supplemental inspection at your Indian Point 2 Nuclear Power Plant. The enclosed report documents the inspection findings which were discussed with you, Mr. John Groth, and other members of your staff.

Last year, the NRC determined that three White findings existed within the emergency preparedness (EP) cornerstone area (Inspection Report 05000247/2000-006). The White findings that resulted from the February 15, 2000, steam generator tube failure event were the lack of capability to: (1) perform timely augmentation of the emergency response organization, (2) perform timely accountability of onsite radiation emergency workers, and (3) consistently disseminate information to the media and the notification of local officials. Under the NRC's Reactor Oversight Program, these findings resulted in the EP cornerstone being degraded.

This supplemental inspection was conducted to provide assurance that the root causes and contributing causes of the three White findings were understood, to independently assess the extent of the condition, and to provide assurance that the corrective actions to risk significant performance issues were sufficient to address the causes, and to prevent recurrence. To accomplish these objectives, the inspectors reviewed your root cause analysis and evaluation of extent of condition and conducted an independent inspection to assess your conclusions. The inspection team also evaluated progress made in the emergency preparedness area through the past year by reviewing resident inspector observations and the findings from the supplemental inspection (Inspection Report 50-247/2001-002). Importantly, the NRC evaluated your June 21, 2001, exercise to assess your efforts to implement corrective actions and to enhance your emergency response performance and capability.

Based on our inspection, we concluded that your staff performed a sufficiently broad evaluation of the emergency preparedness program, and took corrective actions that effectively address the underlying causes of the three White findings. Further, performance during the exercise on June 21, 2001, demonstrated your proficiency.

The NRC has determined that your actions are acceptable in addressing these White findings. As such, these findings will be removed from the Action Matrix at the end of this quarter. Although the emergency preparedness cornerstone is no longer considered degraded, your facility is maintained under the Multiple/Repetitive Degraded Cornerstone column of the NRC's Action Matrix due to other inspection findings. As noted in the NRC's Annual Letter of May 31, 2001, inspections to assess these issues have been scheduled for later this year. Regarding emergency preparedness, the NRC will continue to monitor this area through baseline inspections and oversight of your performance improvement plan.

The inspectors identified one violation of NRC requirements. However, because of its very low safety significance (Green) and because it has been entered into your corrective action program, the NRC is treating this issue as a non-cited violation, in accordance with Section VI.A.1 of the NRC's Enforcement Policy. If you deny this non-cited violation, you should provide a response with the basis for your denial, within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Indian Point 2 Generating Station.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Sincerely,

/RA by William H. Ruland for/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 05000247
License No. DPR-26

Enclosure: NRC Inspection Report No. 05000247/2001-007

cc w/enclosure:

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Mr. A. Alan Blind

-4-

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U.S. NUCLEAR REGULATORY COMMISSION

REGION I

Docket No: 05000247

License No: DPR-26

Report No: 05000247/2001-007

Licensee: Consolidated Edison Company of New York

Facility: Indian Point 2 Nuclear Power Plant

Location: Buchanan, New York 10511

Dates: June 18 - 25, 2001

Inspectors/Evaluators: D. Silk, Sr. Emergency Preparedness Inspector, DRS, RI
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Observer: Robert Reynolds, FEMA Region II, Regional Assistance
Committee Chairman

Approved by: Richard J. Conte, Chief
Operational Safety Branch
Division of Reactor Safety

* Indicates that personnel were only involved in the exercise evaluation portion of the inspection.

SUMMARY OF FINDINGS

IR 05000247/01-007; on 06/18/2001-06/25/2001; Consolidated Edison Co; Indian Point 2 Nuclear Power Plant; Exercise Evaluation, Performance Indicator Verification, Supplemental Inspection Report - Degraded Cornerstone.

This supplemental inspection was performed by regional specialists and the resident inspector. The significance of most findings is indicated by their color (Green, White, Yellow, or Red) using IMC 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply are indicated by "No Color." The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described at its Reactor Oversight Process website at <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.

Cornerstone: Emergency Preparedness

A. Supplemental Inspection Findings

This supplemental inspection was performed by the NRC to assess the licensee's evaluation of three White findings in the emergency preparedness area that were identified from the February 15, 2000, steam generator tube failure event which were the lack of capability to: (1) perform timely augmentation by the emergency response organization, (2) perform timely accountability of onsite radiation emergency workers, and (3) consistently disseminate information to the media and the notification of local officials. These three findings were previously characterized as having low to moderate safety significance (White) in NRC Inspection Report 05000247/2000-006. During this supplemental inspection performed in accordance with Inspection Procedure 95002, the inspectors determined that the licensee performed an adequate evaluation of the issues associated with the three White findings.

The licensee's evaluation was strongly self-critical; it identified the primary root cause of the performance issues to be insufficient senior management attention to emergency planning matters. The evaluation identified problems with emergency planning section effectiveness as the direct cause of most of the EP performance issues. The licensee identified competing station priorities, flaws in management processes, insufficient involvement with industry peers, and a non-standard corporate policy on emergency communications as contributing causes. The licensee has taken actions to address these causes. Licensee senior management has supported soliciting and receiving outside contractor assistance from a variety of sources, and installing and using a revised automatic responder call-out system. The licensee has revised its emergency personnel accountability procedures to align more closely with industry practices. Additionally, the emergency communication function during declared radiological emergency conditions has been transferred to the licensee's nuclear organization to provide more timely and accurate information to the public regarding the status of any declared emergency.

Due to the licensee's acceptable performance in addressing these three issues, the White findings associated with these issues are closed in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program."

B. Baseline Inspection Findings

Emergency Preparedness

Green. A non-cited violation of 10 CFR 50.54(q) was identified. Licensees are to maintain and follow their emergency plan. The NRC determined that the licensee did not conduct a bi-weekly silent test within the required periodicity as specified in Section 6.6 of the emergency plan during December 2000. This was considered to be more than minor because of a delay in identifying and repairing sirens that would have been utilized to notify portions of the public in the event of a radiological emergency. However, there have been no significant problems with the sirens, the test results are in the green band for the siren testing performance indicator, and route alerting was available to compensate for any inoperable sirens. Under the significance determination process, the finding was considered to be of very low safety significance. (Section 40A1)

Report Details

A. Supplemental Inspection

Background

This inspection was performed by the NRC to assess the licensee's evaluation associated with three White findings documented from a special follow-up inspection (Inspection Report (IR) 05000247/2000-006) of emergency preparedness (EP) issues identified during a steam generator tube failure event occurring on February 15, 2000. These findings involved failures to meet the planning standards associated with emergency response organization (ERO) augmentation, accountability of onsite emergency workers, and dissemination of information to the public. These performance issues were characterized as having low to moderate risk significance (White) in IR 05000247/2000-006 and were related to the EP cornerstone in the reactor safety strategic performance area.

01 Inspection Scope (95002)

To assess the licensee's evaluation and corrective actions, the inspectors 1) reviewed documentation related to the licensee's evaluation of the causes of the White findings and the corrective actions (see attachment, Documents Reviewed); 2) interviewed various EP personnel, contractors, and other licensee personnel responsible for correcting or implementing the EP program; and 3) assessed the licensee's performance during the June 21, 2001 partial-participation exercise (Section 2.04)

02 Evaluation of Inspection Requirements

02.01 Problem Identification

- a. Determination of whom (i.e., licensee, self-revealing, or NRC) identified the issue and under what conditions.

The problems (augmentation, accountability, and dissemination of information to the media) were self-revealing in the February 15, 2000, steam generator tube failure event. In a special inspection following the event, the NRC determined the three findings to be of White significance as defined above (Background Section).

- b. Determination of how long the issue existed, and prior opportunities for identification.

It was unclear as to how long these specific problems existed. The licensee conducted a five year look-back at all EP issues identified in drill reports, audit reports, self-assessments, and NRC inspection findings to determine the history and overall status of the Indian Point 2 EP program. This five year review reasonably bounded the existence of these problems.

- c. Determination of the plant-specific risk consequences (as applicable) and compliance concerns associated with the issue.

The licensee's root cause evaluation did not address the risk consequences of the White issues that were identified by the NRC in IR 05000247/2000-006, furthermore, a plant specific probabilistic risk assessment is not applicable to the EP area. Since the licensee's root cause evaluation was very broad in scope (covering the licensee's entire EP function), it was not possible for the licensee to address the risk consequences of the evaluation. However, the licensee performed assessments of its compliance with the risk-significant and non-risk significant planning standards of 10 CFR 50.47(b), as well as, the requirements of Appendix E to Part 50. The licensee determined that its program met the above requirements. Based upon the most current inspection results, the inspectors concurred with the licensee's assessment.

02.02 Root Cause and Extent of Condition Evaluation

- a. Evaluation of methods used to identify root causes and contributing causes.

The licensee used event and causal factor as well as barrier analyses in its identification of the root cause for the issues analyzed. The root cause team was led by a contractor who was no longer at the site and, therefore, the worksheets detailing the methodologies used were unavailable for inspection. However, the licensee's root cause evaluation contained an overview schematic that showed an application of the event and causal factor analysis. The methods used by the licensee were adequate for such a broad evaluation.

- b. Level of detail of the root cause evaluation.

The licensee's evaluation was of a sufficient level of detail and identified the primary root cause of the performance issues to be insufficient senior management attention to emergency planning matters. The evaluation identified problems with emergency planning section effectiveness as the direct cause of most of the EP performance issues. The licensee identified competing station priorities, some flaws in management processes, an isolationist culture (the EP staff had minimal involvement in industry bench marking and initiatives), and a non-standard corporate policy on emergency communications as contributing causes. The licensee performed an adequate evaluation of the issues associated with the three White findings.

- c. Consideration of prior occurrences of the problem and knowledge of prior operating experience.

The licensee's July 13, 2000, root cause evaluation, which included a review of EP issues for the previous five years, noted that deficiencies had been identified in several aspects of the EP program. The root cause evaluation referenced the reactor trip incident of August 31, 1999, the NRC's evaluation of the 1999 exercise, and the steam generator tube rupture event of February 15, 2000, in determining an overall decline in performance of the emergency planning section. The evaluation's problem statement listed several NRC inspection reports, quality assurance audit and self-assessment findings that supported this

determination. The inspectors assessed the licensee's consideration of prior occurrences as comprehensive.

- d. Consideration of potential common cause(s) and extent of condition of the problem.

The licensee's evaluation considered the potential for common cause and extent of condition associated with the three White findings. The scope of the evaluation was expanded beyond the three White findings to examine a broad spectrum of programmatic, hardware and human resource concerns. The licensee refined the evaluation's adequacy further by retaining an industry peer review team to challenge the conclusions and to provide additional industry perspective to the evaluation team. Overall, the licensee's review of its entire program was thorough and substantiated the identified causes.

02.03 Corrective Actions

The corrective actions identified as a result of the root cause evaluation were based on a review of the root cause evaluation and the licensee's overall program assessment. Each subparagraph of this section of the report will include sections that address the individual inspection requirements as they relate to each of the findings.

- a. Appropriateness of corrective action(s)

The licensee's corrective action recommendations resulting from the root cause evaluation were appropriately geared to the level of the identified causes. Corrective action recommendations of the evaluation include the following:

- Taking aggressive steps to continue upgrading the emergency planning section through training, staffing and reassigning tasks to other organizations
- Strengthening and clarifying station policy with respect to ERO participation
- Increasing management and station-wide visibility of emergency planning performance
- Including station emergency response performance in the management incentive process
- Conducting an assessment of ERO training needs and establishing a fully effective EP training program
- Developing and implementing a specific drill and exercise program that includes appropriate administrative controls, industry good practices, challenging scenarios, and focused training activities
- Including EP needs into the current yearly business plan

- Developing and implementing an emergency planning departmental self-assessment program
- Enhancing the formal emergency planning audit process
- Conducting an in-depth evaluation of the EP program compliance with NRC planning standards
- Conducting a thorough evaluation of the company policy of media communications

i. ERO Augmentation

Actions taken to improve the ERO augmentation were appropriate to the root and direct causes identified in the licensee's evaluation. Responsibility for activation of emergency response pagers was transferred from the corporate communications group to the site security organization and then to the on-shift operations staff. Implementing procedures were revised and personnel were trained to ensure that responders report immediately to their emergency facilities. Station management showed support for improvement of the method of ERO augmentation by approving the:

- changing the emergency pagers to a common pager company
- upgrading to a more streamlined and rapidly mobilized notification system
- augmenting the emergency planning section by the addition of a contractor resource to develop the new system
- distribution of letters from the chief nuclear officer to all ERO members to emphasize management commitment to timely emergency response
- conduct of weekly pager tests, monthly off-hours call in tests and two off-hours report-in drills using the new system to train personnel and identify potential activation problems

ii. Onsite Personnel Accountability

Actions taken to improve personnel accountability during emergencies were appropriate to the root and direct causes identified in the licensee's evaluation. The licensee revised its accountability procedures to require that accountability be performed at either a site area emergency (SAE) or a general emergency (GE) declaration, rather than at an alert declaration as had been the requirement at the time of the February 15, 2000 event. This practice eliminated competition between the priorities of emergency response facility activation and personnel accountability. Responders and security guard force members were trained on the requirements to report immediately to assigned emergency facilities. Non-essential personnel were trained to report to the onsite energy education center. This practice established a central reporting point for these personnel that simplified the need to establish continuous accountability. Station management showed support for improvement of the accountability function by approving the conduct of four accountability drills during calendar year 2000, at least two of which were conducted during site outage conditions. Implementing procedures were revised to provide greater flexibility for decision-makers either to pre-emptively conduct an accountability at an alert declaration or to defer the conduct of accountability based on prevailing emergency conditions.

iii. Dissemination of Public Information

The licensee established a time commitment for activating the news center after the declaration of an alert, SAE, or GE. The emergency planning organization (versus the corporate office) has asserted more influence over news center activities. The organizational structure of the news center has been modified to achieve timely and accurate dissemination to the media. A formal training program was developed and implemented for news center staff qualification. Since the February 15, 2000, event, seven drills have been conducted by the licensee which have included the activation and participation of the news center to improve performance and proficiency. Drill performances at the news center are critiqued which has resulted in further refinements to the facility, organization, and procedures. The EP department developed and is responsible for the news center procedure. Changes to that procedure are now receiving a 10CFR50.54(q) review by the licensee to determine if a decrease in the effectiveness of the emergency plan has occurred.

b. Prioritization of corrective actions

Actual corrective actions were in progress before the root cause evaluation was completed. The licensee's actions related to the root and direct causes of the overall evaluation were appropriately prioritized. The licensee brought in additional contractor support within three months of the completion of the root cause evaluation and have continued to augment the emergency planning staff.

i. Emergency Response Organization Augmentation

The licensee's conduct of an off-hours augmentation drill on April 17, 2000, was 62 days after the February 15, 2000, event. The demonstration by station management of its commitment to ensuring timely augmentation of the response organization and activation of emergency response facilities showed an appropriate prioritization of the corrective actions for this issue.

ii. Onsite Personnel Accountability

The conduct of four accountability drills within 120 days of the February 15, 2000, event showed an appropriate prioritization of these corrective actions. The fact that at least two of these accountability drills were conducted during outage activities demonstrated the licensee's willingness to prioritize EP considerations among competing station priorities.

iii. Dissemination of Public Information

Drills to improve performance issues at the news center began taking place on April 17, 2000, which was 62 days after the February 15, 2000, event. This drill primarily focused on the mobilization of news center staff and facility activation. The inclusion of the news center in this and other subsequent drills had not been previously practiced by the licensee. The conduct of training and drills, and the licensee's commitment of resources to correct and enhance the news center's functionality demonstrated renewed accountability to asserting influence over the news center activities.

c. Establishment of schedule for implementing and completing the corrective actions.

Prior to the event, the licensee had initiated some corrective actions to address previously identified issues. After the event, the licensee expedited and expanded previous corrective actions and developed new ones. Many corrective actions began shortly after the February 15, 2000, event. The licensee has sufficiently completed corrective actions to address these White findings. Comments generated from drills or exercises, audits, self-assessments, or inspections are processed through the licensee's corrective action program to provide ongoing enhancements of these and other areas of the EP program.

d. Establishment of quantitative or qualitative measures of success for determining the effectiveness of the corrective actions to prevent recurrence.

The licensee's conduct of extensive drills is the method by which it has measured the effectiveness of the corrective actions taken. These drills have resulted in refinements to the licensee's corrective actions for each of the three individual issues.

i. Emergency Response Organization Augmentation

The results of licensee augmentation drills showed the need to consolidate emergency pagers under one vendor and to use optimum frequencies. Drill performance analysis also resulted in the transfer of the pager activation function from the security organization to the control room staff.

ii. Onsite Personnel Accountability

The licensee's drill results showed the need to rewrite the accountability procedure to direct personnel accountability at an SAE or GE declaration, rather than at an alert declaration. The licensee also performed industry benchmarking to support this change.

iii. Dissemination of Public Information

Drills have resulted in changes to the facility equipment, procedures, staffing, and the organizational structure of the news center. These changes have occurred to support the goal of timely and accurate dissemination of information to the public. Contractors and consultants were utilized by the licensee to assess the various aspects of the news center to be on par with other news centers.

02.04 Independent Assessment of Extent of Condition and Generic Implications

The licensee's root cause evaluation was broad in scope and the causes described in it affected the licensee's entire EP function. Similarly, the extent of conditions of the root and direct causes were correspondingly broad and pervasive of the entire EP cornerstone. The inspectors made their assessment primarily based on drill and exercise observation. Regional inspectors considered licensee performance during drills through observations by the resident inspectors. Also, the EP program implementation was reviewed in depth during an earlier supplemental inspection (Inspection Report 05000247/2001-002). In this inspection, the inspectors evaluated the effectiveness of corrective actions regarding management support for EP and the emergency planning section performance. This was accomplished primarily through independent evaluation of the licensee's performance during the June 21, 2001, partial-participation exercise. The inspectors evaluated the following onsite areas during their exercise observation:

- Performance aspects and procedural implementation related to the White findings (ERO augmentation, accountability, and dissemination of information)
- The ERO's overall performance and ability to implement the emergency plan to ensure protection of public health and safety by recognizing abnormal plant conditions, demonstrating command and control, maintaining intra- and inter-facility communications, prioritizing mitigation activities, utilizing repair and field monitoring teams, and interfacing with offsite agencies.

- The material adequacy of the following emergency response facilities: simulator control room, the technical support center, the operations support center, the emergency operations facility, and the joint news center.
- The licensee's implementation of the risk-significant planning standards (RSPS) in 10 CFR 50.47 (b) (4), (5), (9) & (10) which are emergency classification, offsite notification, radiological assessment, and protective action recommendations, respectively.
- The post-exercise critique to evaluate the licensee's self-assessment of their ERO performance.

The inspectors did not identify any adverse impact on the above functions that could be attributed to the root or direct causes identified in the licensee's evaluation. The critique was thorough and appropriately self-critical. The licensee appropriately identified performance issues during the exercise and entered them into the corrective action program. Overall, the licensee's performance was an improvement from the June 1, 2000, NRC evaluated exercise and the licensee still continues to demonstrate its ability to implement its emergency plan and procedures to ensure adequate protection of the public health and safety.

Other independent assessments of the extent of condition included a review of the licensee's process for granting ERO members access to the site. Specifically, the inspectors verified that the licensee has a process in place for verifying if emergency responders are fit for duty and how to address individuals who have consumed alcohol within five hours of reporting to the site.

Another part of the independent assessment addressed the staffing of the news center. At the time of the February 15, 2000 event, the news center was mostly staffed with licensee personnel from the corporate office. Corrective actions have resulted in staffing the news center with personnel from the site. If Indian Point Unit 2 is sold, the new licensee will have to staff the news center entirely with personnel from the site. The inspectors determined that 54 of 94 of the current news center staff were comprised of site personnel and that each position has at least one back-up that is available. The EP manager has a plan in place to further increase the news center staffing with additional site personnel and to utilize personnel from neighboring Indian Point Unit 3, which uses the same news center, and is owned by the prospective buyer of Unit 2.

B. Baseline Inspection

EP4 Emergency Plan Reviews

a. Inspection Scope

The inspector conducted an in-office review of licensee-submitted changes for several EP documents to determine if the changes decreased the effectiveness of the plan. The review assessed all emergency plan changes and implementing procedures related to the risk significant planning standards in 10 CFR 50.47(b). Implementing

procedures not directly related to the risk significant planning standards received a cursory review. Documents reviewed included:

Emergency Plan (Rev 01-01, 01-01a, 01-01c)
 IP-1001, Mobilization of Onsite Emergency Organization (Rev 11, 12, 13)
 IP-1002, Emergency Notification and Communication (Rev 22, 23, 24)
 IP-1003, Planned Discharge of Containment to Atmosphere During Accident Conditions (Rev 7)
 IP-1005, MS-2 / SPA-3 to Determine Thyroid Burdens - CANCELED
 IP-1006, Site Perimeter Survey - CANCELED
 IP-1010, Central Control Room (CCR) (Rev 0, 1, 2)
 IP-1011, Joint News Center (Rev 2, 3)
 IP-1012, On-Site Medical Emergency (Rev 10)
 IP-1015, Radiological Surveys Outside the Protected Area (Title Change) (Rev 8)
 IP-1019, Coordination of Corporate Response (Title Change) (Rev 9)
 IP-1020, Airborne Activity Determination (Rev 8)
 IP-1023, Operations Support Center (Rev 14, 15)
 IP-1024, Emergency Classification (Rev 8)
 IP-1026, Emergency Data Acquisition (Rev 0)
 IP-1027, Personnel Accountability and Evacuation (Rev 12, 13)
 IP-1028, Onsite (Out of Plant) Surveys - CANCELED
 IP-1030, Emergency Operations Facility (Rev 3, 4)
 IP-1032, Tornado Emergency - CANCELED
 IP-1035, Technical Support Center (Rev 16)
 IP-1039, Offsite Contamination Checks (Rev 9)
 IP-1040, Relocation of Personnel Dosimetry Facilities - CANCELED
 IP-1041, Use of Triton or Monitoring Radiogas - CANCELED
 IP-1042, In-Plant Radiological Surveys and Sampling - CANCELED
 IP-1045, Alternate Emergency Operations Facility (AEOF) (Rev 9)
 IP-1046, Responsibilities of Con Edison Personnel During Emergencies at Unit No.3 - CANCELED
 IP-1050, Security (Rev 0)
 IAP-10, Shift Manager - CANCELED
 IAP- 12, Watch Health Physics Technician (WHPT) - CANCELED

b. Observations and Findings

Procedures that were canceled were either incorporated into other emergency plan implementing procedures or were appropriately addressed by other plant procedures. No findings of significance were identified.

4. OTHER ACTIVITIES

4OA1 Performance Indicator Verification

a. Inspection Scope

The inspectors reviewed the licensee's process for identifying the data that is utilized to determine the values for the three EP performance indicators (PI):

- Drill and Exercise Performance (DEP)
- ERO Drill Participation, and
- Alert and Notification System (ANS) Reliability.

Since the EP PIs were last reviewed during an inspection in May 2000, this review assessed data and records from that time which included results from the second quarter of 2000 through the first quarter of 2001.

b. Findings

The inspectors identified a non-cited violation of very low safety significance for not conducting a bi-weekly silent test as specified in the licensee's emergency plan. While reviewing siren test records, it was determined that during the December 2000 time frame, the license did not conduct a bi-weekly silent test within the required periodicity as specified in the licensee's emergency plan. The licensee was unaware of this oversight and upon investigation attributed this occurrence to communications problem and limited personnel availability due to vacations and the holidays during that time of the year.

During that time, tests were conducted on November 28, 2000; December 18, 2000; and January 9, 2001. There was no allowance in the licensee's program for extending the periodicity beyond two weeks. Also, when the sirens were tested on December 18, 2000, and January 9, 2001, three and five sirens were found to be inoperable, respectively. This issue effects the emergency planning cornerstone and was determined to be more than minor because there was a delay in detection and repair of the sirens. Historically, there have been no significant problems with the sirens, and the ANS PI test results were in the Green band (a 99.1% average for the year 2000). Also, route alerting was available to compensate for inoperable sirens.

This is a violation of NRC regulations. 10 CFR 50.54(q) states, in part, that licensees are to follow their emergency plan. Section 6.6 of Emergency Plan for Indian Point Unit Numbers 1 and 2 states, in part, that silent tests for the ANS are to be conducted bi-weekly. This issue was evaluated under the significance determination process as a failure to meet a regulatory requirement but not a failure to meet a planning standard. Therefore, the issue was determined to be of very low safety significance (Green) and is a non-cited violation consistent with Section VI.A.1 of the NRC Enforcement Policy. **(NCV 05000247/2001-007-01)** The licensee has entered this item into its corrective action program as Condition Report 200106275.

03. Management Meetings

Exit Meeting Summary

The inspectors presented the inspection results to Mr. J. Groth, and other licensee personnel at the conclusion of the inspection on June 25, 2001. The licensee acknowledged the findings presented.

ATTACHMENT

Supplemental Information

KEY POINTS OF CONTACT

Licensee

Jim Baumstark, Vice Present Nuclear Engineering
Alan Blind, Vice President Nuclear Power
Cindy Brovanski, Communication
John Curry, Engineering
Tony Ferarro, Emergency Planning
John Groth, Chief Nuclear Officer
Steve Hook, Emergency Planning
Frank Inzirillo, Emergency Planning Manager
Bob Masse, Plant Manager
Michael Miele, Radiation Protection/Chemistry
Dave Morris, Nuclear Quality Assurance
Tom Noonan, Business Services
Anthony Spaziani, Nuclear Safety and Licensing
Sofia Toth, Entergy
Kelly Walker, Emergency Planning

NRC

William Raymond, Senior Resident Inspector

Federal Emergency Management Agency, Region II

Robert Reynolds, Chief, Training, Exercises, and Evaluation Branch

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

None

Closed

EA No. 00-155 (Violations for the three White findings from IR 50-247/2000-006)

Discussed

None

DOCUMENTS REVIEWED*

Emergency Plan and Implementing Procedures:

Emergency Plan for Indian Point Nos. 1 and 2, Rev 01-01a
IP-1001 Mobilization of Onsite Emergency Organization, Rev 13
IP-1002 Emergency Notification and Communication, Rev 24
IP-1010 Joint News Center, Rev 1 & 2
IP-1027 Personnel Accountability and Evacuation, Rev 13
IP-1030 Emergency Operations Facility, Rev 4
IP-1050 Security, Rev 0

Other Licensee Procedures:

EP-AD-04, Maintenance of Emergency Response Organization (ERO) Rosters and Telephone Numbers, Rev 0
Indian Point Emergency Telephone Directory, Rev 01-05
Emergency Preparedness Self-Assessment & Performance Indicator Program, Rev 1
SAO-113, Corrective Action Program, Rev 3

Miscellaneous Documents:

Root Cause Evaluation of the Causes of Emergency Preparedness Deficiencies at the Indian Point Unit 2 Nuclear Station, dated July 13, 2000

September 8, 2000, Consolidated Edison letter replying to Notice of Violation from the NRC dated August 9, 2000.

Assessment of Emergency Planning Risk Significant Planning Standards at Indian Point 2 Relative to the Findings of the "IP2 Emergency Planning Root Cause Analysis"

Assessment of Emergency Planning Non-Risk Significant Planning Standards at Indian Point 2 Relative to the Findings of the "IP2 Emergency Planning Root Cause Analysis"

Assessment of the Requirements of 10CFR50 Appendix E at Indian Point Unit 2 Relative to the Findings of the "IP2 emergency Planning Root Cause Analysis"

White Paper - Review of the Emergency Planning White Findings from NRC Report No. 5000247/2000-006, dated June 19, 2001

Self-Assessment of Emergency Response Organization Performance at Indian Point Station - Year 2000, Rev 0

Indian Point 2 Generating Station - NRC Inspection Report No. 50-247/2000-006

Indian Point Unit 2 - NRC Supplemental Inspection Report No. 50-247/2001-002

Summary of Performance Evaluations - Emergency Preparedness Off-Hours Mobilization Drill May 9, 2001

Summary of Performance Evaluations - Emergency Preparedness Off-Hours
Mobilization Drill June 4, 2001

* - Does not include all procedures reviewed in preparation for the exercise evaluation