

**A. Alan Blind**  
Vice President

Consolidated Edison Company of New York, Inc.  
Indian Point Station  
Broadway & Bleakley Avenue  
Buchanan, NY 10511  
Telephone (914) 734-5340  
Fax: (914) 734-5718  
blindaa@coned.com

December 18, 2000

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 2000-007-00  
NL-00-151

U.S. Nuclear Regulatory Commission  
ATTN: Document Control Desk  
Mail Stop PI-137  
Washington, DC 20555-001

The attached Licensee Event Report 2000-007-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Sincerely,



Attachment

cc: Mr. Hubert J. Miller  
Regional Administrator - Region I  
US Nuclear Regulatory Commission  
475 Allendale Road  
King of Prussia, PA 19406

Mr. Patrick D. Milano, Project Manager  
Project Directorate I-1  
Division of Reactor Projects I/II  
US Nuclear Regulatory Commission  
Mail Stop O-8-C2  
Washington, DC 20555

Senior Resident Inspector  
US Nuclear Regulatory Commission  
PO Box 38  
Buchanan, NY 10511



**FACILITY NAME (1)** Indian Point, Unit 2

**DOCKET NUMBER (2)** 05000247

**PAGE (3)** 1 OF 3

**TITLE (4)** Administrative Error Leads to Exceeding Tech Spec 4.10 Surveillance Interval

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIA L NUMBER	REVISIO N NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	17	2000	2000	-007-	00	12	18	2000		05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)				
POWER LEVEL (10) 000	000	20.2201(b)	20.2203(a)(2)(v)	X	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)	
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)	

Specify in Abstract below or in NRC Form 366A

**LICENSEE CONTACT FOR THIS LER (12)**

**NAME** Richard T. Louie, Senior Engineer

**TELEPHONE NUMBER (Include Area Code)** 914-734-5678

**COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)**

CAUSE	SYSTEM	COMPONENT	MANUFACTURE R	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

**SUPPLEMENTAL REPORT EXPECTED (14)**

YES (If yes, complete EXPECTED SUBMISSION DATE).

NO

**EXPECTED SUBMISSION DATE (15)**

MONTH	DAY	YEAR
03	27	2001

**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)**

On November 17, 2000, with the unit at zero percent power and in a refueling outage, an internal audit identified that several Technical Specification required surveillances were inadvertently exceeded. These surveillances are required to be performed every 31 days by Technical Specification Sections 4.10.A (items 4 and 5) "Radioactive Liquid Effluents" and 4.10.B (items 4, 5, and 6) "Radioactive Gaseous Effluents". These radioactive effluent surveillances are dose calculations and dose projections performed utilizing data from the previous month, and then documented in a single report around the 15<sup>th</sup> of each month. However, the surveillance for the month of October 2000 had been documented earlier than usual (10/5/2000). During an internal audit, it was subsequently discovered that the November surveillance had been documented on the 15<sup>th</sup>, thereby exceeding the 31 days allowed by the Technical Specifications. Furthermore, when allowance is taken for the maximum allowable extension of 25 percent per Technical Specification 4.0.1, the surveillance interval was still exceeded by 3 days. Since the surveillances (cumulative and projected doses) evaluate data from the previous month, the affected surveillances were satisfactory and did not reveal any radiological release or dose limits being exceeded. There were no adverse safety consequences as a result of this event.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

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**TEXT** (If more space is required, use additional copies of NRC Form 366A) (17)

PLANT AND SYSTEM IDENTIFICATION

Westinghouse 4-Loop Pressurized Water Reactor

EVENT IDENTIFICATION

Administrative Error Leads to Exceeding Technical Specification 4.10 Surveillance Interval

EVENT DATE

November 17, 2000

REFERENCES

Condition Reporting System Number: 200009107

PAST SIMILAR EVENTS

LER 1998-017

EVENT DESCRIPTION

On November 17, 2000, with the unit at zero percent power and in a refueling outage, an internal audit identified that several Technical Specification required surveillances were inadvertently exceeded. These surveillances are required to be performed every 31 days by Technical Specification Sections:

- 4.10.A Item 4 "Cumulative dose contribution from liquid effluents for the current calendar quarter and the current calendar year"
- 4.10.A Item 5 "Projected doses due to liquid releases to unrestricted areas"
- 4.10.B Item 4 "Cumulative dose contribution for the current calendar quarter and current calendar year for noble gases"
- 4.10.B Item 5 "Cumulative dose contribution for the current calendar quarter and current calendar year for iodine-131, tritium, and radionuclides in particulate form with half-lives greater than 8 days"
- 4.10.B Item 6 "Projected doses due to gaseous releases from each reactor unit to areas at and beyond the site boundary"

For scheduling purposes these radioactive effluent surveillances are documented in a single report around the 15<sup>th</sup> of each month. However, due to schedule conflicts, the surveillances for the month of October 2000 had been performed earlier than usual (10/5/2000). During an internal audit, it was subsequently discovered that the November surveillances had been documented on the 15<sup>th</sup>, thereby exceeding the 31 days allowed by the Technical Specifications. Furthermore, when allowance is taken for the maximum allowable extension of 25 percent per Technical Specification 4.0.1, the surveillance interval was still exceeded by 3 days. Since the surveillances evaluate data from a previous month, the affected surveillances (cumulative and projected doses) were satisfactory and did not reveal any radiological release or dose limits being exceeded. There were no adverse safety consequences as a result of this event.

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**TEXT** (If more space is required, use additional copies of NRC Form 366A) (17)

EVENT ANALYSIS

This event is reportable in accordance with 10CFR50.73(a)(2)(i)(B), which requires a report of, "Any operation or condition prohibited by the plant's Technical Specifications." The Radiological Support group normally performs these monthly surveillances and compiles them into a single report on the 15<sup>th</sup> of the month. Cumulative and projected dose contributions from liquid effluents/releases are required to be determined in accordance with the methodology and parameters in the Offsite Dose Calculation Manual (ODCM) at least once per 31 days. Similarly, cumulative dose contributions and dose projections are required for gaseous (and particulate form) releases in accordance with the ODCM every 31 days. During the month of October, the report was issued on October 5, 2000 due to schedule conflicts. The November surveillances (determining dose contributions and projections from the previous month) were compiled in a report and issued November 15, 2000. Personnel failed to notice that the required 31-day Technical Specification interval had been exceeded. No formal station program was being used by the Radiological Support group to schedule these monthly Technical Specification surveillances. The preliminary root cause determined for this event is the lack of a formal program schedule, including proper oversight, for the Radioactive Effluent Technical Specification surveillances. An extent of condition review is being performed to determine if there were other similar events in recent years.

EVENT SAFETY SIGNIFICANCE

The objective of the surveillances is to ensure that the releases of radioactive materials to the environs are maintained as low as reasonably achievable (ALARA) and within allowable regulatory limits. During the 3-day period that the technical specification intervals were exceeded, there were no negative impacts because the surveillance is performed on the previous month's data. Therefore, no incremental dose increase/releases were seen by exceeding the Technical Specification limit for three days. The results of the affected surveillances were satisfactory and did not reveal any radiological release or dose limits being exceeded. There were no operational or safety consequences.

CORRECTIVE ACTIONS

Immediate corrective action is being taken to formally schedule the subject surveillances with an early start and late finish date within the 25 percent schedule extension allowed by Technical Specification 4.0.1 in the Work Control surveillance testing database. As part of our corrective action process, an apparent cause analysis is presently being conducted. When this analysis is complete, a summary of conclusions and corrective actions will be provided in a supplement to this report.