Indian Point 2

Initiating Events

Significance: G Aug 10, 2002
Identified By: Self Disclosing
Item Type: FIN Finding
CONTRACTOR WORKED OUTSIDE HIS ESTABLISHED JOB SCOPE FOR LANDSCAPING ACTIVITIES
On July 19, 2002, a contractor worked outside his established job scope for landscaping activities. The consequences of this human performance error were the accidental electrocution of the individual and an offsite power electrical transient (loss of the 138 kilovolt station auxiliary transformer for approximately seven hours). This partial loss of offsite power event was more than minor, in that it impacted the reactor safety cornerstone with respect to the initiating event objective of limiting the likelihood of an event that upsets plant stability and challenges the critical safety function of the on-site emergency diesel generators. Notwithstanding the loss of life (which the Department of Labor, Occupational Safety and Health Administration is reviewing), this electrical transient event was of very low safety significance because it did not contribute to the likelihood of: loss of coolant accidents, a reactor trip and the unavailability of accident mitigation equipment or functions being unavailable; or of a fire or internal/external flood. No violations of NRC requirements were identified.
Inspection Report# : 2002005*(pdf)*

Significance: G May 11, 2002
Identified By: Self Disclosing
Item Type: FIN Finding
REDUCTION OF PLANT POWER BY CONTROL ROOM OPERATORS DUE TO CONDENSATE PUMP MOTOR FAILURES
On April 20, 2002, and on May 8, 2002, the control room operators reduced plant power due to condensate pump motor failures. A lack of a predictive maintenance program and an improperly set oil level indication system were the causes for two separate condensate motor failures. The events are more than minor since both events increased the likelihood of an initiating event. Operator response was necessary to ensure an automatic reactor trip did not occur due to a low steam generator level. The performance issues were of very low safety significance since there was no impact to normally available mitigating equipment.
Inspection Report# : 2002003*(pdf)*

Significance: G Mar 30, 2002
Identified By: NRC
Item Type: FIN Finding
INAPPROPRIATE PROCEDURE FOR INOPERABLE STATION AUXILIARY TAP CHANGER
The procedure in use was inappropriate in that it did not require that the 138 kilovolt off-site power system be declared inoperable during scheduled maintenance on the station auxiliary transformer (SAT) tap changer. On February 28, 2002, for approximately 51 minutes, control room operators had placed the SAT tap changer in manual and local control in accordance with system operating procedure (SOP) 27.1.7, "Operation of Main, Station and Unit Auxiliary Transformers," section 4.8. The scheduled maintenance was not intrusive into tap changer operation, however, the licensee had not fully evaluated if the intended function could be maintained with operator compensatory actions to restore the tap changer to automatic. The limiting condition for operation in technical specification 3.7.B.3 for a loss of the 138 kilovolt power system is 24 hours, which was not exceeded during this scheduled maintenance activity. The issue had a credible impact on safety. Inappropriate control of the SAT tap changer impacts the initiating event cornerstone in that a loss of off-site power is more likely following a reactor trip. This issue was determined to be of very low safety significance (Green) using phase one of the SDP because no reactor trip occurred during the inspection period and no mitigating systems were directly impacted by the maintenance on the SAT tap changer.
Inspection Report# : 2002002*(pdf)*

Mitigating Systems

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: FIN Finding
UNTIMELY OPERABILITY DETERMINATION FOR THE 21 DIESEL GENERATOR

On October 9, 2002, the licensee's organization did not identify in a timely manner that the 21 emergency diesel generator was inoperable. The causes for the untimely operability evaluation were fragmented communications between Entergy departments, untimely drip tank sample results, system engineering turnover, and a lack of sensitivity to a loss of the emergency power source safety function. The time between when the non-licensed operator had reported and added inventory to the jacket water expansion tank to the time the emergency diesel generator was declared inoperable was 7.5 hours which exceeded the limiting condition for operation within TS 3.0.1 to be in hot shutdown within seven hours. In the absence of reasonable expectation that a component is operable, the component shall be declared inoperable immediately. The untimely operability evaluation affects the mitigating systems cornerstone objective. The attribute is human performance pre-event. This finding is of very low safety significance in phase 1 of the SDP since the 21 EDG was subsequently declared inoperable and actions within the TS were adhered to. This finding did not result in an actual loss of the emergency on-site power source safety function nor did it increase the risk significance for external events. No violations of NRC requirements were identified.
Inspection Report# : 2002007*(pdf)*

Significance:  Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IDENTIFY THE CAUSE OF 23 EDG OUTPUT BREAKER TO CLOSE
The inspector identified that Entergy did not adequately evaluate the cause blown control power fuses on the 23 EDG output breaker cubicle on November 10, 2002, that subsequently caused the breaker from closure on November 14, 2002. On November 14, 2002, Entergy identified the cause of the breaker failure as improper operation of the inertial latch mechanism. This performance issue is being treated as a Non-cited Violation of 10 CFR 50 Appendix B, Criterion XVI. This violation is more than minor because the failure to identify the cause and preclude recurrence was considered a precursor to a more significant safety issue, in that, the plant could have started up with only 2 available EDGs - a violation of TS - and not have know it for approximately one month. The issue was determined to be of very low safety significance (Green) in accordance with MC 0609 Appendix G, since greater than three offsite and onsite power sources were available to cope with a postulated loss of offsite power.
Inspection Report# : 2002007*(pdf)*

Significance:  Dec 28, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
INADEQUATE POST WORK TEST ON STEAM STOP CHECK VALVE
The post work test on the 22 steam generator stop check valve (MS-41) failed to identify that the valve plug was installed upside down. This self-revealing event was identified on November 20, 2002, when operators responded to steam leak-by from this tagged closed valve that resulted in a fire alarm in the auxiliary feedwater pump room. This finding is considered a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," in that, the post work test, PT-R67A, Reverse Flow Check at MS-41 and MS-42 Alternate Test, revision 1 did not adequately verify that MS-41 was properly reinstalled after preventative maintenance. The performance finding is considered more than minor, since the improperly installed valve plug would not have been identified prior to auxiliary feedwater system operability, had it not been identified during an unrelated tagout on the steam supply to the 22 auxiliary feedwater turbine. This is considered very low risk significance in accordance with NRC MC 0609 Appendix G since two alternate core cooling paths were available. This is an example of insufficient Entergy oversight of contractor work activities.
Inspection Report# : 2002007*(pdf)*

Significance:  Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CONFIGURATION CONTROL FOR A SAFETY RELATED SYSTEM
The inspector identified an example of inadequate configuration control for a safety-related system. On November 20, 2002, the inspector identified that two 125 vdc circuit breakers were in their correct position (open) but administrative locking devices were not installed. The breakers are used to cross-connect the 21 and 22 125 vdc buses. This is considered a Non-Cited Violation of Technical Specification 6.8.1.a., which includes requirements for procedure adherence and operations of safety-related systems including the 125 volt DC system. Check off list (COL) 27.1.6, Instrument Buses, DC Distribution and PA Inverter, revision 18 requires the breakers to be open and locked. This performance deficiency is more than minor since more than one breaker was in the required position, but not locked. The finding impacts the mitigating systems cornerstone and is associated with pre-event human error. The finding is considered very low safety significance (Green) since the operability or availability of the 21 and 22 DC buses were not impacted.
Inspection Report# : 2002007*(pdf)*

Significance:  Sep 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

NON-CITED VIOLATION OF TS 6.8 INVOLVING DEFICIENT GUIDANCE IN PROCEDURE AOI 27.1.1
Abnormal Operating Instruction (AOI) 27.1.1, "Loss of Normal Station Power," was deficient, in that no steps were provided in the procedure to identify that the lockout relays for the component cooling water (CCW) pumps were required to be reset following a loss and restoration of power to the motor supply breakers. This deficient procedure is being treated as a Non-Cited Violation of Technical Specification (TS) 6.8, "Procedures and Programs," in accordance with the NRC Enforcement Policy. The consequence of this finding was that the pump lockout relays would have prevented the 21 and 23 CCW pumps from starting automatically on low CCW system header pressure, for 12 days and 21 days, respectively. This finding represented a partial loss of the CCW system function and would reasonably have been corrected by operator action.
Inspection Report# : 2002006*(pdf)*

Significance: G Aug 10, 2002
Identified By: NRC
Item Type: FIN Finding
OPERATORS DID NOT IDENTIFY THE APPLICABILITY OF A SHUTDOWN TECHNICAL SPECIFICATION
On July 19, 2002, operators did not identify the applicability of a shutdown Technical Specification (TS) associated with the planned removal from service of the 22 emergency diesel generator (EDG) while the 138 kilovolt off site power system was still out-of-service. This finding was associated with the reactor safety cornerstone with respect to the mitigating systems objective of ensuring the availability, reliability and capability of the EDG to respond to initiating events, such as a loss of offsite power, to prevent undesirable consequences. No violation of NRC requirements was identified, since Entergy restored the 22 EDG prior to exceeding the allowed outage time per TS 3.0.1. This finding was of very low safety significance since it did not represent a total loss of emergency power safety function.
Inspection Report# : 2002005*(pdf)*

Significance: W Jul 19, 2002
Identified By: NRC
Item Type: VIO Violation
VIOLATION OF THE APPROVED FIRE PROTECTION PROGRAM/THREE-HOUR RATED WALL CONSTRUCTED TO SEPARATE THE CONTROL BUILDING FROM THE TURBINE BUILDING
WHITE - The team identified a violation of License Condition 2.K of Facility Operating License DPR-26. License Condition 2.K requires that Entergy implement and maintain in effect all provisions of the NRC approved fire protection program, which states that a three-hour rated wall will be constructed to separate the control building from the turbine building. In 1978, to meet the three-hour rating, the wall was to have been built in accordance with the design specification Underwriters Laboratories (UL) U902. Contrary to the above, in February 2002, the wall was found not to be constructed in accordance with UL U902. The combined effect of the identified deficiencies was that, as of February 2002, passages existed through both the outer brick and inner portions of the wall. If a significant amount of smoke and gasses were to penetrate the wall, this could result in the CCR becoming uninhabitable, causing the operators to resort to using the Alternate Safe Shutdown System. These conditions did not represent a three-hour fire barrier. The NRC risk assessment, using Phase 2 of the NRC Fire SDP described in MC 0609, Appendix F, considered the wall a moderately degraded fire barrier having low to moderate safety significance (White). Until repairs could be completed, Entergy established a compensatory fire watch in accordance with the IP2 fire protection program. Entergy actions in identifying original construction deficiencies in the CCR west inner wall in February 2002 were commendable. However, the corrective actions taken were not fully effective in restoring the wall to its three-hour rated design configuration. Additionally, the initial extent of condition was not sufficient to identify other degraded fire barrier walls. [Final Significance Determination and Notice of Violation docketed in NRC letter, dated November 8, 2002. Entergy response to NOV dated December 9, 2002]
Inspection Report# : 2002010*(pdf)*

Significance: G Jul 19, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
TURBINE DRIVEN AUX FEED PUMP OIL ISSUES
The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning three issues with the control and monitoring of lubrication oil used on the turbine driven auxiliary boiler feed water pump (22 ABFP). Each issue involved incomplete evaluations that led to repeat problems and potential for pump damage. The evaluation and corrective actions following identification in February 2002 that the wrong oil was added to the turbine speed governor were not fully effective. The evaluation of this issue identified that operators were not logging the quantity or specification of oil added during rounds or operation of equipment, but no actions were taken to address the issue. Additionally, the team noted that on July 10, while preparing to run the pump, Entergy identified additional confusion regarding the specification of oil to be added to the governor, an issue that should have been resolved. Station personnel did not identify that oil analysis results in May 2002 showing a decrease in oil viscosity indicated that the wrong oil was likely added to a pump bearing and that corrective actions for a similar problem previously identified in May 2001 were ineffective. The evaluation and corrective actions following identification in October 2001 of issues with the required oil level in the pump inboard bearing were not fully effective, specifically the design drawing, the vendor manual, and operator training contained inconsistent information. These issues were evaluated using Phase I of the NRC SDP to have very low safety significance (Green), because pump operability was not directly affected. These issues are being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based on the very low safety significance, and because the

issues have been entered into Entergy's CAP. (NCV 50-247/02-010-002
Inspection Report# : 2002010*(pdf)*

Significance: G Jul 19, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
SETPOINT DATABASE NOT CORRECTED FOR CIRCUIT BREAKER OVERCURRENT PROTECTION DEVICE SETPOINTS
The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning the failure to promptly identify, determine the cause, and correct circuit breaker amptector setpoint database errors. The control of design setpoints is necessary to ensure the availability, reliability and capability of safety-related electrical systems. This issue was evaluated using Phase I of the NRC SDP and determined to have very low safety significance (Green), because the team did not identify any instances where a circuit breaker would not have been able to perform its safety function. This issue is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based on the very low safety significance, and because it has been entered into Entergy's CAP. (NCV 50-247/02-010-003)
Inspection Report# : 2002010*(pdf)*

Significance: G Jul 19, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
SAFETY INJECTION TOPPING PUMP VIBRATION CONSEQUENCES TO SAFETY-RELATED PIPING
The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning the failure to identify that vibration of the non-safety-related SI accumulator topping pump caused stresses in adjacent safety-related piping that were above the code allowable values. The team evaluated this issue using Phase I of the NRC SDP, determining it to have very low safety significance (Green), because liquid penetrant examinations in the areas of high stress did not identify any piping damage. This issue is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based on the very low safety significance, and because it has been entered into Entergy's CAP. (NCV 50-247/02-010-004
Inspection Report# : 2002010*(pdf)*

Significance: G Jun 29, 2002
Identified By: Self Disclosing
Item Type: FIN Finding
MULTIPLE GROUNDS ON THE PROTECTIVE CIRCUIT FOR UNIT 1 SUBSTATION 102NS3 RESULTED IN A LOSS OF THE 13.8 KILOVOLT LIGHTING AND POWER BUS SECTION 3
On May 17, 2002, multiple grounds on the protective circuit for Unit 1 substation 102NS3 resulted in a loss of the 13.8 kilovolt (kv) lighting and power bus section 3. The consequence of this event was a loss of alternate safe shutdown power to all major alternate safe shutdown pumps and selected instrumentation. At the time, the Unit 2 normal and emergency electrical power supplies were available to supply power to the above stated mitigation equipment and instrumentation. The licensee repaired and restored the 13.8 kv bus section 3 within 30 hours of the fault. The performance issue is inadequate retirement of protective circuits for 440 volt substations (132PC3 and 142PC3) that could impact availability of alternate safe shutdown power supplies. This issue is more than minor since unavailability of alternate safe shutdown equipment for 30 hours is viewed as a precursor to a significant event and the alternate safe shutdown power supplies are a risk-significant maintenance rule system which was unavailable for greater than 24 hours.
Inspection Report# : 2002004*(pdf)*

Significance: G Feb 09, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE DESIGN CONTROL FOR A TEMPORARY FACILITY CHANGE INVOLVING THE AUXILIARY FEEDWATER SYSTEM BACKUP NITROGEN SUPPLY SYSTEM.
The inspector identified that a temporary facility change (TFC) for the backup auxiliary feedwater system (AFW) nitrogen supply was deficient because component specifications critical to the design were not identified in the design package. This issue was considered more than minor because of the potential for an improper component substitution to impact operability of a risk significant system. However, this issue was determined to be of very low safety significance using phase one of the SDP because the modification was adequate as installed. The failure to include design specifications in the TFC was a violation of Criterion III, Design Control. This is being treated as a Non-cited violation.
Inspection Report# : 2001014*(pdf)*

Significance: Y Nov 05, 2001
Identified By: NRC

Item Type: FIN Finding
CREW HIGH FAILURE RATE DURING THE 2001 ANNUAL REQUALIFICATION SIMULATOR EXAMINATIONS
This supplemental inspection was performed by the NRC to assess the licensee's evaluation associated with crew high failure rate (four of seven crews failed) during facility-administered annual licensed operator requalification examinations conducted last fall. The finding was previously characterized as having substantial safety significance (Yellow) in NRC Inspection Report 50-247/01-13. The inspectors noted that the licensee's evaluation identified a fundamental underlying weakness: The station has yet to overcome cultural weaknesses that include an unwillingness to confront poor performance, an over reliance on procedures to change behavior, and compartmentalization. More specifically, the licensee identified three root causes: 1) Operations training had not focused on the basic building blocks that ensure a healthy program; 2) The station had not maintained a core of career oriented, plant knowledgeable instructors and operators; and 3) Operations department involvement with Operations Training had often been ineffective. The inspectors concluded that the methodology and level of detail of the licensee's root cause evaluation were reasonable. The licensee implemented a number of corrective actions to address the identified causes. The corrective actions are described in the station's Training Improvement Plan. The more significant corrective actions included initiatives that aimed to 1) improve the quality of training and training materials; 2) increase the number of instructors who have Unit 2 plant experience; and 3) provide additional management support and oversight of training. The inspectors determined that the corrective actions are appropriately focused on the identified causes. These actions were appropriately prioritized, and either complete or scheduled for completion. Notably, the licensee took strong immediate corrective actions following the requalification examination failures to provide extensive retraining to each shift, and continue to provide this high intensity training. The inspectors independently assessed the extent of the underlying conditions that led to the Yellow finding and found that performance issues had also existed in other Operations Training programs, such as initial licensed operator and non-licensed operator training programs. These problems existed for at least three years, both prior to and following the steam generator tube failure event in 2001. Although licensee audits and assessments had identified most of the performance problems prior to the crew high failure rate, they did not identify long-term operator performance as a concern. The inspectors concluded that the licensee's extent of condition review appropriately bounded the underlying conditions that led to the Yellow finding as evidenced by the fact that the licensee had also identified the duration and extent of the problems, and the failure to recognize the long standing issues. (Updated) FIN 05000247/01-013-01: Proposed finding due to crew high failure rate during the 2001 annual requalification simulator examinations. This finding was documented in an October 2001 inspection and initially characterized as a potential Yellow finding, the final safety significance to be determined (TBD). This finding was subsequently evaluated under the significance determination process (SDP) and characterized as (reference NRC to Entergy letters dated December 5, 2001, and February 28, 2002). The 95002 Supplemental Inspection (reference Inspection Report No. 50-247/02-09, dated May 31, 2002), assessed the licensee's evaluation of the crew high failure rates and the corrective actions taken to address this performance issue. As stated in the cover letter to Inspection Report No. 50-247/02-09, this finding remains open until after the completion of Entergy's licensed operator requalification examinations, scheduled for September-October 2002, and further review by the NRC. This item remains open.
Inspection Report# : 2001013*(pdf)*
Inspection Report# : 2002004*(pdf)*
Inspection Report# : 2002009*(pdf)*

Significance: G Apr 13, 2001
Identified By: NRC
Item Type: URI Unresolved item
Adequacy of Hemyc Cable Wrap Fire Barrier Qualification Test and Evaluation
Based on the review of test reports CTP-1026 and CTP-1077, the team determined that the results of the engineering test alone were inconclusive for qualifying the fire barrier system as a one hour rated fire barrier. The team noted that ConEd had only credited the Hemyc fire barrier on the 23 ABFP for 30 minutes, however, due to identified test discrepancies, the 30 minute rating was also inconclusive. This issue is unresolved pending further NRC review to determine whether the qualification tests of the Hemyc fire barrier wrap systems are acceptable.
Inspection Report# : 2000004*(pdf)*

Barrier Integrity

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
OPERATORS DEVIATE FROM PLANT OPERATING PROCEDURES
On November 23, 2002, during a plant cooldown, Entergy deviated from the guidance of plant operating procedure (POP) 3.3, Plant Cooldown, Rev. 57. The consequence of the failure to follow the POP guidance was to exceed the operational limits on the steam generator tube sheet differential pressure of 1600 psid with a maximum value of approximately 1855 psid. Control room operators were unaware of this operational limit. Reviews of steam generator manufacturer specifications and the Updated Final Safety Analysis Report design basis accident analysis information indicated that the steam generator tubes were designed to withstand up to 2485 psid during upset and hydrostatic conditions. Therefore, the structural integrity and qualification of the steam generator tubes was maintained. Failure to document the basis of marking non-conditional steps in POP 3.3 as not-applicable is considered a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V. This issue was considered more than minor because it represented a lack of understanding of procedure requirements and awareness of plant

operational limitations. This finding is considered very low safety significance (Green) in accordance with manual chapter 0609 Appendix G, in that the core cooling pathway via the steam generators was not impacted.
Inspection Report# : 2002007*(pdf)*

Significance: G Jun 29, 2002
Identified By: NRC
Item Type: FIN Finding
DURING SURVEILLANCE TESTING OF THE SAFETY INJECTION DISCHARGE MOTOR-OPERATED VALVE 851B, THE VALVE FAILED TO STROKE CLOSED
On May 27, 2002, during surveillance testing of the safety injection discharge motor-operated valve (851B), the valve failed to stroke closed. The initial operability evaluation did not consider the non-automatic containment isolation function for this valve. This event was documented in condition report No. 200205433. The performance issue associated with this finding is a weakness in operator knowledge of multi-function safety system components. This is the second recent example where operators did not consider this function for a safety-related valve. The first example was documented in NRC report 50-247/2002-003, section 1R15. The untimely and incomplete operability assessment for safety injection discharge valve 851B has very low safety significance since the containment isolation valve was restored to an operable status prior to exceeding Technical Specification 3.6.A.3.a.2.d limiting condition for operation.
Inspection Report# : 2002004*(pdf)*

Significance: G May 11, 2002
Identified By: Licensee
Item Type: FIN Finding
UNTIMELY OPERATOR EVALUATION FOR CONTAINMENT ISOLATION VALVE 869B
On April 11, 2002, operators did not complete a timely operability evaluation for containment isolation valve 869B after the disconnect switch operating handle on motor control center (MCC)26BB broke while applying an equipment tagout. At the time, the operators neither verified that the disconnect would operate nor completed an adequate evaluation regarding the ability to close valve 869B to perform its containment isolation function. An operability evaluation was completed about six hours later by a different operating crew and the operators then entered a four-hour limiting condition for operation and isolated the containment penetration per the technical specifications 3.6.A.3.a.2.b. The untimely operability evaluation increased the unavailability time for the containment spray system. The inoperable containment isolation valve issue was more than minor because it impacts the containment barrier. This issue had very low safety significance since the containment isolation valve was repaired and restored to an operable status prior to exceeding technical specification 3.6.A.3.a.2.d. This issue was an example of untimely operator implementation of technical specification requirements in response to degraded safety equipment.
Inspection Report# : 2002003*(pdf)*

Significance: G Feb 09, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
POSTULATED CONTAINMENT LEAKAGE IN EXCESS OF TS 3.6 LIMITS
The licensee identified a minor leak in the service water piping while the plant was in cold shutdown for a maintenance outage. The leak was repaired prior to startup, and an extent of condition review identified no other defects in service water piping. The licensee determined that the leak most probably initiated during the shutdown period; however, for significance determination the licensee postulated that the defect existed during plant operation prior to the outage in order to conservatively estimate containment leakage during design basis events. This issue was determined to be more that minor because the defect in the service water piping created a potential leakage path from containment. However, the issue was considered to be of very low safety significance using phase two of the SDP because the service water leak did not affect the function of safety equipment, and the containment leakage potential was significantly less than that which would result in a large early release. The failure to maintain containment integrity was a violation of TS 3.6. This is being treated as a Non-cited violation.
Inspection Report# : 2001014*(pdf)*

Emergency Preparedness

Significance: G Sep 27, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CORRECT PREVIOUSLY IDENTIFIED CONDITION IN THE JNC REGARDING THE TIMELY AND ACCURATE DISSEMINATION OF INFORMATION
During the emergency plan exercise conducted on September 24, 2002, the licensee JNC personnel proceeded with a 1:55 p.m. press

conference informing the media that no release was in progress when, according to the exercise events, a release had begun just prior to the press conference. This information was not in conflict with the emergency alert system message that was in effect at the time of the briefing. However, the failure to provide updated information could cause confusion for those receiving it through the media. This failure was a previously identified weakness as documented in Drill Critique Reports and in condition reports. This is a non-cited violation of 10 CFR 50 Appendix E Section IV.F.2.g which requires, in part, that weaknesses or deficiencies that are identified during a drill or exercise shall be corrected. The risk associated with this release of incorrect information was determined to be of very low significance because it does not constitute a loss of function in meeting the applicable planning standard (10 CFR 50.47(b)(14).
Inspection Report# : 2002012*(pdf)*

Significance: N/A May 11, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
VIOLATION OF 10 CFR 50.54(q) FOR ACCOUNTABILITY
On March 6, 2002, the licensee implemented changes to the accountability process that decreased the effectiveness of the Emergency Plan (E-Plan). The finding was considered more than minor because, if left uncorrected, it would become a more significant safety concern. Changing commitments in the E-Plan without prior approval 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 it did not preclude the function of accountability from being performed, albeit delayed. The licensee has implemented the corrective actions and has since met the timeliness goal. This change which decreased the effectiveness of the Plan is being treateed as a non-cited violation consistent with Section VI.A of the Enforcement Policy, issued May 1, 2000.
Inspection Report# : 2002003*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: G Aug 10, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
UNIT 2 SECURITY RESPONSE FORCE MEMBER WAS FOUND INATTENTIVE TO ASSIGNED DUTIES
On July 29, 2002, a member of the Unit 2 security response force was found inattentive to assigned duties. This inspector identified finding was treated as a non-cited violation of 10 CFR 73.55(b)(1)(i), and the Indian Point 2 Physical Security Plan. The security response force officer's inattentiveness to duties was determined to have very low safety significance, using the Interim Physical Significance Determination Process. The finding did not involve a significant compromise of the Physical Security Plan; no actual intrusion occurred; and, there have not been greater than two similar findings in the past four quarters.
Inspection Report# : 2002005*(pdf)*

Miscellaneous

Significance: G Aug 10, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAIL TO USE THE APPROPRIATE TOOLING DEVICE FOR MOVEMENT OF FUEL ASSEMBLY G28 ON JULY 23, 2002
GREEN. On July 23, 2002, Entergy did not appropriately evaluate and implement short-term actions associated with Condition Report (CR) IP2-2002-07253. The consequence of the finding was the relocation of spent fuel assembly G-28 without the appropriate handling tools and precautions. The finding is more than minor since it could be reasonably viewed as a precursor to a significant event (dropped spent fuel assembly in the spent fuel pool). The Significance Determination Process is not modeled for a finding of this type. However, in accordance

with NRC Manual Chapter 0612, this finding was reviewed by NRC risk analysts and management and has been determined to be of very low safety significance because no actual consequence existed and there was no unintended radiation worker exposure. The finding was determined to be a violation of 10 CFR 50, Appendix B, Criterion V, and is being treated as a non-cited violation. (1R20)
Inspection Report# : 2002005*(pdf)*

Significance: N/A Jul 19, 2002
Identified By: NRC
Item Type: FIN Finding
Improved performance in the areas of design control, equipment and human performance, and corrective actions.
Overall, the team found that Entergy operated IP2 safely and that through implementation of the FIP, progress had been made in improving performance in the areas of design control, equipment and human performance, and corrective actions, Specifically, the team determined overall: quality of engineering products has improved, and design and licensing basis control have been strengthened; equipment performance improved (including reduced backlogs of corrective maintenance work orders, operator workarounds, CCR deficiencies, etc); station human error rate and number of equipment mis-positioning events have declined; and, improved effectiveness of corrective action program, including identification and documentation of issues at a low threshold.
Inspection Report# : 2002010*(pdf)*

Significance: N/A May 11, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
VIOLATION OF TECHNICAL SPECIFICATION 6.8.1.a - IMPROPER PROCEDURE USAGE
On April 20, 2002, during a trip of one of the three condensate pumps, control room operators took incorrect action based on an abnormal operating instruction (AOI 21.1.1 step 5.6.4, by using a suction pressure number from this step that did not apply which resulted in their taking operator actions resulting in an unnecessary power transient. A May 8, 2002 condensate pump trip exemplified that this transient (a rapid down power) was not necessary to restore feedwater pump suction. The issue was more than minor since operator improper procedure usage is considered a precursor to a more significant event. Operator knowledge and skill performance issues have been captured in a number of individual NRC findings in past reports. Examples include operator re-qualification simulator test failures in September 2001 (reference NRC report 50-247/2001-013), and an overpower condition in August 2001 (reference NRC report 50-247/2001-09). The operator performance issues associated with the condensate pump trip were documented in the corrective action system as CRs 2000204180 and 200204183. Improper AOI 21.1.1 procedure usage was a violation of Technical Specification 6.8.1.a. This is being treated as a non-cited violation.
Inspection Report# : 2002003*(pdf)*

Significance: N/A Mar 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW PROCEDURES FOR SW VALVE LOCKING DEVICES
A personnel error (human performance cross cutting issue) resulted in the failure to properly maintain locking devices on five service water test stop valves. The failure to maintain locking devices on service water valves per the operating procedures was a violation of Technical Specification 6.8.1.a. This is a non-cited violation.
Inspection Report# : 2002002*(pdf)*

Significance: G Mar 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
INADEQUATE CORRECTIVE ACTIONS FOR REPEAT FAILURE OF SWN-7
The manual operator on service water (SW) valve SWN-7 failed on March 9 during operations to swap essential SW headers. SWN-7 is the isolation valve for the service water supply to turbine building loads. The inoperable valve could have resulted in insufficient service water flow for the emergency diesel generators and other safety systems had there been a demand for those safety systems. The operator on SWN-7 failed 6 other times since 1995. Following the early failures, an engineering evaluation determined that the design margin for the gear box in the manual operator was marginally adequate. Engineering work request 12110-99 was issued to replace the gear set on SWN-7 and similar valves with high strength materials. The engineering request was canceled in July 1999 and no action was taken. This issue had very low safety significance since the specific failure on March 9 and corrective actions occurred within the limiting condition for operation for the service water system, and no operating or stand-by mitigating equipment supported by service water was called to perform its intended function. The failure to take adequate corrective action for repeat failures of service water valve SWN-7 was a violation of 10 CFR 50, Appendix B, Criterion XVI. This is being treated as a Non-cited violation.
Inspection Report# : 2002002*(pdf)*

Significance: N/A Mar 30, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
10 CFR 50 APPENDIX B, CRITERION III, "DESIGN CONTROL"
10 CFR 50 Appendix B, Criterion III requires in part, that measures be established for the identification and control of design interfaces and for coordination among participating design organizations. The licensee did not ensure that the pressurizer level instrument drift evaluations were

consistently bounded by the assumed instrument uncertainty within the safety analysis for a postulated Loss of Normal Feedwater event and a Loss of Offsite power event. The licensee documented this issue in condition report 2002000313.
Inspection Report# : 2002002*(pdf)*

Significance: N/A Feb 09, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW TAGGING PROCEDURE RESULTS IN INOPERABLE EDG
An operator error during a tagout verification rendered the 21 emergency diesel generator (EDG) inoperable. This occurred when the 23 EDG was inoperable for planned maintenance. The tagout error was considered more than minor since it could reasonably be viewed as a precursor to a station blackout event and impacted mitigating systems cornerstone. The issue was determined to be of very low safety significance using phase two of the SDP because the exposure time was of very short duration (approximately five minutes), and the error was self-revealing so that operator action could be credited for timely restoration of the safety function. The failure to properly verify the tagout was a violation of TS 6.8.1.a. This is being treated as a Non-cited violation.
Inspection Report# : 2001014*(pdf)*

Significance: TBD Apr 01, 2000
Identified By: Licensee
Item Type: FIN Finding
Contamination in Storm Drains
Con Edison staff appropriately responded to the discovery of trace amounts of contamination in the Unit 1 storm drains and took proper actions to resolve the condition and to investigate the cause. The material was not associated with the Unit 2 steam generator event or any recent plant activities, and there was no radiological dose consequence due to the contamination.
Inspection Report# : 2000003*(pdf)*
Inspection Report# : 2001010*(pdf)*

Significance: TBD Apr 01, 2000
Identified By: NRC
Item Type: FIN Finding
Steam Generator Tube Leak Root Cause Evaluation
Con Edison completed the investigation of the plant response to the February 15, 2000 steam generator tube leak. Corrective actions to address the causes of weaknesses in the plant response to the event were in progress at the end of the inspection period and NRC review will be the subject of an AIT follow-up team inspection. The results of the root cause investigation for the steam generator tube failure were not reviewed and are being provided by Con Edison to the NRC Office of Nuclear Reactor Regulation for review.
Inspection Report# : 2000003*(pdf)*

Last modified : March 25, 2003