

Below is a list of 41 CRs created in the last 24 hours. (9/28/00 2:43:01 PM to 9/29/00 2:43:01 PM)

Condition Number	Condition Description
<p>200007306 System: COM TagNumber: N/A</p>	<p>8/31/99 Trip Event Follow-Up: As part of the NQA Self Assessment concerning effectiveness of corrective actions from the 8/31/99 Trip Event, it appears the intent of the following ICA may not have been met. The ICA (from 199906868) states, "Establish a single number available for outside phone calls so they can be directed to the correct person." This action was closed with the following response, "Switchboard for the purpose of establishing a single number for outside callers has been installed. Senior Management direction is to delay implementation of service requiring full time assistance as recent experience has shown that calls may be directed to a listed Consolidated Edison Corporate telephone number and calls will be directed to Indian Point. At such time as Indian Point is under different management, the outside line for general calls may easily be implemented." [Closed &amp; Approved 01/05/00]. Follow up verification has shown that this switchboard has not been installed and it appears that this switchboard has been misplaced. Suggest SL-3 to [REDACTED]</p>
<p>200007307 System: FP TagNumber: FP-289</p>	<p>Upon completion of cycling FP-289(Unit 1 LO Storage Room and H2 Seal Deluge) for PT-A18, the valve was found to leaky excessively.</p>
<p>200007308 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a procedure revision or revision of a NRC commitment in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to Test and Performance with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. The subject of Licensing Correspondence NL-88-161 is the transmittal of the report of reactor vessel material surveillance program for IP2 to the NRC for the analysis of Capsule V. The letter identifies that heatup and cooldown curves in the Tech Specs are valid for projected operation up to 15 EFPY and that "Prior to the expiration of the 15 EFPY curves, a license amendment application will be submitted for NRC approval to revise these curves to be applicable for up to 32 EFPY of operation. The revised heatup and cooldown limitations will be based on the analyses summarized in the enclosed Capsule V report." As a means of commitment verification, the following was reviewed: IP-2 Technical Specifications Graph Book, curves RCS-1A and 1B The IP-2 Technical Specifications Sections 3.1.B.1 and 4.3 both identify that the current temperature-pressure relationship curves are to be followed for the first 21.63 EFPY of operation. The IP-2 Technical Specification Figures 3.1.B-1 and 3.1.B-2 both identify that the current temperature-pressure relationship curves are applicable to 21.63 EFPY. Graph Book curves RCS-1A and RCS-1B both identify that the current temperature-pressure relationship curves are applicable to 21.63 EFPY. This is not considered an operability issue. RECOMMENDATION: Review Licensing Correspondence NL-88-161. Determine if the commitment NL-88-161-CD1 is still applicable, and based on the results of the review and determination, implement the following - If the identified commitment is no longer applicable, then either revoke licensing commitment identified in licensing communications NL-88-161 or revise the commitment to identify why the current plant heatup and cooldown curves fulfill the intent of original commitment. - If the identified commitment is still applicable, then revise Technical Specifications to meet commitment.</p>
<p>200007309 System: FP TagNumber: N/A</p>	<p>While performing PT-M55, the roll-up fire door that goes from the transformer yard to 15' PAB did not function properly. The governor did not engage causing the door to slam shut and preventing the door from being lifted into its normal position. This is a repeat occurrence, do not close to a work order. Please have engineering evaluate cause of failure and recommend corrective action.</p>
<p>200007310 System: HVAC TagNumber: N/A</p>	<p>The A/C unit in the hall of the Lower Level of 1 PP is NOT running this contributes to the poor Air Quality in the Lower Level</p>

ENCLOSURE 3

<p>200007311 System: HVAC TagNumber: N/A</p>	<p>(A) - On thursday 9-7-00 the air in the Lower Level of 1 Park Place was tested by [REDACTED] it was found to contain the following readings for Carbon Dioxide 2 @ 600 ppm and 1 @ 1000 ppm I would like a follow up for this test. (B) - Also in Feb or March a test was done in the sam area for Carbon Monoxide found to be unacceptable I would also like a follow up test on this subject</p>
<p>200007312 System: MSCL TagNumber: N/A</p>	<p>Current NPIN database calc. index does not identify the status of as APPROVED or DRAFT. NPIN calc. index has a field called 'SCANNED'. The response for the field is 'Y' or 'N'. If the calc. is 'SCANNED', it can be confirmed that it is 'APPROVED'. If the calc. is not 'SCANNED', its status can not be not determined. Recommended Action: A new data field: 'APPROVED' with 'Y' or 'N' response should be added to NPIN calc. database.</p>
<p>200007313 System: DOCK TagNumber: CLP-RW-12</p>	<p>While attempting to place CLP-RW-12 pump in service, it was discovered that the the pump appears not to be able to move the system fluid. Attempts were made to vent the pump but nothing came out of the discharge line even when the pump was running. Request pump be inspected and repaired.</p>
<p>200007314 System: N/A TagNumber: N/A</p>	<p>CR 200006195 IDENTIFIED THAT VALVES HAD BEEN REPLACED WITH DIFFERENT MODEL VALVES AND THAT AN EXISTING VALVE DECLASSIFICATION LETTER HAD NOT BEEN UPDATED TO REFLECT THE CHANGE. A ROOT CAUSE TO THIS OCCURRENCE MAY HAVE BEEN THAT THERE IS NO LINK BETWEEN THE SAO 401 DECLASSIFICATION DOCUMENT AND THE MODIFICATION PROCEDURE (OR PROCESS) THAT INSTALLED THE REPLACEMENT VALVES, WHICH WILL INITIATE A REVIEW OF THE DECLASSIFICATION DATA BASE WHEN EQUIPMENT ARE UPGRADED OR REPLACED. THIS CR HAS BEEN ISSUED TO DETERMINE IF NS&amp;L'S NSLAD PROCEDURES SHOULD BE CHANGED TO PROVIDE SUCH A LINK TO PREVENT REOCCURRENCE OF SIMILAR PROBLEMS IN THE FUTURE.</p>
<p>200007315 System: DOCK TagNumber: CLP-RW-11</p>	<p>When performing the 1400 rounds, it was discovered that the High Pressure Alarm for both CLP-RW-11 and CLP-RW-12 (common alarm) was up on the chlorination panel. Upon investigating it was discovered that CLP-RW-11 which was running had tripped. Attempts to place CLP-RW-12 in service failed, see CRS #200007313 Attempts were made to restart #11 pump, however it tripped out on High Pressure each time. In further investigation the pump was started with the Pressure switch( PC-6974-S) isolated. When the pressure switch was valved back in. the pump immediately tripped on high pressure. The other indications that existed in the field at this time was as follows: 72 psig as indicated on the pumps discharge pressure gage. and .2 gpm flow as indicated on FI-6970. These conditions indicated that there is either a problem with the pump's pressure switch (PC-6974-S) or with the pressure control valve (PRV-6970). At this time the high pressure condition could not be verified to exist with CLP-RW-12 since pump would not move fluid as indicated in CRS 200007313. Request PC-6974-S and PRV-6970 be inspected and or repaired.</p>
<p>200007316 System: GT TagNumber: N/A</p>	<p>Ignitor wire on GT-3 is burned off the igniter. Located near pressure switch #6. This is a degradation from the initial reported deficiency on CR 200001718. Discovered by system engineer. Action request 14662 already created for previous CR This may result in a misfire of the turbine or a larger hot gas leak (3/8") from burner basket section GT-3 is possibly not operable. Need furthur review.</p>
<p>200007317 System: N/A TagNumber: N/A</p>	<p>Nuclear Quality Assurance procedures were reviewed to check for biennial review status. The following were found overdue. Specific instances of obsolesence or discrepancy are also listed below where noted. SAO-113, Rev.20, 8/30/98, Deficiency Reports &amp; Stop Work Authority NQA-Q-17.002, Rev. 0, 4/30/98, NQA Staff Training. Refers to non-existent QAA-Q-17.212 for records mgmt; correct reference is NQA-SQ-17.005. NQA-Q-17.003, Rev. 0, 5/4/98, NQA Dept. Procedures. Refers to non-existent QAA-Q-17.212 for records mgmt. Also, refers to a "QA Program Documents Coordinator;" However, no one is currently appointed to this responsibility, and the procedure does not identify which Manager makes this appointment. The significance is that no one is currently responsible for the dept. procedures history file. The following procedure is not overdue for review, but appears to be redundant: NQA-SQ-17.001, Rev. 0, 5:27/99, Stop Work; duplicative of SAO-113. Recommend SL4 Track &amp; Trend, with FYI to [REDACTED], Manager of Nuclear Quality Assurance &amp; Oversight</p>

<p>200007318 System: N/A TagNumber: N/A</p>	<p>Nuclear Quality Assurance procedures were reviewed to check for biennial review status. The following was found overdue. PQA-Q-17.100, Rev. 0, 3/9/98, Evaluation of Class A Vendor QA Programs: Currently undergoing revision, according to [REDACTED] Trend, with FYI to [REDACTED]. Recommend SL4 for Track &amp;</p>
<p>200007319 System: N/A TagNumber: N/A</p>	<p>Nuclear Quality Assurance procedures were reviewed to check for biennial review status. The following QA Programs Section procedures were found overdue. QAP-SQ-17.301, Rev. 0, 6/4/98, Vendor Equipment &amp; Personnel Review, Currently undergoing revision, according to [REDACTED] QAP-Q-17.302, Rev. 0, 5/4/98, QA Program Doc. Review &amp; Index. Recommend SL4 for Track &amp; Trend, with FYI to [REDACTED].</p>
<p>200007320 System: N/A TagNumber: N/A</p>	<p>An unauthorized construction/modification was made to trailer 13 located on the 95' elevation by the Condensate Storage Tank on 9/27/00. This trailer is assigned to WSI working through the Nuclear Projects group. When WSI personnel arrived this morning they found that SGT had taken over half of the trailer by nailing up a plywood wall in the center of trailer leaving them with 50% less space. The trailer is owned by Williams Scotsman and leased by Con Edison. The modification was made without notification or authorization from Con Edison or a Williams Scotsman representative. There is extensive damage to the trailer from this unauthorized activity.</p>
<p>200007321 System: N/A TagNumber: N/A</p>	<p>Nuclear Quality Assurance procedures were reviewed to check for biennial review status. The following procedures of the Audits &amp; Surveillances section were found overdue. QAA-Q-17.205, Rev. 0, 11/10/98, Audit Records Mgmt. (Refers to obsolete procedure QA-720; correct reference is NQA-SQ-17.005.) QAA-Q-17.208, Rev. 1, 8/28/98, Use of CRS to track Audit Findings QAA-SQ-17.210, Rev. 0, 5/6/98, NQA Surveillance Program. The following procedure is not overdue for review, but is not consistent with another department's interfacing procedure: QAA-SQ-17.209, Rev. 0, 5/27/99, Review of Engineering Mod. Pkg.s: Inconsistent with interfacing procedure DE-SQ-12.512, Design Eng. procedure, paragraph 5.7.1.i, which requires NOA review only for welding, mechanical codes and standards, and non-destructive testing areas. The NQA procedure requires review for a long list of technical and quality assurance elements in addition to these. Recommend SL4 Track &amp; Trend, with FYI to [REDACTED].</p>
<p>200007322 System: SEC TagNumber: N/A</p>	<p>While researching prints to support SG Water Chemistry modification SGR-00-12395-00 we found a Security Survey Drawing. This drawing is in Metaphase as a microfilm document. This document was not labeled as safeguards equipment. Drawing was turned over to Security Shift Supervisor. NS&amp;L Manager was notified. Recommend a detailed review of microfilm documentation within Metaphase to ensure no other Safeguards Information is in methaphase.</p>
<p>200007323 System: RCS TagNumber: PC-456F/G</p>	<p>ISSUE: While performing a review of the design data recorded for PC-456F (Opens PCV-456 on High Pressunzer pressure) and PC-456G (Alarm on Low Pressunzer Pressure) to verify resolution of discrepancies identified by CR 199810177, it was determined that the following references and consequences recorded on the Setpoint Device Data Forms were inadequate: PC-456F Nominal Setpoint Source: UFSAR Table 4.1-1 Source of Design Value: UFSAR Table 4.1-1 Limit UFSAR Table 4.1-1 First Consequence of Exceeding Design Value: Reactor Trip The correct inputs should be as follows: Nominal Setpoint Source: Modification FEX-96-12241-E, Rev. 01 Source of Design Value: FEX-96-12241-E, Rev. 01 Limit FEX-96-12241-E, Rev. 01 First Consequence of Exceeding Design Value: PCV-456 Does Not Open. PC-456G Nominal Setpoint Source: UFSAR Table 4.1-1 Source of Design Value: UFSAR Table 4.1-1 First Consequence of Exceeding Design Value: Reactor Trip The correct inputs should be as follows: Nominal Setpoint Source: Modification FEX-96-12241-E, Rev. 01 Source of Design Value: FEX-96-12241-E, Rev. 01 First Consequence of Exceeding Design Value: Backup Heaters Energized. RECOMMENDED ACTION: Assign to the Setpoint Control Group. This CR documents that improper references were used to support the design bases in SPIN. The correct references have been implemented to correct SPIN, which now reflects Modification FEX-96-12241-E, the consequence of PCV-456 not opening for PC-456F, and the consequence of the backup heaters being energized. Therefore, this CR was generated for trending and tracking purposes.</p>

<p>200007324 System: N/A TagNumber: N/A</p>	<p>At approximately 10:30 a Williams worker was removing rigging from a Steam Generator manway mock up when the shackle by his hand rolled down and struck his finger.</p>
<p>200007325 System: N/A TagNumber: N/A</p>	<p>At approximately 1830 hours a Mammoet worker discovered hydraulic fluid had leaked on to the ground underneath the Mammoet transporter. The transporter was parked in the Mammoet lay down area east of the Met. Tower. The leak was estimated at about one pint.</p>
<p>200007326 System: RCS TagNumber: PI-472A</p>	<p>While performing routine walkdown of VC, found a roped-off area posted "Material Lay-down Area for Permanent Plant Mat'l" on 95' Elevation at Column 17. This posted lay-down area is directly in front of Pressurizer Relief Tank Educator Pressure gage and associated valves posted with a red DO NOT BLOCK sign.</p>
<p>200007327 System: N/A TagNumber: N/A</p>	<p>CR to Document Electrician Working on Polar Crane Light Switch without a Permit. At approx. 2130 on 9-29-2000 in the VC an SGT Mechanical Supervisor was inspecting the Polar Crane as part of preparation for testing of the Polar Crane and TLD. These are preliminary activities to the lift of SG-22. The Mechanical Supervisor observed that a rubber-jacketed cable entering a light switch was not clamped by the Bendix type connector at the point where it entered the switchbox. Instead the cable jacket had been pulled loose from the connector. The Mechanical Supervisor contacted an Electrical Foreman, asking him to, "send an electrician to look at something". The Electrician Foreman did not question the mechanical Supervisor as to why he needed an Electrician but assumed that it related to temporary power or lighting or TLD installation. Observing the box, the Electrician believed that it was part of the TLD or temporary power since it is not painted, as is the rest of the Polar Crane. The cable, which is known as "SO" cable, a black rubber, jacketed cable typically used for extension cords and temporary installations. The repair was a simple matter of sliding the cable jacket back into the Bendix connector and tightening the two screws to secure it in place. Not unreasonably, he did not consider the situation to be hazardous or have any reason to believe that the leads inside the switch were loose. There was no indication of any electrical faults, no copper was in view. The Electrician simply reinserted the cable in the clamp and tightened the two screws. The Electrician Foreman and the Journeyman Electrician believed that permits were open on the TLD installation (Permit 55329) and Temporary Power (Permit 55029) either of which would cover the activity. However, the box is not temporary but is a light switch for the Polar Crane and the TLD installation Permit (55329) had been released by SGR only minutes before. Knowing the above it is clear that a permit did not exist to cover the repair. The situation came to light when a ConEd Operator cleaning the tagout of Work Permit 55329 observed the SGT Electrician doing the repair to the switch. The operator did know that the switch was part of the Polar Crane and was concerned with work ongoing while he was clearing the tagout.</p>
<p>200007328 System: GAS TagNumber: 1811B</p>	<p>1811B packing still leaking after maintenance adjusted packing on valve. This was discovered when operator cleared tagout and attempted to do PMT.</p>
<p>200007329 System: N/A TagNumber: N/A</p>	<p>On a routine walkdown of the VC inside the crane wall one of the secondary handholes was discovered to be "accessible" from structural steel. Circumstances: Earlier in the shift (-1 hour) HP technician #1 had been with a work crew preparing for steam generator removal. Based on the previous discussions with HP supervision, it was determined that a locking mechanism or bolted flange would not provide the necessary clearance for steam generator extraction. The work crew objectives were 1) Remove the handhole cover to provide the necessary clearance for steam generator removal. 2) Install an FME cover made of plastic sheeting (herculite, visqueen or grifflyn) 3) Post the area as a Locked High Radiation Area 4) Remove the scaffolding in the area to render the handhole inaccessible. These tasks were reported complete by HP tech #1 covering the work at -2330 on 09/28/00. During a routine walkdown after midnight (-0030 on 09/29/00), HP technician #2 made his way via platforms and structural steel to the vicinity of the secondary handholes. The postings and sheeting were intact but based on prior knowledge of the dose rates inside the handhole, the question was raised whether the covering of the handhold rendered it "inaccessible". It was noted that structural steel is not a normal pathway for access, however, under the current circumstances it could be used by workers.</p>

<p>200007330 System: CM TagNumber: N/A</p>	<p>At approximately 0345 hours while performing functional testing on the Polar Crane and Temporary Lifting Device an anomaly occurred. SGT engineers signaling via radio requested that the Polar Crane bridge be moved. No movement in the bridge occurred but it was observed that the trolley moved about one foot. The signal to move the bridge was given a second time and the same thing occurred. This time the trolley moved approximately 13 feet. Mammoet personnel were on the TLD upper structure when this event occurred. The possibility exists for the crane trolley to make contact with the TLD turntable if this event occurs again.</p>
<p>200007331 System: RCS TagNumber: 21PZR</p>	<p>Modification FMX-96-12106-M ( PRT &amp; RCDDT Vent &amp; Sample Line Improvement ) DMD 9321-2645 shows 1" Stainless Steel vent line sloped toward moisture trap # 7061. During final acceptance walkdown by the Nuclear Projects planner it was noted that the piping is sloped toward the Reactor Coolant Drain Tank and not toward trap # 7061.</p>
<p>200007332 System: HVAC TagNumber: 21ETEF</p>	<p>While researching a tagout for Electrical Tunnel Exhaust Fans 21 and 22 temperature controllers and thermostats (TE-7197, TE-7198, TE-7199 and TE-7200 -- none of which appear in CRS tag number, so I used 21 CTEF), I noted no isolation could be found for the Instrument Air header to TE-7199 or TE-7200 (common IA line). This will not be a large problem, since the line is to be retired in place (capped) anyway per the Mod to install new controllers, but this presents a common problem : all the IA lines for various controllers in the CCR (of which this IA line appears to be common with) have no obvious drawings or references. If drawings DO exist for these IA lines (mostly tubing), none could be located (at least not within the capability of this Ops Planner). A reference (references) need to be shown on the common CCR drawings for Instrument Air, which describe the additional drawings (if they exist) for CCR Instrument Air penetrations and their isolations. A field walk will indicate none of these Instrument Air lines could be traced to any particular location, except to note they penetrate into the CCR floor, since the location of these lines in the overhead of the Cable Spreading Room and the fact they are all bundled together makes field verification almost impossible. In addition, TE-7197 and TE-7198 (also common IA line) DO have isolation valves and a pressure reducing valve shown on print 315038-00 (locally near the controllers) but these valves have no ID numbers, noun names or OE tag information. This should be addressed, since these valves and the associated pressure reducing valve will not be removed by the Mod to update the controllers. This IA line will be capped downstream of these valves. There also exists no information on print 315038-00 on which print to go to for a tie - in to the Instrument Air header, just says "FROM INST. AIR HEADER". Please update the DMD for the new print to give a reference drawing for both of these IA lines. Contact [REDACTED] if more information is desired.</p>
<p>200007333 System: AS TagNumber: UH-841</p>	<p>The following is extracted from CTS00-0564 written by RO: Valve UH-841, the inlet trap strainer drain stop on the aux steam header to the carbon filters, does not appear on COL 33 1 Rev. 16 section 1.16 where it should. This valve is downstream of UH-715 the inlet trap stop (see print B227209). Additionally, all valves in section 1.16 with the prefix AS are also listed on COL 29.1 Rev. 21 Auxiliary Steam Supply and Condensate Return but none of the valves with the prefix UH are on both COLs. It may be desirable to remove all aux steam valves found in section 1.16 of COL 33 1 as well as UH-747, UH-838 and UH-840 from section 1.14 and UH-837 and UH-839 from section 1.15 and put them in COL 29.1. In any case UH-841 needs to be included somewhere. This is not a nuclear safety concern. Please assign as SL-4 to Generation Support.</p>
<p>200007334 System: RMS TagNumber: R-31</p>	<p>HIGH RADIATION MONITOR R-31 FOR MAIN STEAM LINE 24 ALARMED AND IMMEDIATELY CLEARED. THE METER INDICATED DOWNSCALE LOW WHILE THE MONITOR WAS IN ALARM. THIS ALSO OCCURRED TO R-29 ON 9/27/00. AFTER DISCUSSION WITH THE SYSTEM ENGINEER, THE SUSPICION IS THAT THE BACKGROUND COUNTS PROVIDED BY THE SOURCE FOR THESE MONITORS ARE LOWER THAN REQUIRED, CAUSING A MOMENTARY FAILURE ALARM. THIS IS NOT A FAILURE OF THE RADIATION MONITOR AS PER THE SYSTEM ENGINEER.</p>
<p>200007335 System: N/A TagNumber: N/A</p>	<p>Unsafe use of a ladder. An "A" frame ladder is being used as a straight ladder in the 53' NSB hallway to gain access to an overhead pipe chase. This is a violation of our safety procedures. The ladder should be removed and replaced with a straight ladder.</p>

<p>200007336 System: MS TagNumber: N/A</p>	<p>The following is extracted from CTS 00-0566 submitted by SRO on 9/26/00: "COL 18.1 section 3.1 lists Atmospheric steam dump controller as 1005 psig for all four Atmospherics. POP 1.3 initial conditions says that the controllers should be set for 1020 psig." The CTS response: Will correct COL 18.1 to state Atmosphereic to be set at 1020 psig. The valves would have been set for 1020 psig as per POP to perform a power escalation which is correct value. They would have been set at 1005 for reactor start up which is not safty concern. Please assign to GS as SL-4.</p>
<p>200007337 System: COMP TagNumber: N/A</p>	<p>On 9/29/00, I received an email from "system" notifying me that I have been assigned CR# 199904193 (see attachment). My CRS inbox is empty, and I have no qualifications or involvement regarding fire protection systems.</p>
<p>200007338 System: EHT TagNumber: N/A</p>	<p>Unclear on expectations to verify and/or change setpoints. I&amp;C supervisors and planners struggle with changing setpoints of devices based only on e-mails from enginerring when they're assistance is requested. I&amp;C expectation is to rely on the Setpoint program (SPIN). We look for SPIN to be changed or updated, to reflect any setpoint that I&amp;C works with. This issue applies to many of our current situtations and applies to this work order on the RWST het trace circuit.</p>
<p>200007339 System: DC TagNumber: BATT22</p>	<p>During the 8/14/00 performance of PT-Q 1 (Quarterly Station Battery Surveillance and Charging), Station Battery 22 Cells 5 &amp; 56 As Found level corrected specific gravity values were below 1.205 (but greater than the operability limit of 1.195). The system engineer was contacted and he recommended placing the cells on an increased frequency surveillance. On 9/27/00 during the performance of PT-M22 (monthly Station Battery Surveillance and Charging) and the increased frequency for PT-Q1, Station Battery 22 Cell 5 was found to be satisfactory and removed from increased frequency monitoring. However, cell 50 level corrected specific gravity value was below 1.205 (value at time at testing was 1.203). It was then added to the increased surveillance testing of battery 22, cell 56 (which remained at a level corrected specific gravity of 1.203).</p>
<p>200007340 System: N/A TagNumber: N/A</p>	<p>A joint IP2/IP3 Chemistry Self-Assessment was conducted on Laboratory Quality Controls (QC).(A copy of the complete Self-Assessment Report is located on the public R drive under SAssess folder as file name: JointIP3-2SelfAss.doc.) As a results of the self-assessment the following areas for improvement were identified: 1. Prepare a revision of CH-SQ-13.003 correcting typographical errors and evaluate the feedback and suggestions listed in the observations for incorporation into the procedure revision. The proposed changes include the following: • Revise CH-SQ-13.003 correcting or deleting steps 5.4.2 e, 5.7.8 and 5.7.9. • Add a statement under 5.4 of CH-SQ-13.003 regarding the potential longer shelf life of sealed solid chemical samples versus chemical in opened containers. • Revise 5.6.1 including a statement that references should be included in procedures. • Add statement to CH-SQ-13.003 saying that detection limits should be determined for key test parameters. Also include reference to the EPA procedure for calculating Method Detection Limits (MDL). • A reference to ICP-A-307-S, Radiochemistry Intercompansons, will be added which provides instructions for determining that two independent radiochemistry samples are representative. • Change the term "known" in 5.6.6 to "target". • Delete from 5.6.8 a. the words "such as preparation from different bottles OR on different days". • Revise 5.6 to indicate that control standards or check sample should be run, preferably with each batch of samples • Include a list of accuracy requirements or data quality objectives for key chemical control parameters such as boron and lithium • Establish a requirement/practice for recording control data associated with any non-charted analysis analyses referenced to in 5.6.12, CH-SQ-13.003. • Consider removing the information in 5.7.7 from the main body of CH-SQ-13.003, since it does not give direction • Include more specific action instructions as to what the technician should do to return out-of-control QC checks back into control. • Modify Step 5.6.11 to allow use of one standard deviation bias as per INPO 88-021. • Include a statement indicating that 18.0 megohms reagent water should be used for preparing standards. (Also revise IPC-07B to specify 18.0 megohm reagent water.) • Include guidance regarding the issuing of an annual QC summary report. • Establish a practice in a technician aid or include in the procedure instructions for labeling and controlling materials stored in the desecrator. 2. Re-design chemistry lab control charts to display chronological data to allow for easier trending and include warning limits on all charts where appropriate.</p>

<p>200007341 System: WDS TagNumber: PC-1038A</p>	<p>While performing Work Order # 98-03084 (Replacement of Pressure Switch PC-1038A) found that the Material Substitution Authorization Procedure MSAP-99-00471-FFX listed the replacement switch as model H105-146-95009. The switch that we have is model H105-146-9823. A call to the vendor revealed that the switch is the same, the numbers after H105-146 are inventory, stock and date numbers.</p>
<p>200007342 System: N/A TagNumber: N/A</p>	<p>If you attempt to run a query using metaphase to determine the status of a CCR DMD, we have found many discrepancies where the data is wrong because the Design Engineering Department did not promote the as-built dmd to "transferred" upon the release of the new ccr parent drawing revision. If the NRC or other organizations ask you to verify if a dmd is as-built or transferred, I ask that you give them your answer as best you can determine, then e-mail the request to me so I can verify that the computer is correct. Design Engineering is presently working on ( or should be ) correcting the dmds's that did not get promoted to transferred. Please do not open an action to the Record Center as the problem and solution belong to Design Engineering located at Park Place. I anticipate there to be approx 100 discrepancies for CCR DMD queries and about 2,000 for non ccr drawings. ( dmd's status is as-built and should be transferred.) Design Engineering will try to close this CR by adding it to their list of backlogged items. I ask that you assign this cr to an SL level that Design can not close without correcting the problem.</p>
<p>200007343 System: N/A TagNumber: N/A</p>	<p>This CR is being written to document a condition potentially adverse to quality. The HP qualification matrix is inaccurate. [REDACTED] and [REDACTED] have been Con Ed H.P.'s for almost three months and are still listed as contractors on the matrix. [REDACTED] has been a Con Ed H.P. for almost three months and is not listed at all. [REDACTED] transferred to the Environmental group over three months ago and is still on the matrix. The matrix should be updated to reflect our changing qualification needs.</p>
<p>200007344 System: N/A TagNumber: N/A</p>	<p>While it is good to know that the Coned System Trucks can get from zero to 45 mph in less than two blocks. I do not see any reason why our trucks would need to go 45 mph within the protected area. This morning a maintenance truck starting at the cafeteria got up to approximately 45 mph by the time he reached the CAG trailers. Please be a little safer. Suggest SL-4 close to track and trend to Maintenance.</p>
<p>200007345 System: N/A TagNumber: N/A</p>	<p>This CR is being written to document an apparent lack of progress in HP task qualification. There are currently 19 Con Ed HPs and 192 tasks on the qualification matrix for a total of 3648 person-tasks. In the last year, only 4 task qualifications have been completed out of a total 2361 that need to be finished for the HP group to be fully qualified. That is less than 0.2 % of the total. At this rate it will take over 500 years to complete. For every new instrument added to the program, another 15 years can be added to that number. I don't believe we can get that kind of licence extension. WE need some kind of a reasonable qualification goal which can demonstrate REAL progress.</p>
<p>200007346 System: N/A TagNumber: N/A</p>	<p>This CR is being written to document irregularities in the RP Training Program. In the last few weeks, several contractors have been qualified to perform HP and Dosimetry tasks that have until now been performed exclusively by Con Ed personnel. These qualifications were accomplished by interviews, a method not used to qualify Con Ed technicians performing identical tasks. This seems to contradict SAO-502 TRAINING AND QUALIFICATION PROGRAMS 4.11.1 " Contractors hired to supplement the Indian Point 2 staff shall meet the task qualification requirements for the assigned work. Contractor qualifications must be equivalent to those of Indian Point 2 personnel who perform assigned tasks independently." In the case of the contractors qualified to perform HP tasks, a total of 46 tasks were signed off. No written qualification standards exist for any of these tasks. No new Con Ed personnel could be qualified on any of these tasks because the Qualification Guides have not even been written yet. This seems not to meet the spirit of "equivalent qualification " stated in SAO-502. Where is the standard. Where is the quality. WE can do better.</p>

<p><b>200007347</b>  <b>System:</b> N/A  <b>TagNumber:</b> N/A</p>	<p>This CR is being written to document a condition which could jeopardize the HP section's ability to support station functions. There are many HP tasks where no Con Ed HP is qualified according to the HP Qualification Matrix. Admittedly, these tasks are newly identified but these are tasks we have and are currently performing. They were identified months ago but no meaningful progress has been made. Only two people have been qualified on two tasks. One task is to operate the new portals, the other is to operate a monitor used for new fuel receipt. There are 45 tasks for which no Con Ed Hp is qualified. These include : Don SCBA ; Respond to a radioactive spill, ARM alarm ; Radioactive material labeling and marking ; Change gas bottles ; Transport liquid nitrogen ; Provide routine job coverage ; Maintain logs ; Initiate CR ( I may not be qualified to report this. ) and others. These tasks represent some of the most basic HP functions and our qualification in them needs to be addressed.</p>
<p><b>200007348</b>  <b>System:</b> HVAC  <b>TagNumber:</b> 11CAEF</p>	<p>Upon inspection prior to installing fan found a flow diverter wedged in the exhaust damper. Do not know from where flow diverter came from. It is a welded in piece. Airflow is coming back from 12CAEF.</p>
<p><b>200007349</b>  <b>System:</b> HVAC  <b>TagNumber:</b> 12CAEF</p>	<p>Grease is leaching out of both inboard and outboard bearings seals. Approximately 1 lb.of grease is outside of each bearing.</p>

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# CHS - Condition Detail Report

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Condition Number: 200007718

<u>Occurrence Date</u>	<u>Operability Concern</u>	<u>Location</u>	<u>Detection Method</u>	<u>Significance</u>	<u>Reportable</u>	<u>Tag Number</u>	<u>System</u>	<u>Originator</u>
10/11/2000 12:50:47	Originator: No Watch: N/A	ADMIN	AU	-1	No	N/A	N/A	[REDACTED]

## Condition Description:

RE: 98-04-A-F01, CR 199901424

Since this is a Quality Assurance Audit Finding, it needs to be processed as a Significance Level 2 CR.

Recommended Addressee: [REDACTED]

Auditor: [REDACTED]

Audit Finding - 98-04-A-F01

This Condition Report is initiated to cover stranded issues from CR 199901424, which was written to cover items identified by Audit Finding 98-04-A-F01. This CR was inappropriately closed without fully addressing all finding issues and recommendations. The Lead Auditor [REDACTED] was asked by [REDACTED] to discuss this problem with Nuclear Training's [REDACTED] on September 21, 2000. [REDACTED] was also called on October 10, 2000, and was informed that this CR would be written.

## Original Condition

### Requirement:

SAO-502, "Training Policy", Revision 8, Section 1.2, states: "Training shall be a priority in Nuclear Power planning activities and shall be designed and conducted based on prudent training practices inherent to effective and efficient training."

### Finding:

Contrary to the above requirements, Operations Training has not always been a priority in Nuclear Power's planning of activities, and has not always been conducted based on prudent training practices inherent to effective and efficient training.

### Recommended Corrective Action:

It is recommended that Nuclear Training:

- 1. Aggressively pursue the current plans to increase instructor and clerical staffing levels.
- 2. Recognize and reward the efforts of the current Operations Training Staff, by using appreciation portion of morning meetings, employee recognition breakfasts, and

Print Date/Time: 10/12/00 - 9:45:54AM

# CRS - Condition Detail Report

[Click here for the SL Report](#)

Condition Number: 200007718

- management compensation plan.
3. Evaluate the position levels for Operations Training Instructors such that it is seen as a position of distinction within the station.
  4. Make provisions such that when the current licensed class is completed and watch sections are adjusted a license individual is transfer to Operations Training to be developed into an instructor.
  5. Select a replacement for the current [REDACTED] and set up a transition schedule.
  6. Solicit Operations Management, Operators, and Instructors for enhancements to the program. Once increase instructor staffing levels are reached and instructors are qualified, evaluate and prioritize feedback then make necessary changes to the Operations Training Program.
  7. Develop functional areas of expertise for each instructor when Operations Training is fully staffed. Appoint a lead instructor as well as a backup for each functional area.
  8. Prioritize Operations Training staff work load, including preparation time and instructional time. Manpower load this information on a schedule. Do not schedule instructors to be in two classes at once. It maybe necessary to adjust course schedules to insure instructors are provided adequate preparation time and are not over committed.
  9. Define and document all clerical duties required to support Operations Training such that managers and instructors are fully relieved of clerical functions. Arrange for the Human Resources Department to perform an audit of the clerical positions within Operations Training. Based on the results of the audit staff the clerical positions with properly trained and qualified personnel.
  10. Work with the Facilities Management staff to develop a floor plan that accommodates the full complement of Instructor and Clerical staff anticipated in Operations Training within the old simulator building. It maybe necessary to take advantage of portions of the unused classroom four or the old simulator or locate the instructors by function licensed and non-licensed.

Original Rejection - 12/99

Per [REDACTED] following evaluation of your response, it is being rejected for additional information. You must issue an ICA to yourself, or someone within your organization, to implement your planned corrective action, before you close your SL assignment.

[REDACTED]/16/99

Howe's evaluation:

- \*1. It looks to me like this is their "Action Plan" for addressing the "Audit Finding Recommendations."
2. If that is the case, their "Action Plan" does not address all "Audit Finding Recommendations."

- a) Audit Recommendation #1 was not addressed. They need and ICA & Implantation date.
- b) Audit Recommendation # 2 & 3 are OK.
- c) Audit Recommendation #4 was not addressed. They need and ICA & Implantation date.
- d) Audit Recommendation #5 needs ICA for action.
- e) Audit Recommendation #6 was not addressed. They need and ICA & Implantation date.
- f) Audit Recommendation #7 was not addressed. They need and ICA & Implantation date.
- g) Audit Recommendation #8 was not addressed. They need and ICA & Implantation date.
- h) Audit Recommendation #9 was not addressed. They need and ICA & Implantation date.
- i) Audit Recommendation #10 needs ICA for action."

Print Date/Time: 10/12/00 - 9:45:54AM

Click Here for the SL Report

Condition Number: 200007718

i) Audit Recommendation #10 needs ICA for action."

Second Rejection

The "Request for Closure" is being rejected. Nuclear Training has not addressed all Audit Recommendations.

I spoke to the [redacted] last week. [redacted] suggested that I discuss the problem of this Finding with [redacted] Training Section Manager. [redacted] and I met last Thursday (09/22/00) and went over all issues. He said he would follow-up on all issues. [redacted] (09/25/00)

To close this Finding, Nuclear Training will need to address the original rejection from 12/99. They also need to give specific details concerning how each issue was addressed or resolved.

Immediate Action:

Discussed with [redacted] and [redacted] Initiated a new CR.

Operability Review Note:

Narrative:

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IS	<u>Assignor</u>	<u>Assignee</u>	<u>Reviewer</u>	<u>Due Date</u>	<u>Last Update</u>	<u>Date Closed</u>	<u>Status</u>
	[redacted]	CRS Global Controller	CRS Global Controller	10/12/2000	10/11/2000		New + Unread

Action Requested:

Please Process Condition Report.

Response:

Reviewer Note:

Below is a list of 30 CRs created in the last 24 hours. (10/16/00 9:44:05 AM to 10/17/00 9:44:05 AM)

Condition Number	Condition Description
200007858 System: FW TagNumber: 22SG	This CR was initiated as a result of NCR-201. A gouge in the Feedwater piping has been identified approximately 10' from the nozzle cut. Dimensions are 4' long, 3/8" wide, and 3/16" deep and appear to have been made with a grinder. Additionally, there is an abandoned thermocouple that has been welded to the pipe adjacent to the gouge. Both situations are existing as found conditions. Per discussions with [REDACTED], [REDACTED] recommend an assignment to SGR engineering to evaluate and disposition.
200007859 System: BG TagNumber: BGA	During the removal of the existing ABFP Bldg Roof, a 14" pipe stub (hidden by a flashing cap) was discovered to be retired in place. Nothing was holding the pipe stub other than the roofing material. Had the roofers not been alert, the pipe would have fallen through to the next elevation.
200007860 System: N/A TagNumber: N/A	The radiation levels at principal points of interest, resulting from temporary storage of old steam generators, are higher than projected engineered estimates by a factor of at least two. The engineered estimate was thought to be conservative by a factor of two. The reason for the discrepancy and the compensatory actions should be delineated and explained. The impact is with respect to status of workers and their dose accumulation potential; worker status was highly dependent upon the actual radiation levels
200007861 System: RCS TagNumber: N/A	Received a call from Indian Point Computer Applications about Graph NI-2, "Approximate Reactor Power Vs. Expected Parameters. He was looking for whether or NOT 1st Stage Turbine Pressure was on the Graph. It was observed that this was NOT the case. However, on inspection of the Graph, it was also observed by me, and concurred by the IPCA person, that Maximum Average Delta-T was on the Graph, along with Indicated Reactor Power, Maximum Indicated Intermediate Range Currents, and Maximum Indicated Generator Load. Specifically, with respect to Delta-T, the following observations were made: 1) With the new SGs, with almost no tubes plugged, the new DeltaT, associated with a given Reactor Power, IR Current or Generator Load, would be considerably less (non conservative), since MAXIMUM Indicated Delta-T is being used to anticipate expected Reactor Power on Initial SU following a Refueling. This fact may NOT have been considered, during the review of the impact on Operating Procedures. 2) The fact noted in 1. above, when looking at POP 1.3, Step 4.40.1, and 4.40.2, indicates a possible "Show Stopper", if the current revision of Graph NI-2 is used.
200007862 System: NIS TagNumber: NC-31D	During review of the NI Graphs, as part of my discussions with IPCA concerning Graph NI-2 (See CR 200007861), the following discrepancies were observed: 1) On Graph NI-1, the Source Range High Flux Trip is listed as "5.0E-5". This value is the old setpoint (See CR 200005514). 2) Review of CR 200005514, indicates that a Calculation (FIX 00054-00) has lowered the setpoint to 2.3 E5 CPS, but in the Recommended Actions, Item 2, NOT all of the affected Operating Procedures have been identified. The Fourth ICA identifies use of a Generic Modification, presumably to correct Alarm Window 1.6, but it does NOT identify the Affected Operating Procedure, namely ARP FDF, Reactor First Out Annunciator (Window 1-6)
200007863 System: N/A TagNumber: N/A	It was noted over the weekend that one Kodak 240 Digital Camera was stolen from the Radwaste Department
200007864 System: N/A TagNumber: N/A	PT-M67-(TSC Diesel Test) passed its RRD and therefore must be tested prior to declanng the engine operable
200007865 System: DC TagNumber: BATT22	During the performance of Pta35 station battery intercell resistance checks on 22 battery as Pmt#00-16719. The intercell resistance checks failed there criteria. Pmt was performed on 10/13/00. The battery was reworked and Pta35 was reperfomed sal on 10/14/00. T

<p>200007866 System: N/A TagNumber: N/A</p>	<p>It is recommended that this item is assigned to [redacted] for inclusion in the 2001 Training Audit. This CR is initiated for the purpose of following up on an issue previously identified in CR 199901433. The auditor is to revisit the issue discussed below in the 2001 Training Audit. Auditor Evaluation of 199901433/98-04-A-F03: Operations Training has had a large turnover of clerical personnel in the past five years, including the two recent employees that left in the past three months. Personnel turnover and lack of experience and knowledge was one of the contributing factors to this "Finding" in the first place. This condition has yet to improve. Yesterday I spoke to the new clerk. She was the clerk for many years in Operations Training, and left for another job. She has now returned and informed me that conditions have not improved, they've decline. This was also identified, in part, in the recent Operations Training "Self Assessment Report." A follow-up action should be assigned to NQA, to evaluate actions taken to resolve this issue, in the 2001 Training Audits."</p>
<p>200007867 System: N/A TagNumber: N/A</p>	<p>Valve BFD 836 is listed on COL 21.3 as "LT 5001 High Side Stop." This valve has been verified on print # 260510 as LT 5001 High Side Stop. Contrary to this information, Tagout # 2000-N-0000013941 lists valve BFD 836 as "LT 5001 Low Side Isolation." Valve BFD 835 is listed on COL 21.3 as "LT 5001 Low Side Stop." This valve has been verified on print # 260510 as LT 5001 Low Side Stop. Contrary to this information, Tagout # 2000-N-0000013941 lists valve BFD 835 as "LT 5001 High Side Isolation." This error was discovered while writing a TOI for fill and flush of the level instrument lines after installation of the new steam generators.</p>
<p>200007868 System: N/A TagNumber: N/A</p>	<p>Three CRS 200006477, 200006480 and 200006477 were created and should not have been according to agreement with gen support in addition CASC stated that these CRs would not be assigned until the issues were straightened out. CASC also stated CR 200006477 would be assigned to gen support for proper resolution. As stated in CR 200006477 EH&amp;S and Ops jointly paid for a review of the Oil program at IP2 to determine why Ops had not been in compliance with several issues in spite of two corporate audits and corporate environmental procedures which are referenced in SAO 600. There was a mutual feeling that both departments could do a better job at ensuring compliance and working together to locate any gaps. It was agreed upon that no CRs or actions would be taken until both parties reviewed the vendor report to ensure accuracy. Unfortunately 3 CRs were written and all contained erroneous info which could have been resolved if both parties met first before issuing. When this was brought to CASC it was agreed that no action would be taken with these CRS until all info was verified between Ops and EH&amp;S. Apparently it fell through the cracks and the CRS were assigned any way. I spoke with [redacted] who suggested I close out the three CRs to this one and explain what occurred and work with Ops (gen support) to correct any inaccuracies and issue any appropriate CRs as necessary. I am writing this CR to find a way to help the CR process so this type of situation does not occur again. Thank you</p>
<p>200007869 System: N/A TagNumber: N/A</p>	<p>Valves BFD 620, "LT417C Stop" and BFD 628, "LT427C Stop" should be in COL 21.3, rev 17, "Steam generator Water Level And Auxiliary Boiler Feedwater" on page 1 of 50. They are not on that COL. This error was discovered while writing a TOI for fill and flush of the level instrument lines after installation of the new steam generators</p>
<p>200007870 System: 440V TagNumber: N/A</p>	<p>During performance of OPS PM M28 of MCC4 found 20A fuses in bag for tagged out disconnect (CT-P19). As these are newly installed and wired (relatively) are they the correct size for the circuit and or new motors? Not in accordance with print 141591</p>
<p>200007871 System: 440V TagNumber: N/A</p>	<p>While performing OPS PM M28 found the wrong amperage fuses installed in MCC13 as per the print 141591. SF-P5 the Cask Wash Pilot drain pump has 20 amp fuses installed vice the 15 amp as directed per the print.</p>
<p>200007872 System: FP TagNumber: N/A</p>	<p>Entered 24hr action statement per SAO-703 applying WPTO to the outside loop of high pressure fire protection for UT of piping in the utility tunnel. Entered 14 day admin action statement per SAO-703 due to isolation of the cable tunnel fire protection. This is potentially reportable if not restored within 24 hours.</p>

200007898 System: AS TagNumber: UH-89	Lagging at PWST upstream of UH-89 needs repair. EHT lines exposed.
200007899 System: DC TagNumber: BATT125V-11	During a pre job walk down for the load test of #11 Battery which is scheduled for Wednesday 10/18/00. It was noticed that #11 Battery was Tagged out. The Tag out was applied approximately 2 weeks earlier for construction to do a mod. The battery load test was on the schedule for 2 weeks. A vendor was brought in to conduct the test. The vendors costs approximatley were 3000\$ to perform the test. The Turbine emergency oil pump was also attempted to run on 10/16/00 for Pdm which was on the schedule. The pump switch was not tagged out out. When ops when to start the pump the pump would not start. This was likely due to the discharged state of the batteries due to the taggout being applied for approximately 2 weeks. After the pump failed to start A stop tag was hung on the switch to reflect the taggout on #11 battery.
200007900 System: AS TagNumber: N/A	UH-1286 drain line is not lagged, EHT wires are exposed, it appears as if that the drain valve was repaired & lagging not replaced. Found during engineering walkdown of EHT sys
200007901 System: PW TagNumber: PW-3	Lagging damaged upstream of PW-3 (PWST drain stop). Found during engineering walk down of EHT sys
200007902 System: SIS TagNumber: LT-5751	LT-5751 (21 RWST lvl control) cabinet enclosure is missing fasteners on the bottom of the cabinet door. This was discovered during engineering field walkdown of the EHT sys
200007903 System: N/A TagNumber: N/A	Drawing A141591 is not correct as per as found field conditions. DMD IP2--S--000377AB and 378AB are changing the pumps for the CSB Sump Tank. These also reference the drawings to be affected and changes to be made. But,,, drawing A141591 is not listed as being in need of change.
200007904 System: FW TagNumber: N/A	A Nonconformance Report (see Ref) was written to document "pipe wall thickness under size" on the nozzle end of spool piece for feedwater to 21SG. The NCR documented readings of 0.640" to 0.650" at locations at the end of the spool piece. At least one of the locations was determined to be caused by "excessive flapping from working the weld prep". The NCR states that the minimum wall thickness is 0.609" based on a calculated 0.544" minimum wall and adding back the 0.065" corrosion allowance from Code B31.1. The following observations were made by the FAC Engineer 1. The section of elbow/spool piece had been identified in the FAC program as BFD-99 This section was UT inspected in 1995 and the corresponding locations at or near TDC approaching the nozzle were shown to be 0.644" in three of the four locations at this point. Therefore, there does not appear to be any significant wear in the previous five years at this point. 2. The 1995 Structural Evaluation for BFD-99 also used a minimum wall of 0.544 (although it is not normal practice at IP2 to add back the corrosion margin). 3. The observation has been logged in the Plant & Industry Experience binder as Report #00-01.
200007905 System: FP TagNumber: N/A	This CR is being written at the request of the Shift Manager to document the as found conditions of two foam carts used for Fire Protection in the Turbine building. The fittings that were found on the carts would not have allowed the the supply hose or spray nozzle to be hooked up for fire fighting. The carts were fitted with the nght adaptors at the request of the SM and will now allow for proper use if required by the watch. This condition should be closed to track and trend, the carts are located on 15 foot north end and the 72 foot Fan room.
200007906 System: RPS TagNumber: FM-418C	Dunging the performance of PC-R32, Feedwater Flow, we found that FM-418C, I/I converter was unsat. The output is offscale high and zero adjustments made no change in output. This is causing computer point F0403 for SAS and Proteus to be offscale high. Left unsat.
200007907 System: FW TagNumber: FI-428A	Dunging the performance of PC-R32, Feedwater Flow, we found and left FI-428A unsat. The meter is sticking.
200007908 System: FW TagNumber: FI-428B	Dunging the performance of PC-R32, we found and left FI-428B unsatisfactory. The meter is sicking.

<p>200007909 System: N/A TagNumber: N/A</p>	<p>While performing an independent review of the performance indicators for the RHR system per the requirements of SAO 114 rev 0 (Preparation of NRC and WANO performance indications). I noticed that the SAO section 4.2.1 states "The notebook shall include, but not be limited to: ... j. Department or Section procedures used to calculate the performance indicator(s)"... The [redacted] does not have a department or section procedure to calculate the performance indicator(s). The [redacted] uses the NEI 99-002 calculation. This was discussed with the preparer of SAO 114 and he agrees that using NEIs calculation is acceptable and that the SAO need to be clarified. This CR need to be assigned to the owner of SAO 114 "CAG" to make this change during it next revision.</p>
<p>200007910 System: 440V TagNumber: N/A</p>	<p>Found fuse clip broken in MCC 8 disconnect for "EHT EMER PWR". Lower fuse clip of three has broken clip and fuse is hanging from one clip in cubicle. Need to repair/replace fuse clip.</p>
<p>200007911 System: WDS TagNumber: LT-940</p>	<p>During the performance of PC-2Y55, VC Sump Discrete Level Instruments, step 7.3.4 which asks the technician to verify that all lights extinguish in descending order and CCR alarm clears, the 4th and 5th lights extinguished simultaneously.</p>
<p>200007912 System: GT TagNumber: GT2</p>	<p>The following occurred while performing tests PT-2Y11B &amp; PT-M38B for gas turbine #2. During start up alarm #37 (turning gear not sensed) came up and cleared. GT-2 went on the bus. After about 30 minutes the lights in the GT-2 control room started to flicker. Checked the black start diesel which was supplying load and noticed the ampere meter bouncing every two seconds. Started normal shut down of GT-2, while ramping down GT-2 tripped on shut down alarm # 49 (high lube oil reservoir temp.). The lube oil cooler fan was making a loud screeching noise. It was then noticed that the lube oil circulating pump was not running, after pressing the thermal overload reset button the pump started but cycled on and off about every two seconds. The pump then stayed on and ran properly. It was noticed that after the circulating pump was running the lube oil temperature came down much faster.</p>
<p>200007913 System: N/A TagNumber: N/A</p>	<p>The Station battery surveillance test Pta35 has steps that need clarification on what the intent is. Step # 3.2.3 states when making a measurement of a "totally new kind" to reverse the c leads to determine dc interference. Note on the data sheet after proper corrections have been made on the data sheet. What is meant by totally new leads? What is meant by Noting the readings after the proper corrections have been made on the data sheet? What are the Proper corrections on the data sheet?? There are no steps to tell the techs what to do with the numbers if interference is found and what this means. There is also no steps to set the range on the meter, and how to read the range when a measurement is taken? This needs to be clarified prior to the performance of the next Pta35.</p>
<p>200007914 System: N/A TagNumber: N/A</p>	<p>While performing O.J.T. on the Gamma 40/60 Portal Monitor two procedure deficiencies were identified. Deficiencies were minor and recommend assign SL-4 to [redacted]</p>
<p>200007915 System: HSB TagNumber: 10 DEAERATOR</p>	<p>While reviewing tagout for removal found two valves with same designation. AF-40 is used as a drain off the City Water level column for the #10 Deaerator and also as the sample isolation off the HSB pump suction header for the Deaerator. Per COL 29 1 1 this designator should be used for the level controller drain. Need to redesignate the sample isolation</p>
<p>200007916 System: RCS TagNumber: N/A</p>	<p>Conflicting operating standards exists regarding minimum acceptable RCP #1 seal differential pressure. SOP 1.3, Reactor Coolant Pump Startup and Shutdown, step 3.5 and Figure #1, both indicate a minimum Delta-P of 200# is acceptable. However, ARP SAF, rev 20, Window 2-9, step 3, requires that 275# be maintained. Note, the 275 # limit is difficult to maintain during low RCS pressure pump operation.</p>
<p>200007917 System: N/A TagNumber: N/A</p>	<p>NPMEL (IP2 Nuclear Power Information Network) has been down for close to three weeks. With this system down data searches for calculations are no longer retrievable. If this problem is not corrected soon it has the potential to impact the completion of DBD's that were committed to the NRC to be completed this year.</p>

<p>200007918 System: EHT TagNumber: EHTA</p>	<p>During a system walkdown of the Nuclear Tank Farm for EHT System, the following conditions were found: 1. In the Electric Heat Trace Cabinet door of Local Control Cabinet #24 is binding up and is not allowing to close properly. The door needs to be repaired and gasket material should be replaced. 2. The small outside box that encloses the ambient sensors is rusting through and needs to be replaced. Near the PWST: Near equipment UH-1286. Drain Line is not lagged, exposing EHT wires. UH-89. Lagging at PWST Steam Return line upstream of OH-89 needs repair. 3. Near the LT-5751 Enclosure cover is missing fasteners at bottom of box. Area near Concrete Parapit: EHT Wires are hanging and exposed from Splice that is attached to the concrete parapit. See attached photo. Lagging is damaged down stream of 1262-B on CVS line. See attached photo. Deficiency tags were hung in the area with the referenced Cr's.</p>
<p>200007919 System: HVAC TagNumber: FC-6605-S</p>	<p>This CR is being written to address PM testing of PAB exhaust fan flow switches FC-6605-S and FC-6606-S. FC-6605-S and FC-6606-S had their setpoint values (low flow alarms) specified as 0.5 inWc by modification FPX-98-83038-F. FC-6605-S and FC-6606-S were tested by Post Modification Test PMT-17770 and require an ICPM to be generated to insure continued testing under the I&amp;C PM program. The setpoint information is entered into SPIN and is shown as Validated but remaining red-flagged until an ICPM is generated.</p>
<p>200007920 System: DOCK TagNumber: 27TSC</p>	<p>During troubleshooting on 27 and 28 Travelling screen spurious trouble alarms, we found that: 1. The spray line pressure switch (PC-6985S and PC-6984S) sensing lines clogged with "mud". 2. The timer, T5 (screen motor start) set to 5 seconds whereas the drawing shows 15 seconds. 3. The spray line valve for 27 travelling screen (FCV-6983) takes almost twice as long to operate when compared to 28 travelling screen's (FCV-6982).</p>
<p>200007921 System: RCS TagNumber: N/A</p>	<p>Procedural direction provided in POP 3.3, rev 48 and SOP 3.3, rev. 23 provide RCS pressure control guidance that is in conflict with the recent changes to RHR operational limitations, as defined in SOP 4.2.1, rev 43, which if followed up to maximum/recommended pressure bands, could challenge the RHR system integrity. Specifically, RHR operation is limited to RCS pressures up to 370#, as defined in SOP 4.2.1, rev 43, step 4.1.2(2) and enforced by the low pressure interlocks associated with opening MOVs -730 and -731 (RCS pressure &lt; 365#). Step 4.25.4 of POP 3.3 directs RHR to be placed in service per SOP 4.2.1 (370# limitation). However, the next step, 4.26.1 allows a nitrogen bubble to be established in the pressurizer, per SOP 3.3, up to 425#. Additionally, the NOTE preceding step 4.26, states that pressure shall remain above 400# for proper operation of the RCP seals</p>
<p>200007922 System: EDG TagNumber: 23EDG</p>	<p>During performance of PT-M21C, very large swings of KVARs were produced when the automatic voltage control rheostat was varied. The station aux transformer tap changer was placed to min. voltage but this problem persists. This rheostat may need cleaning or replacement. The test was successfully completed with an average KVAR load of 125 but some swings occurred which were nearly full scale</p>
<p>200007923 System: N/A TagNumber: N/A</p>	<p>During the monthly notification drill an attempt was made to activate the telephone message system through the [REDACTED]. The telephone number on for IP-1002-4 was dialed and a message stated that the phone number [REDACTED] was disconnected. An alternate number was used and an answering service took the message that there was a problem with accessing the [REDACTED]. The operator reported the condition to [REDACTED] and a technical rep. returned the call to the security command post. The telephone message was then successfully activated. The tech rep then gave me a new number [REDACTED] to use. Form IP-1002-4 needs to be revised to use this new number and delete the old number.</p>
<p>200007924 System: FW TagNumber: 21SGMW</p>	<p>SGT was observed to be using the lubricant Loc-Tite N-7000 for installation of Replacement Steam Generator lifting trunnions. Previously ConEd had determined that Fel-Pro N-5000 would be the lubricant of choice for use on the RSG's. This information had not been passed on the SGT.</p>
<p>200007925 System: SSS TagNumber: SSSN</p>	<p>During sodium hypochlorite system walkdown with NRC, it was discovered that the residual chlorine monitor for the essential service water header requires calibration. In addition, this instrument does not have a tag number.</p>

200007926  
System: N/A  
TagNumber: N/A

In the performance of 10/17/00 field activities for Radiation Protection Audit 00-03-C, two electronic dosimeters at the HP-2 control point were found out of calibration: dosimeter #104448 was due for calibration on 9/30/00; dosimeter 140105 was due for calibration on 10/13/00. Dosimeter #104448 was found in return box with dose on it. Dosimeter #140105 was found in the "available" box. Calibration stickers on four additional dosimeters were found with illegible calibration due information. The audit team leader [REDACTED] reserves significance level determination.

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Below is a list of 16 CRs created in the last 24 hours. (10/22/00 9:09:31 AM to 10/23/00 9:09:31 AM)

Condition Number	Condition Description
200008071 System: N/A TagNumber: N/A	An NPO while making rounds received a minor laceration to the top of his head. He was bent over looking at the containment spray pump and when he stood up he hit his head on a valve.
200008072 System: N/A TagNumber: N/A	Scaffold for 98'pab boric acid rail mod is missing a few kick plates.
200008073 System: N/A TagNumber: N/A	Inlet line to seal return heat exchanger insulation has a few holes. Holes should be wrapped by asbestos worker.
200008074 System: N/A TagNumber: N/A	98'PAB VCT cell , line insulation is ripped . asbestos insulator should wrap the exposed material. Insulation is by valve lcv-112a, 6' in overhead.
200008075 System: N/A TagNumber: N/A	Wetable insulation wrap is open on line 5' above R-27. Housekeeping is needed material is on hanger under line. area should be rewrapped by asbestos insulator.
200008076 System: EDG TagNumber: N/A	22 Emergency Diesel Generator Explosion cover on the southwest side has an active(minor) leak.
200008077 System: N/A TagNumber: N/A	Industry Safety field walk 10-20-00 (Morning) Steam Generator area (Kenny Lane and Overlook Drive) 1- Two 55 gallon barrels, One stated diesel oil/water and the other stated Hydraulic Oil were not a containment. 2- Two Air compressors 600:300 which had no containment 3- No clearly designated smoking area, there are cigarette smoking occurs everywhere on job site. 4- Light 38416 Mote needs repair. 5- There are multiple stains on the ground appear to be oil. 6- A saw horse was found with weld slag & one of the leg charred / burned wood (fire not reported) 7- Unmarked 55 gallon drum on the corner of Kenny Lane and overlook drive Next to the ITEL container 8- Generator next to Steam Generator building needs the containment extended 9- Worker was on back of trailer while trailer was in motion. 10- Containment next to the maintenance training area is full n; there is oil sheen. Yard # 7 11- Just before entering the yard there is a compressor, that has no containment 12- Next to the building there is an additional compressor with not containment 13- There are also housekeeping issues. 14- There is an apparent sandblast and paint spray booth installed with out any HASP or any knowledge of EH&S. Photo on R drive Under [REDACTED] Industry Safety field walk 10-22-00. Industry Safety field walk 10-22-00 (Morning) Steam Generator area (Kenny Lane and Overlook Drive) Found Item 1,3,7,8 & 10 taken care of form Industry Safety field walk on 10-20-00 (Morning) 1- Forklift which was supposed to have been taken off site on Friday was found still on site Sunday morning and appears to still being used and still leaking fuel oil. The forklift was sitting in front of the existing Steam Generator building. There are stains on the ground below the fuel oil fill line. This forklift was the same one leaking fuel oil on Friday at the 95' equipment area. Key was pulled out of the ignition and given to security until forklift is removed from site 2- The blasting booth inside the existing Steam Generator building needs additional work. There are areas that still have holes in the poly, the entrance way next to the roll up door need to be re-secured prior to any work starting. We suggested that a drape be placed at the bottom of the roll up door the avoid the wind from destroying their work area. 3- Directly behind the existing Steam Generator building in the welding/training facility there are propane heaters inside the building used to heat the building. The propane tanks are outside the building but the rubber hoses that supply the heaters run through the building where cutting, burning, grinding and welding is/are taking place. There are two problems here: ignition source (Propane) and oxygen depletion (CO & CO2). 4- Two sets of Acetylene and oxygen bottles on carts together and no work being performed, one of the sets had the torch disconnected from the set up. 5- Cylinders inside the building were secured improperly. 6- Cylinder in storage rack next to roadway (Overlook Drive) not secured. 7- Directly behind the existing Steam Generator

	<p>building next to Overlook Drive and behind the SGT welding / training building, there are three large stains on the ground which appear to be new to the area. The area appears to be a re-fuel area for SGT vehicles. There is a 55-gallon drum with fuel oil, in a containment area and the containment area is full of oily rags and rubber gloves. The 55-gallon appears to be filled up by the 250-gallon tank that sit directly behind the 55-gallon drum. Directly opposite the 250 gallon tank there is a holding containment area with what appears to be fuel oil red in color and three 5-gallon kerosene containers. 8- Cylinder storage area behind the SGT warehouse has cylinders, which are not secured properly. These area also have cylinders that are also mixed with one another. Oxygen, Argon, Propane, Acetylene, cylinders which are next to each other require a minimum of a 2 hr fire stop or need to be 20 feet from one another. 9- Temporary road lighting across from the new Steam Generator building does not have containment. 10- There is a drain in the new Steam Generator Building that is back up with rainwater.</p>
<p>200008078 System: 480V TagNumber: MCC25-2H</p>	<p>MCC-25 compartment-2H for Roof fan 29 was found making a loud humming sound when the fan was in operation. The fan was secure, recommend Fin Team to investigate condition and make suggestions for repair.</p>
<p>200008079 System: FP TagNumber: EL-17A</p>	<p>EL-17A, 21 Aux Feed pump and valve area Emergency light trickle charge lamp is out. This condition should be investigated and repaired as required.</p>
<p>200008080 System: N/A TagNumber: N/A</p>	<p>Emergency Diesel Building floor grate lock down clips are loose and should be tightened. This condition was noted on several occasions in the past and were tightened. A weekly check by the system engineer should be initiated until a suitable substitute clip can be installed.</p>
<p>200008081 System: N/A TagNumber: N/A</p>	<p>This condition report is being written as a follow up to CR 200002465. The referenced CR was initiated on 4-7-00, to identify a potential GL-91-18 issue associated with our Maint &amp; Outage Building (MOB) Fire Detection System, being out of service for an extended period of time. The System Engineer [REDACTED] concluded that while the MOB Fire Detection system is not specifically called out in our design and licensing basis, it is none-the-less degraded, and important return to service. Because of this background, I was assigned an FYI in the condition report to initiate a new CR if the repairs were NOT completed as scheduled. This CR identifies that the MOB Building Fire Detection remains out of service, today, which exceeds the projected schedule date. Extensive efforts have been applied over the past 6 months to get this job completed by working with Maintenance planning, operations, and Test &amp; performance. The job has now been placed on Engineering hold status, and is a dead end. The system engineer [REDACTED] recommendation following unsuccessful attempts at placing this system in service, is that this repair should be performed utilizing RES-1201-99 and not a work order. Based on this, I recommend this CR be used to assign the appropriate priority to making the modification.</p>
<p>200008082 System: MS TagNumber: LG-1117</p>	<p>During system walkdown with SM [REDACTED] it was discovered that LG-1117. Kaytek level glass was missing its glass tube and orange, magnetic indicator "slug". This renders visual level readings impossible. Recommend replacement or repair of level glass</p>
<p>200008083 System: SEC TagNumber: SECN</p>	<p>At 0533 hrs. the SFS reported that an NPO lost his assigned key ring containing security keys. The NPO discovered that he was missing his key ring sometime between 0430 hrs. and 0500 hrs. Security compensatory measures were immediately implemented per procedures and a search with Security and OPS personnel commenced. At 0558 hrs. the NPO's key ring was found in the CVCS hold up tank pit. The keys were lost in the CVCS hold up tank pit sometime between 0035 hrs. and 0115 hrs. while the NPO was performing a valve line up. The CVCS hold up tank pit is a LHRA under the control of the watch HP and security. During this time there were no other entries into the LHRA and security computer printouts showed no unexplained alarms. No degrade in security.</p>
<p>200008084 System: FP TagNumber: FP-46</p>	<p>While attempting to close FP-46 in order to establish a secure boundry for the upcoming piping replacement, the brass bushing on the stem broke. Valve is closed and tagged. Request bushing be replaced.</p>

<p>200008085  System: N/A  TagNumber: N/A</p>	<p>While walking in the loading well, it was observed that lagging debris was left on the floor near the eye wash station. It was observed earlier in the shift that some lagging material was lying in the same area and since was removed. Status of type of lagging is unknown ( hung asbestos barrier tape around area) and source is unknown. Request lagging debris be cleaned up as soon as possible.</p>
<p>200008086  System: N/A  TagNumber: N/A</p>	<p>While drilling and undercutting holes for the installation of maxi-bolts, an SGT ironworker's finger was caught between the stop plate on the undercutting tool and the wall. This caused his right middle finger to split. SGT safety personnel responded to the work area for treatment.</p>
<p>200008087  System: N/A  TagNumber: N/A</p>	<p>Pig pack, 15' north end of unit 2 is half empty.</p>

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Below is a list of 23 CRs created in the last 24 hours. (10/22/00 4:43:45 PM to 10/23/00 4:43:45 PM)

Condition Number	Condition Description
200008082 System: MS TagNumber: LG-1117	During system walkdown with SM [REDACTED] it was discovered that LG-1117 Kaytek level glass was missing its glass tube and orange, magnetic indicator "slug". This renders visual level readings impossible. Recommend replacement or repair of level glass.
200008083 System: SEC TagNumber: SECN	At 0533 hrs. the SFS reported that an NPO lost his assigned key ring containing security keys. The NPO discovered that he was missing his key ring sometime between 0430 hrs. and 0500 hrs. Security compensatory measures were immediately implemented per procedures and a search with Security and OPS personnel commenced. At 0558 hrs. the NPO's key ring was found in the CVCS hold up tank pit. The keys were lost in the CVCS hold up tank pit sometime between 0035 hrs. and 0115 hrs. while the NPO was performing a valve line up. The CVCS hold up tank pit is a LHRA under the control of the watch HP and security. During this time there were no other entries into the LHRA and security computer printouts showed no unexplained alarms. No degrade in security.
200008084 System: FP TagNumber: FP-46	While attempting to close FP-46 in order to establish a secure boundary for the upcoming piping replacement, the brass bushing on the stem broke. Valve is closed and tagged. Request bushing be replaced.
200008085 System: N/A TagNumber: N/A	While walking in the loading well, it was observed that lagging debris was left on the floor near the eye wash station. It was observed earlier in the shift that some lagging material was lying in the same area and since was removed. Status of type of lagging is unknown ( hung asbestos barrier tape around area) and source is unknown. Request lagging debris be cleaned up as soon as possible.
200008086 System: N/A TagNumber: N/A	While drilling and undercutting holes for the installation of maxi-bolts, an SGT ironworker's finger was caught between the stop plate on the undercutting tool and the wall. This caused his right middle finger to split. SGT safety personnel responded to the work area for treatment.
200008087 System: N/A TagNumber: N/A	Pig pack. 15' north end of unit 2 is half empty.
200008088 System: MSCL TagNumber: N/A	This is for trending only On Friday 10/20/00 while reinstalling the batteries to siren 247. The siren inadvertently went off. Two technicians were at the location. One was on the bucket truck by the control panel and the second was on the ground. Upon activation of the siren the Technician immediately deactivated the unit by pushing in the cancel button in the siren control panel. The siren ran for about two seconds
200008089 System: SW TagNumber: 22CCHX	Service Water System supplies water to various users through essential header and non essential header during normal plant operation. After the Loss of coolant accident (LOCA) and Loss of off site power (LOOP), two service water pumps on the essential header supply water to the Fan Cooling Units and the EDG Coolers during the injection phase. The component cooling water heat exchangers are not needed in this phase. At the beginning of the recirculation phase at least one of the service water pumps on nonessential header is started to supply CCW heat exchangers (FSAR section 9.6.1.2). Thus after the accident during the injection phase CCW Hx loop will be stagnant. CCW heat exchangers are located at the highest elevation (104ft.) in the system and service water system is an open loop discharging to the canal. Thus the ccw hx discharge piping will be drained to the canal and the inlet piping will be drained through the balance of plant users before the flow path is secured. All these piping and ccw heat exchangers will be filled with air ingested from open vents located at ccw hx discharge piping. When the SW pump on the nonessential header is started for the recirculation phase, the system could experience column separation, water hammer and unstable operation. No calculations/documents were found to determine if this condition is analyzed.

<p>200008090 System: SW TagNumber: 22CRFCC</p>	<p>Calculation PGI-00371-00 (9145.002-F-SW-003, 9145.002-SW-004) is a hydraulic model of the service water system. The calculation models the system for normal plant operation and accident conditions. The calculation is found to be deficient in following area: Calculation treats essential header (supplying water to fan cooling units, emergency diesel generator coolers etc) and non essential header (supplying water to component cooling water heat exchangers and balance of plant equipment) as two independent systems. In reality CCW heat exchanger discharge piping is physically connected to fan cooling units discharge piping and has a common discharge to the canal. The backpressure in this header will affect the operation of the service water pumps on the essential header as well as non essential header. The hydraulic model is incomplete. For example, while analyzing non essential header CCW Hx discharge piping is not modeled. For the essential header, the FCU discharge piping is modeled half way (upto elevation 12ft 6in). The discharge canal is @ an elevation of 6 ft. This may affect the total system resistance and pump flows. Attachment C of the calculation is a LOCA case with 3 service water pumps in operation. Node point 8D is system discharge to the canal and thus will carry water from CCW HXs, FCUs, EDG Coolers etc. The flow at this point is calculated to be 3880 gpm. This is a flow from CCW HXs only. Node point 6 (Elevation 75 ft) is a junction point of both CCW HX discharges. The pressure at this point is calculated to be (- 29.7 psi). This is more than double the absolute vacuum and clearly unachievable. On the CCW Hx discharge piping, open vents are located after the isolation valves (elevation 104 ft.). If the system is at sub atmospheric pressure at this location, air will be ingested into the system, creating two phase flows, potential water hammer affecting pump operation. The calculation does not analyze this scenario. Thus the flows and pressures calculated by hydraulic model are suspect and does not provide data to monitor system performance during normal operation or predict flows to various components in accident condition.</p>
<p>200008091 System: N/A TagNumber: N/A</p>	<p>SAFETY CONCERN. Reported by ██████████ Location: 15' main loading well north walkway. The deck plate is loose and concrete is broken.</p>
<p>200008092 System: LO TagNumber: PC-5503S</p>	<p>During recent performance of ICPM-0251, PC-5503S was found to be out of specification and non-calibrateable. W.O 00-17909 has been issued and planned to perform replacement and calibration of PC-5503S. This CR is to document that PC-5503S is being replaced for the 3rd time in as many PM's. PC-5503S was replaced under 95-77543 (4/95) and 97-93090 (11/97). This device is BEARING LIFT OIL PRESSURE INTERLOCK FOR TURNING GEAR. The current field model number is DAW-23-153-13S. this information is not consistent with the OE database which has as a model number DXA-24-3 R13.5. Request this CR be assigned to the system engineer for verification of correct model number for application Update OE database or install correct model. Request System engineering review failure history and recommend corrective actions so that this device can be PM'd as opposed to being replaced at each cycle. Possibility of location problem due to being mounted on Machine and also review the use of a Snubber to preclude pressure shocks to the device when in service.</p>
<p>200008093 System: RMS TagNumber: R-38-2</p>	<p>R-38-2 was calibrated per PC-EM35 on September 23, 2000. It was found SAT. However, the exposure calibration values were approaching the low end of the test's acceptance band</p>
<p>200008094 System: FP TagNumber: N/A</p>	<p>This condition report is being written in response to the improper closure of a SL-2 CR 199905069 written for Audit Finding 99-07-A-F02 in regards to increasing the number of spare SCBA bottles to meet SAO requirements. Further investigation by QA into the Licensing Basis led to the following: Docket No. 50-247 from the USNRC to Con Edison, dated October 31, 1980, page 32 of 43 states: "4.4.3 Breathing Equipment: There are 45 self contained breathing units on the site and a manifold-cylinder system for control room personnel emergency air supply. However, there are insufficient spare air bottles to maintain the breathing air supply for the required 6 hours. The licensee has proposed to provide additional cylinders so that 10 men can be supplied for 6 hours on the basis of three air cylinders per man per hour, and to improve the method of distinguishing between full and empty replenishment cylinders in the bottle refill area. We find that, subject to implementation of this modification, portable breathing equipment satisfies the objectives of Section 2.2 of this report, and is, therefore, acceptable." The Licensing Document requires us to have 6x10x3 = 180 SCBA bottles. The on-site inventory has 89 one-half-hour bottles. See closed CR 199905069, which also</p>

	<p>attempts to take credit for the Eagle Air Cascade System to fill bottles. However, usage of the Eagle Air System is ineffective since we can't fill the required bottles in a timely manner (see CR 200006699 which details the fire brigade response to a fire in our Vapor Containment and SCBA bottles were not replenished within 7 days, 200005248 , and 200006169). Even if we tried to take credit that the Eagle Air System can replenish 15 bottles an hour, the following would result: 1st hour...90 bottles, use 30 bottles, and replenish 15 bottles = 75 SCBA left; 2nd hour...75 bottles, use 30 bottles, and replenish 15 bottles = 60 SCBA left; 3rd hour...60 bottles, use 30, and replenish 15 = 45 SCBA left; 4th hour...45 bottles; use 30, and replenish 15 = 30 SCBA left; 5th hour...30 bottles, use 30 and replenish 15 = 15 bottles left. We won't have enough SCBA bottles to enter the 6th hour. From this calculation we can not meet the Fire Protection Impairment Criteria stated in SAO-703, Addendum 1, Item 13, which requires a minimum number of charged SCBAs to supply 10 people for 6 hours. This requirement is applicable at all times, and should be an administrative LCO if not met. Indian Point does not have enough SCBA bottles and is not meeting our commitment on the required number of SCBA bottles. This issue was passed from section to section with no ownership. The simple solution is to purchase the required number of SCBA bottles. The list price quoted for MSA 30-minute 2216 psig Fiberglass Hoop-Wound Cylinder is \$514 each; \$750 @ for Fiberglass Fully-Wound, and \$860 @ for the STEALTH model. Buying in bulk should yield a 15% to 20% discount... Therefore for 100 SCBA bottles at \$600 @ would cost approximately \$60,000.</p>
<p>200008095 System: FP TagNumber: TST-PI-M8</p>	<p>During performance of PI-M8 (Fire hose cabinets and stations) it was discovered that Fire Hose Cabinet #7 has a damaged roof. The roof has been hit and is buckled. There is a corner of the cabinet roof that has separated from the cabinet. This can expose the contents of the cabinet to the elements.</p>
<p>200008096 System: LO TagNumber: FCV-5272</p>	<p>While performing the valve position verification for COL 26.1 Rev. 15, Main Lube Oil System, a couple of discrepancies were observed. In the field, the instrument air supply piping to FCV-5272, R4D4 (Westfalia Separator) Recirculating Valve, has an oiler, a pressure regulator and a relief valve located between IA-1069, FCV-5272 Instrument Air Root Stop Valve, and solenoid valve SOV-5271. The oiler, pressure regulator and relief valve does not appear on Print# 9321-F-2037-61, the Lube Oil Print, COL 26.1, the Main Lube Oil System COL, nor are they labeled in the field. The other discrepancy occurred while adjusting the unlabeled pressure regulator. The COL indirectly states that the pressure regulator should be set to between 2.0 and 2.5 bars, but while attempting to do this, the unlabeled relief valve prematurely lifted at 1.8 Bars and did not reseal until pressure dropped to 1.6 Bars. Also, the CR system should state that FCV-5272 is R4D4 Recirculating Valve and leave out the other information included in its noun description.</p>
<p>200008097 System: 480V TagNumber: 52/AF3</p>	<p>PT3Y5 test documenting the Amptector results for 23 Aux Feed Pump breaker, AFP-CSP-2008-002, can not be located. The test data sheets are needed to evaluate the unsatisfactory Long Delay Trip Time recorded during the 'as found' testing</p>
<p>200008098 System: SIM TagNumber: N/A</p>	<p>This is a Simulator condition report. The PW (Primary Water) Flow Controller on the FLight Panel is difficult to adjust. Please adjust or lubricate as necessary to allow free rotation of the setpoint dial.</p>
<p>200008099 System: SIM TagNumber: N/A</p>	<p>This is a Simulator condition report. The SAS-RO display and its repeater above the flight panel are flickering. It appears as if the display is about to fail. Please investigate and repair</p>
<p>200008100 System: N/A TagNumber: N/A</p>	<p>During a training scenario in the simulator, it was brought to the instructor's attention that the booklet containing the EOP Critical Safety Function Status Trees contained revision 30, even though revision 34 is the current revision issued for use. There was a correct revision 34 located in the back of a different book (the "F" set book). Operations training believes that the revision 30 critical safety function status trees did not result in any new exam or training issues. Recommend that this CR be assigned to Operations Training as a Level 4 SL for Tracking/Trending purposes. The condition has already been corrected.</p>
<p>200008101 System: N/A TagNumber: N/A</p>	<p>Safety concern. Location: AFB 33' south end in batch room. Floor drain will not lay, secured in floor.</p>

<b>200008102</b> <b>System: RMS</b> <b>TagNumber: R-5976</b>	While performing PT-M98 C/S pushbutton did not respond to touch.
<b>200008103</b> <b>System: EHT</b> <b>TagNumber: 26-1/NTFCF</b>	the alarm does not clear readily on doing periodical testing (as per dsr18 logs)
<b>200008104</b> <b>System: SW</b> <b>TagNumber: N/A</b>	During chemistry procedure revision, a field walkdown was conducted to determine valve line up to incorporate into the procedure. It was discovered that a valve (1/2" Nupro tubing valve) exists in the field which does not appear on the referenced flow diagrams. The valve is located on the service water supply to the high pressure feedwater sample cooler for the corrosion product transport panels. The valve is located downstream of SWT-573 and directly at the inlet to the coolers. Recommend work order to Chemistry to remove the valve.
<b>200008105</b> <b>System: FP</b> <b>TagNumber: FP-633</b>	Attempted to remove FP-633 to clean threads and repair a leak. While removing FP-633 the pipe nipple broke off inside the inlet of the valve. The pipe nipple wall was thin and deteriorated due to corrosion. A new pipe nipple needs to be welded into the header to affect a repair.

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Below is a list of 43 CRs created in the last 24 hours. (10/23/00 6:30:00 PM to 10/24/00 6:30:00 PM)

Condition Number	Condition Description
200008111 System: N/A TagNumber: N/A	AT APPROXIMATELY 17:00 ON 10/23/00 AN SGT FORKLIFT WAS ON ROUTE FROM THE CONTRACTOR PARKING AREA TO OVERLOOK DRIVE WHEN THE MAST OF THE FORKLIFT STRUCK AND DOWNED A TELEPHONE LINE. THE TELEPHONE LINE, WHICH SUPPLIED THE ENVIRONMENTAL LAB, WAS PULLED LOOSE AT THE SPLICE AND DOES NOT APPEAR TO BE DAMAGED.
200008112 System: N/A TagNumber: N/A	High Rad Area swing gate to the 21 Reactor Coolant Pump was found with tape over the audible alarm rendering it non functional.
200008113 System: BG TagNumber: N/A	Floor drain in the Service Water Zum Strainer pit is clogged. This was evident while draining the zum strainer for a Tagout, water accumulated on the floor with a trickle flow going to the sump. There is now an accumulation of mud on the floor in this area.
200008114 System: SIM TagNumber: N/A	This is a simulator condition report. Simulator was initialized to IC-8. While trying to control RCS temperature with the atmospheric steam dumps 21 steam generator narrow range level increased from 65% to 100%. RCS temperature was about 310 degrees. RCS pressure was about 400psig. RHR had been secured. 21 level stayed at 100% for an hour. Aux feed to 21 steam generator was secured during this time. 23 and 24 RCPs were running.
200008115 System: FW TagNumber: N/A	During field review of SGT work package 3085A (Installation of Feedwater Piping) it was identified that OC and WCQ hold points for steps 2, 3, 4, and Field Engineer hold point for step 6 were not signed off prior to performance of following steps. Also, work package notes indicated that these steps were to be performed prior to final fitup of the new steam generator. Identified to problem to SGT and informed SGT that this is violation of the work package work steps as well as a procedural violation of SGT OEP 11.01 for hold points. No NCR is being written by SGT QC to document these findings.
200008115 System: MS TagNumber: FT-429B	Incidental observation of the steam flow instrument piping identified that the piping elbow located between the MS 43-2 instrument root valve and the condensate pot is in hard contact with the main steam riser piping. Need to evaluate condition for use as is or identify corrective actions to be taken.
200008117 System: HVAC TagNumber: FIC-5093-S	The "CCR Intake Toxic Gas Conc. Hi or Monitor Fault" alarm came up in the Central Control Room (panel AS-1 window 4-7) at about 23:00 on 10/23. The alarm was annunciated and reset. The recorder for channel 1 indicated that channel 1 chlorine had spiked to 0.9ppm then returned to less than 0.1ppm. The CCR Ventilation System was checked and was found to be partially in Mode 3 (100% return air). The white light for "damper A prime closed" was lit indicating outside air was being blocked. The lights for dampers CCRD4 and CCRD5 closed were lit indicating Fan K-8 was off. However, the white light for "damper A closed" was not lit. The bulb for "damper A closed" tested good (push-to-test). In the 72' ventilation room the monitor for channel 1 chlorine was in alarm. The alarm was reset and CCR ventilation returned to normal (Mode 1). The watch chemist checked the CCR air and found nothing abnormal. No chlorine odor was evident. Either damper A failed to close or it closed but failed to make-up the switch that would light the "damper A closed" light. Note: Safety Evaluation 00-529-EV has been approved to remove the requirement for CCR Toxic Gas Monitors in the U FSAR.
200008118 System: GT TagNumber: N/A	GT1-PI-2 is not installed in the field! Field conditions do not match Drawing. Downstream of GT1-V6 a plug is in place rather than PI-2. This condition was found during valve labeling evolution.
200008119 System: WDS TagNumber: 11LWTP	Both 11 & 12 laundry waste drain tank pumps seals are both leaking. 12 pump seal sprays. 11 pump seal leaks excessively.
200008120 System: WDS TagNumber: CT 04-LXP/1	11 LWT level tracks app. 2-3 in. per inch of level transfered from 12 LWT.

<p>200008121 System: N/A TagNumber: N/A</p>	<p>ccr recieved call at 0241 from HP requesting an ambulance. A SGT employee recieved a laceration to his leg from a carpet knife. He had been working in the VC at 95 ft el. Individual was not contaminated. Ambulance arrived on site at 0255 and departed site at 0306</p>
<p>200008122 System: N/A TagNumber: N/A</p>	<p>At approx. 0235, on October 24, 2000 an SGT Pipefitter cut his right leg below the knee with a razor blade type knife. The apparent circumstances were that the Fitter was working on his knees or in a crouched position removing cotton diapers from TLD hydraulic hose connections and was using the knife to expedite the process. The knife apparently slipped when he cut at a tie-rop and cut his leg.</p>
<p>200008123 System: N/A TagNumber: N/A</p>	<p>SAFETY CONCERN. Half of the road lighting in the contractor parking lot (top of covered stairs) are not performing their intended function. SGT light tower is aimed at the lot for lighting.</p>
<p>200008124 System: N/A TagNumber: N/A</p>	<p>Location: 36' unit 2 under ISO DUCT. A section of piping has damaged jacketing and an Asbestos label on it.</p>
<p>200008125 System: N/A TagNumber: N/A</p>	<p>While reviewing SL-3 for quality it became apparent that Support Services is closing out SL-3 c/rs to SSR (support service requests). This is against the SAO112 procedure. Suggest SL-3 to CAG for evaluation and determination on whether procedure needs to be upgraded to include this.</p>
<p>200008126 System: N/A TagNumber: N/A</p>	<p>NRC Regulatory Issue Summary 2000-18, GUIDANCE ON MANAGING QUALITY ASSURANCE RECORDS IN ELECTRONIC MEDIA This is an OE item from the NRC website observed while conducting daily reviews of the Website. The purpose of NRC Regulatory Issue Summary is: "The U.S. Nuclear Regulatory Commission (NRC) is issuing this regulatory issue summary (RIS) to provide guidance on managing quality assurance (QA) records in electronic media. This RIS does not supersede or revise existing guidance or abrogate the guidance in Regulatory Guide (RG) 1.88, Revision 2, or RG 1.28, Revision 3. It does not provide guidance on submitting electronic records to the NRC as required by Section 50.4(c) of Title 10 of the Code of Federal Regulations (10 CFR 50.4(c)). The guidance in this RIS is intended to provide, for those licensees with QA programs, a way to satisfy the requirements for the maintenance of QA records. However, the guidance can also be applied to the record keeping and maintenance requirements present in other parts of the regulations that specify that storing records in the form of electronic media is acceptable. This RIS does not create any new or changed NRC requirements or staff positions, and it requires no specific action or written response. Any action on the part of addressees to use electronic media for managing QA records is strictly voluntary." The addressees for this Reg Issue summary are: "All holders of operating licenses for nuclear power plants, including licensees that have permanently ceased operations and have certified that fuel has been permanently removed from the reactor vessel. In addition, those materials licensees, including certificate holders and vendors, that are required to have an NRC approved quality assurance program." The discussion section of this issue summary includes: "Although the guidance in GL 88-18, RG 1.88, and RG 1.28 remains relevant and acceptable, licensees and nuclear steam system suppliers have suggested that additional guidance on the acceptability of new information management technologies is needed. NRC regulations already recognize the acceptability of storing and maintaining licensee records in electronic media. Specifically, 10 CFR 50.71(d)(1), "Maintenance of Records, Making of Reports," states that records that must be maintained pursuant to 10 CFR Part 50 "may also be stored in electronic media with the capability of producing legible, accurate, and complete records during the required retention period." In addition, various other parts of the regulations, such as in Part 20, Parts 30-39, and Parts 40 and 70 for example, indicate that electronic media are acceptable for use when the requirements for authentication, reproduction, and storage are met. This RIS provides the additional guidance requested by the nuclear industry on storing and maintaining QA records in electronic media. The guidance applies to QA records that are subject to the requirements of Appendix B to 10 CFR Part 50, Part 60, Part 71, Part 72, or Part 76, and that are noted in a licensee's QA program description. In addition, this guidance may be followed to satisfy the record keeping and maintenance requirements found in other parts of the regulations that specify that electronic media are acceptable for storing documents....." Recommend a SL3 assignment to Quality Assurance to evaluate and recommend further corrective actions, with FYIs to Records Management, Training, Operations, Maintenance, NS&amp;L,</p>

	Radiation Protection and Engineering departments.
200008127 System: N/A TagNumber: N/A	On 10/24/00 a TLD belonging to a WSI employee was returned to Dosimetry by another contractor who found it outside his hotel in the grass. This tld had been reported lost on 10/18/00 and a dose evaluation was done. This is another incident where WE should be evaluating our policy of taking dosimetry home.
200008128 System: PACS TagNumber: PACSA	During development of quarterly system health report for Post Accident Containment Air Sampling (PACS), it was discovered that a modification to the system is necessary due to the new passive hydrogen recombiners which was not addressed as part of that modification. Specifically, the oxygen alarm setpoint in the CCR should have been eliminated or changed to reflect our new mode of operation. Currently, the alarm is set for 7% which is attributed to minimum value for flame stability for the original flame recombiners.
200008129 System: N/A TagNumber: N/A	While vacuuming the flyash from the House Service Boiler Breaching, it was noticed the there was a breach of the HEPA filters installed inline to prevent fly ash dust from exhausting into the environment. .
200008130 System: HVAC TagNumber: HVACA	15' and 33' dampers to Control Building (480V Room and Cable Spreading Room) have blue roughing filter material installed. This roughing filter material looks generally unprofessional. Is there a better way to install it? Perhaps a grid of angle iron can be attached which will allow the filter material to be held in place easier with rubber straps or whatever? System Engineer please investigate.
200008131 System: N/A TagNumber: N/A	<p>There is a concern about reducing the current Source Range Reactor trip setpoint from 50,000 counts to 23,000 counts. The concern is a reduction in the operator time to perform required verification steps in POP 1.2, and then de-energize the source range instruments in time to prevent a plant trip. The operator is required by Plant Operating Procedure 1.2, rev 29 to do the following:</p> <p>===== 4.26 WHEN P-6 is actuated, AND the LOW POWER PERMISSIVE BLOCK NOT ENGAGED alarm occurs at 1.0 E-10 amps, PERFORM the following: 4.26.1 BLOCK Source Range High Flux trips. _____ 4.26.2 OBSERVE SOURCE RANGE TRIP BLOCKED light lit. _____ 4.26.3 VERIFY SOURCE RANGE LOSS OF DETECTOR VOLTAGE alarm actuates. _____ 4.26.4 VERIFY both source range voltages read zero. _____ NOTE</p> <p>WHEN the HV Manual Control Switch is taken out of NORMAL, the HV Manual Control Light should illuminate. The HV Manual Control Light is NOT an indication of detector voltage The detector voltmeter should be checked as the primary indication of detector voltage. 4.26.4.(1) IF source range channel(s) are still energized (a) PLACE the affected channel(s) HV Manual ON/OFF switch to the HV OFF position Source Range Channel 31 (SR 31)HV OFF _____ Source Range Channel 32 (SR 32)HV OFF _____ On plant startup on 08/25/97, this occurred. Data is from the Safety Assessment system (SAS) computer. High Volts off occurred at 15.284 counts on N0035 at 06:21:55 on 08/27/97. The startup rate at that time was .28 DPM (Note: POP 1.2 allows up to a .5 DPM startup rate with an absolute limit at 1 o DPM) Using the SUR equation the time until a trip would have occurred with 50,000 CPM trip limit is as follows: 1) Counts final (C2) = Counts initial (C1) x 10<sup>4</sup>(SUR x T) where T is in minutes. Putting in the numbers we get 2) 50,000 = 15,284 x 10<sup>4</sup> (.28 x T) 3) 3.271 = 10<sup>4</sup> (.28 x T) 4) Log 3.271 = .28 x T .51 = .28 x T 5) T = 1.838 minutes = 110.3 seconds On 08/25/97 the operators had 110.3 seconds to perform the checks in POP 1.2 prior to de-energizing the Source Range Instruments before a plant trip would occur. The revision in effect on this date had the same requirements as the current revision in this area. They were successful. With the proposed 23,000 CPM Source Range reactor trip limit, performing this same set of equations produces: T = .634 minutes = 38 seconds These equations are performed with actual plant data. If the operators had been at the .5 DPM SUR that POP 1.2 allows them to be at, the new time to trip with a 23,000 CPM trip limit would have been 6) 23,000 = 15,284 x 10<sup>4</sup> (.5 x T) 7) T = .355 minutes = 21.3 seconds This series of checks was also performed with the 07/27/97 startup. On that date, CPM was 14,463 on channel N0035 with a SUR of .32 DPM when the Source Range were de-activated. Performing the same series of equations, the time to trip from the actual conditions was: T = 101 seconds. With the proposed reduction in Source Range Trip the new time to trip would have been T = 37 seconds The operators are in a position where they have to make certain checks and verifications of proper instrument overlap between the Intermediate Range instruments and the Source Range instruments before they can de-activate the Source Range instruments. They have to do this with a positive SUR and increasing power since the overlap checks by definition</p>

	<p>occur on increasing core power. They have to see P-6 AND 1.0E-10 amps before they are allowed to act. A situation where a single Intermediate Range instrument is slightly under compensated could easily delay that one instrument from responding as rapidly as the other. The operator is looking for both to respond. As reactor power is coming up, this and the P-6 interlock light are his focus. It is very possible to have a delay in Intermediate Instrument response. It is possible to have a momentary distraction like an annunciator going off that takes the operators attention a few seconds. Even if his eyes are glued to the Source range instruments his attention will be wondering what that alarm was and what impact it might have on his evolution until another control room operator calls out the alarm. At the allowed .5 DPM the operator might be at, and the counts it is known that plant was at, there are 21 seconds to trip. The question is, is the gain to the station in reducing the 50,000 counts in place since October 1973 (PL&amp;S documented level; P-1-8, 10/73) to 23,000 counts worth the risk in reducing the operators allowed time to diagnose and react from the measured 101-110 seconds to the new 37 -38 seconds, and potentially 21 seconds worst case? That is what will occur.</p>
<p>200008132 System: N/A TagNumber: N/A</p>	<p>Subject: WESTINGHOUSE FUEL ISSUE, MR Number: H-00-0060Westinghouse Date: 10/20/00 This is an OE item from the NRC website, observed while conducting daily reviews. This item entered to facilitate tracking of the issue. A brief summary of the letter follows: "A potential generic concern that could introduce loose parts into the reactor coolant system of Westinghouse PWRs has been identified at Vogtle, Unit 1. Plants using Westinghouse fuel containing Vantage Plus upper nozzle leaf springs could be affected. The screws holding down the upper nozzle leaf springs have been cracking due to primary water stress corrosion cracking; the screws are manufactured of heat treated Inconel 600 a material of known susceptibility. The cracking and ultimate fracture occurs in the screw shank immediately beneath the screw head. This failure mode has been known for over a year and broken screws have been found during refueling; what makes the Vogtle occurrence novel is that a screw head was found lodged in a steam generator hot leg tube stub. Information was provided by Westinghouse through its owner's group contact during October 5 and 11, 2000 telephone calls." Recommend a SL4 assignment to Reactor Engineering to review and take any appropriate action.</p>
<p>200008133 System: N/A TagNumber: N/A</p>	<p>Dung assessment of the CAP monthly metrics it was noted that many of the packages sent to CRS owners during the month of July and August had erroneous information contained on it. The electronic media remained correct however, the transfer from the computer to the mass handouts went wrong (human performance error). All information is correct now. Suggest SL4 to CAG for track and trend purposes.</p>
<p>200008134 System: N/A TagNumber: N/A</p>	<p>Dung final review of SGT work packages the following discrepancies were noted: WP 2575A 1) Wrong magnetic particle batch number on MT Report on page 17 of 20. WP 2575B 1) Wrong QEP 12.05 rev. no. on pages 3, 4, and 5 2) Wrong QEP 12.03 rev. no. on pages 5 and 19 3) Wrong WPS SM/3.3-1 rev. no. on page 5 4) Wrong MT particle batch no. on pages 15, 16, and 18 WP 2575D 1) Wrong QEP 12.05 rev. no. on page 3 2) Wrong MT particle batch no. on pages 25, 26, and 27 3) No WPS rev. no. entered for WPS SM/3.3-1 on page 16 The hardware for the above Work Packages is not affected, documentation errors only.</p>
<p>200008135 System: DOCK TagNumber: 21TSC</p>	<p>8' X 8' TIMBER MATS MADE OUT OF 12" X 12" SOUTHERN PINE TIMBER ARE BEING PURCHASED TO FORM A TIMBER PLATFORM THAT A TRACTOR CRANE WILL USE DURING REPLACEMENT OF 21 TRAVELING SCREEN. THIS PLATFORM HAS BEEN SPECIFIED BY CIVIL ENGINEERING ON DRAWING # 324792. THESE 'TIMBER' MATS WILL BE USED ON UNIT 2 DOCK WHENEVER THIS PARTICULAR CRANE IS USED FOR A LIFT OF THIS NATURE. DUE TO THE SIZE AND USE OF THESE MATS DO THESE MATS HAVE TO BE FIREPROOF? DURING A CONVERSATION WITH FIRE PROTECTION ENGINEERING I WAS TOLD THEY DO NOT BUT PURCHASING HAS REQUESTED SOME FORM OF WRITTEN EVALUATION PRIOR TO PURCHASE.</p>
<p>200008136 System: DC TagNumber: 1-V108A/BATTCHG22</p>	<p>Contractor completed work on site before the purchase order was issued. [redacted] completed the load test on station battery 22 before requisition 994 00 0056 000 was sign by procurement engineering. The technical and Q.A. requirements were communicated to performance and test before the load test was performed.</p>

<p>200008137 System: FW TagNumber: 21SG</p>	<p>SGR QA wrote a field note "SGRP -163" which stated that during the transfer of RSG-21 though the containment equipment hatch, hard contact was made between the SG steam dome and the hatch barrel. This event happen on October 12. CR 200007961 which documents the the fact that this event was recorded on SGTs "NCR-200" was written on 10-19-00. SAO 185 parag. 4.2.4 Corrective Action Program item c. states " The Corrective Action Program directive establishes the process for review of outside contractor/vendor-identified conditions potentially adverse to quality, to ensure that conditions which warrant a Condition Report (CR) are initiated in the Con Edison (IP2) Condition Reporting System (CRS). ... The SGR CAT shall meet daily (normal workweek) to review conditions potentially adverse to quality identified since the last meeting." This CR is being written to ask questions and concerns which are as follows: 1- Why it took 5 days to write CR 200007961? It does no good now since all of the other SG's have been brought into the VC. What if corrective action on Con Eds part was needed or anyone else, such as SGT required by Con ED to ensure that this type of event would not happen to the remaining SGs. Its a little to late. 2- Also please note that CR 200007961 has a SL rating of a "4"! A SG weighing approx. 325 tons making HARD contact with containment is a 4? How can the potential to damage the last boundary that protects the public from radiation be considered SL 4? Therefore I question our SL levels also. 3- Now since this event apparently slipped through the crack of the SGR project I need to question out of the 200 or more NCRs from SGT how many more should have been CRs and fell though the cracks? 4- CR 200007961 Narrative disposition only address the concern for the condition of SG 21. It does not address any concern for containment. Is there any damage to the containment or are we even going to do any inspections to see if we did any damage to containment? Please note that the VC is a ASME Section XI component, therefore is a section XI inspection required such as an ILRT or visual (VT3)? Also please note that the direction given in the disposition is incomplete. There is no acceptance criteria give for the P Tor MT.</p>
<p>200008138 System: N/A TagNumber: N/A</p>	<p>Identified poly being used to construct House Service Boiler containment as not fire retardant</p>
<p>200008139 System: N/A TagNumber: N/A</p>	<p>During a routine inspection, members of the Safety organization observed contractor employees working in an area not specifically addressed by the contractor's site EH&amp;S plan. Contractor was in the process of drilling anchor holes for rock slope stabilization when Safety Reps noticed potentially loose rocks above</p>
<p>200008140 System: GT TagNumber: 52/GT2NS</p>	<p>During performance of the referenced procedure step B.3.7 the insulating link on a phase was found to be unacceptable. This link was replaced in the same procedure, no further action is necessary.</p>
<p>200008141 System: HVAC TagNumber: FHEF</p>	<p>During preparation of a revision to SOP 11.1, implementing a MOD (the MOD being implemented is NOT at issue in this CR), a Communication To Staff was reviewed (CTS 98-1008) for incorporation in the procedure. The CTS stated the following: "S O P 11 1 page 7 [now page 5] 4.2.1(6) when the jog pushbutton is depressed the fan will stay on This is most likely due to the retirement of the FSB FATU'S Step 4 2 1(7) refers to fan(s) and desired fan combination. There is only one fan for this panel on the FSB controlled at the panel." This CR is a Technical Question, namely whether the statement, " when the jog pushbutton is depressed the fan will stay on This is most likely due to the retirement of the FSB FATU'S." is still, or was ever true This should have been addressed at the time the CTS was first submitted, by another means, since there was no procedural way to prevent what occurred Step 4.2.1.(6) states, "TEST FSB Exhaust Fan by pressing JOG button " Subsequent Step 4.2.1.(7) states, "START the FSB Exhaust Fan by placing the FSB Ventilation Master Switch (Fan Room Control Panel 80 FT. EL PAB) in START AND ENSURE that the fan has started."</p>

<p>200008142 System: N/A TagNumber: N/A</p>	<p>Apparent Procedural Non-Compliance: SAO-180, Rev. 0, "ADMINISTRATIVE STEAM GENERATOR PROGRAM PLAN," Section 5.3, "Additional Reporting Requirements," Step 2 states: "The number of tubes plugged in each steam generator shall be submitted to the NRC within 15 days after completion of the in-service inspection. It is not apparent that this data has been submitted to the NRC within the procedurally required time frame. This is an issue with the Old Steam Generators and may also be an issue for the new Steam Generators. A "45 day" post inspection report (CMOA) was submitted to the NRC on June 2, 2000 with the results of the old steam generator inspection/plugging data, however, not within the 15 day requirement. Note that this requirement is not a Tech. Spec. requirement. Rather, it was included in Rev. 0 of SAO-180 since it is a requirement set forth in NEI 97-06 "Steam Generator Program Guidelines." Recommendation: Assign Evaluation (SL3) report to the [REDACTED] to determine the apparent cause for implementing a new SAO without having all affected procedural changes in place prior to the new procedure being effected. Assign an ICA to NS&amp;L to ensure SAO-125 "Station Written Reporting Requirements" includes this administrative reporting requirement. Assign an ICA to [REDACTED] to determine/ensure the information on the new SGs has been submitted to the NRC.</p>
<p>200008143 System: N/A TagNumber: N/A</p>	<p>WSI worker reported to HP that his MG had received 14mr accrued. Further investigation revealed that his cell phone was causing the MG to alarm and accrue dose.</p>
<p>200008144 System: N/A TagNumber: N/A</p>	<p>The DRD's located in the old command post are out of calibration. These are issued to emergency response personnel. Please reference this to CR 200006528, Vapor containment, fire.</p>
<p>200008145 System: SIM TagNumber: N/A</p>	<p>This is a Simulator condition report. During a training scenario on 10/24/00, an anomolous condition occurred which cannot be repeated, and cannot be explained based on the conditions which existed at the time. This is CR is to document that the anomaly occurred. No corrective action is required. Please assign to the Computer Applications Simulator Support group for tracking and trending only. Dunning the training scenano, following a reactor trip and safety injection, 480 VAC buses 2A and 3A failed to transfer to buses 5 and 6 as would be expected. The operating crew and the simulator instructor attempted to repeat the condition several times, but each time the inside buses auto transferred to the outside power as expected. The simulator was backtracked to just prior to the trip and the sequence of events was repeated, but the anomaly did not repeat itself. The simulator was backtracked to just after the trip, but the operating crew and instructor could not determine why the inside buses failed to auto transfer.</p>
<p>200008146 System: SEC TagNumber: N/A</p>	<p>A review of the performance indicators for security shows a clerical error of two hours and nine minutes that were counted in the Intrusion Detection System indicator which have not been included.</p>
<p>200008147 System: SEC TagNumber: N/A</p>	<p>Both alarm monitors assigned to the security shift supervisor and the lieutenant shift supervisor are not functioning.</p>
<p>200008148 System: N/A TagNumber: N/A</p>	<p>At approximately 1430 24 October, 2000, it was detected by SGR personnel, dunning routine walkdown, that the Main Steam header, tacked into place on #21 Steam Generator was slack on the rigging. Upon investigation, it was determined that there was no operator in the cab of the 175 Ton crane which was holding the load. It is required for the crane to retain the load (approximately 14,000 lbs) until the root pass and hot pass welds have been completed. This is a violation of OSHA and site programmatic requirements.</p>
<p>200008149 System: GT TagNumber: GT3</p>	<p>While performing PT-2Y11C Gas Turbine #3 blackstart timing, the following was noted. The test refers you to AOI 31.3 to transfer the auxiliaries to the black start diesel. To verify a successful transfer AC amps on the local black start panel should be indicating 180-220, they were indicating &lt;100. Checked with CCR and system engineer before proceeding, this extended the time of the test 4 or 5 minutes. The test exceeded the accepted time of 39.5 minutes by 2.5 minutes. The values expected in AOI 31.3 may need to be evaluated, the black start was operating properly while the amps were reading less than expected.</p>

<p>200008150 System: N/A TagNumber: N/A</p>	<p>During fall pm and troubleshooting of heating unit in maintenance warehouse found that heat exchanger on furnace has a 8" crack.</p>
<p>200008151 System: N/A TagNumber: N/A</p>	<p>Industrial Safety walk 10/24/00 All work on 21 and 22 Steam Generator was stopped at approx. 1555 above 95', the work was stopped due to the scaffolding being used for both personnel and rigging. All Scaffolding that is being used for both personnel and rigging needs to be designed by a New York state registered professional engineer and the design shall be documented by a drawing and by calculations. SGT told Local EH&amp;S that they did not have this documentation. SGT was told to get all personnel off the scaffolding until a Professional Engineer approved the scaffolding and all supporting documents was received from the professional engineer. See OSHA regulation 1926 subpt L</p>
<p>200008152 System: GAS TagNumber: N/A</p>	<p>While walking down the VC nitrogen system in response to CRS #200008110 the following Minor Nitrogen leaks were detected. PC-3102S (Porv Accumulator 455C's Nitrogen Low Supply Pressure Alarm) has a minor leak on the upstream connection of it's union where it threads into the connecting nipple. 4111 leaks by - this was detected by leaking flange (leaking flange will be corrected by Operations, only valve leakby needs to be addressed.) 4125 leaks by - this was detected by leaking cap (leaking cap will be corrected by Operations, only valve leakby needs to be addressed.) Upsteam of the Porv accumulator Nitrogen Supply check valves the following minor leakage was detected. (note check valves may not seat against minimal D/P so supply header leakage would affect the Porv accumulator system) 891A, 891B, and 891D have minor packing leaks. Conval 4313 has a minor packing leak and will be corrected by Operations. All leakage was minor and could not be heard, could only be detected by use of Leak Tek.</p>
<p>200008153 System: RCS TagNumber: 516</p>	<p>516 (PRT Air Operated Valve to Vent Header) has a moderate (Leak Tek not necessary to detect, can be heard by ear) Instrument air leak on it's union upstream of them Air Operator's IA PRV. Valve is located on top of the PRT.</p>
<p>200008154 System: GAS TagNumber: DPI-7643</p>	<p>gauge does not read accurate pressure. When the driver filled the tank it read 10,000 lbs. actual level when full is 12,000 lbs.</p>

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Below is a list of 35 CRs created in the last 24 hours. (10/25/00 11:47:52 AM to 10/26/00 11:47:52 AM)

Condition Number	Condition Description
200008178 System: 480V TagNumber: 480VA	It was pointed out by one of the mechanics that several new pole bases DB breakers have chips in them. The chips in the pole bases appear to be from physical damage. At this time the pole basis were on a rolling cart to be used as replacement parts. The mechanic stated that the pole bases were on one of the large skids with cardboard sides and were not individually protected. If these polebases were installed on a breaker when the next PM was performed a defficency would result because the PM requires tha the pole bases be inspected for cracks and chips. These parts are destined to be installed on safety related breakers and are very expensive therefore they should get better treatment.
200008179 System: N/A TagNumber: N/A	WE attempted to use the ESP Qual Guides (QGs) as they exist on the IP-2 Web under Technical Training Site for ESP Qualification. I have now repeatedly asked for a version of the NS&L QGs in either Word or Word Perfect so that the first page except for signatures could be typed. In addition, when the Web version of the QGs are printed there is no control over page breaks, thus, WE will end up with signatures on pages they are not associated with. All in all a very unprofessional piece of work. Technical Training provides mixed messages when WE have pursued the solution to these problems. ESP people indicate that the ESP QGs are on an access database developed by a summer student and he is no longer around. So WE have to live with the problems or use a copy of their hard copy to generate the QGs for personnel use. Others in Tech Training indicate that the QGs are in MS Word and WE should be able to get them and solve our problem. Besides the unprofessional appearance WE will end up Qualifying from uncontrolled QGs if WE are required to continue as indicated.
200008180 System: N/A TagNumber: N/A	The purpose of this CR is to document the inspection of controlled operating procedures based on Records Audit exit meeting on 10/19/2000. An inspection of procedures in the Convention NPO Office on 15' El. was done on 10/23/2000. The inspection included SOPs, COLs, OADs, AOIs, ARPs, LARPs and TPCs. The result of this inspection found that there was one missing procedure (COL 11.1) otherwise there were no other missing procedures, all dates, revisions and TPC's were correct. Please assign this as Track and Trend to Generation Support. Send FYI to Manager Audits and Surveillances.
200008181 System: WTP TagNumber: N/A	THIS CONDITION REPORT IS BEING GENERATED TO DOCUMENT A DISCREPANCY WITH THE VALVE NUMBERING METHOD BETWEEN CONTROLLED DRAWING B249125 ,FLOW DIAGRAM FOR THE WATER TREATMENT PLANT, AND TNMS ,OE AND COL 33.1.TNMS AND OE DISPLAY AN EXTRA DASH IN THE VALVE NUMBERING.WHEREAS THE DRAWING DOES NOT.THE CHECK OFF LIST AGREES WITH TNMS AND OE BUT NOT THE DRAWING.THE WATER TREATMENT PLANT IS SLATED FOR RETIREMENT
200008182 System: SW TagNumber: 24SWP	The PM for 24SWP was scheduled for completion 7-30-00 per the PPMIS sheet in the package (which was pnnted 7-28-00). This PM was STARTED on 10-25-00.
200008183 System: PACS TagNumber: PACSA	Conducted quarterly walkdown of Post Accident Containment Air Sampling SYstem and noted the following: (1) The "Power On" lamp is not illuminated on the analyzer for channel 1 (80' PAB Old Chem Sample Cell). Note: this was previously identified in last quarterly walkdown and documented in CR200005043. (2) Temporary insulation present at heat trace zone 2 thermocouples (68' PAB). Note: this was previously identified in last quarterly walkdown documented in CR200005043 and previous CR 200002796. In addition, the insulation integrity is beginning to degrade. (3) Zone 2 heat trace for channel 2 remains energized and channel 1 is cycling. This is uncharacteristic operation and maybe due in part to the temporary insulation and its degradation. (4) Numbers hand written in pencil on the face of the remote control panels under the heat trace controllers in the 98' MCC Room. These numbers may cause someone to believe they are the temperature setpoints. Writing needs to be removed. (5) Tags are missing for the local analyzer panels (AIT-5109-1, AIT-5109-2, AIT-5110-1 and AIT-5110-2) in the 80' PAB Old Chem Sample Cell. Numbers hand written in black ink on the face of the local control panels at the top. (6) "Heater On" lamp is illuminated for channel

	<p>2 but not channel 1. This appears to be uncharacteristic since both analyzing cabinets are next to each other and draw a sample from the exact same location. Recommend work order to investigate both channels for proper operation. (7) The indicating lights (green) for SOV's 5018, -5022, and -5023 are not as brightly illuminated at -5019. In addition, the light bulbs for the SOV associated with channel 2 (SOV-5020, -5021, -5024, and -5025) has the same intensity matching -5019. It appears there is a mismatch in light bulbs.</p>
<p><b>200008184</b> System: ILWH TagNumber: LW-675</p>	<p>The piping between LW-675 and 13 WDTP has a thru wall leak at the top of the second weld from the valve. The hole is such that the pump is wetted when LW-675 is open. Leak developed during release of 13 WDST.</p>
<p><b>200008185</b> System: WDS TagNumber: 21RCDT</p>	<p>While reviewing Modification FMX-96-12106-M to prepare a tagout for the mod installation, became aware of intent to place a trap on the line from the RCDT to the vent header in the piping pen. TECHNICAL QUESTION.....Is it a good idea to place a trap on this line? Is there a possibility that, if the trap blows down and the sealing surfaces don't seal, that we could empty the contents of the vent header to the PAB?</p>
<p><b>200008186</b> System: DOCK TagNumber: FI-6970</p>	<p>FI-6970 was recently cleaned. It was reinstalled backwards and upsidedown.</p>
<p><b>200008187</b> System: N/A TagNumber: N/A</p>	<p>Safety concern. Location: 53' near front of One Stop Shop. Plate has two 4"x2" holes. These holes are over the insulators fabrication area and are a tripping hazard.</p>
<p><b>200008188</b> System: N/A TagNumber: N/A</p>	<p>The following procedure discrepancies were identified during the Formal Self-Assessment being performed by the Setpoint Control Group. Station practice, and the implication of the guidance in SAO-452 Section 2.2.1 and Addendum II, has been to initiate non-hardware (setpoint-only) changes via the Condition Reporting System. This conflicts with the instruction in SAO-405 Section 4.12.2 which states that " personnel seeking to obtain new or add/change setpoints shall be required to submit all change requests on a SAO-415 Request for Engineering Services (RES) Form. Recommend assigning this CR to Setpoint Control Group for evaluation and coordination of resolving this procedure discrepancy with the Modification Optimization Project.</p>
<p><b>200008189</b> System: N/A TagNumber: N/A</p>	<p>This condition was identified during the Formal Self-Assessment being performed by the Setpoint Control Group. Setpoint types required to be controlled at IP2 are identified in SAO-452. The means of control is via the Setpoint Information Network (SPIN) database Per SAO-452 Section 2.3.6.d, Computer Applications department is responsible to provide to the Setpoint Control Group computer PTIDs for which SPIN needs to be populated. To date this transfer of information (as a complete listing) has not occurred. Transfer of information from other groups to which this condition applies is typically accomplished on a piecemeal, as needed basis, rather than as a complete package. Recommend assigning this CR to Setpoint Control Group for determination of extent of condition, evaluation, and followup.</p>
<p><b>200008190</b> System: 13.B TagNumber: 13.8N</p>	<p>During the performance of the blackstart timing test for GT-3 (PT-2T11C), the total black start time once again exceeded the acceptance time of 39.5 min. The time recorded was 42min until the GT reached a stable condition and 16MW. There seems to be a problem with the nomenclature of step 7.8 of the test which requires the timing be performed when the GT is STABLE at MINIMUM load. Per the system engineer minimum load is 2-3 MW and this is where the timing should take place. Step 7.8 specifically indicates that the GT should be stable and this does not occur because the GT is still ramping up to 16MW. Per the system engineer perhaps this step should be changed to indicate 2-3MW and the test would then meet it's required time. This would also prevent operations from performing this test unnecessarily in the future if in fact this is true. Please resolve this prior to operations performing the test again or repair the alleged problem. This CR is being written as a test failure.</p>

<p>200008191 System: IA TagNumber: IAA</p>	<p>During walkdown for tagout associated with work order NP-98-98582 (air leak at FE-6448), it was discovered, prior to tagout being applied, that an IA line that among other things provides indication of IA to the nuclear side to the CCR does not appear on drawing 9321-F-2036-80. The other components that this IA line supplies are the following: 1) LC-1130 (IACC Expansion tank lvl input to lvl controller) IA isol valve is IA-1333. 2) PT-1192 (IACC pumps discharge header press) IA isol valve is not labled. 3) TCV-1113 (SW outlet TCV for IACC HX's) IA isol valve is IA-879. 4) There are also at least 3 connections that go to components that no longer exist off this line. This IA line taps off at a point between FE-6448 &amp; IA-36-2. This tap off is physically located just west of the TSC UPS bus # 2 emer transfer switch in the 480v room on the 15' elevation.</p>
<p>200008192 System: MS TagNumber: MS-94-3</p>	<p>While getting ready to weld in a drain line with valve on MST-40 Inlet Drain Pot Stop, Work Order# NP-00-17722, My welder [REDACTED] looked into the elbow we were welding to and saw a fermanite nut stuck in the elbow. Tried unsuggsefully to remove nut. I informed my supervisor [REDACTED] that there was foreign material stuck in the elbow. Mr. [REDACTED] came out and inspected the elbow. He instructed us to cut out the elbow and put it in a bag and give it to him. [REDACTED] cut out the elbow. We also found serveral pieces of metal. We put the elbow and the other FME in a plastic bag and gave it to Mr. [REDACTED]</p>
<p>200008193 System: FW TagNumber: 22SG</p>	<p>SGT has welded or partial welded numerous Upper Lateral support plates at SG 22 and has not documented base material, weld material, welder qualifications, material cleanliness, or weld fit up. The support plates are T-13 through T-29 and the welds in question are FW-7 through FW-30. The SGT weld history card only requires their QC to perform a final visual examination of the finished weld. SGT QC did verify the gap between the support plate and the steam generator as per work package.</p>
<p>200008194 System: SIM TagNumber: N/A</p>	<p>Simulator Deficiency. Dunning plant start-up operations, using IC-23, noted that a 150 lb pressure difference existed across the Main Boiler Feed Pumps, prior to placing the MBFPs in service. On panel FAF, Feed Pump Suction Pressure read 550# and the Feed Pump Discharge Pressure indicated 700#.</p>
<p>200008195 System: SW TagNumber: N/A</p>	<p>Stator Cooling Water Cooler 21A leaks at north end bell.</p>
<p>200008196 System: N/A TagNumber: N/A</p>	<p>Stator cooling water filter YRFI-1 leaking at head.</p>
<p>200008197 System: WDS TagNumber: 6359</p>	<p>During walkdown of WDS in PAB, noted that 6359 and 6360 tap off the vent header line BETWEEN 1679 &amp; 1613 not to the right of 1613 as shown on the drawing. Please field verify then correct the drawing. Valves are located on the upper platform in the LGDT cell.</p>
<p>200008198 System: N/A TagNumber: N/A</p>	<p>megaohmmeter mg-003-91 sent to vendor . vendor reports operational failure</p>
<p>200008199 System: N/A TagNumber: N/A</p>	<p>megaohmmeter mg-006-93 sent to vendor .vendor noted operational failure</p>
<p>200008200 System: N/A TagNumber: N/A</p>	<p>ammeter am-004-97 sent to vendor, vendor reports operational failure</p>
<p>200008201 System: FW TagNumber: BFD-616</p>	<p>During walkdown it was observed that the newly installed BFD-616 spool and condensate pot had been installed out-of-plumb. Modification FMX-00-52429-A and work package 3520A, Attachment 23 require the level instrument piping and condensate pots to be level. Upon further investigation, it was discovered that this problem also existed for the following valves: BFD-620 BFD-626 BFD-628</p>

<p>200008202 System: SEC TagNumber: N/A</p>	<p>An individual in the cafe was acting in an unusual manner; a possible Fitness for Duty concern and/or a Continued Behavioral Observation candidate. Upon interview of the individual it was determined that it was not FFD/CBOP but a person with diabetes and having low blood sugar. The patient corrected the problem and returned to work.</p>
<p>200008203 System: SGBD TagNumber: N/A</p>	<p>During walkdown of Blowdown supports it was identified that support 47-SR-3 had been disconnected with the bracket end pin taped to the strut. Upon reviewing work package 3520A, for reinstallation, I was not able to locate the reinstallation of this support within the work instructions. It is not known when this support was unpinned.</p>
<p>200008204 System: SGBD TagNumber: N/A</p>	<p>While performing a surveillance in the VC it was noticed that all of the new insulation for the Steam Generators is being brought into the VC, wrapped in plastic bags, creating a tremendous amount of Rad Waste. There are about 2000 bags that weigh about one (1) pound each. This could also create an increased fire load in the VC. Some of the bags of insulation that have brought into the VC are staged on the Steam Generator platforms. I have noticed several people walking on the bags which are in the walkway on the platforms.</p>
<p>200008205 System: N/A TagNumber: N/A</p>	<p>Asbestos. Location: 36' unit 2 west side, in overhead by 21 condenser inlet. Found open elbow on pipe.</p>
<p>200008206 System: N/A TagNumber: N/A</p>	<p>The purpose of this condition report is to document the receipt and disposition of Movats Users Technical Notice (MUTN) 2000-01. This notice was issued to inform all Crane Movats users that the "Ease of Use" accuracy statements found in ER 5.0 for the DMT, TST, and Optical DMT may not be conservative.</p>
<p>200008207 System: N/A TagNumber: N/A</p>	<p>The purpose of this condition report is to document the receipt and disposition of Movats Users Technical Notice (MUTN) 00-02. This notice was issued to inform all Movats users that there were errors found in the Check Valve Analysis portion of the [redacted] software version 3.0.0.2. The anomalies affect the display of information and the analysis of results. In no case will the anomalies or the omitted features result in an incorrect interpretation of the data.</p>
<p>200008208 System: N/A TagNumber: N/A</p>	<p>Contrary to SAO-460 SE 00-598-MD did not meet expectations when presented for approval as follows 1. Scope of proposed activity was not clearly defined in SE without referencing previous modification and present modification package. 2. In two instances the word "not" was missing in sentence responses which changed the meaning of the answers. In one case the question asked for "inoperable" alarms and the response discussed "operable" alarms. 3. Some information in SIQ should have been addressed in "Other Considerations" section of SE. (Need to revise SOP). In general this may be another example of not meeting industry standards. (CRS 200005854 reported in Engineering Self Assessment dated August 14, 2000)</p>
<p>200008209 System: N/A TagNumber: N/A</p>	<p>Safety Evaluation 00-598-MD was presented for approval prior to having a Performance Indicator assessment being conducted contrary to management expectations. Items noted in CRS 200008208 were not corrected prior to presenting SE for approval. Performance Indicator process is not fully implemented at this time</p>
<p>200008210 System: GT TagNumber: GT1</p>	<p>During labeling of the Fuel Forwarding system found that drawing 260586 does not completely reflect field conditions. The following valves are shown external to the tanks GT1-GT18 and GT1-GT22. They are physically located inside the tank. On the tank side of GT1-GT16 is a flow stop isolation installed in the system that does not show on the print. On the tank side of GT1-GT20 is a flow stop isolation installed in the system that does not show on the print. Request that the print be updated to show these isolations and have identification assigned to them. A marked up copy of the print will be submitted.</p>

200008211  
System: RCS  
TagNumber: 251A

During SGR QA field observation of the radiation protection and ALARA aspects of work associated with removal of the temporary 21 steam generator intermediate leg pipe rupture restraint shims, what appeared to be an inappropriate method of shim removal was observed. The job foreman and the two workers used a power saw to cut off a crowbar end to fabricate a tool to drive out the shims. Using a small sledgehammer and the crowbar as a drift, they attempted to drive out the shims. When questioned by the observer, the foreman stated that it might take four hours to beat the shims out. This method of shim removal (beating the shim with a cut piece of crow bar and a sledgehammer) does not appear to provide adequate controls to ensure no resultant damage to the RCS piping. This information is also documented in SGRP Field Note 190.

200008212  
System: TURB  
TagNumber: 63-2/HLV

PROBLEM: Condition Report 200005490 was generated by the Turbine System Engineer based on his review of CR 200004420. The System Engineer identified that the supporting documentation for the setpoints of the Turbine Runback components are not current and there are inconsistencies between the different supporting documents. It was requested that the design basis information be reviewed and updated to reflect the current operating conditions. It was pointed out that setpoints for 63-2/LLV and 63-2/HLV are not VERIFIED in the SPIN database. Also identified is the need to update ICPM-1709 to reflect new or revised setpoints as well as any Simulator and/or DBD documents. In addition, the setpoint verification needs to take into account the anomaly as outlined in CR 200004420. After completion of the SL3 evaluation for CR 200005490, the Setpoint Control Group closed-out the CR 200005490 based on the procedural requirements of SAO-405, revision 14, step 4.12.2, which states: "Personnel seeking to obtain new or change/add setpoint(s) shall be required to submit all change requests on an SAO-415 Request for Engineering Services (RES) form (reference 6.17)." Also, section 4.3.2 of SAO-112 allows Condition Reports to be closed to Request for Engineering Services (RES). Therefore, ESR 1209-00 was initiated to have existing modifications associated with the Turbine Runback circuits revised and for the Steam Generator Project to evaluate the impact on the existing setpoints. This approach was discussed with the Main Turbine System Engineer. Based on discussions with the System Engineer on 10/25/00, the expected end results of having the SPIN updated to reflect the new setpoint information for pressure switches 63-2/LLV and 63-2/HLV has not happened. Expecting to address both issues: one being the pressure differential as reported in the original CR, and two, being the review of the plant parameters returning from this S/G outage and the possible effects on the runback setpoints. The Setpoint Control Group (SPCG) explained that it had expected aggressive action on RES-1209-00. However, to date the System Engineer is not confident that this ESR will be resolved and appropriate follow-up corrective actions implemented by Engineering and support groups in time to support plant startup. In fact, a Project Number has not even been issued (currently listed status-Management Review). It was agreed that closing out the CR to this RES may have not been appropriate because SPIN is not updated and the initial condition still exists. The RES had outlined all the expected actions required by Engineering after revision of the appropriate calculations, which included issuing the Setpoint Device Data Form (SPDDF). Currently there is no success path to follow the needed actions to the end and assure the issue is addressed prior to plant start-up. Currently WO 00-16227 is in ENG HOLD, with a SYNCH HOLD grouping, in I&C and pending the evaluation previously discussed. Based on proposed revision to SAO-405 and SAO-415 in support of the Modification Optimization Project the RES is no longer considered the appropriate means to close-out setpoint related conditions reports. Also, CR 200008188 was written to identify the conflict between SAO-405, SAO-415, and SAO-452, as well as current plant practice. THE FOLLOWING IS THE SL3 EVALUATION FROM CR 200005490 (CLOSED): The Setpoint Control Group's preliminary investigation of the setpoint design basis of pressure switches 63-2/LLV and 63-2/HLV determined it is associated with Safety Evaluation NS-2-85-083, "Raising the Load Cutoff For Turbine Runback From 70% to 86%", dated 2/27/86. The main supporting document of the Safety Evaluation is Westinghouse letter to ConEd IPP-85-795, "Dropped Rod Analysis for Increased Turbine Runback Setpoint", dated November 18, 1985. During the evaluation, a verification of setpoints for TD-LRB1 and TD-LRB2 associated with the Turbine Runback was performed. The Runback circuits were recently modified by FPX-95-11048-F, Rev. 01 "Turbine Runback on Rod Drop". A review of the latest revision (Rev. 3) of ICPM-1709 revealed that the setpoint changes required have been incorporated. Also, the SPIN database is "Green Flagged" for these time delay relays. The setpoints for TD2X-LRB1 and TD2X-LRB2 associated with the Turbine Runback

	<p>circuits were recently modified by FPX-94-10153-F, Rev. 02 "Main Turbine Runback on Loss of One MBFP System Upgrade". A review of the latest revision (Rev. 3) of ICPM-1709 revealed that the setpoint changes required have been incorporated. Also, the SPIN database is "Green Flagged" for these time delay relays. In addition, the following minor issue was identified: CR 199908237 was written to document that ICPM-1709 needs to be updated to reflect the new setpoints specified by FPX-95-11048-F, Rev. 01. CR 199908237 was closed-out to CR 199909153 (see page 7 of 11), which is part of the Maintenance Improvement Plan per SAO-250 and is still open. The fact that this issue is resolved needs to be brought to the attention of the owner of CR 199909153, so it can be deleted from the listed of open items. Likewise the Component Function database developed by the 50.54(f) group needs to be updated to reflect this issue has been resolved. The SPIN database records for pressure switches 63-2/LLV and 63-2/HLV used in the Turbine Runback circuit are "Red Flagged". An inspection of the SPIN records indicates that the setpoints for 63-2/LLV and 63-2/HLV have not been validated or verified by the Setpoint Control Group. <b>RECOMMEND CORRECTIVE ACTIONS:</b> The SPCG should investigate the design basis information for the setpoints of pressure switches 63-2/LLV and 63-2/HLV and update SPIN in accordance with SAO-452. The RES should be completed. New operating parameters may not only affect the pressure switch settings, which are red flagged in SPIN, but may affect the timers that are currently used in the system (and green flagged in SPIN) and based on past plant parameters. If the design basis investigation reveals that the setpoint of 39 psig decreasing used in ICPM-1709 is incorrect the following actions will be performed: An ICA will be issued to I&amp;C Maintenance to have the ICPM revised. An ICA will be issued to the Computer Application group to notify the Simulator group of the setpoint change. An ICA will be issued to System Engineering to evaluate the impact on the System Description. An ICA will be issued to Configuration Management to evaluate the impact on the Component Function Database. Information for the set-points of the pressure switches will be conveyed to I&amp;C so as the pressure switches can be set accordingly in WO 00-16227 prior to start-up. If the RES finds that the new steam generators will affect the setpoints of the entire runback circuit, the same action path as outlined above will need to be implemented, with even more components affected. SEE ATTACHMENTS TO CR 200005490</p>
<p>200008213 System: N/A TagNumber: N/A</p>	<p>On the morning of 10/26/2000, I had noticed that the keys for the files located in the Generation Support file room were not located in the same position that they were left in from the evening before. Visual inspection of the key ring has shown that the key for file cabinet #6 has been broken at its base. On visual inspection of the file cabinets, cabinet #6 showed the lock was in a semi-unlocked position with the missing piece of the key jammed inside the lock. Notified [REDACTED] Wrote CR item. Submitted B&amp;G Request form for locksmith to repair</p>

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Below is a list of 61 CRs created in the last 24 hours. (10/31/00 3:34:55 PM to 11/1/00 3:34:55 PM)

Condition Number	Condition Description
<b>200008390</b> System: LO TagNumber: COST	During performance of PI-M9, step 3.2.1.a, verified that no excessive oil leaks on the tank roof of clean and dirty oil storage tanks but could not verify for corrosion or buckling damage due to current contractor's activities and stuffs on top of the tank. This is unsatisfactory.
<b>200008391</b> System: RCS TagNumber: N/A	During a work package inspection for the shims removed on SG 21 Cold Leg rupture restraints, it was identified that there were scratches in the areas of the shim removals. In addition, two of the shims in the upper horizontal pipe restraints remain between the Cold Leg and the rupture restraint. These areas around the removed shims on SG 21 may require PT & UT. There may be an extent of condition for all typical SG restraints.
<b>200008392</b> System: RCS TagNumber: N/A	A change to SGT QEP 11.01 Work Packages, paragraph 5.2.5 was made on 17-Oct -00 to allow work steps to be N/A provided justification is entered in the "Other" column. As a result, WP 3085A "Feedwater Line Installation", step 27 was NA'ed by a Field Engineer that deleted the requirement to vibro-etch a 2 inch mark at four locations, 90 degrees apart around the pipe. No justification was provided in the work package. Marking of the weld is required by ASME B&PV Code, Section XI, IWA 2600 that requires a weld reference system at regular intervals along the welds. The weld marking is also required by Raytheon PSI procedure NDE-Ref, Rev 1 that was submitted to SGR and approved for this application. No tag was hung.
<b>200008393</b> System: COMP TagNumber: N/A	This CR is written to document a condition this morning during which users in the MOB and Construction Complex were unable to access the LAN. When a non Con Ed PC, connected to the IP2 Con Ed LAN was disconnected, LAN connectivity was established throughout the area.
<b>200008394</b> System: RMS TagNumber: R-41/42	There is a safety issue when changing the continuous filter paper on the plant radiation monitors. When Health Physics is summoned by the CCR to replace the filter paper on the monitors, the CCR shuts down only the compressor and do not de-energize the unit. This has become a concern since the filter housing has terminal connections with 120VAC throughout the filter housing and the potential for electric shock is of concern. During installation/removal of filters, it is near impossible not to touch a terminal connection. Using low voltage gloves would not work because of the intricate work involved in installation of the filter and the gloves being too bulky. At this time, any unit that needs filters changed should be de-energized until a different method of filter change can be resolved.
<b>200008395</b> System: SIM TagNumber: N/A	This is a simulator condition report. In IC 59, during a plant startup, the following discrepancies were noted. - While attempting to ensure that AC and DC control were at minimum in preparation for exciting the generator, when shifting to AC the DC minimum LED turned off and the DC max LED lit. Several attempts to switch back and forth finally lit both MIN leds. - NIS chart recorder at panel FC, blue pen did not record (NOTE: Bob Harns worked on this today and got this working with a new pen, issue appears resolved.) - During rod movement in manual, Bank D group 2 would start to move out first, followed by group 2. - Delta I indicated 5% with reactor power at 7%, and then moved positive with increases in power and no rod movement - while diluting, reactivity effects appear within a few seconds and appear to produce the entire reactivity change in too short a time. - Feed pump discharge pressure appears 150# too high. The model agrees with the FA panel meter indication, however, with a 300# delta pressure, we were unable to feed using the bypasses past approx. 2.5E05 lbm/hr/gen. The procedure calls for the transfer to FRVs at 5E05 to 1E06 lbm/hr. - With 22 and 23 steam generators at 55% and using demand for FRV position continued to call for open. No windup in controller since generators had been stable on program for approximately 1 hour using bypasses.

<p>200008396 System: LGHT TagNumber: LP-3</p>	<p>On 10-30-00 at approximately 11:30 AM, CKT #1 on LP-3 (labeled as LTG PNL MOB 3) tripped &amp; was reset by Ops. This powers the lighting receptacles in the first two cells of the MOB laundry storage area. On 10-31-00 at approximately 4:45 PM, it was reported again that power had been lost to the same area as well as in the "CO2 room". CKT #1 as well as CKT #3 were found tripped &amp; again reset by Ops. Power was thus restored to the area. The electrical loading on these circuits should be investigated &amp; the loads spread out more evenly to prevent tripping the ckt breakers.</p>
<p>200008397 System: SIM TagNumber: N/A</p>	<p>This is a SIMULATOR condition. While in IC 27, performing a plant startup, the Toxic Gas monitor alarm and the Containment sump level high alarm on Unit 1 panels, the 21 and 22 MBFP speed control alarms and the Saturation monitor alarms came in all at once and cleared. This was accompanied a beeping alarm in the instructor booth.</p>
<p>200008398 System: SIM TagNumber: N/A</p>	<p>This is a SIMULATOR condition. While in IC 1 on the training load, the SUBCOOLING MARGIN MONITOR alarm on FC came in 3 times. On page 102 of plasma display RCS subcooling computation based on RTDs indicated all question marks (?????). Pressing the ACK button on Accident Assessment panels cleared the FC alarm.</p>
<p>200008399 System: SIM TagNumber: N/A</p>	<p>While in IC-1, recirc valve for 22 MBFP failed to close while switch was in close. Joystick on 22 MBFP foxboro controller appears loose, control erratic.</p>
<p>200008400 System: FCCH TagNumber: FSBW</p>	<p>While working on the crosby clamps for the fuel storage building (fsb) upender wire rope, the straight pins on the rope were found to be loose and they came out to easily. The nuts on the crosby clamps also were really loose.</p>
<p>200008401 System: FCCH TagNumber: FCCHA</p>	<p>While working on the actuator plates for the fuel transfer system, it was discovered 2 proximity switches had loose screws.</p>
<p>200008402 System: N/A TagNumber: N/A</p>	<p>This Condition Report documents a negative trend regarding SGT's inappropriate revision of processes and procedures that have resulted in violations of an ASME Section XI code requirement, the SGT Quality Assurance Program Manual and Quality Execution Procedures. In addition, despite entering the heavy field work phase of the project, SGT OA recently revised their Program to reduce the frequency of field surveillances by Quality Engineers. Collectively these occurrences point to a lack of rigor in implementing their quality programs. Data points for this trend are as follows: (1) SGT Quality Finding Report QFR-IP2-2000-004, issued on 10/8 in response to a finding by SGR QA, documents that revisions to QEP 15.01 violated the requirements of the SGT Quality Assurance Program Manual. These QEP revisions exempted certain NCRs from Client review and approval, when the QAPM required all NCR be submitted for Client review. Two NCRs were not submitted for Client review based on use of the improper exemption. (2) On October 21, [REDACTED] distributed a memorandum that documented SGT's decision to immediately amend the QEP 12.02 Quality Surveillance frequencies. The previously specified surveillance frequencies were changed from periodicities ranging from daily, twice a week and weekly to "As needed". It is noted that many of the twice a week and weekly surveillances were associated with areas of current, intense field activity. Based on discussions with the [REDACTED] the motivation for this change was to provide flexibility in using QA Engineers in supporting both document closure and field quality surveillances. Based on concerns raised by SGR QA, the [REDACTED] issued a memorandum on 10/27/00 to reinstate previous surveillance frequencies for key activities. (3) On October 29, SGR QA observed Foreign Object Search and Retrieval (FOSAR) activities on the feedwater piping to SG #23. These activities were being performed in accordance with Work Package 3085 C, Install Feedwater Piping SG #23. During the observation, SGR QA determined that a Work Package Change Notice (WPCN) 9, which had been issued that morning, changed the length of piping to be examined by FOSAR from 52 feet to 8 feet. The configuration of this feedwater line is a sweeping elbow into a vertical section of pipe that drops roughly 30 feet prior to another horizontal run. WPCN 9 had been processed as a "Non Intent Change" and the FOSAR of the 8-foot section of pipe had been completed and preparations for fitup of the feedwater pipe and spool piece to the SG were in progress. (4) On October 31, SGR QA determined that a change to SGT QEP 11.01, Work Packages, was made on 17-Oct-00 to allow work steps to be NA'ed provided justification is entered in the "Other" column. As a</p>

	result, WP 3085A "Feedwater Line Installation", step 27 was NA'ed by a Field Engineer who deleted the requirement to vibro-etch a 2 inch mark at four locations, 90 degrees apart around the pipe. No justification was provided in the work package. Marking of the weld is required by ASME B&PV Code, Section XI, IWA 2600 that requires a weld reference system at regular intervals along the welds. The weld marking is also required by Raytheon PSI procedure NDE-Ref, Rev 1 that was submitted to SGR and approved for this application.
200008403 System: FP TagNumber: N/A	Fire Water Storage Tank Heater Control Breaker ERC-3 trips free after 30 seconds of heater pump operation.
200008404 System: N/A TagNumber: N/A	UNIT 1 VENT STACK FLOW MAGNAHELIC AND 84' NSB VENT FLOW RECORDER DIFFER BY 21,000 SCFM. VENTILATION ALIGNMENT HAS NOT BEEN CHANGED AND THE MAGNAHELIC VALUE HAS REMAINED RELATIVELY UNCHANGED. THIS IS A PT-D5A FAILURE DUE TO THE SPREAD EXCEEDING 14,000 SCFM. D.I.Tag #02117
200008405 System: DOCK TagNumber: N/A	Insulation around valve WW-193 is exposed and not protected by the weather shield.
200008406 System: DOCK TagNumber: WW-33	Insulation around WW-33 is degraded and the weather shield has separated.
200008407 System: DOCK TagNumber: WW-37	Insulation around WW-37 is crushed and the weather shield is off.
200008408 System: RCS TagNumber: 527	There is a section of 1/2" ss tubing from N2 reg to Valve 527, at about 100'el, to the top of the pressurizer that has no engineered supports. It is attached to existing B-line by ty-wraps and banding straps.
200008409 System: CYW TagNumber: CYWN	THIS IS FOR TRACKING A COMMUNICATIONS TO STAFF: THE WATER METER HOUSE HEATERS WERE FOUND OFF BY THE OUTSIDE ROVER ON 10/30/00 WHILE MAKING HIS MIDNIGHT ROUNDS. THE HEATERS WERE RE-ENERGIZED. IN CHECKING OAD 22, SOP 11.5, COL 11.5, SOP 30.1 & COL 30.1 IT WAS DISCOVERED THAT NONE OF THESE DOCUMENTS THAT COVER STATION WINTERIZATION CONTAIN ANYTHING ABOUT THE WATER METER HOUSE.
200008410 System: DC TagNumber: EGA4	During tour of Cable Spreading room noticed that 24 Static Inverter was indicating 61.3 cycles and the in sync light was not illuminated.
200008411 System: SW TagNumber: N/A	On 10-30-00, Low Pressure River Water was removed from service for planned maintenance. The Control Room Supervisor believed that Unit 2 Service Water was in two header alignment. This was not the case. After the operating degassing pump tripped, investigation revealed the Unit was on three header alignment. Service Water was realigned to two header operations.
200008412 System: SW TagNumber: SWT-806	SW is leaking at threaded elbow downstream of SWT-806. Corrosion has worn away the stainless steel threads of the corrosion monitoring rack. Located next to the turbine hall closed cooling heat exchangers.
200008413 System: WCPS TagNumber: 80AIRLOCK	While performing PT-V24J on the 80' air lock interior door, check valve 85c failed to pass any flow. the purpose of the test is to demonstrate the operability of the bleeder check valves in accordance with tech spec 4.2. As per the p&Is of the test it shall be performed when the rcs is less than 200 degrees.
200008414 System: BG TagNumber: BGA	This is the second CR written on the following condition: The first CR was closed out, but the condition still exists. The East HVAC Unit on the TSC leaks oil that has deteriorated the roof rubber membrane. I recommend a Carlisle membrane patch for repair, and if the oil leak is not repaired install a suspended oil pan to catch the drippings.

200008415  
System: RPS  
TagNumber: 52/BYA

Discrepancies have been found in the Controlled Metaphase Drawings which describe the interconnections in the CCR Reactor Protection Racks E3/E6 & F3/F6. Drawing 208859 shows relays LF-1X, LF-2X, LF-3X & LF-4X (Low Flow Trips) as residing in cabinet E3/F3 or L4, in the 38,39,40, & 41 positions in Dwg 208685. There is no Con Ed internal wiring diagram for the E/F racks, so relay-to-relay wiring is shown only in the inherited Westinghouse wirelist drawings 615B119, 615B127&29, 615B130,31,32&33. Westinghouse wirelist 615B119 Sh 10 has an extensive array of listings describing Relays LF-1X through LF-4X as being in the E4/F4, or L3 cabinet, in the 5,6,7 & 8 positions, per Dwg 208685. Moreover, this same 615B119 sh 210 shows the E3/F3, or L4 positions 38,39,40,& 41 now occupied by LF-1X,LF-2X,LF-3X & LF-4X (and verified by field inspection) as anomalously being occupied by unknown relays LF-1,LF-2,LF-3, & LF-4. In the opinion of this writer, a part of our RPS Design Basis has been lost, and must be reconstituted, in the case of wirelist 615B119. Further.. in the case of Reactor Trip wirelist 615B130, sheets 13,14,15,16,17,18, & 19 contain Change Orders such as "Remove...Add" or "Existing...Change to" on the parent drawing, with no means for the viewer to verify if the "Existing" conditions have been actually changed, or if the "Add" orders have actually been implemented. Therefore Two (2) conflicting versions of our Reactor Trip wiring exist side by side on the same issued drawings. The Schematic drawing representing this system, Dwg 110E073 in some cases does show, and in some cases does not show the Relay terminal numbers for the relays, so the ambiguity in 615B119, & 615B130, cannot be fully resolved by reference to 110E073. In the case of a recent mod FIX-95-11057-E, partial internal rack wiring diagrams such as 306373, were specially created for that mod alone, in lieu of a set of corrected overall Rack Internal Wiring Drawings. In the opinion of this writer, if the ambiguities in 615B130 sheets 13-19 are not resolved, this will lessen our margin of safety in any RPS emergency, and also places our RPS Design Basis in an ambiguous state. A suggested fix would be creation, by Qualified Senior Design Personnel, of corrected versions of 615B119,615B130,110E073, AND the creation of NEW internal wiring drawings for our Reactor Protection Racks. Moreover any attempted change in these racks, prior to solution of these inconsistencies, would be, in my opinion, less than conservative. Note: correct tag number did not appear in CRS menu, selected a random tag to initiate this CR.

200008416  
System: N/A  
TagNumber: N/A

I recently received an e-mail from the [REDACTED] (transmitted to the [REDACTED] group [REDACTED] with me and several senior plant managers on courtesy copy) criticizing my findings in CRS 200005173. The transmittal was caustic and contained language that could discourage a questioning attitude and a willingness to document problems. That transmittal and two related documents, as follows, are attached: - The 10/27/00 e-mail which was sent from the [REDACTED] to the [REDACTED], - The text of the SL2 narrative prepared by [REDACTED] on August 29, 2000, and - A proposed revision of the SL2 narrative attached to the 10/27/00 e-mail. At issue in the CRS was whether a setpoint change for the gas turbines had been performed as there was no documented evidence of it in the work control process, and field personnel believed the setpoint change had not been performed. The manager, however, ignored the issue and stated "...the condition listed in the CR is not accurate"... "The real issue, as I see it, is the lack of appropriate review by the originator of the CR"... "I do not want to take anymore of this section's time addressing this non-issue" and "My recommendation is that this be assigned to the section that the CR originator is assigned." Subsequent investigation has shown the original issue described in CRS 200005173 to be valid, however, that isn't the issue of concern in this CR. The concern is not technical. The concern is that plant management responded to a CRS originator in a way that makes him appear to be inept and insisted that he take the issue back and perform the tasks to "erase" the problem. As previously noted, the e-mail was sent to other senior plant managers. This action serves to dampen the questioning attitude that WE are trying to cultivate here at IP2. Unfortunately, this is not the first episode of criticism of problem identification by influential senior, supervisory or managerial personnel that I've witnessed. I am generating this condition report to formally document this as another incident of an adverse cultural attribute that is known throughout the industry at troubled plants as "chilling effect." By reviewing the attached documents it can be seen that in August the design engineering department agreed with the issue as described in the CR, and believed corrective actions were necessary. ICAs were assigned to resolve the issue. Two months later the [REDACTED] submitted a proposed revision to the SL2 report which offered no real new information and proposed the apparent cause for the condition as "...the lack

	of appropriate review by the originator of the CR." I recommend referral of this condition to senior plant management so that a plan to reverse this adverse cultural trend that discourages problem identification and a questioning attitude can be formulated and implemented.
200008417 System: N/A TagNumber: N/A	In review of SAO-300 section 4.4.8, refers to portal monitor requirements for all personnel who enter the protected area.
200008418 System: N/A TagNumber: N/A	This Westinghouse procedure (see ref.) was brought to me and [redacted] because of a good questing attitude from the planner for advice and counsel and implementing a good team work effort. The following issues need to be addressed before any work can be performed and I suggest that a time out needs to be called by the SGRP QA because the following issue number one is a repeat issue which violates stations procedures. Issue 1- A vendor procedure (Westinghouse) went to SNSC without a Con Ed cover sheet and no Con Ed required approvals. Issue 2- I question the quality of the SNSC review based on the fact that in section 9.7 in a NOTE instructs you to perform work to reference 4.1.3. In section 4.0 item 4.1.3 requires you to perform work to " NES Document 83A9475, Rev.1. ....". Therefore this reference document would require SNSC review as well and what was reviewed by SNSC was NES Document 83A9475 Rev. 0. The wrong rev was reviewed. Issue 3- This wrong rev. may not be a big issue but what is a big issue is that this reference document that is really going to be the work instructions and has no sign offs or hold points which are required by IP 2 procedures. Also this reference work instructions calls out appendices which has errors such as Appendices B, C, and D are marked as "DRAFT COPY" with no rev. number. Issue 4- The Westinghouse procedure LTR-SGDA-00-248 also does not contain the proper and required QC Hold Points i.e. section 9.7.1 which is the finnal stud tensioning step.
200008419 System: DC TagNumber: DCN	Drawing 138656, current revision shows reference to alot of retired and removed equipment. Please update this drawing to show current Unit 1 CCR panel configuration. Drawing 138559-16 and 138930-07 also reference many retired and removed Unit 1 equipment. Please update drawings to remove this equipment. An OAD-40 Operations Troubleshooting was performed on 4/1/00 to verify all the 48vdc loads on the Unit 1 48vdc CCR panels. Please contact [redacted] in Operations Planning to review this information and update drawings per this information Also. COL 27.1.14 should be updated to match prints and field conditions per this Troubleshooting which was performed.
200008420 System: TURB TagNumber: TURBN	Dungng system walkdown found the vacuum gauges PI-1220C reading 2"Hg and PI-1221A reading 1 6"Hg with condensers at atmospheric pressure. Gauges need calibration.
200008421 System: TURB TagNumber: TURBN	On west side of the Main Turbine, near the turning gear, under the lagging is terminal box "L". This terminal box was found with no cover, bare wire connections hanging with no termination, and the box had debris and dirt in it. This box needs a cover, to be cleaned, and hanging wiring addressed.
200008422 System: TURB TagNumber: TURBN	Dungng system walkdown found wiring to condenser pressure transmitters (PT-6514, PT-6515, PT-6516,---for all LP's) not run in conduit and bare wire nuts hanging joining wires The wiring run for these transmitters seems to have been initially installed with poor craftsmanship. The wiring and connections should be addressed to meet expected standards.
200008423 System: DC TagNumber: DCN	Drawing 138385-01 shows the auto transfer switch in the Amplifier Room (43' NSB) which has been removed in the field for seven or eight years. Also, the breakers on 48vdc busses 1 and 2 which previously fed this transfer switch are closed and still labelled as feeding this equipment (not as spare). COL 27.1.14, rev. 2 also shows these breakers as "ON". The same conditions were noted for the Unit 1 H2 panel, which, I believe, was a Unit 1 panel which no longer exists. System Engineer, please evaluate the above and have drawings, COL and field labels : breaker positions updated to reflect current conditons.

<p>200008424 System: N/A TagNumber: N/A</p>	<p>The 2000 Help Desk Self-Assessment has identified the following weaknesses in the area of SUPPORT STAFF: SS-W1 - The current Manager for the call center and the Desktop teams have not been trained in how to operate this type of business. SS-W2 - The Help Desk staff level is inadequate to meet the expectations of their customers. SS-W3 - The call center, desktop team and Help Desk management are located in separate offices. Recommendations: SS-W1 - Attendance by the support staff to Help Desk Management Seminars (from Help Desk Institute, Help Desk 2000, or similar institution) and training courses and peer mentoring from outside of the organization will enhance the knowledge and skill level of the staff. The Learning Center can provide a list of soft skills training courses and local seminars. The corporate Help Desk personnel can recommend training courses and provide mentoring of Help Desk analysts and the supervisor. A visit to another Help Desk operation within the NYC area (perhaps the corporate Help Desk) to benchmark will help support staff to determine necessary skills sets and Help Desk operation standards and best practices. SS-W2 - It is recommended that an additional desktop team member be added to the group OR that one of the already present members be assigned to this duty to bring the total up to two full time desktop staff to respond to trouble tickets (PC). An additional person should be added to the call center (bringing the total analysts to three), so that the administrative tasks are rotated on a weekly basis between team members. This allows the two analysts left to concentrate on answering calls from the end users. SS-W3 - It is recommended that the call center, desktop team and manager consolidate their operations into one location. This location should allow for oversight of the call center by the manager. The Help Desk analysts must be in close proximity to the operating equipment to quickly assess the status of the equipment.</p>
<p>200008425 System: N/A TagNumber: N/A</p>	<p>The 2000 Help Desk Self-Assessment has identified the following weaknesses in the area of PROCESSES AND PROCEDURES: PP-W1 - There are no clearly defined processes, manual, procedures or escalation lists for the Help Desk. PP-W2 - Absence of Call observance practices within the Help Desk (QA). PP-W3 - There is no clearly defined path of escalation for analysts. Recommendations: PP-W1 - A manual containing processes and procedures should be created for the call center and signed off by upper management within the group to insure that policies are correctly written and actually represent what the department needs before distribution to the Help Desk analysts. Critical applications need to be identified by each department, with the help of IPCA staff, in order for the Help Desk to prioritize incoming trouble calls. PP-W2 - The Call Observance practice should be put into place as quickly as possible to maintain consistency of support to the customer base. PP-W3 - Escalation process / procedures should be developed to provide a clear path for Help Desk analyst to route a call that cannot be resolved within a specified timeframe. A "HOT" list of Tier II and Tier III support staff by skills sets and system responsibility with phone numbers, pagers or cell phone numbers, would eliminate confusion on who is responsible for what system.</p>
<p>200008426 System: TURB TagNumber: TURBN</p>	<p>During system walkdown, found insulating blankets on crossover piping to LP22 just sitting on flange, not made up properly. Flange needs to be insulated properly.</p>
<p>200008427 System: N/A TagNumber: N/A</p>	<p>The 2000 Help Desk Self-Assessment has identified the following weaknesses in the area of CUSTOMER RELATIONS: CR-W1 - There is no on-going customer satisfaction program. CR-W2 - The Help Desk does not market their support services. CR-W3 - There are no Service Level Agreements (SLA's) between the Help Desk and their customers. CR-W4 - The Help Desk does not have a mission statement. CR-W5 - The lack of customer training adds to the volume of Help Desk calls. Recommendations: CR-W1 - A customer satisfaction survey should be sent to a random number of callers to solicit information to measure the effectiveness of the Help Desk. Statistics, reported back to Computer Applications manager periodically, will show overall and individual customer satisfaction results and areas for improvement. CR-W2 - Develop an effective marketing strategy using published/electronic newsletters, e-mail and verbal communications. CR-W3 - Computer Application should develop Service Level Agreements based on those services that provide best value to the business in meeting the needs of each organization. CR-W4 - A Mission Statement specific to these two groups be developed and used in the marketing strategy along with the IPCA overall Mission Statement. The Mission Statement for the two teams (call center and desktop) should stay in line with the goals and objectives of the overall IPCA statement, and it in turn should be consistent with the Mission Statement for the company. CR-W5</p>

	<p>- Quick Reference Guides (QRG's) can be designed to distribute to all employees to answer the most commonly asked questions about specific software applications. These Quick Reference Guides should be kept as brief and to the point as possible, to make them usable to the end users. Also, once a problem management tracking system and metrics are in place, information should be forwarded to Training to develop and implement courses.</p>
<p>200008428 System: N/A TagNumber: N/A</p>	<p>The 2000 Help Desk Self-Assessment has identified the following weaknesses in the area of HELP DESK TOOLS: DT-W1 - The telephone system does not use an Automatic Call Director. DT-W2 - The current remote control software is not working consistently. DT-W3 - Inconsistent use of the Problem Management System. DT-W4 - There is no knowledge base or technical library for analysts to research open calls. DT-W5 - The Help Desk analysts do not have access and rights to some LAN administration functions. Recommendations: DT-W1 - Upgrade the phone system to support an Automatic Call Director (ACD). In the interim, an Excel spreadsheet should be developed and given to the call analysts. Commonly known as "tic" sheets, the analysts would make a mark in the column that corresponds with when the call arrived. This information can be used to start developing some metrics while the ACD is being installed and tested. DT-W2 - The LAN team should work with call center to analyze and fix issues surrounding the current remote management system so the product works faster and more consistently. DT-W3 - IPCA should use the same problem management system as its corporate Help Desk - Magic. This would ensure consistency across the board for Con Edison employees as well as allow seamless escalations for those issues that need to be resolved by the corporate Help Desk. DT-W4 - A technical library of manuals should be compiled and stored at the call center. This would also include information manuals for proprietary systems. Once this is put into place, an electronic knowledge base can be purchased or built to store common answers to problems for applications supported by the Help Desk. DT-W5 - Allow the Help Desk more access to some LAN administration functions. NT and other operating systems can be locked down so that only certain individuals have certain rights - and no access to anything else. This would also allow simpler network issues (such as password resets, printer queue deletes, etc.) to be completed in a timely manner by the Help Desk analyst.</p>
<p>200008429 System: N/A TagNumber: N/A</p>	<p>The purpose of this CR is to document the inspection of controlled operating procedures based on Records Audit exit meeting on 10/19/2000. An inspection of procedures in the EDG building satellite location was done on 10/23/2000. The inspection included LARP's and SOP's. The result of this inspection found that there were no missing procedures and all dates and revisions were correct. Please assign this as Track and Trend to Generation Support. Send FYI to Manager Audits and Surveillances</p>
<p>200008430 System: DC TagNumber: DCN</p>	<p>Drawing 138379-21 shows 125vdc panel #4 as having as one of its loads a "Undervoltage Relay Panel". I believe this panel is retired (the one on 33' Unit 1??). Request System Engineer to research and have drawing, field labelling at breaker updated accordingly. 125 vdc panel #9 shows two breakers as Special AC Backup Load Board #1 and Special AC Backup Load Board #2. These have no other description, and field labelling does not help (similar to labels on drawing). Request Engineering find out what these breakers supply. It seems control power is supplied to all breakers on the Special AC Load Boards, so I am unsure what these 125vdc breakers do</p>
<p>200008431 System: CW TagNumber: 22CWP</p>	<p>DURING THE PERFORMANCE OF OPS PM M-30 WHICH CHECKS THE SETPOINTS OF THE BEARING MONITOR IN THE CCR, THE ALARM SETPOINTS FOR 22 CIRCULATING WATER PUMP WERE FOUND TO BE HIGHER THAN THEY SHOULD BE ACCORDING TO AOI-26.4.4.[HIGH BEARING TEMPERATURE] THE ALARMS FOR ALL CIRCULATING WATER PUMPS WERE FOUND TO BE 185 DEGREES. AOI 26.4.4 WAS CHANGED IN MAY TO LOWER THE SETPOINT TO 175 DEGREES FOR 22 CIRCULATING WATER PUMP. TWO QUESTIONS ARISE HERE. 1. WHY IS THE SETPOINT BEING LOWERED FOR ONLY 22 CIRCULATING WATER PUMP? 2. WHY WAS THE SETPOINT NOT RESET WHEN THE AOI WAS REVISED IN MAY OF THIS YEAR.?</p>
<p>200008432 System: N/A TagNumber: N/A</p>	

<p>200008433 System: FO TagNumber: 11FOST</p>	<p>Document PI-M9 failure due to 11FOST (No. 11 Fuel Oil Storage Tank) Control Room level indicator Out of Service (TO 2000N14133) and inability to perform tank roof inspection on CDLOFT (Clean &amp; Dirty Oil Storage Tank-Turbine L.O. System) due to contractor equipment on top of tank (CR 200008390).</p>
<p>200008434 System: N/A TagNumber: N/A</p>	<p>The purpose of this CR is to document the inspection of controlled operating procedures based on the Records Audit exit meeting on 10/19/2000. An inspection of procedures in the Gas Turbine #1 building satellite location was done on 10/23/2000. The inspection included AOI's, COL's, LARP's and SOP's. The result of this inspection found that there were no missing procedures and all dates and revisions were correct. Please assign this as Track and Trend to Generation Support. Send FYI to Manager Audits and Surveillances.</p>
<p>200008435 System: DC TagNumber: DCN</p>	<p>Drawing 149095 shows 3 breakers from 125vdc panel #11 (located 43' NSB) feeding Instrument Panel 1-N2. I believe this equipment is retired / removed. Request System Engineer to verify whether or not this load is retired and if so, update drawing 149095 accordingly. Determination should also include whether or not the breakers in the field on panel #11 need to be closed (on), as is currently the situation. These are the only 3 breakers on 125 vdc panel #11 which are closed. We could eliminate part of an annual test (PT-A30) if this panel is no longer necessary.</p>
<p>200008436 System: N/A TagNumber: N/A</p>	<p>NRC Inspection Report 2000-011 identified a Non-Cited Violation (NCV 2000-011-02) in that Tech Spec 6.8.1 requires compliance with procedures and during implementation of a mod workers failed to perform a walk down, pre-job brief, and review of removal drawings which resulted in the wrong line being cut (N-2 to accumulators)</p>
<p>200008437 System: N/A TagNumber: N/A</p>	<p>Upon review of Receipt Inspection Reports, the following condition was observed on Receipt Inspection Report RIR No. 00-RI-038. On May 30, 2000 Stores received 200 lbs of coated weld wire (E309-15) from the vendor of which 60 lbs (one case) was damaged during shipment or handling. The cardboard box was caved in and all six cans inside were crushed and two cans were punctured. The vendor was contacted but too much time had elapsed since the shipment so the vendor did not accept any responsibility for the damage. On July 26, 2000 the receipt inspector dispositioned the damaged cans by opening the two punctured cans and checking all the electrodes for any sign of defects. All the rods were found in satisfactory condition and based on that examination the six cans were found acceptable. On July 28, the two open cans were sealed with plastic tape, green tagged and the six cans were released to stores for use in the plant. MPAD-703 states that a receipt inspector does not have authority to accept nonconformances</p>
<p>200008438 System: CVCS TagNumber: HCV-105</p>	<p>DURING PERFORMANCE OF MAINTENANCE TO REPLACE DIAPHRAGM ON HCV-105 IT WAS NOTED THE REGULATOR APPEARS TO BE CLOGGED. IT TAKES A LONG TIME FOR THE REGULATOR TO RESPOND TO PRESSURE CHANGES. THE REGULATOR NEEDS TO BE REPLACED WITH NEW. WILL REPLAN NP-99-06151 TO REPLACE REGULATOR.</p>
<p>200008439 System: N/A TagNumber: N/A</p>	<p>While preparing to initiate an outgoing NRC Licensed Operator Renewal document, it was noted that a previous submittal, NL-99-086, dated August 30, 1999, did not contain the Certification Signature of the Vice-President on the NRC Form 396 Attachment.</p>
<p>200008440 System: 120V TagNumber: 120VN</p>	<p>Unit 1 120vac Special AC Backup System Load Board #1 shows an emergency feed to 43' NSB Valve Control Center V8 and Load Board #2 shows an emergency feed to Valve Control Center V9. These Valve Control Centers feed only retired equipment. Please update drawing to list this equipment as retired. Also, Ops Manager should determine if breakers off 120 vac Special Load Boards 1 and 2 can be placed "off" and labelled as "retired equipment". 120vac Special Backup Panels SA-1A and SA-2A contain mostly retired loads. There is a question of whether or not Unit 1 CCR Emergency Lighting (SA-1A) and Outdoor Evacuation Alarm (SA-2A) are still active loads on these panels or if they have been transferred to Unit 2 feeds. System Engineer, please determine the loads on these CCR panels and if no longer in service, please update drawings and field conditions accordingly. No COL currently exists for this system.</p>

<p>200008441 System: N/A TagNumber: N/A</p>	<p>PT-Q31A (21 Auxiliary Component Cooling Pump Test) passed its RRD. PC-EM 9 (VC Sump Discharge Flow and Temperature calibration) &amp; PT-Q77 (Effluent Radiation Monitor R-54 Test) entered their surveillance grace periods.</p>
<p>200008442 System: N/A TagNumber: N/A</p>	<p>POP 3.3, PLANT COOLDOWN, has CONTINUOUS REACTOR HEAD VENTING - PRZR LEVEL LESS THAN 350° inappropriately indicated as title on cover page.</p>
<p>200008443 System: RPS TagNumber: TC-4120</p>	<p>During an ICA evaluation of condition report 200007777 an adverse condition was identified. The ICA assigned to the Setpoint Control Group requested a review all CCR Annunciator windows, which have setpoints on their engraving, against the values contained in the SPIN database or supporting design bases documents. ISSUE: The Setpoint Information Network (SPIN) database specifies a setpoint of 540°F for Low Tavg bistables TC-4120, TC-4220, TC-4320, and TC-4420. The records in SPIN for these "Grade 1" bistables are "Green" flagged, which means the setpoint attributes are validated and verified. The definition of validated and verified basically means that supporting setpoint design bases documentation exist, the setpoint is installed in the field, and implementing procedures contain the correct setpoint information. The engraving of CCR Annunciators SAF, window 3-6, "LOW T AVE 541°F" and CCR FDF, window 1-7 are in conflict with SPIN, which lists the Low Tavg bistable setpoints as 540°F, not 541°F. Reactor Engineering provided the Setpoint Control Group with Tavg scaling information from procedure RFE-S-16.017 "RCS Delta-T, Tavg, and Flow Measurement". The procedure indicates that both the Thot and Tcold RCS temperature loops are calibrated over a range of 510 to 600°F, which corresponds to a voltage range of 0.4 to 10.0 VDC. A review of procedure PT-Q52 determined that the Low Tavg bistable trip setpoints are tested by holding Tcold constant at 3.600 VDC (540°F) and lowering Thot until bistable trips (expected tnp is 3.81 VDC (3.81 to 3.85)). A scaling check revealed the following: Tcold: <math>(3.600 - 0.4 \text{ VDC}) / (10.0 - 0.4 \text{ VDC}) = (X - 510^\circ\text{F}) / (600 - 510^\circ\text{F})</math> Solving for "x" = 540°F Thot: <math>(3.81 - 0.4 \text{ VDC}) / (10.0 - 0.4 \text{ VDC}) = (X - 510^\circ\text{F}) / (600 - 510^\circ\text{F})</math> Solving for "x" = 541.97°F Tavg based 3.81 VDC = <math>(541.97 + 540^\circ\text{F}) / 2 = 541.0^\circ\text{F}</math> Thot: <math>(3.85 - 0.4 \text{ VDC}) / (10.0 - 0.4 \text{ VDC}) = (X - 510^\circ\text{F}) / (600 - 510^\circ\text{F})</math> Solving for "x" = 542.34°F Tavg based 3.85 VDC = <math>(542.34 + 540^\circ\text{F}) / 2 = 541.2^\circ\text{F}</math> Therefore, range of the Low Tavg setpoint = (541.0 to 541.2°F). A review of [REDACTED] Table 3-183 indicates a "Trip Setpoint (4)" of 540°F. Note 4 states: "As noted in plant Technical Specifications". I&amp;C Design Engineering stated that there is no Low Tavg calculation. The setting of 541°F is conservative with respect to the Technical Specifications and also is the original plant setting. RECOMMENDED ACTIONS This CR should be assigned to the Setpoint Control Group for evaluation and resolutions of the SPIN issue. This is a configuration control issue regarding the setpoint information in the SPIN database. This is not an operability concern.</p>
<p>200008444 System: N/A TagNumber: N/A</p>	<p>NRC Inspection Report 2000-011 contained a Non-Cited Violation (NCV 2000-011-01) of license condition 2k in that an inadequate fire fighting strategy existed to align fire suppression water to the VC (9/3/00 fire in VC)</p>
<p>200008445 System: NIS TagNumber: NC-35E</p>	<p>During an ICA evaluation of condition report 200007777 two adverse conditions were identified. The ICA assigned to the Setpoint Control Group requested a review all CCR Annunciator windows, which have setpoints on their engraving, against the values contained in the SPIN database or supporting design bases documents. ISSUE: The Setpoint Information Network (SPIN) database specifies a setpoint of 21 - 22° PWR for the NIS Intermediate Range Rod Stop (bistables NC-35E &amp; NC-36E) Reactor Engineering stated that this setpoint is based on their procedure RFE-S-16.024 "NIS Intermediate Range Setpoint Determination". However, this setpoint does not agree with the one engraved on CCR Annunciator FCF, window 1-2, "INTERMEDIATE RANGE HIGH FLUX LEVEL ROD STOP 20%". The second issue is as follows: One of the setpoints of CCR SAF, window 1-2, "PRESSURIZER HIGH PRESS 2300 PSIG" is not reflected in window engraving. The setpoint for bistables PC-455I, PC-474B and PC-457F are listed as 2300 psig in SPIN (the value engraved on the window). However, the setpoint for bistable PC-456F is listed as 2335 psig in SPIN. There is no acknowledgement of the 2335 psig setpoint on the window. This bistable performs a fixed high alarm function. RECOMMENDED ACTION: I&amp;C Projects and Programs to evaluate if FCF, window 1-2, "INTERMEDIATE RANGE HIGH FLUX LEVEL ROD STOP 20%" should be re-engraved to reflect the actual plant setpoint. If it is determined that it needs to be re-engraved, the following is a suggested re-engraving</p>

	<p>*INTERMEDIATE RANGE HIGH FLUX LEVEL ROD STOP 21 - 22% PWR*. I&amp;C Projects and Programs to evaluate if SAF, window 1-2, "PRESSURIZER HIGH PRESS 2300 PSIG" should be re-engraved to reflect the multiple setpoints associated with this window. If it is determined that it needs to be re-engraved, the following is a suggested re-engraving "PRESSURIZER HIGH PRESS 2300 / 2335 PSIG".</p>
<p>200008446 System: N/A TagNumber: N/A</p>	<p>NRC Inspection Report 2000-011 contained a Non-Cited Violation (NCV 2000-011-03) for failure to comply with license condition 2K for the failure to properly evaluate and control transient combustibles during a grinding evolution (9/3/00 fire in VC)</p>
<p>200008447 System: GEN TagNumber: GENN</p>	<p>During system walkdown, found local alarm at GE Board on 15' elevation for "Machine Gas Purity Low"-window 1-2 on LARP 15. When walking down CCR, did NOT find the "Machine Gas Purity Low" alarm up on GE Generator Aux Board as expected-window 1-2, ARP GE Generator. Both have the same initiating device and both should be in alarm in the current system status-IA in machine. This deficiency needs to be investigated and repaired.</p>
<p>200008448 System: N/A TagNumber: N/A</p>	<p>On 11/01/00 at approximately 11:59 AM all ERO pager holders received a numeric page on their E-Plan pagers of "1 111-111-1111". At approximately 12:04 PM they received a second page of "22222". I then sent out a page to all E-Plan pagers to disregard the previous pages. At approximately 12:12 PM another page went out to all E-Plan pagers with "888-8888". I then sent a duplicate page out to all E-Plan pagers to disregard the previous messages. These pages caused mass confusion to the ERO Organization. I contacted ██████████ for them to investigate these pages. ██████████ contacted ██████████ in IR-Electronic Communications and left him a message regarding this situation. After investigation ██████████ contacted me with his findings. It seems that a member of IR-Application Services, ██████████ had the numeric group page number that we use to send the page out to our E-Plan pagers. Since IR has 4 E-Plan pagers that are used when we perform testing, ██████████ had replaced 2 of the 4 that seemed to be defective. ██████████ then gave the E-Plan group page number to a technician and told him to test the 2 replacement pagers. This set off all of the pagers for the Emergency Plan.</p>
<p>200008449 System: N/A TagNumber: N/A</p>	<p>A GROUP OF VISITORS ENTERED THE 95' VC CLEAN AREAS FOR 15 MINUTES. WHEN THE VISITORS CAME BACK TO HP 1 THEY INFORMED ME THAT ONE HAD LOST HIS MERLIN GERLIN AND ANOTHER VISITORS MERLIN WAS PERIODICALLY ALARMING AND SHOWING THAT HE HAD PICKED UP 13 MREM.</p>
<p>200008450 System: N/A TagNumber: N/A</p>	<p>CR s 199905813 and 199908622 documented occurrences of failing to meet the NRC administrative requirement of having licensed operator renewals to the NRC within 30 days of license expiration. Corrective actions were taken to ensure that this requirement would be met until the business plan goal of writing a procedure/process for license renewals was completed. CR 200006261 was issued to ensure the business plan item was completed. The corrective actions under CR's 199905813 and 199908622 were ineffective at preventing recurrence, and one operators license was identified to expire in mid November, inside the 30 day requirement</p>

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Below is a list of 31 CRs created in the last 24 hours. (11/5/00 10:44:08 AM to 11/6/00 10:44:08 AM)

Condition Number	Condition Description
200008569 System: HVAC TagNumber: N/A	UNIT HEATERS 235 AND 237 LOCATED ON 95' ELEVATION IN THE UNIT 2 VC NEED TO BE DECONED. THESE HEATERS WERE NOT ENERGIZED AS OPERATORS PERFORMED SOP 11.5 [SPACE HEATING AND WINTERIZATION.] AT THE REQUEST OF HEALTH PHYSICS BECAUSE THEY ARE CONTAMINATED.
200008570 System: GT TagNumber: N/A	GT-2 AC Fuel oil forwarding pump shaft gland is weeping oil , minor in nature pads are in place. Investigate and repair as required, unable to adjust the gland due to it's design.
200008571 System: GT TagNumber: N/A	GT-2 AC Fuel forwarding pump suction piping weld closest to the pump is porous. Investigate and evaluate what type of repair is needed.
200008572 System: GT TagNumber: N/A	GT-2 DC Fuel oil forwarding pump shaft gland is damp, investigate and repair as required.
200008573 System: GT TagNumber: N/A	GT-2-13, GT-2 Fuel oil forwarding supply valve is weeping oil from the valve body, investigate and repair(minor in nature).
200008574 System: 120V TagNumber: 120VN	Electric panel located on the south wall of the City Water tank house is missing the cover screws and door lock, replace as required.
200008575 System: HVAC TagNumber: N/A	Unit heater 228, fan is running in reverse investigate and repair as required. Located behind the VC Purge supply fan in the overhead.
200008576 System: EHT TagNumber: N/A	Electric Unit heater 2 does not operate as required, found during S.O.P. 11.5. Located in the back of the Nuclear side Operations field office 98 PAB.
200008577 System: HVAC TagNumber: N/A	The MOB hot water heating system piping is badly rusted and should be evaluated before being placed in service. This condition has been identified in the past but no work has been done to correct the problem.
200008578 System: EHT TagNumber: N/A	EUHR-102 is missing the air flow vanes replace as required. Located on the Fuel handling building level in the Boron storage room.
200008579 System: EHT TagNumber: N/A	EUHR-113 housing is damaged replace as required, located on the Fuel Handling building level, this does not affect operations..
200008580 System: BG TagNumber: BGA	the door to the elevator machinery room on 108' el. does not have any louvers at the bottom of it. a gaping hole exists where the louvers used to be,have situationn rectified as soon as possible
200008581 System: AS TagNumber: 234UHR	During performance of SOP 11.5, Space Heating & Winterization Procedure, Unit Heater 234 electric fan motor failed to operate. Adjusting the temperature setpoint on its thermostat to different settings failed to achieve satisfactory results. Unit Heater 234 is located on the west side of 80' el in the PAB.
200008582 System: 440V TagNumber: ASSEMBLY K-2B	Unable to install 440v breaker 2034-50 "G-10619" in assembly K-2B. The breaker is not able to be pushed in flush with the breaker frame, cause unknow. The spare breaker that was in the cubicle was reinstalled without difficulty.
200008583 System: N/A TagNumber: N/A	ON THIS DATE, A SMALL BAT WAS OBSERVED TO BE FLYING AROUND THE UNIT 2 CENTRAL CONTROL ROOM. THE BAT HAS BEEN REMOVED BUT THE CCR VENTILATION NEEDS TO BE CHECKED FOR OPENINGS THAT WOULD HAVE ALLOWED THE BAT TO ENTER
200008584 System: NIS	BETWEEN 9AM AND NOON ON THIS DATE, THE CCR RECEIVED APPROXIMATLY 20 HIGH FLUX AT SHUTDOWN ALARMS. SPIKING WAS

TagNumber: NC-31C	OBSERVED ON BOTH NIS SOURCE RANGE CHANNELS. NO ELECTRICAL SWITCHING WAS IN PROGRESS. ONE POSSIBLE CAUSE COULD HAVE BEEN WELDING IN THE UNIT TWO VC.
200008585 System: EHT TagNumber: N/A	Cable Spreading room heater EH-10 is not operating as expected, investigate and repair. The heater control knob is damage and can not be turned to energize the heater as required for S.O.P. 11.5.
200008586 System: N/A TagNumber: N/A	Framatome employee (TLD# [REDACTED]) received facial contamination while performing FOSAR on 23 Hot Leg. Contamination indicating 400 ccpm was found on the individual's face below the mouth. Initial decontamination attempt was successful.
200008587 System: N/A TagNumber: N/A	Radioactive Material was found outside the fenced Radioactive Materials Area in the vicinity of the VC Equipment Hatch and M&O Bldg. The material was within the Protected Area. Eleven shackles and two tumbuckles were found outside the fenced area next to the SGT offices. The shackles and one tumbuckle were on a wooden pallet and the other tumbuckle was located on the ground next to the fenced area with several slings. Initial survey results indicated loose surface contamination up to 300 dpm/100cm2 loose surface contamination and 200 to 10,000 dpm/100 cm2 fixed contamination.
200008588 System: 120V TagNumber: N/A	SGR was contacted by SGT safty about an unsafe condition that had been addressed before. On el. 46 VC on the NW corner by S/G 22 12' from the floor el. there is an energized junction box [1900 box] that was missing a cover plate. Due to work starting in this area the situation was unacceptable.
200008589 System: FP TagNumber: EL-23A	Condition Report to document as-found condition of EL-23A as follows: 1) As-found condition of battery tray unacceptable due to the need for cleaning. The tray was cleaned to an acceptable condition and and recorded in the as left column of the step list. 2) The battery terminals were unacceptable as found due to the presence of oxidation and the need for NO-OX to be applied. The oxidation was removed and NO-OX applied. The as left condition was recorded as acceptable.
200008590 System: MSCL TagNumber: TBWEST	Westinghouse Electric Company has issued a Technical Bulletin "Steamline Break Mass & Energy Releases Outside Containment", W-TB-00-04, September 18, 2000. This affects all plants for which Westinghouse has performed licensing-basis analysis of the main steamline break outside containment, therefore, it could potentially affect Indian Point Unit 2. The Westinghouse steamline break (SLB) mass & energy (M&E) release methodology for compartments outside containment was initially focused on maximizing the enthalpy of the superheated steam releases. The primary concern of the NRC in 1984 when Information Notice IN 84-90, was issued was the effect of superheated steam on the environmental qualification of equipment. The Westinghouse analysis method developed to address the issue included assumptions to maximize the production of superheated steam in the steam generators, which maximizes peak compartment vapor temperatures. This was believed to produce the worst case consequences for the compartment and equipment evaluation models used at that time. However, the assumption of maximizing the superheated steam release may not have in all instance resulted in a bounding time frame of elevated temperatures in the areas affected by the steam line break (outside containment). It has now been determined that maximizing the total energy released from the break rather than maximizing the the steam enthalpy could result in a higher integrated energy release and therefore could result in a worse envelope of temperature than was used in the environmental qualification(EQ) of equipment outside containment. It is recommended that this bulletin be reviewed immediately and that any potential non-conservatism in the analysis be evaluated in terms of its impact on the environmental qualification of equipment. It is recommended that this issue be resolved before the plant goes above 350 degrees, since it is above that temperature that the analysis of steamline breaks is applicable.
200008591 System: LO TagNumber: N/A	The main turbine oil sample results were returned from the vendor. The vendor states that there is a highwater content in the main turbine lube oil. He recommends processing of the oil to remove the water content. After processing is completed take another oil sample and check results. The vendor is National Tribology Services [REDACTED] attn [REDACTED] Sample# 3083
200008592 System: N/A TagNumber: N/A	From CAP monthly metrics (October). This C/R documents organizations who are representing the limiting weakness for closing out condition report evaluations in a timely manner during the month of October. This is the first month as an outlier in this area for these organizations. A third consecutive month would require documented



Below is a list of 46 CRs created in the last 24 hours. (11/8/00 6:26:30 PM to 11/9/00 6:26:30 PM)

Condition Number	Condition Description
200008737 System: N/A TagNumber: N/A	During the DC System SSFA, the reviewer observed the simultaneous use of both new General Design Criteria (form 10CFR50 Appendix A) and old Criteria (designated as GDCs in the UFSAR taken from proposed Atomic Forum Criteria issued for comment by the AEC on July 11, 1967). Sect. 8.1 of the UFSAR refers to GDCs 2, 17, 18, 24, and 39 with GDC 2, 24, and 39 being "old" GDCs and GDC 17 and 18 being "new" GDCs. A sentence is being added to UFSAR Sect. 8.1 (detailed in UFSARCR 294) preceding the descriptions of "new" GDCs 17 and 18 that links them to 10CFR50 and our 8/11/80 response to the NRC on how the plant complies with the "new" GDCs. Sect. 1.3 of the UFSAR lists the "old" GDCs by group (1-5, 6-12, etc.) with references to the UFSAR sections where these GDCs, and how they are met, are described. The UFSAR does not contain a one by one listing of the "old" GDCs with a cross reference to the "new" GDCs. The UFSAR describes "new" GDCs 17 and 18 and how we meet their requirements. However, the UFSAR has no such description for the other "new" GDCs. This resulted in the SSFA reviewer being concerned as to how we meet the "new" GDCs. We were originally licensed to the "old" GDCs. With the NRC Confirmatory Order of 2/11/80, we were asked to explain how the plant meets the "new" GDCs. This was explained in the 8/11/80 response to the NRC, which was concurred by the NRC on 1/19/82 (this is stated in UFSAR Sect. 1.3). This CR is being written to identify the SSFA reviewer's concern with the way that the GDCs are described in the UFSAR. Two e-mails from the reviewer on this issue are attached.
200008738 System: N/A TagNumber: N/A	Illegal parking brought to the attention of the SSS by Shift Manager Mr. [REDACTED] 2001 Buick Centry Plate # [REDACTED] parked in assigned space #19 in Lot 4. Disregard for permit only parking sign.
200008739 System: AS TagNumber: N/A	Unit Heater K-52 on 15' of Water Treatment Plant above NSG Pumps is experiencing water hammer. Suspect the steam trap(UHT-621) is not working properly, due to no temperature difference across trap and trap barely warm to touch.
200008740 System: HVAC TagNumber: N/A	Drawing 138932-16 incorrectly describes the location of Purge Auto Switch as being on H&V Panel K-199 The switch is actually located in the CCR on the column behind the Watch Engineers Desk. Additionally, the Purge Auto Switch is labeled in the field as 'Emergency Vent
200008741 System: ILWH TagNumber: CT971-FRE	CSCR discharge flow recorder stopped working. The cable that drives the pen for the chart recorder has broke
200008742 System: TURB TagNumber: N/A	Identified possible source of oil leak documented in CR 200008687 dripping down north wall of 23B Condenser as the dennison valve used to adjust oil flow to the number 2 bearing Leaking out the side of the valve body.
200008743 System: RMS TagNumber: R-50	Rad Monitor R-50 for the Large Gas Decay Tanks and the MSA Gas Analyzer are inoperable due to a lagout on 125 VDC Power Panel 22. Enter 30 day action statement per TS 3 9 B.2 c and informed chemist of sampling requirements. No off gassing operations are expected while these monitors are inoperable. dc.
200008744 System: N/A TagNumber: N/A	The Conventional Watch Nuclear Plant Operator twisted his left ankle while walking on the gravel in the Transformer yard (adjacent to the Unit Aux Transformer) during the performance of rounds at approximately 0200 on 11/9/00.
200008745 System: SEC TagNumber: SECN	A potential CCTV performance indicator concern has been raised by the new security management with regard to periodic sunglare..
200008746 System: COMP TagNumber: COMPA	This condition report addresses a problem with the Condition Reporting System. The due date in a NEW + UNREAD Implement Corrective Action (ICA) sub-assignment can be modified from the FCA assignment by the FCA Owner. The new due date can exceed that of the parent ICA assignment. This problem was identified in CR numbers 200001417 and 200002109. Please assign as a SL4 to Computer Applications.
200008747 System: TURB TagNumber: TURBN	Upon review for extend of condition for CR 200008421, for (2) additional junction boxes under turbine skirt missing covers. Terminal Box K, drawing 201B91 and Enclosure #5, reference drwg 227508. Terminal Box K is under the skirt near the

	<p>turbine turning gear. Enclosure #5 is under the skirt on LP 21, north end, east side. Enclosures should be cleaned, and new covers installed to protect equipment. Please FYI [redacted] and [redacted] unknown reason why these covers are missing.</p>
<p>200008748 System: N/A TagNumber: N/A</p>	<p>1. On 11/8/00 at approx. 1500 hours observed RSG 21 MS riser gamma plug welding in progress above the 95' level. The welding stopped and firewatch proceeded down off the scaffolding; the welder then started to use the oxyacetylene torch to heat the weld area without the firewatch present; I stopped the work and told the welder about the need to have his firewatch present. 2. On 11/8/00 at approx. 1315 hours observed RSG 24 upper ULS welding in progress at two locations at the 95' level inside the bioshield wall area. During the welding activity, the firewatch was observed leaving his location to perform a nearby non-firewatch duty. This was immediately brought to the attention of the SGT Supervisor who was present inside the bioshield wall area. The work was stopped and the SGT Supervisor spoke to the firewatch.</p>
<p>200008749 System: RCS TagNumber: LIT-3100</p>	<p>While performing PC-R46-1 (Cold Shutdown RCS Water Level-VC) found transmitter LIT-3100 out of spec. Adjusted and left in spec.</p>
<p>200008750 System: SIM TagNumber: N/A</p>	<p>Simulator Condition Report for tracking purposes. Simulator running IC-19 on Test Pac, for JIT09 Startup Training. Received one set of spurious alarms on Area Radiation Monitor, ARM, high alarms on R-2, R-4, R-5, R-6, R-7, R-8.</p>
<p>200008751 System: SIM TagNumber: N/A</p>	<p>Simulator Condition Report Simulator running IC-19 on Test Pac During JIT09 Startup Training. De-energized 125 VDC Buss 22, Simulator lost indications for components controlled from the 125 VDC Busses other than Buss 22, ie: control power to main generator output breaker '7' SOV-201 21 Emergency Diesel Generator 'Emergency/Normal' status lights Please reverify DC control power distribution in the Simulator is in agreement with the AOI 27.1.11 list of DC loads</p>
<p>200008752 System: N/A TagNumber: N/A</p>	<p>During a meeting of the group tasked with writing our new procedure that addresses the requirement of the new Maintenance Rule (a)(4) the following observation was made: Currently the PRA group reviews Safety Evaluations for Modifications issued for approval to determine whether there are any potential impacts on the Safety Monitor. The Safety Monitor is a PRA computer modelling program that the Operations Planning department uses to quantify the risk associated with the planned work week schedule. The question was asked whether the process would be improved if the Design Engineer were to contact the PRA group during the conceptual design phase of the modification, before the Safety Evaluation is written and the modification is essentially complete. This could turn the review process from a reactionary style of review (where the PRA group is essentially stuck with the proposed design), to a progressive process where the Design Engineer is now cognizant of potential Safety Monitor impacts and modifies his/her design accordingly. Procedural references: OAD-37- On-line Risk Assessment, NUMARC 93-01, Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants, Draft SAO for Operational Risk Management (attached). The (a)(4) procedure group is currently composed of: [redacted], [redacted], [redacted], [redacted] and [redacted]. It is recommended that this Condition Report be assigned to the people involved in the Modification Optimization Process and the PRA group within NS&amp;L.</p>
<p>200008753 System: N/A TagNumber: N/A</p>	<p>The reported Liquid Effluent Release section "C" data reported in the 1999 Annual Effluent and Waste Disposal Report was from the 1998 Annual Effluent and Waste Disposal Report. The data provided by the Radiation Specialist for section "C" of the 1999 report did not get transposed into the Annual Effluent Report. A review was performed to verify that no other sections of the report contained 1998 data. Additionally, a review of the 1999 reported Liquid Effluent Pathways Dose to Individuals. Section E indicated the liquid effluents doses to individual did not have a significant implication for public health and safety or common defense and security. This failure to include the 1999 Liquid Effluent data in section "C" was a result of indications brought to light during the conduct of QA audit 00-03-F.</p>
<p>200008754 System: GEN TagNumber: N/A</p>	<p>INPO Operating Experience Item OE11592 - Inadequate Follow-up to Generator Purity Monitor Low H2 Indication resulted in the Utility making an alarm response and system operating instruction procedure change. These changes should be evaluated for applicability to Indian Point 2. Recommend an SL4 to Generation Support for further review and action.</p>
<p>200008755</p>	<p>During Fire Protection System Engineering Walkdown on 11/8/00 several Appendix</p>

<p>System: FP TagNumber: EL-3A</p>	<p>"R" emergency lights appeared to be aimed incorrectly and should be verified per test requirements. They are as follows: EL-3A, north lamp; EL-3B, west lamp; EL-4, both lamps; EL-6, both lamps; EL-7, west lamp; EL-10, south lamp; EL-10B, both lamps; EL-11, both lamps; EL-17A, both lamps; EL-20, both lamps; EL-21, south lamp; EL-22, lamp mounted on battery; EL-22D, lamp mounted on battery; L-22E, north remote lamp; EL-22F, lamp mounted on battery; EL-23A, north lamp; EL-25A, lamp mounted on battery; EL-26, south lamp; EL-26F, both lamps; EL-27B, west lamp; EL-28, both lamps; EL-29, south lamp; EL-30, south lamp; EL-31, east lamp; EL-32, both lamps; EL-33, east lamp; EL-35, south lamp; EL-38, north lamp; EL-40, west lamp; EL-40A, north lamp; EL-41, both lamps; EL-49, west lamp; EL-50, south lamp; EL-51, both lamps; EL-55, both lamps; EL-56, both lamps; EL-59, both lamps. These emergency light units are rendered impaired but are only required when the plant is above cold shutdown. Recommend the Test Dept. to perform the lamp alignment portion of tests PT-M49A and PT-M49B.</p>
<p>200008756 System: FP TagNumber: N/A</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following corrosion and painting conditions were observed and require maintenance for preservation: • Pipe under valve FP-500 is corroded (packing leak is no longer active) and needs refurbishment and painting. Also the packing gland follower and stem of valve FP-500 are corroded and need to be cleaned. (Turbine oil reservoir deluge - A227552) • FP piping in the north-east Turb Bldg 15' serving the Main Turbine Lube oil area is in need of general preservation painting. • Vertical FP piping that feeds valve FP-678 (above valve and against structural steel) needs to be refurbished and painted for preservation (Hose reel #28, 36' TH West - A227554) • Emergency light EL-15 (Screenwell Pump House) battery mounting box is corroded and needs to be cleaned and painted for preservation. • FP pipe supply to the H2 deluge (5' Screenwell) needs to be refurbished and painted for preservation • FP piping (generally) that serve the H2 deluge needs to be cleaned and repainted for preservation. • Valve FP-675 has corrosion on the threaded connection to the valve. (Hose reel #22, 36' TH West - A227554) • The new suction valve, discharge check valve and discharge "T" on #11 Main Booster Fire Pump need preservation painting. • Electric Tunnel Deluge Valve House corrosion on strainer "T" connections and where supply piping enters the valve house (this is a bad spot because caulking is gone creating a water trap). • Packing gland followers for valves FP-614, FP-613, FP-612 (EDG Day Tank sprnkler stop valves) are corroded and need to be cleaned and refurbish. • Several piping joints in the vicinity of valve FP-826 have residue from old leaks that need to be cleaned and repainted. (80' PAB Southeast - A227551) • Diesel Fire Pump packing gland leakoff drain is clogged with corrosion products None of these conditions are operability issues.</p>
<p>200008757 System: FP TagNumber: EL-22D</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed • Seismic restraint for emergency light EL 22D (AFW Bldg El 77') is not secured to the battery mounting box.</p>
<p>200008758 System: SEC TagNumber: SECN</p>	<p>An act of vandalism occurred to the left and right signs located at the Indian Point entrance (Broadway and Bleakley). The words "slow death" were written in black magic marker in the middle of the signs. This is a repeat occurrence, see CR200003623 from 5/15/00</p>
<p>200008759 System: AFW TagNumber: 23AFP</p>	<p>During Fire Protection System Engineering Walkdown the following condition was observed • Thermal wrap for AFW pump power cable has minor damage (cuts and tears) where it makes contact with the floor.</p>
<p>200008760 System: 480V TagNumber: SWPA-2050-002</p>	<p>During the performance of PT-3Y5 for SWPA-2050-002 we found that long delay pickup did not trip the Amptector at 115% of the pickup value.</p>
<p>200008761 System: FP TagNumber: FP-563</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • The manual actuation pull box cover for valve FP-563 doesn't stay "up" to protect the manual actuation lever</p>
<p>200008762 System: FP TagNumber: FD-32</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • One Electro-thermal link (ETL) "J" hook is installed backwards on damper FD-32 (480 V Swgr Rm south wall, lower east quadrant). Hook opens "in to" rather than "away from" the damper.</p>
<p>200008763 System: N/A TagNumber: N/A</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • Normal access path illuminated by emergency light EL-11 is blocked (area by Aux Condensate Receiver, 15' TH) and needs to be cleared prior</p>

	to startup. Path is blocked by steel drums and SS braided hose.
200008764 System: FP TagNumber: FPA	A portion of the Fire Protection piping system which is located in the Utility Tunnel will be replaced in accordance with the referenced work orders. The piping that maintenance would like to use for this class "FP" pipe replacement was procured in 1998 using purchase order number 807617, requisition number 746-8-0572. However, the piping was procured non-class A instead of class "FP" as required by SAO-401 paragraph 3.5, since at the time the requisition was written, it was to be used on the non-class A City Water system. I verified the following material marking of "5LB/ASTM A53B / ASME SA53B" on all of the piping sections prior to paint being applied. The paint now has been applied in order to maintain the current schedule of returning the High Pressure Fire Protection Piping System to Operations. I also verified the heat number of Y19433 on the 12" sections of piping. I then contacted the vendor who supplied the piping to Con-Ed for their assistance in obtaining manufacturers inspection certification documentation of material. Using the heat number supplied to them, the vendor has found the inspection certificate matching the heat number on the 12" piping. This inspection certificate has been given to [REDACTED] for review.
200008765 System: N/A TagNumber: N/A	During a routine field observation SGR-QA noted that several of the SGR-HP records do not meet all the labeling and authentication requirements expressed in Sections 3.3 and 5.2 of AD-SQ-2.001. These records included: dose evaluations performed by the SGR-HPs, assessments performed by the SGR-HP Assessor, SGR-HP Lessons Learned forms, Abnormal Dose Investigation forms, ALARA Job Review forms, special survey records, and log books.
200008766 System: FP TagNumber: N/A	During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • Two FP pipe hangers, one above the south-west end of the Main Oil Reservoir and one on the west end of the Main Turbine Oil Reservoir are mis-positioned.
200008767 System: LGHT TagNumber: N/A	During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • Normal access lighting for AFW Bldg EI 64' 8" is burned out
200008768 System: N/A TagNumber: N/A	PT-Q29C (23 Safety Injection Pump Test) & PT-Q32A (21 Boric Acid Transfer Pump Test) entered their surveillance grace periods.
200008769 System: N/A TagNumber: N/A	Drawing 307893-00 has been received in the Record Center showing two two different drawings with the same drawing number. It appears that a revision was done using mod number flx-94-10154-e which dramatically changed the drawing from the other drawing of the same number. Please open an item to Design Engineering Personnel [REDACTED] and [REDACTED] as their names appear on the drawing. The other drawing numbered 307893 was done by Atometrics. The revision boxes of both drawings were signed 4 years apart.
200008770 System: FP TagNumber: N/A	During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed • Sprinkler head located over the Main Turbine Oil Conditioner has a damaged deflector (15' Turb Bldg eastern most sprnkler head) and the sprinkler head needs to be replaced.
200008771 System: FP TagNumber: N/A	During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed • A temporary rubber hose is routed over the closure device which could cause interference for fire door closure to Waste Drumming Room.
200008772 System: N/A TagNumber: N/A	This CR concerns the new I&C store room located on the 5' level. While looking for parts today I noticed what could be some serious safety concerns. There is a person working in the area as a inventory specialist, and this does not seem to be a temporary storage location. One CR was already written concerning the lack of a fire suppression system This CR addresses other concerns. 1) Inadequate lighting - lighting there is not suited for a continuous working environment. A drop light is being used to supplement the lighting, this is not an improvement There are numerous low hanging beams and pipes which when combined with the poor lighting may lead to a head injury. the lighting is of such a poor quality the after a short period of time the strain on the eyes is noticeable. This may be an ergonomic and safety concern. Also, power to the area is via an extension cord. 2) Person working in the area does not have proper office equipment. An example is the desk the person is using, which is a piece of wood with legs, that is about knee high. This is another ergonomic concern 3)

	The floor is not in great condition. Tripping hazards and water are very noticeable. Combined with poor lighting this makes the risk of injury even greater. 4) Piping in the area is very old and has peeling paint. This may be a lead/asbestos concern. 5) This person is working alone down on the 5' elevation. There is no phone or other means of calling for help if something were to happen in that area. This is not a high traffic area.
200008773 System: FP TagNumber: FP-689	During the Fire Protection System Engineering walkdown on 11/8/00 the following condition was observed: • Valve FP-689 has a broken hand wheel. This is the stop valve to #213 hose reel, 15' TH, NE.
200008774 System: RCS TagNumber: 897D	During a visual inspection of valve 897D on 14" SIS injection line-350 boron leakage was noted between the valve body and bonnet. The line of boron is about 7" long and is bright white. It is not running down the side of the valve but along edge of the body to bonnet mating surfaces. This inspection was performed in accordance with ASME Code Relief Request #35. The leakage shall be evaluated in accordance with IWA-5250.
200008775 System: SW TagNumber: SWN	During service water system walkdown performed on 11/8/2000 in the vapor containment and PAB there were several supports which were inspected and found in need of repair. SWN-740-2 needs a unistrut support on the line downstream of the valve. It is a small line and appears that there used to be a support there, but not anymore. SWN-51-5A has a bracket missing on the support downstream of the valve. In the PAB where the inlet piping to the CCWHX is, the support on the 1-2-3 header looks slightly bent. The rod between the supports is sticking out alot compared to the support on the 4-5-6 header. The bolting on the support below SWN-35-1 needs to be tightened. The bolting can be tightened.
200008776 System: FP TagNumber: 25 HPH	Consider revising SAO 703 - Fire Protection Impairment Reporting Criteria & Surveillance, to relax fire protection program impairment criteria regarding the 14 day response time.
200008777 System: SW TagNumber: SWN	On 11/8/2000 went on service water walkdown. Cable from valve SWN-44-5C limitorque may need replacement. This cable looks old compared to the ones on the other valves in the area. This is in the PAB mezzanine area. Down in the service water pipe chase in the PAB valve TCV-1104 has three cables connected to the controller on the valve. These cables are hanging loose and should be fastened together or supported somehow
200008778 System: SW TagNumber: SWN	
200008779 System: SW TagNumber: DPI-5106	DPI-5106 is the differential pressure gauge on 24FCU. This gauge appears to need calibration. It is showing pressure with the inlet and outlet valves to the gauge closed.
200008780 System: SW TagNumber: SWN-71-1B	In the PAB pipe pen, while walking down the service water system fan cooler unit motor cooler outlet valves on 11/8/2000, it was noticed that the conduit junction box coming from valve SWN-71-1B is missing a screw.
200008781 System: SW TagNumber: SWT-658	SWT-658 near the degassing pumps looks like the valve is due for a re-pack.
200008782 System: SW TagNumber: SWN	During a system walkdown of the Service Water System, the following items were observed. 1) On the 5' elevation of the turbine building, a couple of support bolts do not have full thread engagement. These are supports for service water piping supplying the main boiler feed pump lube oil coolers. 2) There is a rust stain below the drain plug on the cooling water side of the 21 lube oil cooler (21TLOC). It looks like the plug may have been leaking by. 3) The vacuum breaker on the discharge of the Turbine Lube Oil Coolers (21TLOC & 22TLOC) appears to be heavy compared to the attached piping. This should be evaluated to ensure proper dead weight load supports are in place. 4) Turbine Lube oil Cooler service water outlet temperature control valve (TCV-1102) has instrument air tubing that is not properly supported.
200008783 System: SW TagNumber: SWN	Inspected service water pumps on dock during service water walkdown on 11/8/2000. A few conditions were noted. On the service water pumps the plexiglass should be cleaned so the pump shafts can be seen turning better. Bolts on the base of 24SWP

	<p>are in a degraded condition. The bolting appears to be rusting as compared to the other 5 pumps. The ground wire on 26SWP is very long and could be a potential tripping hazard. The grounding wire should be shortened. 23SWP has paint peeling on the exterior of the pump.</p>
<p>200008784 System: N/A TagNumber: N/A</p>	<p>The following deficiencies were identified by HP during the EP Drill of 11/9. 1) The EOF Survey Team HP procedures need: a) The addition of an operability procedure for the MS-2. b) The addition of the scale the Triton should be operated on, with the appropriate alarm set point. c) The Site Map for the Onsite Survey Team needs to be improved. 2) The MS-2 Mini Scaler failed source check. This is a recurring problem on both the EOF and TSC units. Suggest SL3 to [REDACTED]</p>
<p>200008785 System: 13.8 TagNumber: 13.8N</p>	<p>During a walkdown of the 13.8 KV underground vaults with Altran, vaults M4, M5, M6, M7, located along the south wall outside Unit 1, were noted to have between 2 feet and 5 feet of water accumulated inside. 13.8 KV feeders 13W92, 13W93 and 13W94 are located in 3 of these vaults. It was impossible to determine the extent of deterioration of the feeder conduits due to the depth and turbidity of the water. It is surely only a matter of time before a conduit fails and we experience a major electrical fault. Action should be taken to determine possible PCB and radiological contamination levels of the water and these vaults should be pumped out ASAP. It should also be noted that these vaults are adjacent to the north wall of the 5' EL Utility Tunnel and could be a major source of water seepage into the tunnel.</p>
<p>200008786 System: SW TagNumber: SWN</p>	<p>During system walkdown of the service water system, the following items were identified: 1) In the valve pit, SWN-6 and SWN-7 appear to have been supported below these lines at one time. The supports are totally corroded away. The piping appears to be sufficiently supported by the valve pit walls. The piping needs to be evaluated to ensure it is properly supported 2) The pressure sensing lines in the valve pit are totally unsupported.</p>
<p>200008787 System: FP TagNumber: N/A</p>	<p>During the Fire Protection System Engineering walkdown on 11/8/00 the following conditions were observed: • Valve FP-715 has a minor packing leak (15' TH, NE, Hose reel stop. 9321-F-4006, DI Tag 02705) • Valve FP-711 has a minor packing leak (15' TH, W, Stop to nser. 9321-F-4006, DI Tag 02701) • Drain valve FP-800 has a minor leak by its seat and leaking on the floor (15' TH, MBFP Deluge inlet drain, A227552, DI Tag 02702) • The 3/4" drain plug on valve FP-523 has a minor leaking (15' TH, H2 Seal Oil Deluge, A227552, DI Tag 02703) • Valve FP-1 has a minor packing leak (#12 FMBP Room, overhead, A227553, DI Tag 02704) • Valve FP-678 has a minor leak and corrosion at the threaded connection to the valve (36' TH, W, Hose reel #28, A227554, DI Tag 02713)</p>
<p>200008788 System: SW TagNumber: SWN</p>	<p>The following items were observed during the SW system walkdown: 1) The sump pump in the valve pit is very rusted. The sump pump and actuator are rusted. The sump pump discharge piping is not supported properly. The junction box for the sump pump should be sealed better so no water can enter. 2) The scaffolding on the floor of the pit is dangerous This should be replaced with a better walking surface.</p>
<p>200008789 System: 480V TagNumber: SWPA-2050-002</p>	<p>While performing the inspections in the referenced work order the night alarm switch normally open contacts failed the test criteria. All readings were required to be less than 0.5 ohms and within +/- 0.1 ohm. The actual values obtained were 0.4, 0.1, 0.3, 0.2, 0.5 ohms This breaker was in the maintenance shop for routine PM at the time of the test No part of the PM except the amptector as found (PT3Y5) had so far been performed The work instructions contain resolution for this problem no action is required, this CR for documentation only.</p>
<p>200008790 System: N/A TagNumber: N/A</p>	<p>During the movement of drums that had water from the condenser hot well, one drum leaked &lt; 1 cup of water on to the floor. HP was present and smeared water and counted in lab. All results were</p>
<p>200008791 System: RCS TagNumber: LT-7610</p>	<p>I attended a SAO-405 Pre-Implementation Meeting today for MOD FIX-93-09275-1, Revision 1. Rev. 1 adds alternative upper tap at 537C, and 537B, with vacuum tested connections, for LT-7610 and the MLMS ([REDACTED]). This MOD was supposed to address the problems associated with OUR attempt at vacuum fill, following the 2000 RFO. My CR addresses two issues, one specific, and the other generic. 1) Specifically, when this MOD first went before the DDR (Detailed, Design Review) Meeting, after some questions beforehand regarding its necessity, the meeting received details indicating that the MOD's original premise; i.e., dynamic effects on the level instrumentation during vacuum fill might be flawed. An attempt at that time was to have the MOD quashed, since there were large lead times for</p>

equipment, accessibility issues for the MOD installation, and implementation, and the obvious question of the flawed premise. In any case, the MOD proceeded. Today, at the SAO-405 Meeting, WE received confirmatory information, corroborating the suspicions of the flawed premise. See the following text of an e-mail from Operations, forwarded by Design Engineering: "On Tuesday November 7 another series of vacuum tests were performed on the [REDACTED] and LT-7610 (Intermediate Level). All valve line ups on this test were the same as on Saturdays test. The only difference was the Graph Scaling on the computer read out in the CCR was changed by [REDACTED]. The system was taken to 9" and held for 15 minutes. Both level monitors tracked evenly. The system was then taken to 18" and held for 10 minutes. Again both levels tracked evenly until LT-7610 went off scale high. Vacuum remained stable at both points not showing any signs of decaying off. The system was then depressurized slowly, about 5 minutes. Both level monitors tracked down together. At no time did the MLM act erratically as it did on Saturdays test. A second test was performed with the same results as the first. It was the opinion of those present in the CCR ([REDACTED], [REDACTED], [REDACTED]) that the MLM is functional and capable of being used for vacuum refill. A mod is presently planned for this system with a second tap running from 537 to the level christmas tree on top of the pressurizer. This would add a redundancy to the system for operations and would also allow the MLM and LT-7610 separate tap off areas if desired. Any questions please call me at 5804." END OF E-MAIL TEXT There are still equipment testing issues, and implementation issues that will be required EACH TIME the new equipment is used. MOD Installation will require building of a 24 ft. scaffold; there is now a scheduling conflict due to the need for the polar crane. This remote accessibility problem will also be an issue when aligning, and vacuum testing the alternate level tap. EACH TIME the equipment is used. This MOD affects five (5) Operating Procedures, albeit minimally (COL 1.1, POP 1.1, SOP 1.1, SOP 1.1.1, and SOP 1.2), plus necessitating a Periodic Test, EACH TIME this equipment is used. 2) The Generic issue is associated with the attendees at the SAO-405 Pre-Implementation Meeting. I attended, representing Generation Support, as the Modification Co-ordinator; i.e., co-ordinating procedure revision issues associated with the MOD. I also attended for Operations, since they rarely attend these meetings, and I have been asked to go in their stead. This is the crux of my second concern. SAO-405, Step 4.6.2.c.5. states the requirements for Operations Attendance as follows: "a. Shall attend all Pre-Implementation Meetings. b. Shall ensure that the modification performs the intended function. c. Shall address Human Engineering concerns. d. Shall ensure the PMA has identified work permit requirements. e. Shall approve PMTs \* Operations, the end-user of the MOD, NOT Generation Support (or even a Watch Engineer for that matter). is the organization that is the most prepared to address the Operations issues at the meeting. They are the ones that need to know that it "performs the intended function". They are the ones who do the Human Factors Review (OAD 29) They are the ones who interface with Ops Planning, and Work Control, addressing issues that the PMA might encounter. They are the ones who approve PMTs, since they control the forces necessary to perform them.

200008792  
System: MS  
TagNumber: N/A

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Condition Number	Condition Description
<p>200008795 System: N/A TagNumber: N/A</p>	<p>Condition Report (CR) # 200002297 asked the following question: "Procedure MMS-M-014-A states to reference Drawing B227170 for the torque value of Hilti Kwik Bolt II's. B227170 would torque a 1" Hilti Kwik Bolt II to 200 ft.-lbs, but the Hilti Product Technical Guide would torque the same 1" bolt to 450 ft.-lbs. Preliminary Generic Mod Drawings being reviewed for comments by Planning, do not specify any torque values for the Hilti Kwik Bolt II's. With such a large differential in values, (200 ft.-lbs. vs 450 ft.-lbs), which is correct for the final torque value?" Mechanical Engineering discussed the question with the Planner and provided an answer with the correct torque value to be used on the specific job. However, in response to the CR Mechanical Engineering added Note 6 to drawing B227170: "6. FOR INFORMATION NOT CALLED FOR, SEE MANUFACTURERS CATALOGS." Maintenance had also pointed out some other information on the drawing that was different from the information provided in Hilti, inc. technical information. Instead of revising the drawing to contain the correct information, Mechanical Engineering issued drawing as Revision 4 with a large stamp stating: "OBSOLETE REFER TO MANUFACTURERS CATALOG FOR THE LATEST INFORMATION" Drawing B227170 contains design installation details for concrete anchor bolts by Phillips (Redhead wedge and Nuc. Grade wedge types), Hilti (Kwik Bolt II and Drop-In types), and Drillco (Maxi-Bolt type) used on seismic supports in all Systems including ASME Section XI Quality Groups A,B and C. The drawing provided the critical installation requirements including minimum embedment, minimum bolt spacing, minimum edge distance to the edge of the concrete, minimum distance to edge of plate, maximum angularity, required installation torque, and checking torque. This drawing is frequently used in Maintenance Work Packages and is referenced in some Maintenance Procedures which require the installation of concrete anchor bolts for seismic supports. Our Work Packages also require the Quality Control Inspectors (QC) to verify all of the critical installation characteristics listed above for every anchor bolt we installed in "Class A", "Class FP" and "Class AS" applications. A review of the Hilti "Controlled" Vendor Manual (# 1653) found that this manual was last updated on 2/18/1986 and only contained technical information for Hilti Kwik Bolt I type of anchors dated 1974, 1977 and 1980. WE have not used the Hilti Kwik Bolt 1 design for many years. There are no Engineering approved vendor manuals or catalogs any of the anchor bolt types identified on drawing B227170 including Phillips (Redhead wedge and Nuc. Grade wedge types), Hilti (Kwik Bolt II and Drop-In types), and Drillco (Maxi-Bolt type). Station Administrative Order, SAO-409 Revision 5 - VENDOR INFORMATION REVIEW PROGRAM, paragraph 2.6.1 states: "2.6.1 Only controlled manuals are used for any purpose defined in Section 2.0 of this SAO." and paragraph 2.0 states "This SAO applies to all Indian Point personnel who use vendor manuals for the operation, maintenance testing, quality inspection, repair, modification, installation or removal of plant components" 1 Since there are no Engineering approved and "Controlled" vendor catalogs for the anchor bolts currently being used, how are the above requirements of SAO-409 to be met? 2. If we are to "REFER TO MANUFACTURERS CATALOG FOR THE LATEST INFORMATION" as stated on drawing B227170-04, what Qualification, Validation and Verification (QV&amp;V) controls has Design Engineering placed on these vendors' current and future catalogs so that installing anchor bolts using the catalog data will ensure that the seismic design requirements of Indian Point 2 Structures, Systems and Components will be met?</p>
<p>200008796 System: SFPC TagNumber: 21RWPP</p>	<p>Refueling water purification pump located 68" PAB leaks from seal package area. This pump may need to run for an additional 2 days. Leak rate is about 1 drop per 2 seconds. Recently returned from tagout</p>
<p>200008797 System: N/A TagNumber: N/A</p>	<p>This CR is being submitted to track the loss of the working copy of work permit #55081, issued 8-29-00 to SGT work package 1524, for the removal of RCS 24 Loop Flow Transmitter piping SGT work package 1524 has been through closure review and a search was performed to find this permit. The work for which this permit was issued was reinstalled under work package 3524 and permit 56142 and work package signatures and QC inspections have been completed in the work package and weld cards.</p>
<p>200008798 System: FP TagNumber: DFPBATT</p>	<p>The battery cells 8,9,&amp; 14 on Battery Bank 1 for the Fire Diesel Pump were greater than max fill line. This was identified while performing PT-W5.</p>
<p>200008799 System: FW TagNumber: BFD-707</p>	<p>while performing ICPM1121 relating to the steam generator level (wide range transmitters) we encounter difficulties isolating the transmitters due to the fact that the low side isolating stop valves are all leaking through they are: BFD-707 / BFD725/BFD749/BFD769.</p>
<p>200008800 System: DC TagNumber: DCA</p>	<p>When removing 21 Static Inverter from service received the expected alarm "21 or 22 Inverter Trouble". At the same time we received the "Excess Letdown High Temp 200 F" alarm (panel SF window 1-4) This alarm continued to come in and out constantly every 2-3</p>

	seconds. Tried to replace alarm can but the results were the same.
200008801 System: FP TagNumber: TST-PT-2Y6	21 DC Power Panel is being tagged out for breaker replacement. The following fire protection impairments are incurred as part of this planned evolution: Hydrogen Seal Oil Unit Detectors, 30 day action statement, 4 Hour fire tour (OPS); Clean Oil Storage/ Dirty Oil Storage Tank Detectors, 30 day action statement, 4 hour fire tour (OPS); Main Lube Oil Reservoir Detectors, 30 day action statement, 4 hour fire tour (OPS); Main and Auxilliary Transformers Detectors, 30 day action statement, 4 hour fire tour (OPS); PAB Charcoal Filter Detectors, 30 day action statement, 4 hour fire tour (OPS); Electric Tunnel Detectors, 14 day action statement, hourly fire tour (security). All action statements and fire tours per SAO 703, Addendum I, Item 1. Fire impairment forms have been initiated. Expected duration of impairment is 24 hours or less.
200008802 System: FW TagNumber: LT-437B	It has been observed that the tape being used for FME covers on the cut tubing end for LT-437B has become loose creating a possible FME concern. Previous condition has been noted by CR 200007632.
200008803 System: N/A TagNumber: N/A	Installation of steam generator 21 shoe pin keeper plate had commenced and it was identified that the fire watch failed to sign the post hot work inspection section on sheet 2 of HWP #227. There were no workers in the area at the time of this observation. This is a requirement of SGT SP 6.0 for Hot Work.
200008804 System: N/A TagNumber: N/A	During walkdown of Main Steam 21 piping, it was identified that HWP 190 was still in field with an expiration date of 10-9-00. It was also identified that the last fire watch also failed to identify the area at the end of his watch as Sat/Unsat as required by SGT SP 6.0. No hot work has been performed since this permit has expired.
200008805 System: N/A TagNumber: N/A	On the evening of 11/9-11/10 it was observed that during a grinding operation on MS #22 Williams' PF's were flapping an area on the pipe with out proper hot work precautions such as a bamer to stop sparks from flying out of the area, no hot work permit posted in the area after the work was completed
200008806 System: SGBD TagNumber: MS-67-C	As a result of briefings with Walkdown participants ( System Engineers, NPO's and NRC Inspectors ) several areas for improvements were identified in System Walkdown performance. System Walkdowns were scheduled and performed to assess System material condition as an input to Unit Start up preparations. Methodology of SE-SQ-12.110 was followed to conduct walkdowns. To improve walkdown performance System Engineers were given Walkdown Awareness Training in the third quarter of 2000. Examples of improvement areas are as follows: Inconsistent Briefings at start of walkdown to discuss walkdown stratagy Support Group preparations ( Maintenance ) needs to be more clearly defined Isolated incident of System Engineer unfamiliarity with System. Procedural guidance lacking on post walkdown debriefing requirements.
200008807 System: FW TagNumber: 23SG	This Condition Report is being written to track the disposition of a condition identified during Steam Generator Replacement (SGT NCR - 111, copy attached). During welding preparation activities, the required bevel angle and the nozzle ID for RSG 23 were out of tolerance in three of the four areas measured. Recommend SL-4 for tracking.
200008808 System: FW TagNumber: 24SG	This Condition Report is initiated to track the disposition of a condition identified during Steam Generator Replacement activities (SGT NCR - 113, copy attached). During welding preparation, the machine face of the RSG 23 feedwater nozzle included areas of slag inclusions and porosity open to the surface. Assign as SL-4 to [REDACTED]
200008809 System: RCS TagNumber: N/A	This Condition Report is initiated to track the disposition of a condition identified during Steam Generator Replacement activities (SGT NCR - 114, copy attached). While performing weld buildup on RSG 23 inlet nozzle, a 1 1/2 " long slag inclusion boiled to the surface of the weld. Assign SL-4 to [REDACTED]
200008810 System: MS TagNumber: 1EX-1	This Condition Report is initiated to track the disposition of a condition identified during Steam Generator Replacement activities (SGT NCR - 118, copy attached). A 12 inch long intermittent arc strike was located in one of the RSG 22 Main Steam Flow restrictor tubes - a preexisting condition. Assign SL-4 to [REDACTED]
200008811 System: FW TagNumber: 21SG	This Condition Report is initiated to track the disposition of a condition identified during Steam Generator Replacement activities (SGT NCR - 115, copy attached). After initial RSG 21 Feedwater nozzle end preparation machining, there were remnants of the hydrocap weld with areas of slag inclusions and porosity open to the surface. Assign SL-4 to [REDACTED]
200008812 System: CVCS TagNumber: 21BAT	Chemistry Surveillance Test IPC-ST-W02-S for 112000 failed the acceptability criteria for 21 Boric Acid Tank (BAT). The concentration of boric acid in 21BAT was 11.2% by weight. The acceptability criteria is 11.5 - 13.0% by weight. The acceptability criteria is based on Technical Specification (TS) section 3.2.B.2 that states the boric acid concentration in the BATs shall be 11.5 - 13.0% by weight when the reactor is critical. Since the reactor is not

critical, the failure of 21BAT to meet acceptability criteria is not a TS violation. The tank could not be recirculated prior to sample collection resulting in a non-representative sample. Samples are taken and analyzed for boric acid concentration every Monday and Thursday. The acceptability criteria for 21BAT was met on previous surveillance tests. Plant procedures also require the BATs to be sampled for proper boric acid concentration, and to be adjusted if necessary, prior to reactor criticality.

200008813  
System: N/A  
TagNumber: N/A

The following issues related to EP Training and Conduct of Drills were identified during the 11/2/00 Emergency Planning Training Drill from observations and post-drill critiques: The drill scenario presented little opportunity for the Emergency Operations Facility (EOF) to be accessed in the area of Assessment & Corrective Actions. Drill participants were generally enthusiastic and maintained focus through the entire drill. Response actions were demonstrated in a manner that would be expected for an actual event. Some instances of participants not ending telephone or radio communications with "This is a Drill" were observed in each of the facilities. The controlling organization performed adequately with regard to drill control activities and evaluation. Controllers were at their job locations throughout the drill and controlled activities in a timely manner. However, the following concerns were noted: - Some controllers (e.g., those with repair teams in the field) would benefit from additional controller messages in the scenario package so that participant performance could be more realistically challenged. - There was a delay in getting information to the TSC/OSC on the status of the leak, do to missed communications from the field. The field Controller provided participant information at the correct time but did not ensure it was reported properly to the OSC. In addition the OSC controller did not correct the situation in a timely manner.

200008814  
System: N/A  
TagNumber: N/A

The following Process and Procedure issues were identified during the 11/2/00 Emergency Planning Training Drill from observations and post-drill critiques: A TSC Operations Advisor failed to respond to the TSC during the drill. Actions were taken to contact the EOF to assist in contacting and having respond, an Operations Advisor. However, the TSC staff eventually stopped pursuing obtaining the needed operational expertise. This was evaluated to be a contributing factor in the delayed recommendation in emergency classification at the Site Area Emergency level. The OSC was activated within 25 minutes (players were pre-staged) of the declaration of the Alert. Command and control in the OSC was effectively established by the OSC Manager. Necessary resources were promptly identified as events progressed. The team sent to attempt to close valve 856D from the breaker took 30 minutes to assemble and brief. This delay was caused by Coordinators not working together to dispatch the team. The NPO and HP were not present when the team briefing began and the briefing was stopped twice while needed individuals were located. The areas in which team briefings were conducted sometimes became congested. The congestion could have been avoided by better use of available office space offered in the TSC/OSC complex. The staging of technicians in the briefing room should be avoided and rooms dedicated for briefing and planning purposes only. EOF communications between facilities and external points of contact were adequate with regard to ensuring a coordinated response effort with one notable exception. The Site Area Emergency (SAE) declaration was delayed due to the inability of the EOF to determine if the "leak" could be isolated. Numerous discussions were held on this point between members of the EOF and other emergency facilities. The Emergency Director (ED) twice requested a determination if the leak could be isolated and if not, he would need to upgrade to a SAE. This decision was delayed approximately 43 minutes waiting on this information from the TSC or CCR. This delay caused the SAE classification to be untimely. There was confusion between the NYS Radiological Emergency Data Form IP-1030-1 found in IP-1030 and the form printed out by MEANS. The two forms do not currently match. This is due to recent changes to the data form and in progress changes to the MEANS computer program. The new program, with updated form, is in the process of being verified and validated at this time and will be issued soon. The CCR demonstrate effective assessment capabilities for the drill, however, the CCR staff did not provide adequate input to the Emergency Director in the EOF regarding the need to upgrade the emergency classification to a Site Area Emergency based on an unisolable leak outside containment. Corrective actions were taken in accordance with approved operations procedures. The TSC staff, in general, maintained awareness of existing plant conditions and fission product barrier integrity, with the exception of the recognition of the RSC leak location. The TSC staff properly characterized actual and potential radiological releases throughout the event. The TSC Staff did not make appropriate and timely emergency classification recommendations to the EOF based upon exceeding EAL thresholds. The OSC staff was effective in dispatching teams into the plant to assess conditions and make corrective actions. However, there was a delay in dispatching the critical team to the valve 856D control breaker. This was caused by not properly involving all coordinators in team preparation. Also obtaining conditions from the team sent to locate the leak in the Pipe Pen area was delayed by poor communications and OSC Coordinators not aggressively pursuing information from the team in the field. Procedures in the EOF were generally adequate and properly utilized through the course of the event. In addition, the staff was familiar with their roles and responsibilities as prescribed by the IPs. The Dose Assessment

	<p>HP (DAHP) stated that his procedure did not give instructions for operating MEANS. The DAHP stated he did not have controlled copies in his Position book. Position books only have verified copies, not controlled copies. The DAHP stated there was a procedural problem with IP-1007, addendum 8.2 instead of the correct number of Step 5.3.2 directs the DAHP to open MEANS and go to the dose assessment and PAR. By doing this, the DAHP cannot get back to the screen for completing the NYS Radiation Emergency Data Form IP-1030. Ip-1030 does not require the DAHP this responsibility, but he has traditionally started it. Tech Spec limits need to be placed in the DAHP for other EPF implementing procedure. Recommend SL3 to Emergency Planning</p>
<p>200008815 System: CM TagNumber: 21PC</p>	<p>This Condition Report is initiated to track the disposition of a condition identified during Steam Generator Replacement activities (SGT NCR - 119, copy attached). During cleaning of Polar Crane welds, a slag pocket was uncovered in a corner on [redacted]. Assign as SL - 4 to [redacted]</p>
<p>200008816 System: FW TagNumber: 22SG</p>	<p>This Condition Report is initiated to track the disposition of a condition identified during steam generator replacement activities (SGT NCR - 121, copy attached). After initial machining of RSG 22 feedwater nozzle, remnants of the hydrocarbon [redacted] with one area having a slag inclusion open to the surface exists. Assign SL-4 to [redacted]</p>
<p>200008817 System: SW TagNumber: SWT-7</p>	<p>A work order was properly written for a leak (2" pipe, threaded) on the vacuum breaker for Service Water outlet from the main lube oil coolers. In work order 00-18159, a question was raised as to the adequacy of the supports for the pipe associated with SWT-7. An engineering response to the writers' supervisor, from engineering "the present arrangement is as per the original construction documents, is not safety related, and does not need to meet seismic requirements" is not the right answer. The very cause of the leakage reported in the work order is the placement of a new, (March, 2000) approximately 50 to 70 pound vacuum breaker, on a 10" horizontal run of 2" threaded pipe - WITH NO SUPPORT. If the system is placed into service with the observed installation, complete failure will most likely occur. We must address the concern stated in the work order.</p>
<p>200008818 System: RPS TagNumber: TT-441B</p>	<p>Dunning field inspection of RPS racks E3-E6 &amp; F3-F6, for Mod. IPX 12449-F, the following deficiencies were found: On relay RT-4, the "C1" contact has popped loose from the Phenolic body, and is floating in free space. the wires appear to be made up, but the connection could impinge on surrounding relays, if disturbed. RT-18 &amp; RT-18(B) wiring penetrates the backplane to the test side, avoiding the panduit. Two (2) unidentified, untaped, unterminated #14 wires are laying in the bottom of "F" cabinets, with exposed burndy lugs attached. A large, asbestos-sheathed, unterminated, untaped cable is hanging loose in "E" cabinets. Relay Tagged incorrectly RT-3, RT-13, RT-15, RT-16, 52/RCP21-X(B), 52/RCP22-X, 52/RCP23-X, 1/MT1-X, SIAM1-X, Wire Tagged incorrectly. 21(B)-9, 21(B)-17, 21(B)-13, 22(B)-9,, 15-9, 15-13, 16-9, 16-13, 15(B)-9, 15(B)-13, 16(B)-9, 16(B)-13, P7-1-22 21-9, 22-9, 22-13, RT-16-5, 17-9, 17-13, 18-9, 18-13, RT-17-C1, RT-18-5, 17(B)-9, 17(B)-13, 18(B)-9, 18(B)-13 RT-17(B)-C1, P7-3(B)-8, P7-4(B)-17, No Wire Tag 52/RCP22-X(B)-C2, P10-2(B)-12, P10-2(B)-16, P10-2-12, RT-17-1, RT-17-5, RT-18-C1, RT-18-1, RT-18-C2 LF-4X-5, RT-17(B)-5 RT-17(B)-C2, RT-17(B)-1, RT-18(B)-1, RT-18(B)-5, RT-18(B)-C2, RT-10(B)-C2, P8-2(B)-20 The following wires did not appear to follow the Computer/Annunciator/Logic Panduit Separation Scheme as outlined in Drawing 208685. notes * 4,5,6 P10-1(B)-10, P10-1(B)-11, P10-2(B)-10, P10-2(B)-11, 15(B)-18, 16-18, 52/RCP24-X(B)-22, 52/RCP24-X(B)-23, P10-1-10, P10-1-11 P10-2-10, P10-2-11, 15-17, 15-22, 15-18, 16-17, 16-22, 16-18, P7-1-14, P7-1-17, P7-1-21, P7-1-22, P7-1-24, P7-2-17 P7-2-19, P7-2-21, P7-2-22, P7-2-23, 1/MT1-X-21, 1/MT2-X-21, 52/RCP21-X-18 52/RCP21-X-19, RT-17-1, RT-17-5, RT-17-C1, RT-18-C1, RT-18-1, RT-18-C2, P7-3-17, P7-3-4, P7-3-8, P7-3-21, P7-4-17, P7-4-4, P7-4-8, P7-4-21, P8-1-17, P8-1-18, P8-1-21 P8-1-22, P8-1-23, P8-2-17, P8-2-19, P8-2-21, P8-2-21, P8-2-22, P8-2-23, LF-1X-1, LF-1X-4, LF-1X-18, LF-1X-19, LF-1X-22, LF-1X-23, LF-1X-24, LF-2X-18, LF-2X-20, LF-2X-22, LF-2X-23, LF-3X-18, LF-3X-20, LF-3X-23, LF-1X(B)-18,19,24,5 LF-2X(B)-5,19,20,24, LF-3X(B)-5,18,20,22, LF-4X(B)-5,18,20,22, RT-1(B)-1,C2, RT-17(B)-C1,1, RT-18(B)-1, RT-5(B)-5, RT-6(B)-21 RT-18(B)-1, RT-5(B)-5, RT-6(B)-21, P7-4(B)-17,21, P8-1(B)-18,19,22,23, P8-2(B)-18,19,22,23 With 49 wire identification problems and a potential 119 channellization discrepancies, added to the drawing shortfalls outlined in CR 20008415, system operability may be subtly degraded, despite the lack of an incident so far. Note: The Tag Menu Available for RPS entries on the CRS Application, did not contain the proper Tag (s). Used a random RPS Tag to initiate this CR. Further note: A relay designation such as "P10-1" denotes the "A" channel "E" racks A relay designation such as "P10-1(B)" denotes the "B" channel "F" racks.</p>
<p>200008819 System: FW TagNumber: 24SG</p>	<p>This Condition Report is initiated to track the disposition of a condition identified during steam generator replacement activities (SGT NCR - 124, copy attached). During dimensional inspections of RSG 24 feedwater nozzle, three ID measurements out of tolerance. Assign SL - 4 to [redacted]</p>
<p>200008820</p>	<p>The following discrepancies were found during the walkdown of RPS, NIS, ESFA and</p>

<p><b>System:</b> MSCL <b>TagNumber:</b> N/A</p>	<p>AMSAC in the CCR. A RACKS FRONT Cabinet A-6: 1. PQ-188 kinked ground wire. Cabinet A-10: 1. Cable tray covers adrift in the cabinet. Cabinet A-12: 1. QM-421A and QM-421B setpoint dials are "locked" with tape. 2. LC-460A/B Terminal block missing spare screws. A RACKS REAR Cabinet A-4: 1. Multiple ground wires were landed on terminal blocks without lugs. Cabinet A-5: 1. Multiple ground wires were landed on terminal blocks without lugs. 2. Cable tray cover is adrift in the cabinet. 3. Electrical tape on the spare lead from cable bundle H52J662 must be re-wrapped. Cabinet A-6: 1. Multiple ground wires were landed on terminal blocks without lugs. Cabinet A-7: 1. Multiple ground wires were landed on terminal blocks without lugs. 2. Cable tray cover is adrift in the cabinet. Cabinet A-8: 1. Multiple ground wires were landed on terminal blocks without lugs. 2. The ends of multiple spare/retired wires need to be re-insulated. Cabinet A-9: 1. Multiple ground wires were landed on terminal blocks without lugs. Cabinet A-10: 1. Multiple ground wires were landed on terminal blocks without lugs. Cabinet A-11: 1. Multiple ground wires were landed on terminal blocks without lugs. Cabinet A-12: 1. Multiple ground wires were landed on terminal blocks without lugs. 2. The ends of multiple spare/retired wires need to be re-insulated. B RACK FRONT Cabinet B-1: 1. FC-446, PC-949B and PC-948B/E are missing spare screws from terminal block. Cabinet B-2: 1. LC-447E/F and PC-439A/B are missing spare screws from terminal block. 2. The ends of multiple spare/retired wires need to be re-insulated. Cabinet B-3: 1. LC-461A/B and PC-457B are missing spare screws from terminal block. 2. The ends of multiple spare/retired wires need to be re-insulated. 3. TC-431C/D Cover mounting post is missing. Cabinet B-4: 1. LC-447I/J is missing spare screws from terminal block. 2. FM-419M and PC-409A are missing permanent tags. 3. Two unidentified controllers, in the second rack from the top of the cabinet, are missing tags. 4. PC-408A setpoint dial is missing its knob; the setpoint dial is locked with tape. Cabinet B-5: 1. Cable tray covers are adrift in the cabinet. 2. PC-406A setpoint dial is tapped. Cabinet B-6: 1. LC-459E/F and LC-459G are missing spare screws from terminal block. Cabinet B-7: 1. QC-412C/D is missing spare screws from terminal block. 2. Cable tray covers are adrift in the cabinet. 3. Setpoint dials on QC-412A, TC-412G, TC-412D, and TC-412E are tapped. Cabinet B-9: 1. LC-447A/B, LC-447G, LC-437A/B, LC-437G and PC-948A/D are missing spare screws from terminal block. 2. Top cable tray cover is loose. 3. Setpoint dial on PM-949A is tapped. Cabinet B-10: 1. Setpoint dial on QM-441A is tapped. B RACKS REAR Cabinet B-1: 1. Ground wire for 118VAC outlet used to supply PM-402-2 is not connected to the cabinet ground bus. This ground wire should either be removed or connected to the cabinet ground bus as appropriate. Cabinet B-2: 1. Multiple ground wires landed on terminal blocks without lugs. Cabinet B-3: 1. Multiple ground wires landed on terminal blocks without lugs. Cabinet B-4: 1. Wire JL1JF43 (bottom left of the cabinet) must be re-insulated. Cabinet B-6: 1. Multiple ground wires landed on terminal blocks without lugs. 2. Choke connected to terminal 7 on terminal block B6A is connected to only one point. The other side of this choke has been tapped. It appears that the choke has been retired. The choke should be removed if it is retired or connected to the appropriate terminal point if it has not been retired. Cabinet B-7: 1. Cable tray cover adrift in the cabinet. 2. The ends of multiple spare/retired wires need to be re-insulated. Cabinet B-9: 1. PM-949A is missing a spare screw on terminal block. C RACKS FRONT Cabinet C-5: 1. The spare/retired wire on cable EX4 must be re-insulated. C RACKS REAR Cabinet C-5: 1. The ends of multiple spare/retired wires need to be re-insulated. Cabinet C-6: 1. Ground strap for the N-32 chassis is connected without a lug. E RACKS FRONT Cabinet E-1: 1. Permanent tags for test points L934B, L934C and L934D are missing. 2. PC-936 C/G is missing spare screws on terminal block. E RACKS REAR Cabinet E-6: 1. Cable tray covers are loose. Cabinet E-8: 1. The ends of multiple spare/retired wires need to be re-insulated. F RACKS FRONT Cabinet F-1: 1. Permanent tags for test points L935A, L935B, L535C and L535D are missing. F RACKS REAR Cabinet F-1: 1. Ground wire landed on terminal 6 of terminal block F1F without a lug. G RACKS Auxiliary Relay Cabinet 2: 1. The ends of multiple spare/retired wires need to be re-insulated. General Comments: 1. All surfaces of the cabinets in the 'A' and 'B' racks were covered with excessive amounts of dust. 2. Debris from past maintenance was found in the bottom of all cabinets in the 'A' and 'B' racks. 3. The replacement of BFD relays was in progress in the 'E' and 'F' racks during the walkdown. 4. All of the above findings are maintenance-practice and housekeeping issues. These deficiencies do not threaten the operability of RPS, NIS, AMSAC or ESFAS</p>
<p>200008821 <b>System:</b> FW <b>TagNumber:</b> 22SG</p>	<p>This Condition Report initiated to track the disposition of a condition identified during steam generator replacement activities (SGT NCR - 130, copy attached). During dimensional inspections of RSG 22 feedwater nozzle, measurements were out of tolerance. Assign SL - 4 to [REDACTED]</p>
<p>200008822 <b>System:</b> FW <b>TagNumber:</b> 21SG</p>	<p>This Condition Report initiated to track the disposition of a condition identified during steam generator replacement activities (SGT NCR - 131, copy attached). During dimensional inspections of RSG 21 feedwater nozzle, found that ID measurements out of tolerance. Assign SL-4 to [REDACTED]</p>
<p>200008823 <b>System:</b> GT</p>	<p>AT GT2 -3 gas turbine site, west of the GT2/3 fuel oil tank where truck parks to load fuel oil tank, wet pavement shows rainbow traveling the roadway down to the grass area on the</p>

<p>TagNumber: GT2</p>	<p>south end of the pavement. ( Not even a 1/4 to a 1/5 pint of oil appears present). Appears to be a trace of either slight leakage overtime or just oil from pavement. Oil poads were dispersed to ensure a trace amounts of oil were absorbed. Truck has not started unloading YET and no leak has been detected on the truck. Record this CR for tracking.</p>
<p>200008824 System: RCS TagNumber: N/A</p>	<p>This Condition Report is initiated to track the disposition of a condition identified during steam generator replacement activities (SGT NCR - 141, copy attached). While final machining weld profile on RSG 22 hot leg, the machining equipment failed causing a step in the face of the weld prep. Assign SL-4 to [REDACTED]</p>
<p>200008825 System: RCS TagNumber: N/A</p>	<p>This Condition Report initiated to track the disposition of a conditions identified during steam generator replacement activities (SGT NCR - 144, copy attached). Assign SL-4 to [REDACTED]</p>
<p>200008826 System: CM TagNumber: 21PC</p>	<p>This Condition Report initiated to track the disposition of a condition found during steam generator replacement activities (SGT NCR - 150, copy attached). During weld upgrade of polar crane, discovered gouge at FW 175. Assign SL-4 to [REDACTED]</p>
<p>200008827 System: FW TagNumber: 23SG</p>	<p>An Over-Inspection of the Steam Generator Upper Lateral Upper Shim Plates revealed rejectable welding discontinuities, in previously accepted, (by SGT QC), welds, as noted below. SGT was given the opportunity to correct these conditions and, as of the time of this CR issuance, has chosen not to take action. WELD# DISCONTINUITY 7 &amp; 8 Slag and Dirt 10 &amp; 12 Slag and Dirt 14 &amp; 15 Slag and Dirt 23 &amp; 24 Slag, Dirt &amp; Overlap 26 &amp; 27 Slag, Dirt &amp; Overlap 29 &amp; 30 Slag, Dirt &amp; Overlap 31 &amp; 32 Slag, Dirt &amp; Overlap 35 &amp; 36 Slag and Dirt 37 &amp; 39 Slag and Dirt 43 &amp; 44 Slag, Dirt &amp; Crater Crack 47 &amp; 48 Slag, Dirt &amp; Overlap Reference the following AWS Code &amp; Quality Execution Procedure Paragraphs/Tables for acceptance criteria: AWS D1.1 2000 - 5.30.2 and Table# 6.1 Categories # 1 &amp; 4 QEP 12.03 - 3.6.2, 4.4.2b and Attachments # 2 &amp; 8</p>
<p>200008828 System: RPS TagNumber: N/A</p>	<p>This condition may require an UFSAR change; recommend assignment to the 50.54(f) team for disposition. While reviewing UFSAR Section 1.3.4 (Segment 19497), as part of the 50.54 (f) effort for IP2, a discrepancy was discovered in the statement: "Bypass removal of one trip circuit is accomplished by placing that circuit in a half-tripped mode; i.e., a two-out-of-three circuit becomes a one-out-of-two circuit. Testing does not trip the system unless a trip condition exists in a concurrent channel. The trip signal furnished by the two remaining channels would be unimpaired in this event." Safety Evaluation 90-220-MD for Modification Procedure MPE-88-01989-E, indicates surveillance testing of analog trip channels has been modified and no longer requires tripping of a channel for testing. In general, signal comparators (i.e., bistables) are tested by placing the bistable trip switch into the "test" position, which enables the analog trip logic to be bypassed during the test and maintains the logic (trp) relays energized. Recommend revising UFSAR Section 1.3.4 (Segment 19497), to state "The analog channel trp bistables have the capability to be bypassed for surveillance testing. This "test in bypass" feature allows the bistable to be bypassed for trip channel testing. Testing does not trp the system unless a trip condition exists in a concurrent channel." This condition is a configuration disparity and does NOT involve an operability question.</p>
<p>200008829 System: SW TagNumber: 24SWPS</p>	<p>During performance of Post Maintenance Test #18036 for 24 Service Water Pump Zum Strainer, differential pressure was observed to be 5 psid. Acceptance criterion for PMT is less than or equal to 4. Acceptance criteria were not met.</p>
<p>200008830 System: DC TagNumber: DCA</p>	<p>CCR Drawing 9321-3008 Rev 75, for 125VDC Power Panels 21,22,23 &amp; 24, shows a feed to a Common Voltmeter &amp; Switch(Located on the Rear of CCR Flight panel "FD" &amp; can be selected to any one of the four DC Buses) through a single 3 Amp fuse directly from each DC Power Panel. While in the process of clearing Tagout #14054, on 125VDC Power Panel 22, Two - 3 Amp fuses were reinstalled the Double Fuse Block located inside 22 Power Panel Cabinet. The CCR reported a zero voltage reading on 22 DC Bus with the Main (supply) Fuses installed. The Two 3-Amp fuses to the voltmeter were removed and checked with a DVM and found to be good. Further investigation of the Fuse Block revealed that while the line side of the fuse block was wired to 22 DC Bus; there were no wires connected to the load side of the Fuse Block, nor were there any loose wires inside the cabinet that appeared to be associated with the fuse block. 22 Battery Bank Terminal voltage was then checked with a DVM and found to be reading -126 VDC and then 22 Battery charger was placed in service per SOP 27.1.6 and DC Bus Voltage was adjusted to -131 VDC, IAW SOP 27.1.6. Next 22 DC Power Panel Circuit #12, Supply to 125 VDC Distribution Panel #22, Was closed, with all the load breakers on the distribution panel left open, and the CCR Voltmeter still selected to 22 DC Bus began to indicate -131 VDC. Next 125 VDC Power Panel 21 was inspected and the same conditions exist with respect to the Double Fuse Block being installed, connected to 21 DC Power Panel, with fuses installed but no wiring connected to the load side. While Tagout #13326 was being applied, the Installed CCR Voltmeter was selected to 21 DC Bus while all circuits were opened on 125 VDC Distribution Panel 21 and it continued to indicate 130 VDC. Then 125 VDC Power Panel Circuit #16 was opened and</p>

	<p>the CCR Voltmeter then indicated 0 VDC. In Conclusion it appears that the installed Selectable CCR Voltmeter is connected to the buses or incoming feed to 125 VDC Distribution Panels 21 &amp; 22 located on the rear of the CCR Flight Panel. An inspection of this must be accomplished to determine if there are Fuse Blocks installed on these connections. This could be an operability concern due to Train Separation/Cable Separation. If there are no fuse blocks installed on these wires, a single failure of the Voltmeter Select Switch could cause two (or more) DC Buses to be tied together. Also 125 VDC Power Panels 23 &amp; 24 should also be inspected for the location of their associated fuse blocks.</p>
<p>200008831 System: MS TagNumber: PCV-1120</p>	<p>This CRS is written to document design problems with HPSD. It also illustrates the absolute importance of understanding IP2 Design Basis before changing it. The lessons were learned while investigating recent problems with high-pressure steam dump system. The system is currently undergoing a modification (FIX-95-11199-1) to return it to the original design. Problem: HPSD system has a history of problems associated with sluggish response when in modulating mode. This troubled CCR operators for years and contributed to the control system's instability. There were two RCS overcooling incidents in recent years (1/17/95 and 2/15/00). Findings: 1. Investigation and testing lead to the following finding. The original spec calls for 10 -20 seconds closing stroke when modulating. The actual was measured at 70 to 80 seconds. 2. Root cause analysis of 2/15/00 RCS overcooling led to a finding that the original PM-404 (I/P converter) was replaced by an inadequate model with insufficient pressure rating and air capacity. Subsequent tests indicated that not only it made entire system more prone to accidental opening of 12 dump valve through single failure, it also delayed control signal by up to 3 times due to small air capacity. No modification was found! 3. Additional investigation revealed that the original control system was modified significantly. Specifically, arming solenoid SOV-1 was relocated. Investigation lead to a 1980 Safety Evaluation (NS-2-80-115) referencing a problem "solved". It stated that the relocation prevented "momentary opening of the control valve when control air is applied to the valve positioner". The relocation created a new problem. It placed a unidirectional SOV-1 in the flow path where air moves in both directions. It also added a third restriction (and hence time delay) to the actuator vent. "Solving" one problem created another! 4. Further analysis lead to an observation that the current (trouble free) IP3 control system is identical to the original IP2 control system. In addition to difference in SOV-1 location (described above), IP2 is missing a component - response-enhancing booster relay. No documented reason for the disappearance was found. No modification was found after an extensive search! 5. Further analysis of the original (and IP3) control system lead a conclusion: problem described in and "solved" by NS&amp;L safety evaluation NS-2-80-115 (see item 3 above) was caused by the disappearance of the original booster relay. The reason for the "momentary opening of the control valve when control air is applied to the valve positioner" was in removal of the original booster. It served not only as a pneumatic amplifier but also as an isolator. When installed as shown on the original drawings it "dead-ends" the positioner output and provides an extra venting capacity for the actuator. Conclusion: Lack of documentation and understanding of the original design lead to numerous and cascading problems. Recommendation: Return the system to its original design by adding boosters, returning SOV-1 to the original place between SOV-2 and air header and by possibly enlarging all check valves with 1/2" or 3/4 inch</p>
<p>200008832 System: AFW TagNumber: AFWA</p>	<p>The following conditions related pipe supports were identified during Auxiliary Feedwater system walkdown. 1) AFW pipe support strut for SR-501 is out of alignment with pipe clamp. Located in next to MS-41. 2) AFW pipe support strut for SR-507C is out of alignment with pipe clamp. Located next to PCV-1310B. 3) A pipe support strut on Hot Pen Blower discharge piping next to T1-1266 is not aligned properly with pipe clamp. 4) AFW pipe support strut is out of alignment with pipe clamp. This is first support downstream of BFD-39. 23 AFP discharge check valve 5) A pipe support clamp is making contact with a nearby support structure. This is a second support downstream of BFD 79-3, Aux Feed to 23 SG. 6) A rod between the spring can and pipe clamp is bent. This is a second support downstream of BFD-79-4. 7) A drain line running next to Aux Feedwater supply line near BFD-79-3 needs to be restrained better. May require additional restraint to prevent it from shaking and hitting nearby components.</p>
<p>200008833 System: GEN TagNumber: SC-22(B)</p>	<p>22B (West) Stator Cooling Heat Exchanger is leaking about a drop every 2 seconds at its north end bell.</p>
<p>200008834 System: AFW TagNumber: AFWA</p>	<p>The following items with degraded insulation were identified during Auxiliary Feedwater system walkdown. 1) Piping insulation is deteriorated on 1310B by pass line near BFD-64-5 and MS-503-3 located in AFW building. 2) Insulation was missing on PCV-1139, steam supply to 22 AFW Pump located in AFP room. 3) The lagging is deteriorated on nitrogen supply line from the liquid storage tank near CST. 4) The insulation inside the CST N2 Control Cabinet Extension is loose and breaking off. Located near CST.</p>

<p>200008835 System: AFW TagNumber: AFWA</p>	<p>The following items with degraded pipe supports were identified during Auxiliary Feedwater system walkdown. 1) Less than adequate thread engagement at one anchor bolt for a base plate of spring support. This is supporting the air operator for PCV-1310B, steam supply to 22 AF Pump. 2) Less than adequate thread engagement for conduit supports. This is for 1st and 2nd support from power supply junction box for 21 Aux Feed Pump. Located in Aux Feedwater pump room. 3) Missing nuts on one side of the u-bolt on bottom side for the first pipe support upstream of BFD-69, 22 AFP discharge relief valve located near 22 AFW pump. 4) Both nuts on one side of the u-bolt for a pipe support are backed off. This is 1st support from BFD-70-1, exhaust end bearing cooling for 22 AFW Pump. It is on 2" line next to 22 AFW Pump. 5) Nuts are missing on one side of the u-bolt for pipe support on MST-65 by-pass line. Located near PCV-1139 in AFW Pump room.</p>
<p>200008836 System: MS TagNumber: PCV-1130</p>	<p>While observing stroke tests on HPSD valves PCV-1123, 1125 and 1130 (w/o 00-18414) noted air supply on PCV-1130 positioner is set high.. The positioner gage reads 87 psig and the regulator gage reads 95 psig. This is considerably higher than on the other two valves - around 65 psig. The results of the test suggest that the high initial supply pressure extended the actuator exhaust time by an estimated 5-7 seconds while under the spring action. This occurred in spite of high exhaust capacity of Bailey AV1 actuator (35 scfm). PCV-1130 positioner is Model AV1 and PCV-1123 and 1125 positioners are Bailey model AP4 (25 scfm capacity). Recommendation: For optimum stroke and performance do not exceed positioner setting of 75 psig.</p>
<p>200008837 System: AFW TagNumber: AFWN</p>	<p>The following house keeping related items were identified during Auxiliary Feedwater system walkdown. 1) Snubber SR-3034 is covered with a plastic material, which should be removed. Located next to MS-42. 2) Several lights throughout the Aux Feedwater pump building were burnt out. 3) AFW O2 dissolved analyzer cabinet door has broken handle. Located near CST. 4) Clips to hold the floor gratings in place are missing at several locations in Aux Feedwater Building.</p>
<p>200008838 System: AFW TagNumber: BFD-53</p>	<p>Packing leak at valve BFD-53, 21 AFW Pump recirc stop. Located in AFW Pump room near north wall. Identified during AFW system walkdown.</p>
<p>200008839 System: AFW TagNumber: CST</p>	<p>This condition was identified during AFW system walkdown. The CST N2 Control (Matheson) cabinet located near the CST is deteriorating. The lagging is missing and/or deteriorated inside the cabinet. The door seal needs to be replaced. Insulation foil has burnt mark near the strip heater.</p>
<p>200008840 System: AFW TagNumber: FIT-6854</p>	<p>2) This item was found during AFW system walkdown. The flow indicator located inside the CST N2 control cabinet was reading 27 gpm outlet flow from CST although there was no flow from CST. Flow transmitter should be recalibrated.</p>
<p>200008841 System: N/A TagNumber: N/A</p>	<p>At about 1445 hrs I responded to A Gamma 60 Portal Monitor alarm at the Security Command Post. A Westinghouse worker, from Sweden, had alarmed the monitor three consecutive times. I had the worker walk through the monitor again, once with his jacket on and again with his jacket off. He only alarmed the monitor with his jacket on. I then escorted the worker to HP1 and instructed him to use the Wholebody Frisker. The monitor alarmed the upper zones and arms. I questioned the worker about where he had been. He informed me that he had not entered any Normal RCA areas or any other RCA's or Rad Material areas. I asked the worker if he had had a Whole Body count to which he answered yes but he had not worn the jacket at the time. I then did an analysis of the jacket with our Canberra which indicated the jacket contained CO-60 and MN-54. I have the jacket stored at HP1.</p>
<p>200008842 System: WCPS TagNumber: WCP-299</p>	<p>A group of Weld Channel Pressurization System (WCPS) tubing located on approximately the 78' elevation of the vapor containment above WCP 293 through 300 sample valves has been damaged. It appears that the "tugger" barrel may have hit the tubing cluster at two points denting the tubing.</p>
<p>200008843 System: SW TagNumber: SWT-37-2</p>	<p>While attempting to fill and vent the recently replaced Service Water piping for the Isophase Bus Duct Cooling HXCH's for PMTs, The evolution was stopped when it was determined that the sensing line off the 14" supply header to H2 coolers and Isophase coolers was not indicating any pressure. This line is needed for PCV-1180, PI-1187, and PC-1123S. The lines associated with these components were checked clear. The line blockage is on the upstream or downstream side of valve SWT-37-2. This is a welded line with several elbows on it. This line is vital for pressure control (PC-1180) pressure indication (PI-1187) and CCR alarm ((PC1123S). Alarm is for high pressure 42# on Panel SJ window 2-4 in CCR. With line blocked and no pressure indication, CCR would have no indication of a problem for Generator Cooling. Without sensing pressure indication, system cannot be placed in service. or place pressure control in automatic.</p>
<p>200008844 System: SW</p>	<p>After mechanical repair on TCV-1101, it was discovered that valve was not responding properly to signals from controller while in manual. NNI suggested to have I&amp;C set the valve</p>

<b>TagNumber:</b> TCV-1101	controller signal/calibrate output. Valve was not able to be set at a certain position (i.e. 50% open) in manual Valve either operated full open or full close. As per BOP supervisor, this would be a sync hold for operation. Request I&C correct controller problem.
<b>200008845</b> <b>System:</b> CYW <b>TagNumber:</b> CYWA	A williams contractor working at the water meter house taking down scaffolding he hit the tell tale line on the north altitude valve and broke it.This line is pcv and needs to be fixed immediately.If the valve were to fail while in servicè water could flow freely until the midnight rounds where recorded.
<b>200008846</b> <b>System:</b> RCS <b>TagNumber:</b> 897D	Lesson Learned: A significant emergent repair on RCS check valve 897D identified on 11/9/00 delayed the ability to fill and vent the reactor coolant system as planned on 11/10/00. In addition, the RCS tagout in place for the SGRP was already being cleared at the time of discovery of the issue on 897D. This resulted in the need to reapply protection in the field to allow maintenance to effect repairs to the valve. Repairs could easliy have been completed under the existing protection if identified earlier. The need for this repair could and should have been identified much earlier in the outage as a result of required pprogrammatic ISI inspections on bolted connections in borated systems. Initial explanation for the late inspection linked completion of the required inspection to the completion of an open PM work order for 897D currently active in the PPMIS database. This was an erroneous assumption and conclusion, as the referenced work order NP-99-06664 was removed from the 2000 refueling outage scope on 2/10/00 and placed in a contingency PPMIS project number. The purpose of keeping the work order active in the contingency project (PPMIS PJ# 229) was to have a planned work package available in the event acoustic check valve testing conducted during the outage identified a problem that required the valve to be opened for visual inspection.. Recommend assignment to ██████████ to determine root casue for the apparent programmatic breakdown that resulted in late identification of this deficiency.
<b>200008847</b> <b>System:</b> AFW <b>TagNumber:</b> FE-1121	Unable to verify proper orientation of a flow orifice FE-1121 for 21 AFW Pump suction flow controller FC-1135S. The flow element paddle is painted on. The paint should be removed to verify that the stamp "Inlet" on the tab is facing the inlet side of the flanges. Located in Aux Feedwater Pump room on west wall.

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Below is a list of 17 CRs created in the last 24 hours. (11/12/00 8:23:49 AM to 11/13/00 8:23:49 AM)

Condition Number	Condition Description
200008885 System: COND TagNumber: CONDN	CT-714 and CT-715, N2 supply to CST check valves, are leaking past their respective seats and are filling N2 lines located inside N2 cabinet at the CST. This was discovered when the operator was placing N2 supply to CST in service.
200008886 System: WDS TagNumber: AE-1067	Noted the waste gas analyzer panel is only tracking one reading on the chart recorder paper. The H2 reading does not appear to be inking on the chart recorder paper. The digital reading for both O2 & H2 appears to be working correctly. The MSA is located 80' PAB.
200008887 System: N/A TagNumber: N/A	A contract employee working in the vapor containment injured his left hand, two fingers. First aid given and delivered to SGT nurse.
200008888 System: COND TagNumber: HD-4	Valve HD-4-2 is in the ppmis data base but could not be located in the CRS data base. The valve is a drain valve and is located on the discharge header of the heater drain tank pumps, 15' elevation between 21 & 22 heater drain tank pumps. The valve leaks by it's seat and requires the system to be drained down to repair. Valve HD-4-2 also has a substantial packing leak. We took up on the packing gland and slowed down the leak, but is still leaking quite a bit with no pumps in service. This valve is a con valve and can be repacked on the back seat.
200008889 System: MSCL TagNumber: N/A	Reactor incore instrumentation core position valve G-5. The valves body slides easily in the rack. All the other valves are secured tightly by the racks. G-5 is located at seal table on 68' and is the cable tube #11 stop.
200008890 System: CCF TagNumber: TR-1103	22 Heater Drain Tank Pump MTR TRS Open Alarm came up on the Central Control Room Bearing Monitor. Attempts to find this open circuit failed. Cause is most likely a loose wire/connection. Please investigate/repair.
200008891 System: BG TagNumber: N/A	Failed PMT on WO# NP-99-13054. PMT on fire door on 40' elev was unsat due to door not latching when self closing. This was tried 8 times and the door only latched once. (door does not close and latch automatically). Repair door closure mechanism.
200008892 System: RCS TagNumber: 21RV	While preparing to start refueling, it was noted that the protective cover had been removed from the o-ring stand around the reactor head stand. The o-ring stored in the stand has a piece of metal channel sitting directly on the o-ring. The o-ring has not been protected from damage for an unknown period of time.
200008893 System: RCS TagNumber: 730	Valve 730. Residual Heat Removal pumps suction from Loop 2 Hot Leg isolation exhibited dual indication when reclosed after being opened during the performance of TOI 157" Filling and Venting the RHR and SI Systems from Outage Draindown Condition". Before being opened only the green light was lit. The valve was opened and only the red light stayed on. However when the valve was reclosed, the green light came on and the red light stayed on. This appears to be a limit switch problem because with valve 731 open, valve 730 prevented flow i.e. it acted like a closed valve, even though there was dual indication.
200008894 System: COND TagNumber: CD-8-2	21C/22C LP Heater outlet stop valve has a body to bonnet leak
200008895 System: SEC TagNumber: TST-PT-A38	11-13-00 New Command Post #3 explosive detector went into degrade.
200008896 System: SEC TagNumber: N/A	Vehicle "boot" placed on vehicle # [REDACTED] located in parking lot # 4, space # 10. Disregard for Permit Only parking sign.
200008897 System: HVAC TagNumber: PCV-1191	The "Two-is-True" lights(position and power) are out for PCV-1191 and PCV-1192 the outside Pressure Relief valves. While changing bulbs for 1191 a bulb fell out of the lens cover and into socket area causing a spark. The new bulbs would not light when tested and the "Two-is True" lights for 1192 were no longer lit. A fuse common to the lights for both may have blown.
200008898 System: RHR TagNumber: 22RHRP	Quarterly test PT-Q28B on 22 Residual Heat Removal Pump resulted in vibration point AH being above the Required Value of less than or equal to 0.32 IPS. The actual value was 0.36 IPS.
200008899 System: AS	unit heater 219 has a steam trap (uht-1-219) leak. Please repair/replace as needed. Unit heater 219 is located on the 53' turbine building,north-east side by column #18.

<b>TagNumber:</b> 219UHR	
<b>200008900</b> <b>System:</b> N/A <b>TagNumber:</b> N/A	Procedural enhancement opportunity gained from field note SGRP -212. Current revision of SAO112 notes that a team charter be developed, reviewed and approved for all SL1s. This is ambiguous and in some cases can be over restrictive (given the nature of the deficiency). Suggest SL4 to CAG for tracking (to enhance the procedure). No procedural violation took place .. this is an enhancement.
<b>200008901</b> <b>System:</b> CM <b>TagNumber:</b> 21MPC	2 spare sensotec load monitors were shipped to the vendor Washington Group under purchase order 031643 to be calibrated and returned to the site. The spare sensotec load monitors had internal wiring damage and can not be calibrated as is. The vendor was able to make one complete load cell monitor from the two. This condition report is for documentation purposes only.

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Below is a list of 15 CRs created in the last 24 hours. (11/19/00 8:22:43 AM to 11/20/00 8:22:43 AM)

Condition Number	Condition Description
200009165 System: RCS TagNumber: 514BX1	Swagelock fitting upstream of 514BX1 has an active boron leak with the refueling cavity full. This is on 21 RCS Loop flow transmitter FT-415. This must be fixed prior to RCS pressurization.
200009166 System: RCS TagNumber: FT-415	RCS flow transmitter - FT-415 leaking. The upstream swaglok fitting into valve 514BX1 (FT-415 low side root stop) is leaking with RCS depressurized. Must be fixed before we pressurize the RCS
200009167 System: RCS TagNumber: PCV-455A	Retired support hanging. Retired support on pressurizer spray line from #24 cold leg upstream of PCV-455A (spray valve) . Can be seen from #24 RCP platform. Support should be removed
200009168 System: CVCS TagNumber: 23CHPLT	seal collection tank increased .5 inch over eight hours. this is indicative of a primary seal leak and this data can be used to determine if in-leakage increases.
200009169 System: RCS TagNumber: 21RV	The upper internals assembly is not orientated corectly in the storage stand. I appears that the assembly was not rotated a full 180 degrees per the procedure. This means that the weight of the assembly is now point loaded on the four keyway guide blocks.
200009170 System: N/A TagNumber: N/A	At 2035, received a report that an employee (SGT contractor) was experiencing chest pains at the 95' VC airlock. An EMT and the nuclear operator were sent to the 95' airlock. At 0841 per EMT request and ambulance was summoned to the site via 911. At 2055 the ambulance was on site and 2110 the ambulance departed the site to transport the employee to [REDACTED]. The Employee was not contaminated.
200009171 System: N/A TagNumber: N/A	At 2050 hrs this date an Ambulance [REDACTED] arrived on site to transport an SGT employee complaining of chest pain. The patient was located at 95' at the top of the stairway leading from HP2 and was being treated by Security and SGT EMS personnel. Security escorted the ambulance to the 80' Maintenance and Outage Building (MOB) alleyway. Two EMS personnel were escorted by security to the patient via HP 2. Upon arrival confusion set in as to where the patient would be removed from the RCA. The ambulance was located at 80' and the Health Physics technician at the scene wanted to evacuate the patient via the north- east roll up door on the 95'elevation of the MOB. The ambulance then had to be moved to 95' to accommodate. This added additional time to transporting the patient. I believe it would be a more effective mechanism if the communications to arrange for evacuation and transport from the RCA were limited to one Security person and one Health Physics person. Ideally those at the scene. The Security EMT or his assistant should convey Health Physics directions to the Secondary Alarm Station Operator who would then direct the security officers escorting the personnel and equipment.
200009172 System: BG TagNumber: 21VC	On 9/26/2000, TFC-2000242 was installed providing power cables through the 95' equipment hatch to supply power to the TLD for steam generator replacement. At some point following the SG replacement this TFC was removed without SM permission and without properly executing the TFC removal. As of this writing, the TLD is gone and the equipment hatch and airlock have been reinstalled. This is a case where an SGT WP (WP1050) was used in lieu of work orders and the paperwork loop was not properly closed.
200009173 System: N/A TagNumber: N/A	At 2030 hours a SGT carpenter complained of chest pains and pain radiating down his arms while carrying a ladder in the VC. Individual was walked to the equipment hatch and SGT safety notified.
200009174 System: CCW TagNumber: 789	PT-V24 ds 26 valve stroke test was performed for CCW valve 789 (RCP CCW thermal barrier return isolation valve, CIV). The closing time recorded at step 3.8 is 11 seconds. A transposition error occurred and 9 seconds was recorded on the operability table. Since the limiting value time for this valve to close is less than or equal to 10 seconds, this valve is inoperable.
200009175 System: SFPC TagNumber: N/A	While entering the Spent Fuel Pool area to open the Canal Gate, a circa 1970s brown polyester clip on men's necktie was discovered inside the Level III FME boundary.
200009176 System: N/A TagNumber: N/A	Westinghouse worker inadvertently logged out on RWP #529 with 2111 mRem instead of 21 mRem. The inaccurate entry locked up the RWP because the collective dose exceeded the dose goal and prevented further access on the RWP until the dose discrepancy could be identified.
200009177	While functioning as the watch HP I was informed by HPS of a medical emergency at the

<p>System: N/A TagNumber: N/A</p>	<p>95' MOB. At that time I was also informed that exit from the RCA was to be through the 95' MOB rollup door. I responded to that location and was briefed by another HPS on the situation. Preparations were being made to facilitate a clean exit of the RCA, AND easy access to the RCA by EMS at that location. When the ambulance arrived, it went to 80' MOB. I immediately told a security guard the ambulance was needed at 95' and he radioed these instructions. I went outside and verbally called out to the security escort of the ambulance to come to 95'. These instructions were ignored and EMS entered through 80'. The person was released through the 95' rollup door, and had to wait, without overclothing, in the cold, for the ambulance to get to 95'. 1) In a medical emergency the first consideration is the treatment of the patient. This was delayed by going to 80'. 2) Access to the RCA is controlled by Health Physics, HP instructions were not followed. [REDACTED] are unbadged visitors. 3) Dosimetry was not issued to [REDACTED] by security at the Main Gate. 4) The patient was released clean from the RCA. 5) Dose rates in the areas accessed by [REDACTED] were &lt;1 m/hr. No dose to be assigned. This CR needs to determine the breakdown in Chain of Command and Communication.</p>
<p>200009178 System: FP TagNumber: FPN</p>	<p>At 0330, the CRS received call from [REDACTED] at Fire Systems Inc. that they had received a fire alarm from Broadway and Bleakley (Zone 2). He was notified that we would investigate our MSB. The CRS discussed 0330 hrs entry with Fire Dispatcher who had instructed Buchanan FD to arrive at Buchanan Substation. I directed him not to allow them into the yard and that I was investigating the alarm on our site. He then notified me he would direct the proper FD to our site. At 0350 the Verplanck FD arrived on site and went to the M&amp;SB. At 0405 the Verplanck FD was off site and no fire was found and the alarm was reset.</p>
<p>200009179 System: WDS TagNumber: N/A</p>	<p>TFC 1996-081 has an overdue action date for clearing the TFC. A valid target date for clearance is required by SAO-206. This TFC is for the CSB Sump Pumps and Tank. Based on following email from Manager, Strategic Planning, it appears that there was a commitment made to clear the TFC in 1998: "The CR record is deficient in addressing the original problem. That is that a commitment apparently was made to the NRC in response to a notice of violation to fix the problems with the CSB sump pump and tank level. The condition identified in 1996 is still not fixed." Additional information from the AOM- Shift OPS indicates that we need support from FIN to perform 2 PMTs in order to clear TFC. The commitment comment should be confirmed by NS&amp;L.</p>

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Condition Number	Condition Description
<p>200009181 System: SEC TagNumber: SECN</p>	<p>On 11/20/00 at 0815 hrs. a Vital Area Door failed to secure properly , door was under the control of a Security Officer at the time of the incident. At 1000 hrs. the door was repaired by the locksmith and returned to service.</p>
<p>200009182 System: N/A TagNumber: N/A</p>	<p>During the Surveillance Testing Audit, it was noted that TP-SQ-11.046 rev.0 "Test Procedure Database Administration" has not been officially issued and approved. This procedure provides guidelines and requirements for administrating the Procedure database. In TP-SQ-11.046 are details the administration of Communications To Staff (CTS). CTS are presently being utilized.</p>
<p>200009183 System: N/A TagNumber: N/A</p>	<p>Station Adminstrative Order - 470 Addendum 1 Lists Technical Specification Required Surveillance Tests. This List is not kept current. For example PI-3Y11 "Hydrogen Recombiner &amp; Oxygen Stand Inservice Inspection"; PT-3Y1 "Integrated Leak Rate Test"; PT-V24B "CVCS Check Valve testing"; and a few others have not been performed and are on Test &amp; Performance's Inactive Surveillance Test List. If we are no longer required to perform these tests then these tests should be removed from SAO-470. SAO-470, rev 2 was issued on 6/21/00 and these inactive Surveillance Tests were still listed in Addendum 1.</p>
<p>200009184 System: AS TagNumber: 234UHR</p>	<p>As per condition Report 2000-008581 Unit Heater 234 does not operate. Additional information on condition. Lighting panel 211 CKT 28 (feed for UH 234 and several other UH) was found to be tripped. Circuit was reset all heaters except UH 234 started. When thermostat for UH 234 was adjusted to start heater, Thermostat smoked it was immediately turned down to minimum. As long as UH 234 is off from thermostat CKT 28 on LTP 211 stays closed and other heaters continue to run. Recommend replacement of thermostat and electrical test of Fan motor. This heater is the sole supply of heat for 80 Ft PAB weld channel area. Heater is located on 80 Ft PAB above nitrogen cylinders on east wall.</p>
<p>200009185 System: ILWH TagNumber: 11WCT</p>	<p>DURING PERFORMANCE OF MAINTENANCE ON LW-527 IT WAS NOTED THE REGULATOR WILL NOT FUNCTION AS REQUIRED. THE REGULATOR WILL NOT MAINTAIN PRESSURE AS REQUIRED. WILL REPLAN WORK ORDER 99-07862 TO REPLACE REGULATOR.</p>
<p>200009186 System: N/A TagNumber: N/A</p>	<p>We are unable to locate the OAD-23 Post Trip report assoicated with 2/15/2000 Safety Injection. The individuals who were members of the investigation do not have it and it is not located in any of the Operations Files in the CCR or NPG File Room. A lost document search was instituted without success. One remaining team member may have an electronic copy but he is out of Station until 11/27/2000.</p>
<p>200009187 System: WCPS TagNumber: 95AIRLOCK</p>	<p>Bolting for temporary airlock deck plates and upper half to lower half calls for A-307 B bolts and A-563-A nuts. UE&amp;C spec 9321-01-248-18 permits both ASTM A-193 B-7 and A-307 GR B bolting materials for flanges and various structural components. Please update drawing 235131 to allow the use of both materials for the Temporary Equipment Hatch.</p>
<p>200009188 System: N/A TagNumber: N/A</p>	<p>At 07:20 hours I received a call from Security at that Command Post for a Portal Monitor alarm. A worker for the Steam Generator Team had alarmed the monitor three times. I responded and frisked the worker and found counts on the upper left chest area. I escorted the worker to HP1 and had him frisk in a PCM 1. Both zone 2 and 6 alarmed indicating contamination in area of the chest. I then asked the worker to remove his fleece outer garment and go through the PCM 1 again. This time he did not alarm. I then frisked the fleece pullover in the Automatic Tool Frisker and it alarmed. A direct frisk of the garment with a RM-14 indicated 2000cpm on the upper left chest area. I then frisked the inside of the grament in the same area on found 30,000cpm. I was able to remove the particle with a tape lift after scraping the area with a knife when initial tape lifts were unsuccessful. The particle was then analyzed and was shown to be CO 60. I questioned the worker about his work activities and he informed me that he had made an entry in the Unit 2 Vapor Containment from about 03:00 hours to 04:00 hours. He also informed me that the item with the patricle on it had not been worn into the Normal RCA.. It had remained on his desk during his entry. At this point I initiated Attacments 8.2 and 8.3 of procedure HP-SQ-3.801 and I let the worker go home. As a follow up I did a smear and frisk survey of the workers desk which did not indicate any radioactive material. I then took the particle to the HP2 area to see if it would alarm the Portal Monitor set up there. When I place the particle in my chest pocket and walked through the monitor it alarmed. This needs to be investagated because it is the fourth time a particle has been dedected at the comman post as reported in CRS 200008841, 200007386 and 200006333.</p>
<p>200009189 System: N/A TagNumber: N/A</p>	<p>Design Engineerng procedure OP-290 Section 5.20 "Human Factors Engineering Review" Of Central Control Room Modifications" Section 3.3.d states "If satisfied that the modification was installed correctly, the "Implementation Conformance Review</p>

Form\* (Exhibit E) shall be completed and signed by the HFE, or his designee. This form shall be transmitted to the Discipline Engineer for inclusion in project files.\* Confirmation of compliance with this procedural requirement could not be verified.

200009190  
System: N/A  
TagNumber: N/A

A Tech Spec (TS) Amendment Request was submitted to the NRC with errors on 11/22/99. This was discovered during final review by the NRC. The request provided the new TS pages and marked up TS pages. These two must agree with respect to the changes and they do not.

200009191  
System: N/A  
TagNumber: N/A

Operations procedure A 27.1.9 directs containment entries for several contingency actions yet for many scenarios, RCP seal cooling may have been lost and seal leakage to the containment on the order of 21gpm per pump will most likely be occurring. Without any containment ventilation I/S, it is not likely that any VC entries will be possible. Note: IP3 has alternate actions that do not require early entry and permit entry later, our issues were realized when talking with IP3.

200009192  
System: N/A  
TagNumber: N/A

Operator actions in a CCR evacuation involve tripping the reactor and leaving the CCR, depending on the extent of the fire, seal injection and component cooling water may also be lost. By the time the Reactor Coolant Pumps are tripped from the switchgear, significant seal damage may be occurring. Engineering should evaluate tripping the RCPs prior to leaving the CCR. Natural circulation also prolongs steam generator inventory and increases pressurizer level. This was discovered during discussions with IP3.

200009193  
System: 480V  
TagNumber: 27-1/2A

ISSUE: This CR is being written to document that Set Point Control Group (SPCG) could not determine that the M&TE requirements were met for the CEMCO (Committee to Eliminate Mid-Cycle Outage) Technical Specification amendment to extend (on a one time basis) the surveillance interval for the 480 volt undervoltage relays to 37 months. As part of the effort to extend the surveillance interval prescribed by the Technical Specifications for the 480 volt undervoltage relays in 1999, the uncertainty calculations required the accuracy of the M&TE used for PT-R61 (the applicable surveillance test at that time) to be improved. The responsible Con Edison Engineer [REDACTED], specified the use of a Hewlett Packard system Multimeter No. 3458A (M&TE), which has an overall accuracy of 0.06% at 421 volts. This M&TE instrument required procurement and an agreement was reached between the affected parties as described in the e-mail below dated March 30, 1999 from the Setpoint Control Group to I&C Maintenance and Test & Performance. The Con Ed calculation SNX-00013-04 was not updated based on the assumed acquisition of the M&TE (Hewlett Packard) and subsequent use during calibration. An attempt to clarify whether the M&TE had been procured and used in the applicable tests (PT-R61 is no longer used for this purpose-the functional requirements have been reflected in PT-R13, PT-R13B and PT-R14) has been unsuccessful. Since the use of the Hewlett Packard M&TE was part of the basis for the one time 37 month surveillance extension / Technical Specification Amendment request to the NRC, verification of whether this M&TE requirement met at the end of 37 month cycle, must be achieved. It is also noted that PT-R61 utilized ICPMs to record "as found" and "as left" data. There is an additional concern that control over M&TE used in ICPMs may not be rigorously maintained as required by surveillance procedures. Note: Presently Westinghouse is documenting the setpoints by revising the calculations on the degraded voltage to justify the continuation of surveillance on a 30 month cycle. In addition, Westinghouse has informed the SPCG that Hewlett Packard M&TE is also required to justify the 30 month cycle. RECOMMENDED ACTION: It is recommended that this CR should be assigned to Electrical Projects and Programs to evaluate the impact of the M&TE used to perform the last surveillance calibration and the potential of reportability of not using the recommended M&TE. The evaluation needs to consider the drift assumptions specified in CEMCO Sent Monday, November 13, 2000 11:48 AM To: [REDACTED]

[REDACTED] Subject: FW: Required Test Equipment Just checking- did we buy this equipment or are we using IP-3's. I have to know for our people to update their calculations -----Original Message----- From: [REDACTED] Sent: Tuesday, March 30, 1999 2:30 PM To: [REDACTED] Cc: [REDACTED]; [REDACTED]

[REDACTED] Subject: Required Test Equipment The instrumentation presently used in PT-R61 has been evaluated by Mr. [REDACTED] and found to have an unacceptable accuracy for the purpose of this test (see attached e-mails). Mr. [REDACTED] has specified an alternate which is a Hewlett Packard System Multimeter No. 3458A with an overall accuracy of 0.06% at 421 volts. It costs approximately \$7500 and has procurement time of 8 weeks. since use of this instrument is critical to elimination of the midcycle outage, Mr. [REDACTED] has agreed to purchase two. The account to be charged is H1962. Per earlier discussions, Mr. [REDACTED] has agreed to purchase these instruments with the charges going to this account number. I will prepare a TPRF for a change in the test procedure specifying this instrument. Mr. [REDACTED] is requested to prepare a revised calculation reflecting the new instrumentation and forward it to myself and Westinghouse.

200009194

We require the use of a gas turbine for IP2 Appendix R events, this requires the assumption

System: N/A TagNumber: N/A	of one hour to establish power. If we were able to use power from IP3, including the dedicated safe shutdown diesel. The power from IP3 could almost certainly be provided in less time.
200009195 System: CSS TagNumber: N/A	FI-7739 (21 Spray Pump Minimum recirc flow/ test line flow indicator) does not have a calibration interval. This instrument is used in a technical specification surveillance test (PT-Q35A) to prove operability. The last time the instrument may have been calibrated was 3/98. In addition, this flow indicator does not appear in the equipment database.
200009196 System: N/A TagNumber: N/A	PC-Q 3 (Containment H2/O2 Monitor Calibrations) & PT-M54 (Fan Cooler Unit Test) passed their RRD. PT-Q76 (Effluent Radiation Monitor R-49 Functional Test), PI-M 6 (Fire Protection Valve verification), & PT-Q86 (Effluent Radiation Monitor R-50 Functional Test) entered their surveillance grace periods.
200009197 System: 480V TagNumber: CRF-2035-002	During performance of the referenced work order the alarm switches failed testing. Readings for left NC switch .1 .1 .1 .1 right NO 1.4 11.5 23.1 .9 1.4. This problem will be corrected under the existing WO no further action necessary.
200009198 System: 480V TagNumber: EDG-2053-004	During performance of the referenced WO the mouse trap could not be made to hit the new alarm switches. This problem will be fixed under the referenced WO and MSAP 567. This CR is for documentation only.
200009199 System: FP TagNumber: TST-PI-M8	While performing PI-M8, Fire Hose Cabinets, found Cabinet # 11 located at 72 ft. elev. of chem. systems building facing the command post, short of one 1-1/2 inch dia. hose as required by the test.
200009200 System: RPS TagNumber: RPSA	The "High Steam Flow SI Channel Trip" alarm(panel SB-2 window 2-6 in the Central Control Room) has come up at least six times today. Sometimes it cleared quickly, other times it stayed up for several minutes. The Proteus Alarm printer recorded point FD0446 as tripped (TR) when the alarm was up, when the alarm cleared point FD0446 changed to "NOT TR". Point FD0446 is "Steam Line C Hi F I SI." The steam flow gauges and recorders did not indicate any steam flow.
200009201 System: CM TagNumber: 21MPC	During the performance of PT-R8A, Manipulator Crane Overload and Underload Setpoints, the sensotec display unit was noticed to have its overload and underload setpoints drifting. The Sensotec Display Unit was replaced under work order # np-00-16180 and the applicable sections of PT-R8A were re-performed satisfactorily.
200009202 System: FP TagNumber: TST-PI-M8	While performing PI-M8, Fire Hose cabinet inspection, found Hose cabinet # 10 at the alleyway between PAB and Hold-up tank Pit inaccessible blocked by skid of gas bottles.
200009203 System: ILWH TagNumber: LW-441	During a walkdown inspection to redesign support downstream of LW-441, in 33' SBBPS Heat Exchanger Cell, following deficiencies noted: 1) The deteriorated support downstream of LW-441 has a Tag No BD-13, per A179467-6. BD-13 is 1" s/40 pipe stanchion support, with one end cut to suit and welded to the elbow of the 3" process pipe. The other end is threaded and connected to a 1" - 125# CI flange that serves as the base of the stanchion. Visual inspection indicates that the CI flange is highly corroded. In Addition to the dorrosion of the CI flange the baseplate of the as-built configuration rests directly on the floor while BD-13, per A179467-6, requires a 1" grout pad. This support is in the process of being redesigned. 2) Per A179467-6, a support BD-11 should exists between LW-440 and the 3" - 90 ell. upstream of LW440. This support is missing. Installation of BD-11 is required. 3) Per A179467-6 the 3" process pipe is supported in its north-south run by two supports, with tag numbers of BD-6 The conceptual design of BD-6 is that of a cantilever structure made up of a 2 x 2 x 1/4 angle One end attached to the bottom of an existing I-beam, and the other end with a U-bolt to fix the pipe to the angle. The as-built configuration of these two supports does not match the conceptual design: (A) The BD-6 support on the northern end of the 3" run has a 3/4" gap between the angle and the pipe and no U-bolt exists (no holes on the structural angle). (B) The BD-6 support on the southern end of the run has no U-bolts and no indications of holes on the structural angle for the U-bolt. These supports need to be redesign or reconciled with A179467-6.
200009204 System: N/A TagNumber: N/A	A potential change to the RWST volume has been identified as a result of the plant modifications that have been performed since the issuance of the Cycle 15 Reload Safety Evaluation (RSE). The potential change to the RWST volume can decrease the margin in the Post LOCA Long Term Cooling analysis that was performed for Cycle 15. The result may be that the corresponding acceptable conclusion presented in the Cycle 15 RSE may no longer be acceptable.
200009205 System: SSD TagNumber: 2-HMS-1	A VT-3 examination of 2-HMS-1 after SG replacement found: The current cold setting for the spring can is 22,023, which is greater than 10% beyond the required Cold setting of 19,372. Also the ID plate is stamped Hot- 23,788 and Cold 28,800. Hot should be 17,500.

<p>200009206 System: SIS TagNumber: 882</p>	<p>The angle iron frame supporting the motor actuator for MOV-882 appears slightly flexible. Valve 882 is located on 16" RHR line # 155, RHR pumps suction from RWST. It is located in PAB 15' elevation in RHR pump hallway. This item was identified during system walkdown for SI/RHR systems. Further review indicated that the support is not shown on controlled piping drawings.</p>
<p>200009207 System: FP TagNumber: FP-680</p>	<p>While performing PT-A17B, Fire Hose Station Inspections, it was discovered that FP-680 can not be opened to it's full open position. FP-680 is the isolation to hose reel station #210 on the north end of the turbine building on the 15'. Cause of this condition is that the valve handwheel comes into contact with a conduit that leads to a PA system speaker amplifier box that is on the same column. With valve partially open we still get flow through the isolation, however this is a unsafe condition on the test since PT-A17B calls for the valve to be cycled to the full open position.</p>
<p>200009208 System: N/A TagNumber: N/A</p>	<p>Noticed that RWP# 00-0529, Refueling Radiation Work Permit, and it's associated ALARA Review has a minimum dose available requirement for a individual. Yet there is no requirement for exposure control cards, how can the Health Physics Tech covering the job have the means to ensure that this requirement is met ? When the Exposure control card field is checked on the RWP, the computer system will automatically generate this card so the individual can give this required information to the field HP. Also, it was noted by the HP Tech running the RWP office that there are other RWP's that are written as such.</p>
<p>200009209 System: N/A TagNumber: N/A</p>	<p>Condition Report #200008274, generated on 10/27/00 dealt with an unknown liquid dripping on the MCC from the boiler room. Concern for the MCC was expressed and a desire to ascertain the dried substance was noted. However, the intent of this CR concerns the method of sample analysis request. Station personnel still believe that anything unknown may be simply discarded in the Chemistry labs, without anything more than a note saying "analysis this". Sandy particles in a "Zip-Lock" bag, attached to a copy of CR #200008274 were found this date lying on the Conventional Lab counter with just such a request. Accompanying this was approximately 150 cc's of an unknown taken on 11/14/00 from the Zum Strainer asking for a PCB analysis. No name, no phone number, nothing more to identify the mystery sample. Numerous requests have been made for an established sample analysis request and chain of custody regime (see CR #200006581 of recent note), but none has been created to sufficiently inform and train all interested parties. It's imperative to inculcate this upon all if and when a program is installed.</p>
<p>200009210 System: N/A TagNumber: N/A</p>	<p>At 2348 hrs on 20 November 2000 a Security Officer failed to properly secure his weapon while going off duty. The Officer unloaded and left his weapon unattended at the loading barrel located in the Secondary Alarm Station. Another Security Officer discovered the weapon and turned it over to the Duty Lieutenant Shift Supervisor. Badge reports revealed that during this incident only security personnel (Two Lieutenants, one Access Control Officer and one Security Officer ) were present in this locked and alarmed area. Also a time of two (2) minutes and twelve (12) seconds lapsed between occurrence and discovery. No unauthorized personnel came in contact with the weapon. There was at no time a degrade in physical security</p>
<p>200009211 System: FP TagNumber: N/A</p>	<p>While performing PT-A17B, found the hose reel #23 damaged. Reel is hard to operate and both wheels can be turned separately. Cause of damaged appears to be partial pressurization of the hose. found hose partially filled during inspection.</p>
<p>200009212 System: MS TagNumber: PCV-1120</p>	<p>Modification FIX-95-11199 needs further evaluation of the following safety and design concerns These are documented here due to lack of opportunity to resolve the issues during the the mod review process Concern 1: Proposed hot functional test can cause uncontrolled cycling of RCS temperature and pressure. The test is referenced in the mod but is not described Safety implications of the test are equivalent to safety implications of the mod Its purpose is to prove that the new design is compatible with PC-404 when in Auto. It also provides for PC-404 on-line tuning if the existing control settings result in hunting/cycling. The test implementation requires complex coordination of start up activities, availability of MSIVs (for protection), Operator override actions (for protection) and repeated manipulations of RCS The following specific issues cause my safety concerns: a. The test design forces the dump valves of group 1 to operate in almost closed position because the total heat of 4 RCPs amounts to only 2.5% of nominal total steam flow (10-20% of each valve's nominal flow). This is the region where most flow control valves exhibit inherently poor control. It is particularly applicable to dump valves due to their oversized design and "dumping" flow curve. Specifically, small set point decrease (test intention) is capable of causing overtravel to fully closed position. This in turn will require overcompensation by PC-404 and result in cycling. The system's dead band and unproven response can exacerbate the uncontrolled cycling of RCS temperature and pressure. b. The test was designed for IP3 steam dump control system. Their design differs substantially from the proposed IP2 design. The critical difference is in the control system configuration and response. IP3's FSAR requires a demanding 20-second modulating stroke. IP2's existing stroke of 70-80 seconds is unlikely to improve to 20 seconds. The modification does not provide any clue or</p>

calculations of how the new design's can meet the very demanding 10-20 sec acceptance criteria (see Concern 2.a below) This increases the risk of uncontrolled cycling of RCS temperature and pressure. Concern 2: Design Basis response time (10-20 seconds). The post-mod average closing stroke may improve. But it is not clear if it can meet 20-second spec and the mod's test requirement. The following points need be addressed to show how the mod fulfills the intent of the original design basis - to make dump valves sufficiently fast and responsive to all operating demands of properly tuned control system. a. There are no calculations or evaluations justifying the new design's ability to meet the 10-20 sec acceptance criteria. b. There is no evaluation or basis for relaxing the 10-20 seconds criteria in case it is unobtainable by the new desin. c. There is no specific limiting value for stroke time - what is the slowest acceptable stroke for the control system to do its job.

<p>200009213 System: SIS TagNumber: 4340</p>	<p>4340 RWST Tank Drain Stop is a COL 10.1.1 CLOSED/SEALED valve. The Blind Flange associated with this valve is insulated. As per Note on page 12 COL 10.1.1 "The blind flange on 4340 and 7323 shall be checked by ensuring the insulation installed. IF the valve seal is found broken, THEN the blind flange and insulation shall be checked." The valve seal was found broken and replaced on 11/21/00 therefore the insulation must be removed and the blind flange inspected by Operations.</p>
<p>200009214 System: SIS TagNumber: 7323</p>	<p>7323 SIS Pumps Full Flow Isolation (Future) Stop is a COL 10.1.1 CLOSED/SEALED valve. The Blind Flange associated with this valve is insulated. As per Note on page 12 COL 10.1.1 "The blind flange on 4340 and 7323 shall be checked by ensuring the insulation installed. IF the valve seal is found broken, THEN the blind flange and insulation shall be checked." The valve seal was found broken and replaced on 11/21/00 therefore the insulation must be removed and the blind flange inspected by Operations.</p>
<p>200009215 System: FP TagNumber: N/A</p>	<p>In performing PT-A17B, the following hose reel stations had unsat conditions due to no hydro date on the hoses. 15' Turbine hall: Hose reel stations #21, 210, and 213. 53' Turbine hall: Hose reel stations #212 and 215. Each hose have a "First Field Use" sticker on them and the hydro date has faded to the point where the date can not be seen. these stickers are the same that exist on Hose reel stations #24, 26, and 29, all of which have a hydro date of 2/99 that can be barely determined on them. This list is only a partial list at this time since inspections are not complete at this time. Request the hydro date on the unsat hose stations be verified and a more permanent method of marking the hoses be devised. ( All old hoses that have been sent out for hydro have large labels on them.)</p>
<p>200009216 System: FW TagNumber: N/A</p>	<p>During housekeeping walkdown under SG 23, it was identified that a tubing support for SG 23 level instrumentation has been disturbed from its original location. This support is located under the newly installed upper lateral plates and tubing is now exposed and no longer properly protected.</p>
<p>200009217 System: WDS TagNumber: 1789</p>	<p>During the performance of PT-O13 Data Sheet 129, 1789 exceeded its required range and limiting valve on the Open stroke and exceeded its required range on the Close stroke. Time to open: 20s. Required range &gt;2s and &lt;6s. Limiting valve &lt;10s Time to close: 1s, Required range &gt;2s and &lt;6s. Limiting value &lt;10s Per the test requirements. Valve Shall immediately declared inoperable and a CR shall be written.</p>
<p>200009218 System: CW TagNumber: N/A</p>	<p>The Unit 2 screenwash return line, north line (fish sluice) is plugged between the air relief vent and the underwater discharge point. Vendor with approved hydrolaser must be brought in as soon as possible to clear the line. Maintaining the fish line clear is a requirement of the NY State Dept of Environmental Conservation State Pollution Discharge (SPDES) Permit. Assign as as Pronty 2 Work Order to Maintenance.</p>
<p>200009219 System: COMP TagNumber: COMPN</p>	<p>A Request for Information was sent to Nuclear Safety &amp; Licensing to determine reportability on the subject Condition Report. The Request for Information assignment was closed with the appropriate information entered. per the assignee, but was received by the Global Controller with a blank response box. While there have been instances of Condition Reports initiated where the Condition Description field has been blank, this is the first instance where the response to an assignment has been blank.</p>
<p>200009220 System: CF TagNumber: HANDEP</p>	<p>Handep electric pump for transfer of concentrated chemicals to chemical mixing tank... does not pump ... motor functions but no fluid is transfered from discharge.</p>
<p>200009221 System: SEC TagNumber: N/A</p>	<p>TFC 1999-006 is for Security related issue and has has past due target date for completion. SAO-206 requires that valid target dates fro TFC cleance be provided. Please assign to I&amp;C to clear TFC. The current version of SAO-206 does not require that an open CR or ICA be maintained, but is recommended thag this CT remain active untilthe TFC is clear. The engineering and implementation work has been reproted as complete. Please FYI Generation Support.</p>
<p>200009222 System: WDS</p>	<p>While reviewing the UFSAR, Table 11.1-7 Sheet 2 as part of the 50.54(f) Issue Resolution effort for IP2, a discrepancy was discovered. Recommend assignment to 50.54(f) for</p>

<p>TagNumber: 21STP</p>	<p>disposition. UFSAR Table 11.1-7 Sheet 2, "Component Summary Data", lists major components of the Waste Disposal System. The pump head (ft) and design pressure parameters for the Sump Tank Pumps have not been verified. These original Gould pumps (21STP and 22STP) were replaced via Work Order NP9581355 (Ref. Mod FPX-96-81355-F and Generic Safety Evaluation 96-241-GM) with Chesterton pumps. Two prior condition reports have attempted to verify the design data associated with these pumps; 199807107, which resulted in UFSAR Change Request # 507, and 20004663 which resulted in issue of a new pump curve drawing, 2000MC5469. This pump curve indicates the pump head to be 105 ft. (as opposed to the Table value of 100 ft.). This will necessitate an UFSAR change. Documentation to verify the design pressure (currently 150 psig in the Table), cannot be located. It appears that this data needs to be reconstituted. The OE database should also be re-evaluated and updated as required. RECOMMENDATIONS: 1) Assignment to Mechanical Projects &amp; Programs to evaluate the need to reconstitute documentation to verify the design pressure value. 2) Assignment to 50.54(f) to update the UFSAR. Dependent upon the results of the Mechanical evaluation, a change to the design pressure value listed in the Table may be required. The need for an UFSAR change to the pump head value has already been determined. 3) Assignment to OE Manager to evaluate results of this effort and update OE database as appropriate. This condition is a configuration disparity and does NOT involve an operability question.</p>
<p>200009223 System: LO TagNumber: N/A</p>	<p>TFC 1999-041, Turbine Lube Oil Cooler Moat, has a past due target date. SAO-206 requires that a valid target date be provided. Engineering has issued mod accepting field installation as permanent. The PMA, House Maintenance, has to submit a Report of Installation so that the TFC can be cleared. Please assign to HM, FYI Generation Support. The current version of SAO-206 does not require that an active CR be maintained but it is recommended that this CR remain open until the TFC is cleared.</p>
<p>200009224 System: CYW TagNumber: 1.5MWT</p>	<p>TFC 1999-058, City Water Tank wire to CCR, has a past due target date. SAO-206 requires that a valid target date be provided. Engineering has released mod on 7/5/2000 accepting TFC as permanent. The PMA, I&amp;C, has to submit Report of Installation so that TFC can be cleared. Please assign to I&amp;C. The current version of SAO-206 does not require active CR to track TFCs, it is recommended that this CR remain active until TFC is cleared.</p>
<p>200009225 System: FP TagNumber: EL-26E</p>	<p>EL-26E, the Emergency light in the hallway outside the CCR has both the trickle and fast charge bulbs burnt out. This is an Appendix "R" Fire Protection light, the units area lamps were tested Sat. The units charging circuit board may be in question investigate and repair as required perfect for FIN.</p>
<p>200009226 System: FP TagNumber: N/A</p>	<p>PI-M8 Fire Hose Cabinets and Stations surveillance test was performed with the following discrepancies 1 Fire hose cabinet #10 access was blocked by gas bottle pallet. 2. Fire hose cabinet #11 was missing a 1-1/2" fire hose 3. Fire hose cabinet #12 was missing a 2-1/2" X 1-1/2" WYE As a result of the above discrepancies PI-M8 failed.</p>
<p>200009227 System: CM TagNumber: SFPBH</p>	<p>Procedure FP-IPP-R15 "Reactor Head Book" will allow operation of the Spent Fuel Pit Fuel Handling Crane without the hoist load monitor (see section D.4, page 9.1.8-12,13. The hoist load monitoring system provides load indication and sensing to stop upward and downward movement of the hoist if limits are exceeded (eg. H overload set pt, L low load setpoint, and SC slack cable setpoint) The UFSAR section 9.5.2.2.5 Spent Fuel Pit Bridge.... "It has a load indicator and a load limit switch, which will stop upward movement of a load upon sensing a load greater than set-point (setpoint value is less than 2200 lb.)." Thus, it appears a station approved procedure would allow operations of a piece of plant equipment against what is described in the UFSAR</p>
<p>200009228 System: GAS TagNumber: 4105</p>	<p>Received PCV-456 low N2 alarm and regulator failure low alarm. Dispatched NPO he reports that when he arrived on 95 RV-4105 was lifting and eventually reset he could not find any reason for it to be lifting no one was in the vicinity of the valve nor could he find anyone with any information. Opened PCV-863 and repressurized the system and cleared the alarm. See previous CR#200006363 for this same valve on 8/29/00.</p>
<p>200009229 System: N/A TagNumber: N/A</p>	<p>At 903 an oil leak was reported to the ccr. Approximately 1 quart of motor oil was discovered on the pavement in designated parking spot #3</p>

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Condition Number	Condition Description
<p>200009245 System: 480V TagNumber: N/A</p>	<p>Description: CR Closure Review. CR-199906785 may have been closed without addressing / correcting two separate non-conforming conditions. The CR was written to address two problems: 1. The spare EDG breaker ring lug was bent at the amptector. 2. The EDG spare breaker was not tested properly using primary injection current testing There is no indication that the bent ring lug was ever corrected. The question of required primary current testing is not answered / resolved. The description of the breaker problem is superficial and does not provide sufficient documentation regarding the closeout of this issue. Extent of Condition: This issue was concurrent with a major testing/repair effort conducted after the problems encountered with the 21 EDG breaker after the August 1999 Reactor Trip Event. See extent of condition report in CR 199906643. Safety Significance: The failure of an EDG breaker to operate properly during a loss of offsite power can prevent prompt restoration of power and lead to core damage. Requirement Not Met: SAO-112 requires that responses should include pertinent facts, reference other documents, and address all issues identified in the CR. There was no resolution of the problem with the bent ring lug. There was no resolution of whether the breaker required primary current injection testing or if the existing work order was adequate to ensure that the breaker testing was completed when the testing equipment was restored to operation. Recommended SL and Action: SL-3 to provide corrective action tracking. 1. Repair the bent ring lug (if this is a condition adverse to quality). 2. Determine if additional testing is required for the amptector and conduct the testing if appropriate.</p>
<p>200009246 System: FW TagNumber: N/A</p>	<p>Heater Drain Tank Pump Seal Water Heat Exchangers The heat exchangers each have six connections, five on top and one on the bottom. On the top, when referencing HDV-1 or HDV-2 as the 12 o'clock position, the 2 o'clock position is the pump's seal inlet line (hx outlet) and the 7 o'clock position is the pump's seal outlet line (hx inlet). The 10 o'clock position is the closed cooling inlet and the 5 o'clock position is the closed cooling outlet. The tubing from the heat exchanger's 2 o'clock position to the seal inlet connection also contains a vent stop, which is unlabeled in the field. Only four valves are shown on CCR Drawing 234191, for the THCC system. Please provide a drawing for the other two connections from the heat exchanger to the pump seal and provide a tag number for the vent valve for each pump as described above. Records Management was unable to help me locate the manufacturers drawing of this heat exchanger, the nameplate reads "BW/IP International, Inc." SOP 19 1 contains two locations for venting the pump's seal, step 4.3.1.(2) simply directs the operator to open the vent stop on top of the heat exchanger until seal is vented, there are no valve tag numbers given. The second location is section 4.3.4 which contains a caution requiring appropriate Personal Protection Equipment against a chemical hazard and actually identifies the THCC side of the heat exchanger by valve tag numbers. It appears as if step 4.3.2.(2) is directing the venting of the pump seal side of the heat exchanger without being all that specific. This step has its own hazards, possible hot water or steam being vented or venting THCC water by mistake (there are two vents, one for each side of the heat exchanger). This step needs a caution added and specific valve tag numbers. Sketch provided, deposited outside FSS office drop box.</p>
<p>200009247 System: N/A TagNumber: N/A</p>	<p>SAO 100 Addendum III page 2 of 3 states "COVER SHEET - Each SAO shall have a Cover Sheet formatted as shown on Addendum I. ..." Addendum I cover sheet requires the Manger of Configuration Management signature. SAO 471 rev.0 "Inservice Inspection / Test Program" approved cover sheet does not have Configuration Management Managers signature. Please note that this is a repeat issue with new SAO's (see CR 200005384).</p>
<p>200009248 System: FP TagNumber: FPA</p>	<p>72 hour admin lco for ASSD source range monitor NI-5143 (NE-33) will be exceeded at 1622 today. SAO-703 Addendum 1 item 9. See cr 200009150, ...9157.</p>
<p>200009249 System: N/A TagNumber: N/A</p>	<p>there is a trace of oil at the union above the RCP oil collection tank on 46'. It is the tank closest to the crane wall. I wiped the threads below the union and did not see an immediate leak. It is a very slight leak &amp; would take a very long time to achieve any accumulation.</p>
<p>200009250 System: SSD TagNumber: 46-SR-3</p>	<p>A VT-3 examination of snubber 46-SR-3 per GI.V1A found: The pipe clamp is bent, splayed open at the snubber attachment side. Evaluation or repair is required</p>
<p>200009251 System: HVAC TagNumber: K-43</p>	<p>Heaters K43, K44, and K48 on Drawing 138292-8 reference Ckt 1 on Lighting panel 4MT; Lighting Panel 4MT on Drawing 138314-8 designates Ckts 12, 16, and 30 for these heaters. This discrepancy needs to be resolved.</p>
<p>200009252 System: 138K TagNumber: 33332L</p>	<p>While reviewing autolog for feeder 33332 unavailability for maintenance rule, the following discrepancy in the log was found: On 10/14 feeder 33332 was in the process of being returned to service. At 2:02:04 Breaker BT4-5 was closed and at 6:45:34 breaker BT 5-6</p>

was closed energizing feeder 33332 and returning it to service. In the major equipment OOS feeder 33332 is listed as being OOS for 10/15, 10/16 and 10/17. Feeder 33332 should not have been carried as being OOS after it was returned to service on 10/14. There is no operability concern in that the feeder was returned to operation and the switching moves were recorded in the log. This is a record keeping issue.

200009253  
System: SSD  
TagNumber: PR-8

A VT-3 examination of PR-8 found: The field conditions of the cable retainer do not match plant drawing.

200009254  
System: CF  
TagNumber: TE-6506

While reviewing CR 200003351, a design issue was found. Per the narrative in a related CR, (CRS199908420), a properly sized HOTWATT temperature controller rated at 30Amps was originally installed based on the BAT utilizing a 2000-2400 Watt heater. Work Order NP9912950 has confirmed the tank heater wattage (draws 20Amps). Currently installed however is a FENWAL temperature-indicating controller rated for 15Amps. The heater load exceeds this controller's rating specification. This discrepancy needs to be resolved.

200009255  
System: HVAC  
TagNumber: TCV-5941

While performing start-up of 21 PAB supply fan, lined up aux steam to pre-heat coil using TCV-5941 to control the steam flow. After several attempts to open and close TCV-5941 using the Johnson controller, there was no response whatsoever observed on the control valve. As per ARP in response to low inlet temp. alarm at PAB air handling unit alarm panel, throttled open UH-767 bypass valve to warm the header and cleared the alarm. With CCR permission started PAB supply fan. This condition happens everytime we start-up the heating for the PAB during cold season.

200009256  
System: SSD  
TagNumber: PR-9

A VT-3 examination of PR-9 found: The field conditions of the cable retainer do not match plant drawing.

200009257  
System: SSD  
TagNumber: PR-7

A VT-3 examination of PR-7 found: The field conditions of the cable retainer do not match plant drawing.

200009258  
System: CF  
TagNumber: N/A

The control panel shown on dwg # 9321-3092 is currently labeled "Hydrazine Feed". This is no longer true. The panel needs to be relabeled to reflect its current usage.

200009259  
System: N/A  
TagNumber: N/A

This Condition Report is being initiated to document the remote VT-3 inspection performed on Support# 45-H-7. Note that the cold setting could not be verified at this time. The following conditions were noted: 1) cotter pin at item# 1 is missing 2) Jam nut for item# 2, at top of item# 1 is loose. Please assign to [REDACTED] of SGR, for review.

200009260  
System: SSD  
TagNumber: PR-6

A VT-3 examination of PR-6 found: The field conditions of the cable retainer do not match plant drawing.

200009261  
System: RPS  
TagNumber: TM-431F

While troubleshooting W.O. 00-17779 (Delta-T deviation alarm) found that prints did not match field conditions.

200009262  
System: N/A  
TagNumber: N/A

This Condition Report is being issued, to [REDACTED] to document discrepancies noted during a VT-3 inspection of Support# 45-H-4, using Drwg.# 1976M6489. 1) Spring Can spring is fully compressed 2) Jam nuts on top and bottom of Spring Can are loose. Note: Please assign to [REDACTED] of SGR, for review.

200009263  
System: HVAC  
TagNumber: FCV-1172

FCV-1172. VC Purge exhaust fan duct FME screen is covered with dirt and other debris, clean as required. This component is located above 25 CRF just to the east of the 80 foot Airlock.

200009264  
System: N/A  
TagNumber: N/A

This Condition Report is being initiated, to [REDACTED], to document the results of a VT-3 inspection performed on Support# 45-H-3, using Drwg.# 1976M6488. The following conditions were noted: 1) Spring is at top of spring can. 2) Pipe clamp is bent and missing outside nut and bolt. Please assign to [REDACTED], of SGR, for review.

200009265  
System: N/A  
TagNumber: N/A

Procedure FSAD-7, Rev 0, Processing Changes to the Electronic UFSAR and UFSAR Verification Database, requires the UFSAR Coordinator obtain a completed report of installation (ROI) before processing a UFSAR change request (UFSARCR) when the UFSARCR is necessitated by plant modifications. Contrary to this requirement several UFSARCRs associated with plant modifications have been approved without the required ROI. The list of modifications and associated UFSARCRs are listed at the end of this condition description. Documentation indicates that the modifications are installed in the plant, but the modifications do not have a completed ROI. Although the modifications do not have the required ROI, the existing plant documentation verifies the plant configuration.

	<p>described by the revised UFSAR wording agrees with the actual plant configuration. Separate condition reports have been written to obtain an ROI for each of the completed modifications listed at the end of this Condition Description. This condition report shall be used to track the completion of the required ROIs to ensure any changes made to plant drawings as a result of the ROI process will not impact the UFSAR. ConEd has approved 549 UFSARCRs since FSAD-7 was approved on 7/12/99. Each of the UFSARCRs was reviewed to determine the population of UFSARCRs that have a modification as a verifying document. There are 193 UFSARCRs that have a modification as a verifying document. Twelve (12) of the 193 UFSARCRs do not have a completed ROI. Recommendation: Assign this Condition Report to the 50.54(f) group. When issued review the ROIs for the twelve (12) UFSARCRs associated with the modifications listed at the end of this Condition Description. Initiate any required changes to the UFSAR per procedure SAO-139. FFX-93-09452-M - WITHDRAWN (PMA Construction) PCV-1190, 91 92 CONTROL SYSTEM UFSARCR#: 138 implemented in UFSAR rev 15 FMX-93-09273-M - ISSUED (PMA Construction) ELIMINATE SPRAY ADDITIVE SYSTEM UFSARCR#: 43, 145, 344, 351, 454 implemented in UFSAR rev 15 UFSARCR# 171, 182 implemented in UFSAR rev 16 FMX-95-10912-M - ISSUED (PMA Construction) REPLACE H2 RECOMBINERS UFSARCR#: 449, 572 implemented in UFSAR rev 15 FPX-98-13073-F - ISSUED (PMA Construction) IP-QUALIFY LT-940 &amp; LT-941 UFSARCR#: 5, 8, 56 implemented in UFSAR rev 15 SNX-91-03014-M - ISSUED (PMA Construction) MODERNIZE AGING RMS EQUIPMENT UFSARCR#: 319 (rev 16)</p>
<p>200009266 System: HVAC TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure to issue a Report of Installation (ROI) as required by procedure SAO-405. Modification FFX-93-09452-M (PCV-1190, 91 92 CONTROL SYSTEM) resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) # 138 added a description of the modification in UFSAR revision 15. The modification appears to have been at least partially implemented as inferred from the COMPLETE status of work orders NP 9471080, NP 9471247 and the issuance of several DMDs and as-built drawings. Although work orders and drawings reflect the implementation of Modification FFX-93-09452-M, there has been no Report of Implementation issued for the modification. Both the MODTRACKING database and verbal conversations with Records Management personnel verify that an ROI for Modification FFX-93-09452-M has not been issued. The status in MODTRACKING is WITHDRAWN (PMA Construction). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification and provide the required Report of Installation. Suggest assignment to Maintenance with a FYI to Configuration.</p>
<p>200009267 System: CW TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure properly close out a modification as required by procedure SAO-405. Modification FPX-95-11453-F "RELOCATION OF CONDENSER OUTLET WATER BOXES LEVEL ALARMS" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) # 476 added a description of the modification in UFSAR revision 15. The modification appears to have been fully implemented as inferred from the ROI and COMPLETE status of Work Orders NP 9579203, NP 9788096, NP 9789626, NP 9789627, NP 9911358, NP 9911359, NP 9911360, NP 9911361, NP 9911362, NP 9911363 as well as the issuance of several DMDs and as-built drawings. Although work orders, drawings and ROI reflect the implementation of FPX-95-11453-F, the STATUS of this modification is listed in the MODTRACKING database as WITHDRAWN (PMA I&amp;C). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification properly. Suggest assignment to I&amp;C with a FYI to Configuration.</p>
<p>200009268 System: GT TagNumber: GT3</p>	<p>Drawings 302775-01 and 304122-02 do not show entire fuel oil system supply to and return from GT-3. Missing includes isolation valves GT3-71 and GT3-73 as well as several instrument, vent and drain stops: GT2/3-26, GT3-70, GT3-72 and GT3-74. Please add valves and update drawing(s) as required. Please refer to COL 31.3, section 3.1 for information.</p>
<p>200009269 System: RCS TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure properly close out a modification as required by procedure SAO-405. Modification FPX-98-13074-F "RCS WIDE RANGE PRESSURE TRANSMITTERS PT-402 &amp; PT-403 MODIFICATIONS" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) # 441 added a description of the modification in UFSAR revision 15. The modification appears to have been fully implemented as inferred from the ROI and COMPLETE status of Work Orders NP 9802881, NP 9802882, NP 9802883, NP 9802884 as well as the issuance of several DMDs and as-built drawings. Although work orders, drawings and ROI reflect the implementation of FPX-98-13074-F, the STATUS of this modification is listed in the MODTRACKING database as WITHDRAWN (PMA I&amp;C). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification properly Suggest assignment to Maintenance with a FYI to Configuration.</p>

<p>200009270 System: CSS TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure to issue at least a Partial Report of Installation (ROI) as required by procedure SAO-405. Modification FMX-93-09273-M "ELIMINATE SPRAY ADDITIVE SYSTEM" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) 43 (rev 15), 145 (rev 15), 171 (rev 16), 182 (rev 16), 344 (rev 15), 351 (rev 15), 454 (rev 15) added a description of the modification in UFSAR. The modification appears to have been at least partially implemented as inferred from the COMPLETE status of work orders NP 9684850, NP 9684851, NP 9684852, NP 9684853, NP 9684850, NP 9684854, NP 9800541 and ASBUILT CCR drawings. Although work orders and drawings reflect the implementation of FMX-93-09273-M, there has been no Partial Report of Implementation issued for the modification. Both the MODTRACKING database and verbal conversations with Records Management personnel verify that an ROI for Modification FMX-93-09273-M has not been issued. The status in MODTRACKING is ISSUED (PMA Construction). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification and provide the required Report of Installation. Suggest assignment to Maintenance with a FYI to Configuration.</p>
<p>200009271 System: HR TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure to issue at least a Partial Report of Installation (ROI) as required by procedure SAO-405. Modification FMX-95-10912-M "REPLACE H2 RECOMBINERS" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) 449 (rev 15), 572 (rev 15) added a description of the modification in UFSAR. The modification appears to have been at least partially implemented as inferred from the COMPLETE status of work orders NP 9686778, NP 9686779, NP 9686780, NP 998670, NP 998671. Although work orders and drawings reflect the implementation of FMX-95-10912-M, there has been no Partial Report of Implementation issued for the modification. Both the MODTRACKING database and verbal conversations with Records Management personnel verify that an ROI for Modification FMX-95-10912-M has not been issued. The status in MODTRACKING is ISSUED (PMA Construction). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification and provide the required Report of Installation. Suggest assignment to Maintenance with a FYI to Configuration.</p>
<p>200009272 System: N/A TagNumber: N/A</p>	<p>During a field walkdown of CCR Panel SBF1-B it was observed that there is additional fuse block wiring installed that is not shown on Dwg 225544 (zone E6). This discrepancy between the existing panel condition and Drawing 225544 needs to be resolved.</p>
<p>200009273 System: SIS TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure to issue at least a Partial Report of Installation (ROI) as required by procedure SAO-405. Modification FPX-98-13073-F "IP-QUALIFY LT-940 &amp; LT-941" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) 2 (rev 15), 5 (rev 15), 8 (rev 15), 56 (rev 15) added a description of the modification in UFSAR. The modification appears to have been at least partially implemented as inferred from the COMPLETE status of work orders NP 9802868, NP 9802869. Although work orders and drawings reflect the implementation of FPX-98-13073-F, there has been no Partial Report of Implementation issued for the modification. Both the MODTRACKING database and verbal conversations with Records Management personnel verify that an ROI for Modification FPX-98-13073-F has not been issued. The status in MODTRACKING is ISSUED (PMA Construction). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification and provide the required Report of Installation. Suggest assignment to Maintenance with a FYI to Configuration.</p>
<p>200009274 System: RMS TagNumber: N/A</p>	<p>The purpose of this Condition Report is to document the failure properly close out a modification as required by procedure SAO-405. Modification SNX-91-03014-M "MODERNIZE AGING RMS EQUIPMENT" resulted in a change to the UFSAR. UFSAR Change Request (UFSARCR) # 319 added a description of the modification in UFSAR revision 16. The modification appears to have been partially implemented as inferred from the Partial ROI and COMPLETE status of Work Orders NP 9897771, NP 9897772 as well as the issuance of several DMDs and as-built drawings. Although work orders, drawings and ROI reflect the partial implementation of SNX-91-03014-M, the STATUS of this modification is listed in the MODTRACKING database as ISSUED (PMA Construction). Note related Condition Report CR# 200009265 which documents the failure to verify the issuance of a modification via an ROI before a change to the UFSAR is authorized as required by FSAD-07. Please close out this modification properly. Suggest assignment to I&amp;C with a FYI to Configuration.</p>
<p>200009275 System: N/A TagNumber: N/A</p>	<p>Various Check Off Lists being done by Operations have not been updated to reflect the new OAD-6 criteria for component positioning (locked and sealed). Many of the lists have old information and have not been modified to reflect current conditions in the field. Example: a</p>

	valve listed as sealed when the actual position is locked, this causes double work and Radiation exposure in many cases. Valves in C.O.L. 4:1.1 lists the position of the Residual heat exchanger valve 820B at 25.5 degrees open, this valves position indicator is in 15 degree increments it can not be done. 820A is listed as being at 33 degrees, this valve also has an indicator with 15 degree adjustments, this can not be done accurately. The positioning of these components should be done by alternate means or be assigned settings that are reasonable based on the type of valve position available.
200009276 System: N/A TagNumber: N/A	During a walkdown of the Intake structure we found unidentified wiring from junction box WW1 that feeds into MCC 21 that does not show up on drawing 9321-3248. This discrepancy between the as-found field conditions and drawing 9321-3248 needs to be resolved.
200009277 System: COND TagNumber: CONDA	The Condensate Storage Tank Panel Alarm failed to annunciate when attempting to test the panel alarm while performing the Unit 2 NPO Conventional Watch Rounds.
200009278 System: FW TagNumber: FWN	BFD-1129 (Long loop recirc sys inlet header sample stop) is leaking by its closed seat. Discovered while placing long loop recirc i/s, by chemistry when taking sample.
200009279 System: FW TagNumber: FWN	BFD-1139 (long loop filter outlet sample stop) is leaking by closed seat. Discovered by chemistry when placing long loop recirc sys i/s.
200009280 System: AFW TagNumber: FCV-1205A	FCV-1205A, City water supply to the Aux Feed pumps Instrument air supply regulator pressure indicator is broken, replace same.
200009281 System: AFW TagNumber: FCV-1205A	FCV-1205A, City water supply to the Aux feed pumps Instrument air supply line is supported with a wire tie, install proper supports. Line is hanging and may break if hit or moved.
200009282 System: CSS TagNumber: CSSA	Condition Report 200008352 (SL-4) was issued to identify two modifications that were issued after the "freeze date" for Revision 0 of the CSS DBD, and are not being reflected in the issued DBD. It appears that one of these modifications (FMX-99-12055-M, Recirc.. Pump Replacement) will also affect Revision 0 of the RHR/SIS DBD, which was issued in July 1999. CR 200008352 was assigned to Mech. Design Engineering [REDACTED] as a SL-4 T & T item. The purpose of this CR is to address the control of issued DBDs. The CSS DBD is being issued as a controlled document that does not agree with the current configuration of the station due to modifications. In addition, Revision 0 of the RHR/SIS DBD (issued 7/1/99) no longer agrees with the configuration of the station. As previously addressed in CR 200006963, the issued DBDs are located at [REDACTED] which includes the statement, "The Design Basis Documents can be considered controlled." In addition, the Engineering Operations Manual (OP-290 - Section 5.16) states that the criteria required to perform a calculation can be extracted from "any existing Design Basis Documents." Neither the DBD Index on the web site, nor the DBDs themselves provide any indication that there may be installed station modifications or other changes that have not yet been incorporated into these controlled DBDs. It does not appear that the user of a controlled DBD has any method of readily determining if the document is up to date prior to using it as a reference document. In response to a similar concern, the response to CR 200006963 stated, "SAO 520, which is in the process for signature controls the updates to the DBDs which may arise from design changes, or any other source. In the interim, the SAO draft has been used to process changes to the DBDs which have come up." It does not appear that outstanding changes affecting the issued DBDs are currently being identified to those using these controlled documents as a reference for design inputs. It is recommended that a method of "posting" changes against issued DBDs within a reasonable time be implemented to ensure that the DBD users have access to current information. Appropriate design controls are required to ensure compliance with the requirements of 10 CFR 50, Appendix B if the DBDs are to be considered controlled documents.
200009283 System: N/A TagNumber: N/A	@ 2140 hours, while climbing down from scaffolding by SG 23, it was observed that the PGC was rotating CCW with no crane walker on the leg opposite the operator. After getting down to the 95' floor, ensured that no obstacles were interfering with the crane until it stopped. When the crane stopped, immediately informed the PGS that he had no walker on the opposite leg and directed him not to operate the crane until all proper personnel were in position. Since the lift to be made was in support of Westinghouse, Westinghouse supplied required crane walkers to complete rigging evolution.
200009284 System: CCW TagNumber: 21CCP	21 CCW Pump discharge flange bolts are ALL less than hand tight. This system is under 20 psig pressure when secured, 120 psig when in service. There is no evidence of a leak at this time. This condition found during test PT-Q30A.

<p>200009285 System: CCW TagNumber: 21CCP</p>	<p>21 CCW pump oil level bubbler failed PMT #06765 due to oil leaks on associated piping. Evidence of oil leaks found on piping during the evolution of PT-Q-30A. Inboard and Outboard bubblers have evidence of current oil leaks.</p>
<p>200009286 System: 480V TagNumber: SWPA-2050-002</p>	<p>WHILE PERFORMING AS FOUND SECTION OF BRK-P-002-A, REV #3 ON BRK SWPA-2050-002 UNDER WO # NP-00-16600 THE FOLLOWING UNACCEPTABLE CONDITIONS WERE NOTED: 1. STEP 8.2.2, THE BREAKER FAILED PT-3Y5 TESTING. UNSAT ON LONG DELAY PICK-UP. 2. STEP 8.3.1, PHASE "A" AND PHASE "B" FAILED MICRO-OHM CHECKS. 3. STEP 8.3.14 C, THE X-RELAY SNAPPED .040 AFTER LATCH. 4. STEP 8.3.22, "C" PHASE G GAPS ARE OUT OF TOLERANCE. 5. STEP 8.3.44 B, LEFT SIDE FRONT SQUARE NUT TO THE ROLLER ASSEMBLY IS NOT FLUSH.</p>
<p>200009287 System: IA TagNumber: IA-1442</p>	<p>IA-1442, instrument air drain valve in VC (46', overhead) has its handwheel missing. The valve is a 3/8" ball valve.</p>
<p>200009288 System: SW TagNumber: SWN-78-3</p>	<p>Valve has no operating handle on stem. (T-handle type operator).</p>
<p>200009289 System: FP TagNumber: FPA</p>	<p>On 10/22/2000 at 0130, the fire hydrants for the unit 2 intake structure were removed from service for tag out 14079 as part of the ongoing utility tunnel project. A 30 day administrative action statement per SAO-703 was entered. On 11/22/2000 at 0130, this action statement expired since the intake structure hydrants had not been returned to service. These hydrants protect the SW pumps which are required to be available at all times. All SAO-703 compensatory actions remain in effect until the hydrants are returned to service.</p>
<p>200009290 System: SIS TagNumber: 1802A</p>	<p>During walk through on the 46' elevation, it was identified that the valve SI-1802A has a small packing leak identifiable by the boron buildup around the packing gland. Boron is fresh, and had not been identified during previous walk throughs in the area.</p>
<p>200009291 System: RMS TagNumber: RMSA</p>	<p>Circuit 5 on 23A instrument bus was deenergized as part of tag out 14188. This deenergizes the unit 2 plant vent flow recorder. A 30 TS action statement was entered per TS 3.9.B.2.c. 4 hour supplemental log in effect per TS table 3.9-2.</p>
<p>200009292 System: MS TagNumber: 5EX-30-4</p>	<p>During the planner walkdown for work order 00-18307, written to investigate / repair check valve 5EX-29-4 assist weight (see CR# 200008349), it was noted that the actual tag number should be 5EX-30-4 as verified by flow print 9321-F-2023 Rev.29. There was no discrepancy noted for valve 5EX-29-4. Valve 5EX-30-4 will be repaired under existing work order.</p>
<p>200009293 System: N/A TagNumber: N/A</p>	<p>A VT-3 examination of SG blowdown line #47 support 47-H-1 found: 1. The spring can support rod is bent approximately 2' from perpendicular. 2. The nuts attaching support rod the attachment #1 are installed top and bottom while the drawing requires two on top and none on the bottom.</p>
<p>200009294 System: N/A TagNumber: N/A</p>	<p>A V T -3 examination of 23 SG blowdown line 47 support 47-H-5-1 found: 1. Item #3 3/4" x 6" hex hd bolts- only 3 of 5 are installed 2. Item #2 support rod is attached at top with one nut top and bottom while the drawing call for two nuts on top. 3. Drawing was revised on 2:15:00 referencing CR 98-E03274. A review of that CR found it was written for 47-H-17 and 47-SR-19.</p>
<p>200009295 System: N/A TagNumber: N/A</p>	<p>CI-240-1 Section II - Preparation: Review &amp; Control of Design Documents requires Indian Point to have procedural controls for a number of design activities. A review of OP-290 the DE-SO-XXX procedures indicates that we are not meeting that requirement for the following segments of CI-240-1 "Segment 3.4.e ... Modification of any drawing used or issued for use for construction from the corresponding drawings used for stress analysis shall be certified by NPE, or by the agency designated by NPE as responsible for the stress analysis calculations, to have been satisfactorily reconciled with those calculations." "Segment 3.5.f ... Any modification of any drawing used or issued for use for installation/fabrication from the corresponding drawing used for stress analysis shall be certified by NPE, or by the agency designated by NPE as responsible for the stress analysis calculations, to have been satisfactorily reconciled with those calculations."</p>
<p>200009296 System: N/A TagNumber: N/A</p>	<p>Health Physics did not document an extent of condition review when a controlled (M&amp;TE) digital voltmeter was found out of calibration during the next calibration.</p>
<p>200009297 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-002: Personnel contamination events have not resulted in required condition reports (SAO-112); Contamination logsheets do not show timely supervisory review and trending. Event cause determinations not performed. This is considered SAO-315 program review item. Recommend SL-3. DLS 11/22/00</p>

<p>200009298 System: N/A TagNumber: N/A</p>	<p>At 0230 hours on 11-15-2000 the Watch Health Physics Technician was informed by the Unit 2 Operator that the gamma alarm monitoring the P.A.B. Sump Tank was alarming. He responded and observed the meter moving erratically. He checked the cord and the detector and the appeared to be in good shape. He then surveyed the P.A.B. Sump Tank Cell and all dose rate were normal. He left the instrument in service and noted the condition in the Watch Log. On 11-17-2000 while touring the P.A.B. I observed the same instrument again moving erratically. I then checked the detector and the cord and I surveyed the cell and all were normal. Since this equipment is installed for information only and not required by procedure it was left in service. I informed HPS of this condition. On 11-19-2000 the above mentioned equipment was placed out of service by the Midnight Watch. On 11-21-2000 the gamma alarm was replaced. Suggest a SL 1 for tracking and trending.</p>
<p>200009299 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-003: Deficiencies in air sampling program IMPLEMENTATION: 1. imprecise air flow and sample duration records, 2. inaccurate DAC fraction computation, 3. sampling not taken in high occupancy areas of containment, 4. DAC performance standard (0.1 DAC fraction) not attained with some field analyses due to low sample volumes, 5. status of air moving equipment not widely appreciated by techs and supervisors.</p>
<p>200009300 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-004: The program to reduce stellite (cobalt) valve wear product release to reactor coolant is not effective. Opportunities to replace components with low-cobalt substitutes are being missed. The issue is not entirely within the control of Radiation Protection and, to be effective, uppermost station management needs to get involved. Reduction in stellite addition to RCS reduces plant radiation field potential.</p>
<p>200009301 System: 480V TagNumber: SWPA-2050-003</p>	<p>while working in wsl #1 could not achieve adjustment of the impact spring to alarm switches. The adjustment that was made to the spring was unacceptable, as per engineer, need work step list #2 to replace impact spring, and to slot holes on shunt trip plate for the alarm switches.</p>
<p>200009302 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-005: Quality control checks for laundered protective clothing involves such a small sampling as to make the checks of diminished benefit. Approximately 50 garment items out of 150,000 (or 1 in 3000) have been checked during SGR activities. No PC hoods have been checked. This sampling is a measurable reduction from the previous practices and commitments.</p>
<p>200009303 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-006: The following deal with contamination control: 1. Tool contamination monitor response checks are not documented on proper forms nor are the completed forms reviewed in timely fashion by supervision, 2. Related to 1) above, the several tool contamination procedures should be combined for consistency, and one procedure for defunct equipment (HNS TCM) should be deleted, 3. Workers exiting RCA and finishing successful PCM contamination check (found clean) are stepping into RCA instead of onto clean side of boundary</p>
<p>200009304 System: N/A TagNumber: N/A</p>	<p>Audit 00-03-C-007 SAO-315 requires establishment of a health physics review program in accordance with ANSI 18.1. It is believed this reference is in error and should be NUREG-0855 instead which deals with radiation protection program appraisal. Recommend SL-4 DLS 11/22/00.</p>
<p>200009305 System: COMP TagNumber: N/A</p>	<p>Improved training is needed on the availability, use, and coordination of the various Con Edison information systems used in support of IP2. This CR is being entered by a new employee who has had difficulty in obtaining necessary design information from the on-line record systems (discussions with other new employees reveal similar difficulties). So far, this employee has encountered the following systems: FileNet, FileNet Neighborhood, Metaphase (and an earlier version of Metaphase that is still loaded on my computer), NPMEL, NPIN, PPMIS and OE (PPMIS is apparently part of OE). Also, there are links on the IP2 Web to "Documents and Databases". There does not appear to be any formal training available on how to use these systems. Training is obtained on an "ad hoc" basis by asking the assistance of co-workers (that is, those who have the knowledge) in acquiring specific information. Also, it is not clear how the various systems are coordinated (ie, how they "talk to each other"), so as to ensure that they are using all the same up-to-date information, or how they relate to the official hard copy maintained in the document center (for example, calculations can be found in FileNet as well as NPMEL; also both NPMEL and the mainframe have work order information). It is suggested that some organized training be developed (even if informal) on how these systems are accessed and used, what their limitations are, and whether particular databases are designated as the "design basis" database for particular types of information.</p>
<p>200009306 System: N/A TagNumber: N/A</p>	<p>A significant amount of VT-3 inspection discrepancies have been documented via C/Rs over the past week. The program owner needs to understand, 1) the collective significance of these deficiencies and 2) what is causing the delta in the number of identified discrepancies versus our normal count. Suggest SL-3 to program owner with recommendation to SL-2 if safety significance falls out of collective significance review</p>

<p>200009307  System: 138K  TagNumber: N/A</p>	<p>In the CCR set of procedures, both AOI 27.1.1 and AOI 27.1.11 are titled "LOSS OF NORMAL STATION POWER" on their respective cover sheets. The ABNORMAL OPERATING PROCEDURES INDEX lists AOI 27.1.11 as "LOSS OF 125V DC POWER".</p>
<p>200009308  System: N/A  TagNumber: N/A</p>	<p>The Basic Air Compressors training class scheduled for November 27 through December 1, 2000 has been cancelled. The class was cancelled after a review of the training material by line and training management determined that the class did not contain the appropriate material content. The class is described as a 5 day course in the Maintenance Training Program Description (TPD), however it was developed as a 3 day course. The course will be redeveloped with greater detail and material content and will be rescheduled. The students registered for the class were notified of the cancellation on November 22, 2000. I suggest that this condition report be assigned to [REDACTED] as an SL-3.</p>

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low is a list of 38 CRs created in the last 24 hours. (11/24/00 7:09:09 AM to 11/25/00 7:09:09 AM)

Condition Number	Condition Description
0009391 System: N/A Tag Number: N/A	Two SGT employees exited the RCA and entered an erroneous dose value in the RDMS. This CR written for trending and tracking purposes.
0009392 System: PW Tag Number: LT-1131	While I&C was performing PT-Q38 (PWST Level Calibration) we received no less than 30 Alarms. This for a calibration of one Level Transmitter is an unacceptable and unnecessary distraction imposed on the Control Room. These distractions compromise our operating environment, and take us away from our primary duties. I&C test need to be reviewed for impact on the CCR not only as overlapping concern but in respect to when it would be allowable to remove an alarm can within the body of the test. Operations should have input into and review of these test as they are written or revised to improve their flow and overall impact on CCR.
0009393 System: RCS Tag Number: N/A	Technical Question: Reactor Coolant System (RCS) Crossover leg rupture restraints (both horizontal and vertical) were modified during the SGR outage by eliminating the shim package and reinstalling the restraint with some of the bolts not being reinstalled (essentially Abandon-In-Place) ((FMX-00-5249-A). These restraints identified as LP21-RA and LP21-RB for SG-21 RCS crossover leg were modified on all SG RCS. The support numbers are identical except LP-21 for SG-21 is LP-22 for SG-22 etc. The safety evaluation (IP2-SGR-SE-06) indicates that the restraints can be eliminated based on analysis. These restraints are currently scheduled for VT-3 inspection under the ASME Section XI program. Article IWF-2220 requires inspection of corrected or modified supports unless the owner determines unnecessary by evaluation. Since these supports are essentially Abandoned-In-Place and because of ALARA can the currently scheduled inspections be determined unnecessary and this CR referenced? This inspection is currently scheduled to be performed prior to exceeding 200 degrees F. Recommend that this CR be assigned to [REDACTED] of Engineering and [REDACTED] of the ISI group.
009394 System: MSCL Tag Number: N/A	This CR was written by SSFA 2000 Inspector [REDACTED] (phone [REDACTED]) During a SSFA 2000 plant walkdown, the inner fire door/ventilation bound door on the Turbine EI 53' facing the CCR access was found with a broken handle. The handle was found laying on the floor against the opposite inner door in order to block the door from closing. It was noted that these doors are ventilation boundaries for the TSC and to notify Emergency Planning if the doors were not operable
009395 System: CVCS Tag Number: 23CHP	23 Charging Pump seal return piping has two leaks at the threaded fittings on both ends of the 2" pipe directly below the charging pump seal housing. The pipe is threaded to elbows on both sides. Boron accumulations are present below both of the fitting connections. Line number is not given on reference dwg. 9321-2728-37.
009396 System: FP Tag Number: FEXT-433	This CR was written by SSFA 2000 Inspector [REDACTED] (phone [REDACTED]) The fire protection valves located in the Maintenance Conference Room Unit 1 Screen House where the SSFA 2000 inspection is staged are leaking. One appears to be a valve stem packing leak and the other is a disk-globe leak. These leaks are approximately one drop per minute. Measures were taken to contain the leaks. The only identification on one valve is "FP 76 PRESS REG INLET STOP". The other valve does not have a tag. Fire extinguisher station 433 is located in the same room as the SW Conference Room for location purposes.
09397 System: DC Tag Number: EGA2	22 Static Inverter Frequency is 60.31 Hertz this exceeds the Maximum of 60.3 Hertz, investigate adjust/repair as required. This CR was written at the request of the Shift Manager and noted on DSR-20 This condition should be regarded as important and be highlighted for proper station priority
09398 System: EDG Tag Number: 23FOTP	23 Fuel Oil Transfer pump packing gland has excessive leakage when in service causing oil to weep out of the inspection covers onto the pump pedestal, adjust gland as required. The gland was not adjusted by Operations due to the adjustment possibility affecting the pumps vibration per the Shift Manager. This condition should be given the proper station priority and repaired ASAP.
9399 System: N/A Tag Number: N/A	Station Aux Transformer gate ground strap is broken off at the clamp this is a safety issue and should be replaced ASAP.
9400 System: LO Tag Number: LON	21 Main Lube oil cooler west endbell is leaking excessively and is becoming an Operator burden. The pads must be changed twice a shift to keep up with the leakage, repair as required(The leak has gotten worse in the last 24 hours).
9401	This CR is being written to supplement Bob Trombetta's CR 200009316 that did not contain

System: N/A TagNumber: N/A	a condition description VT-3 inspection of support 48-H-1 on line 48-2*BFD identified an unsat condition. The hanger rod is threaded through the top of the spring can and this condition leaves only 5/16" between the hanger rod and the top of the spring assembly, thereby restricting support movement No tag was hung
200009402 System: HYAC TagNumber: AIT-5092	During 0800 hr rounds on November 24, 2000, found the optical sensor alarms for NH3 Channel 1. NH3 Channel 2. CL2 Channel 2 alarmed and the alarms would not reset. There appears on the flowmeters to be enough flow that the sensors should not be alarmed. The sensor for CL2 Channel 1 is not alarmed.
200009403 System: RCS TagNumber: 21RV	The male flange upper seal seating surface on conoseal #97 has a dimple raised up approx 1/32" away from the seating surface. The male flange lower seal seating surface on conoseal #72 has an area of pitting approx 1/64" depressions.
200009404 System: FP TagNumber: DFP	Pt-M40 diesel fire pump test was performed with the following adverse conditions that need to be addressed. the data logger program and ptm-40 pump bearing references (A&B) are reversed. This could invalidate trending. The actual field point on the pump inboard bearing does not have a target sticker to ensure uniformity of instrument placement for bearing vibration and temperature readings.
200009405 System: MS TagNumber: 4EX-29-10	PIPING BEYOND THE 15'-8" CUT LINE IS BADLY CORRODED INTERNALLY. WHILE PREPARING EXISTING PIPE FOR WELDING THE GRINDER WENT THROUGH THE WALL OF THE EXISTING PIPE.
200009406 System: N/A TagNumber: N/A	PT-M98 (Gaseous Effluent Radiation Monitor Check Source) entered its surveillance grace period.
200009407 System: RCS TagNumber: LT-462	During performance of PCR3-1 (Pressurizer level Calibration) I&C performed specific valve manipulation per their procedure. However PCR3-1 does not take into account that it also drains the reference leg for LT-462 (Pressurizer Cold Cal). At this point in the test the CCR lost Pressurizer Cold Cal Indication on both panel SAF and Proteus point L6041, (falling high.). Upon completion of this test no provision is made to restore the reference leg for LT-462. PCR3-1 also does not inform the test tech nor CCR that this level will be lost. This test needs to be reviewed by I&C and operations before it is used again. Unnecessary loss of Indication may be avoided in the future by a different valve line up. In addition proper planning could have personnel available to restore LT-462 as per operations SOP-1.1.1 attachment and or SOP-1 1 attachment 4. This should also be reflected on the schedule.
200009408 System: FW TagNumber: N/A	This Condition Report is being initiated to document the following conditions, that were noted during a VT-3 inspection of Support# HBF-2, on FW Line# 6, of S.G.# 22. This inspection was performed using Drwg.# 1976M6550. 1) Excessive tape on the upper threaded portion of rod item# 8 2) item# 3 is missing @ integral pipe attachment. 3) Nut, at bottom rod to integral pipe attachment bolt, is tightened to the end of the bolt threads but doesn't make contact with pipe lug. The jam nut is also missing. Note: Cold sat will need to be verified after system is filled. Please assign to [redacted] of SGR, for review.
200009409 System: DC TagNumber: TST-PT-M22A	PT-M22A, Spare Station batteries monthly surveillance test has failed again due to low specific gravities and low cell voltages. This test fails repeatedly as reported in CR's 199808062, 199808958, 199900103, 199907654, 199909057, 200002080 & 200005856 and in WO's 97-89532, 99-05946, 99-11489 & 99-12932. Despite several recommendations included in these CR's and WO's all the conditions still exist that prompted these reports in the first place
200009410 System: SW TagNumber: ICPM-0408	CR written for [redacted] I&C technicians During performance of ICPM-0408 (00-18534) the following conditions were noted Device 28-LCIR was as found by more than 3 times the stated tolerance. as left sat Device 28-T7 as found 4.6 sec, required 5.0. Tolerance for this device is -5/-0, unclear on requirements to document setpoint as found. As left sat Device 28-T4 as found 58 min required 60 Tolerance for this device +6/-0, unclear on requirements to document setpoint as found. As left sat Device 28-T2 as found 115 sec, required 120 Tolerance for this device is +12/-0 unclear on requirements to document setpoint as found. As left sat
200009411 System: RMS TagNumber: ARM-2	While performing PT-D4, which is the daily operational checks of the Area Radiation Monitors in the Unit 1 NSB and CSB I observed the meter for ARM-2 in the Pedestrian Tunnel moving erratically. The needle moves from 0.15mr up to 0.2mr and occasionally it moves low enough to turn the amber light off. The amber light on is part of the daily check. The reading in the Central Control Room behaves in the same manner. These ARM's are required by Unit 1 Tech Specs.
200009412 System: N/A TagNumber: N/A	The following unsatisfactory conditions were noted during a VT-3 examination of PWR 110, on Line# 48, for SG-24. This examination was performed using DWG# 9110. Please see attached Visual Examination Data Sheet for the condition description.

<p>200009413 System: FW TagNumber: 22SG</p>	<p>This Condition Report is being issued to document the following conditions, noted while performing a VT-3 inspection of the S.G.# 22 Support Shoes, to include the back keeper bars. This inspection was performed using SGT Work Package# 3050B, attach.# 2, 3, 7 &amp; 18. 1) Excessive gaps, between the keeper bars and the support shoes of .298", .295", .292" and .293" at points# 22-3-4, 22-3-3, 22-4-3 and 22-4-4, resp. Maximum allowed gap is .285". Please assign to [redacted] of SGR, for review.</p>
<p>200009414 System: AFW TagNumber: CT-764</p>	<p>It was discovered that a CT-764 which is the bypass of lcv-1158 was listed as a locked valve on col 21.3. and not on the safeguards locked valve list as per col 10.0 . This prevented the surveillance of this valve as per the periodicity of col 10.0.</p>
<p>200009415 System: FW TagNumber: FWN</p>	<p>This Condition Report is to document that Modification SGR-00-12405-M for the Long Loop Recirculation System, is not functioning as originally designed. The design of the system is to recirculate 6000 GPM through a filter, demineralizer beds and back to 23 Condenser. The system also has a Pressure Reducing Valve (PCV-7916) that is designed to reduce system pressure from approximately 580 PSIG to 95 PSIG and a Back Pressure Regulator Valve (PCV-7916-1) that will maintain approximately 5 PSIG downstream of the demineralizer beds. During initial startup of the Long Loop Recirculation System, we were unable to maintain 95 PSIG downstream of PCV-7916, due to pressure fluctuations of 10 PSIG that caused the system relief valve to lift (set for 100 PSIG). The setpoint for PCV-7916 was lowered to 80 PSIG. While attempting to raise system flow rate from 3000 GPM to 6000 GPM, excessive vibrations on the piping and controllers was experienced. Due to the vibrations the controller setpoints vibrated upscale, which raised the downstream pressure and resulted in lifting of the system relief valve, manual control of PCV-7916 was taken and system pressure was reduced. The system vibrations also caused PCV-7916-1 controller setpoint to vibrate upscale and raised the backpressure form approximately 5 PSIG to approximately 35 -40 PSIG. The Long Loop Recirculation System flowrate was reduced back to 3000 GPM and vibrations decreased. These changes in system operation also resulted in the need to generate three Temporary Procedure Changes against the System Operating Procedure, SOP 20.2.1.</p>
<p>200009416 System: CW TagNumber: 21AWBI</p>	<p>Discovered 21A waterbox inlet manways (upper &amp; lower) with not all the bolts fastened. The lower manway had only the two top bolts fastened. Reason for waterbox manway doors not fastened unknown.</p>
<p>200009417 System: DC TagNumber: 1-V108A/BATTCHG24</p>	<p>This CR was written by SSFA 2000 Inspector [redacted] (phone [redacted]) CONDITION STATEMENT 125 VDC Battery 24 modification was installed to monitor battery terminal voltage which is described in Operations Procedures and the FSAR, is not properly documented on electrical documents. REQUIREMENTS 1 - Electrical Drawing 9321-LL-3134-10 indicates that the Bus 24 DC Trouble alarm on Panel SFK is, among other items, caused by a low Battery 24 terminal voltage condition via relay 27/Batt 24. 2 - Electrical Vendor drawing 025D13801-B2 reflects Electrical Drawing 9321-LL-3134-10 for the Bus 24 Trouble Alarm. However, relay coil 27/Batt terminate on pins 100 and 101. 3 - 2 - Electrical Vendor drawing 011D13800-B2 confirms Electrical Drawing 025D13801-B2 for the Bus 24 Trouble Alarm. However, relay coil 27/Batt terminate on terminal pins 100 and 101 labeled Battery U.V. 4. - FSAR Section 8 states "Improved status indication of the battery chargers and the direct current system has been provided by segregating the battery charger alarms into four ground alarms and by providing four DC bus trouble alarms, which include an input for low battery terminal voltage" 5 - ARP SKF Rev. 14 Window 2-2 24 DC BUS TROUBLE indicates the 27/Batt relay is an input to the alarm. 6 - 10CFR 50 Appendix B III. Design Control states "Measures shall be established to assure that applicable regulatory requirements and the design basis, as defined in §50.2 and as specified in the license application, for those structures, systems, and components to which this appendix applies are correctly translated into specifications, drawings, procedures, and instructions." DISCUSSION AND OBSERVATIONS The above Requirements 1, 2, 3, 4 &amp; 5 describe the installation of the under-voltage relay. During the 125 VDC SSFA Walkdown of Battery Charger 24, SSFA Inspector and the CRS it was noted that on Drawing A206900-22 terminals for what would be 100 and 101 on Battery 24 terminal sensing voltage for relay 27/Batt indicate SPARE. The terminal board was inspected and cables tagged EDB2 EDAA3 01 was connected to terminals 100 and 101. Drawing A206900-22 was verified with Document Control that it was the latest "as built" available approved document. Due to Battery Charger 24 being in service, a hand-over-hand of the cable could not be made and it could not be concluded as to where the cable was routed. A quick check was made on the Battery Charger 23 for 27/Batt relay and it appears the same condition existed as outlined above. Batteries 21 and 22 were not checked but are suspected of the same deficiency. Requirement 6 defines the necessity of maintaining the drawings current to maintain the design basis of the 125 VDC Battery 24 and associated alarms as described in the FSAR. SHORT TERM RECOMMENDATION Determine what mechanism installed the 27/batt relay determine the apparent cause. Determine if the same deficiencies exist for Batteries 21, 22 and 23. LONG TERM RECOMMENDATION Revise the appropriate documents to reflect the AS BUILT conditions of the plant as required in Requirement 6.</p>

200009418 System: SEC TagNumber: N/A	Exit Card-reader for the Main door to the 15' Aux. Boiler Feedpump Bldg. is now also inoperable in addition to the entry Card-reader. Inoperable access control components may hamper/ slow start-up efforts in the A.B.F.B.
200009419 System: CM TagNumber: 21MPC	21 MPC hoist is making an unusual noise. 21 MPC thyristor drive system is surging and tripping out.
200009420 System: SA TagNumber: 11SADD	During support facility rounds, it was once again observed that the D/P across the dryer skid was 7 psig. This D/P existed with either tower being in service. Verified that purge flow was at 40 psig and d/p did not change. This condition was reported before in the referenced CR. Request condition be investigated and corrected.
200009421 System: FP TagNumber: FP-828	PAB roof fire hose cabinet hasp is broken. The cabinet can not be locked but the doors do stay closed.
200009422 System: RMS TagNumber: RR-43-44-1	CCR CHART RECORDER T-121 (DEVICE # RR-43-44-1) FOR R-43 PLANT VENT PARTICULATE; THE TAKE UP REEL DOES NOT KEEP TENSION ON THE CHART. This requires the chart be manually wound up frequently. This is a Westronics Series 12, Model T4N.
200009423 System: CYW TagNumber: N/A	While applying tagout 14061 to city water for valve JW-5 repair, it was not expected in the planning package that the Maintenance and Outage Building would be lost. I recalled during the construction of the MOB that the city water supply came from the 16" city water header by the Emergency Diesel Generator building. It was thought that valve MW-510 was the supply to the MOB but we partially cleared the tagout and left MW-510 closed and water was restored to the MOB.
200009424 System: DOCK TagNumber: CL-538	CL-538 is leaking from it's threaded joints. Repair and/or replace valve.
200009425 System: DOCK TagNumber: N/A	The common line that comes off the outlet of CL-537 and CL-538, 11 & 12 CLP pumps discharge reliefs, is leaking from the flange under the tanks. This flange is on the portion of the line just prior to it going back up to the inlet of 12 hypo tank. Secured 12 CLP and isolated pump. Request flange be fixed.
200009426 System: DOCK TagNumber: N/A	This CR is to ask a technical question on the Hypochlorite system. The question is as follows #12 hypochlorite has been declared as 'condemned' and is not to receive any hypochlorite. However the relief outlets from 11 & 12 CLP (service water chlorination) and from 12-CLP-RW (river water chlorination) only go back to 12 tank. If 12 tank is not to receive any fluids then how can we operate these pumps knowing that these reliefs go back to this tank. Also when starting 11 or 12 CLP pumps we use the manual operator on the reliefs in order to vent the pumps off. So if 12 tank is out of service, can we still run the service water chlorination without sending the output of these reliefs to 11 tank? Request this issue be investigated and determine if situation is okay.
200009427 System: FP TagNumber: FP-880	FP-880. LP Hydrant isolation to Hydrants LP-C & LP-D, is operated via reachrod in the ground. The guide tube leading from the surface to the top of the valve operator has shifted. This has caused a tight fit around the valve operator. At this time only one of Operations reach rods will work on this valve due to the tight clearances (the solid reach rod). The tube is also remaining filled with water instead of draining off, this may cause a problem with corrosion in the future.
200009428 System: FW TagNumber: LT-5002	Gauge oscillates continuously between low range and pegged high.

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Below is a list of 38 CRs' created in the last 24 hours. (1/10/01 8:26:29 AM to 1/11/01 8:26:29 AM)

Condition Number	Condition Description
200100282 System: 440V TagNumber: MCC10Z-1B	<p>While performing a tagout for cathodic protection, it was noted that there was a discrepancy between the print and the field. This is a duplicate of CR 199908736. However it was not stated in the other CR that the fuses shown on print 244016 for MCC10Z-1B do not exist in the field. This breaker compartment is bolted closed with a door to the fuses. There are no fuses in the fuse holders. It is possible that the fuses were bypassed or that this breaker does not supply any power. The breaker was found in the closed position. I checked with record management for any DMO's on this print. There were none. Please investigate.</p>
200100283 System: N/A TagNumber: N/A	<p>Background: During preparation of several modifications to support the IP2 Chemistry Sampling System upgrades I was required to have data entered into the Wiring and Raceway System (WARS) and Tag Numbering Management System (TNMS). Problems: 1) Presently the Design Engineering Procedures, OP-290 series, do not provide procedural guidance for updating the WARS and only provide verbiage to update the TNMS databases. 2) There are only a few Con Ed WARS and TNMS Database Managers who have the technical knowledge and password access to allow database updates. 3) Training for WARS and TNMS do not comply with the Systematic Approach to Training. 4) Qualification Guide ESP-11, Knowledge Objective 11.29 "Describe the various databases that need to be consulted or updated during and after preparation of a plant modification. Include Design Engineers responsibilities for TNMS, WARS and SPIN". The references for this knowledge objective do not contain information on WARS and TNMS database updates. Recommendations: 1) Develop configuration management procedures to ensure adequate direction for TNMS and WARS updates are provided to the "Responsible Engineer". This task should be discussed with the Modification Optimization Team. 2) ESP CRC appoint appropriate Subject Matter Experts to perform Job Task Analysis for TNMS and WARS database management. 3) Base upon the JTA, ESP CRC/SME's determine the knowledge, skills and abilities (KSA) for a user and database manager training program. 4) Line Management determine who and how many individuals should be trained and qualified for TNMS and WARS database management. 5) Technical Training Design, Develop, Implement and Evaluate a training program for TNMS database management. 6) Technical Training Design, Develop, Implement and Evaluate a training program for WARS database management. 7) Technical Training revise Qualification Guide ESP-11 and/or develop new Qualification Guides for TNMS and WARS database management. 8) Technical Training develop and include TNMS and WARS user training for all Engineering Incumbents in the Fundamentals Program. Development of a new training program and qualification guide is important to the station to ensure quality consistency of database management for WARS and TNMS. Development of appropriate configuration management procedures will ensure the databases within IP2 are properly maintained.</p>
200100284 System: N/A TagNumber: N/A	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Operations Training Section with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. During ConEd's presentation of the recovery plan for the August 31, 1999 event, commitment RA-99-180-C05 was made to the NRC. This commitment was reiterated in NRC letter to ConEd RA-99-180-C05, dated October 5, 1999. NRC Commitment RA-99-180-C05 reads: "Integrate Rapid Response Team formation into Operator Training." A lesson plan or training module which implements NRC commitment RA-99-180-C05 could not be identified. RECOMMENDATION: It is recommended that the Operations Training Section review the material in the Operator Training Program to identify the applicable module(s) and lesson plan(s) and verify that course content adequately addresses the issues described in NRC Commitment RA-99-180-C05. If Licensed Operator Training does not satisfy the NRC commitment either: 1) the appropriate module(s) should be revised, or 2) or a revision to the NRC commitment should be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.</p>
200100285 System: N/A TagNumber: N/A	<p>Condition Report written 11:09 PM, 01/09/01 contained potential safeguards information.</p>
200100286	<p>During a review of all OAD's a total of 17 discrepancies were noted. Some of these have communications to staff submitted</p>

<p>System: N/A TagNumber: N/A</p>	<p>for quite some time. These discrepancies need to be addressed so that WE can demonstrate that WE do business the way WE say WE are going to do business. I will be available personally to discuss resolving these discrepancies and will expect to be contacted.</p>
<p>200100287 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Operations Training Section with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. During ConEd's presentation of the recovery plan for the August 31, 1999 event, commitment RA-99-180-C07 was made to the NRC. This commitment was reiterated in NRC letter to ConEd RA-99-180, dated October 5, 1999. NRC Commitment RA-99-180-C07 reads: "Utilize Field Support Supervisor in Training as they would be used in an actual event." A lesson plan or training module which implements NRC commitment RA-99-180-C07 could not be identified. RECOMMENDATION: It is recommended that the Operations Training Section review the material in the Operator Training Program to identify the applicable module(s) and lesson plan(s) and verify that course content adequately addresses the issues described in NRC Commitment RA-99-180-C07. If Licensed Operator Training does not satisfy NRC commitment either: 1) the appropriate module(s) should be revised, or 2) or a revision to the NRC commitment should be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.</p>
<p>200100288 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Operations Training Section with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. During ConEd's presentation of the recovery plan for the August 31, 1999 event, commitment RA-99-180-C38 was made to the NRC. This commitment was reiterated in NRC letter to ConEd RA-99-180, dated October 5, 1999. NRC Commitment RA-99-180-C38 reads: "Train Facilities Support Supervisor (FSS) and Senior Reactor Operators (SRO) in Shift Manager (SM) Emergency Plan (EP) duties: rotate all SROs into EP roles during simulator scenarios; provide EP training for all SROs; provide training on SM role during the first hour of the EP event; utilize the FSS in simulator scenarios as they would be used in the plant." A lesson plan or training module which implements NRC commitment RA-99-180-C38 could not be identified. RECOMMENDATION: It is recommended that the Operations Training Section review the material in the Operator Training Program to identify the applicable module(s) and lesson plan(s) and verify that course content adequately addresses the issues described in NRC Commitment RA-99-180-C38. If Licensed Operator Training does not satisfy NRC commitment either: 1) the appropriate module(s) should be revised, or 2) or a revision to the NRC commitment should be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.</p>
<p>200100289 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Operations Training Section with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. During ConEd's presentation of the recovery plan for the August 31, 1999 event, commitment RA-99-180-C39 was made to the NRC. This commitment was reiterated in NRC letter to ConEd RA-99-180, dated October 5, 1999. NRC Commitment RA-99-180-C39 reads: "Train operations personnel on revisions to the EP including: emergency response teams' roles and responsibilities; new Emergency Action Levels (EAL); use of MEANS computer software." A lesson plan or training module which implements NRC commitment RA-99-180-C39 could not be identified. RECOMMENDATION: It is recommended that the Operations Training Section review the material in the Operator Training Program to identify the applicable module(s) and lesson plan(s) and verify that course content adequately addresses the issues described in NRC Commitment RA-99-180-C39. If Licensed Operator Training does not satisfy NRC commitment either: 1) the appropriate module(s) should be revised, or 2) or a revision to the NRC commitment should be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.</p>
<p>200100290 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Operations Training Section with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. During ConEd's</p>

presentation of the recovery plan for the August 31, 1999 event, commitment RA-99-180-C42 was made to the NRC. This commitment was reiterated in NRC letter to ConEd RA-99-180, dated October 5, 1999. NRC Commitment RA-99-180-C42 reads: Provide operator training on: cool down without waste gas compressors; battery theory/DC distribution system. NRC commitment RA-99-180-C42 is partially satisfied via actions tracked in CRS 1999006643. An ICA was written to Operations Training ( ) to review battery fundamentals with licensed operators. This ICA was closed on 10/06/99 by including battery fundamentals in the internal operating experience report (IOER) provided to operations as required reading. This required reading was issued on 10/01/99 and was to be completed before startup. Additionally, a simulator scenario capturing the 8/31/99 event has been developed that includes battery response and the selection of loads to shed. It was scheduled for inclusion in Cycle 6 of licensed operator continued training (Nov-Dec 1999). A lesson plan or training module which implements verification of operator training on cool down without waste gas compressors and the DC distribution system, remains to be identified. RECOMMENDATION: It is recommended that the Operations Training Section review the material in the Operator Training Program to identify the applicable module(s) and lesson plan(s) and verify that course content adequately addresses the issues described in NRC Commitment RA-99-180-C42. If Licensed Operator Training does not satisfy NRC commitment either: 1) the appropriate module(s) should be revised, or 2) or a revision to the NRC commitment should be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.

200100281  
System: GT  
TagNumber: GT1

GT1 lube oil filler cover appears to be leaking from the cover. Tag number on the filler is GT1-LOF however PPMIS would not accept that tag number. This should be corrected prior to running the unit.

200100282  
System: FW  
TagNumber: FWA

Condition Report 200003486 was closed inappropriately and without providing sufficient documentation. There were a number of deficiencies with regard to the closeout. These are as follows: 1. There was a lack of depth in the review of the potential issue. 2. There was a misinterpretation of the types of failures that must be considered when performing UFSAR accident analyses. 3. There was no communication with the originator to determine the basis for the original CR and to discuss the suggested closeout. 4. There was an incorrect assumption about the ability of the OT and OP delta T trips to protect the core for rapid transients. 5. There was no review of industry experience as was recommended by the original CR. Specifically: 1. There is no discussion in the closeout about any communications with Westinghouse, the vendor who performs these analyses, to get their review of the issues raised in the CR. 2. There is no a priori justification to rule out the failure of manual valves as an initiator of a UFSAR accident scenario (in this case a reduction in feedwater enthalpy). There are many valves whose failure (to open, close or block the line) that could result in bypassing one feedwater heater or a string of feedwater heaters. There are a number of potential paths that only bypass one heater that could reduce the feedwater temperature by more than the 10 degrees assumed in the analysis which would make the analysis non-conservative. The list of valves includes the following: CD-11, CD-12 (Drawing 9321-F-2018) CD-16, CD-16-1, CD-16-2, CD-17, CD-17-1, CD-17-2, CD-18, CD-18-1, CD-18-2, CD-19, CD-20 (Drawing A235307) BFD-3, BFD-4, BFD-3-1, BFD-4-1, BFD-3-2, BFD-4-2, BFD-8, BFD-9 (Drawing 9321-F-2019). 3. In the original review, no documentation could be found for the 10 degree delta T assumption in the UFSAR. The closeout does not give documentation for the 10 degree and only states that this number "does not appear to be questionable". 4. The statement in the UFSAR that the OT and OP delta T trips prevent any power increase that could lead to a DNBR that is less than the DNBR limit is based on the fact that a 10 degree reduction in feedwater temperature would result in a relatively slow transient for which these trips do limit DNBR. A larger decrease in temperature could cause a more rapid transient and a computer analysis would be required to determine if these trips would still prevent a reduction in DNBR below the limit. 5. There have been very severe transients in the industry resulting from reduction in feedwater enthalpy due to bypassing feedwater heaters. These industry transients should have been reviewed before closing out the CR.

200100283  
System: RMS  
TagNumber: R-48

PT-Q75 (Effluent Radiation Monitor R-48 Functional Test) passed its FRD date on 1/6/01 and must be performed prior to declaring the radiation monitor operable.

200100284  
System: OPS  
TagNumber: OPSA

PT-V14 (OPS Analog) & PT-V15 (OPS Logic) tests must be performed prior to placing the OPS system in service.

<p>200100295 System: N/A TagNumber: N/A</p>	<p>Improper Closure of CR # 200005482 The original CR was written to address the safety concern of VC entries when Containment Integrity is required. This CR is being written to address two failures: 1) The original concern was not addressed. 2) Closing out CRs prior to corrective action implementation is a recipe for disaster, and diminishes workers respect for the system. To repeat the original concern: WHEN CONTAINMENT INTEGRITY IS REQUIRED, AND ENTRIES MUST BE MADE INTO THE VC, IF THE 95' AIRLOCK MUST BE USED IN AN EMERGENCY BY THE ENTRY PARTY - THEIR IS NO ONE QUALIFIED TO DO SO. THIS IS A TRAINING AND QUALIFICATION ON OPERATING EQUIPMENT ISSUE. 1) Responses to the original CR varied from how many people can inhabit the VC, how many people can fit through a 31 inch door, lighted exit signs, blah blah blah... NOT RELEVANT! The only response that marginally addressed this issue came from the Station Safety Administrator. SAO 219 was to be revised to have a formal documented pre job brief included, with an IN FIELD demonstration of airlock operation, if requested by the entry party. To date SAO 219 has not been updated, and we all know that at three in the morning, an in field demonstration ain't happening. 2) A CR should NEVER be closed out prior to implementation of Corrective Actions. A containment entry was made on 1/6 to prep for Congresswoman Sue Kelly's visit. At the pre job ALARA brief I was asked if I was able to operate an airlock. My response was, NO. The issue of this CR came up. Present at this briefing were Senior management. The issue was skirted when someone said that instructions for operation were attached to the 95' airlock. OK, I'll bite. Went into VC and proceeded to the 95' airlock. No instructions. No kidding. Upon exit I was told they were INSIDE the airlock. Gee thanks. Closing out identified problems without correction not only can have IMMEDIATE ramifications, it can set up unknowing personnel for future harm.</p>
<p>200100296 System: LO TagNumber: N/A</p>	<p>R4D4 tripped during testing (PT-A13C-Main Lube Oil Reservoir Foam Fire Protection System Test). CR written for tracking. No cause for trip during testing.</p>
<p>200100297 System: GAS TagNumber: HS-48</p>	<p>Sample of the Main Generator for hydrogen dewpoint today was unsatisfactory. Measured dewpoint was +68 degrees f. Action level is greater than +40 degrees f. Reported results to FSS, System Engineer to be notified. Hydrogen dryer is o/s.</p>
<p>200100298 System: CF TagNumber: N/A</p>	<p>MATERIAL LIST ON THE REF. DWG. INDICATES PART NO. 3100 SIZE 2 FOR VARIABLE SUPPORT PSUP2120-H-001. A SIZE 3 CAN WAS SUPPLIED BY THE VENDOR.</p>
<p>200100299 System: COMP TagNumber: COMPA</p>	<p>ERDS computer found to be inoperable during performance of CA-SQ-14.300 "ERDS Operability Test Procedure" which was being executed in preparation for the Quarterly Test to be executed on 1/11/2001.</p>
<p>200100300 System: N/A TagNumber: N/A</p>	<p>Location: dock, steps north side of 23 screen. Date: 01-09-01 at ~ 10:30. An insulator walk down the steps and slipped on the ice at the bottom. She thought it was snow. She tried to stop herself from falling and felt the back muscle pull.</p>
<p>200100301 System: N/A TagNumber: N/A</p>	<p>It is recommended that this condition report be assigned to the Civil Engineering Department with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. Background: Licensee Event Report 1999-012-00 (Transmitted in ConEd letter NL-99-110) Identified design deficiencies associated with fire protection (FP) piping Victaulic couplings which were discovered while conducting engineering/procurement activities. While evaluating the material differences of the proposed replacement couplings, an impact susceptibility concern with the couplings was discovered. Design criteria did not consider impact resistance as a requirement for the PAB FP standpipe system. The PAB FP piping was subsequently evaluated to assess the potential for flooding during a seismic event. Where Victaulic couplings were utilized, the evaluation indicated the flooding concern was limited to one location of the nine evaluated, as a result of high impact loads. The LER committed to the following corrective action (NRC Commitment NL-99-110-C01): "To correct this design deficiency, additional piping supports were installed to limit pipe movement at the affected area. The required modifications were completed within two days of notification of this condition." A search of the Modification Tracking and PPMIS data bases was unable to identify the modification and/or work order packages for these FP piping supports. RECOMMENDATION: It is requested that Civil Engineering identify the appropriate modification documents for the FP piping supports added in response to LER 1999-012-00 and provide this information to Configuration Management so that NRC commitment NL-99-110 can be verified and dispositioned. This is not considered an operability issue.</p>

<p>200100302 System: 480V TagNumber: SIP-2007-006</p>	<p>WHILE PERFORMING PM ON WO#00-16008, THE FOLLOWING UNACCEPTABLES WERE RECORDED, 8.3.1 - A "PHASE" &gt;100 MICROHMS...120 8.3.14C - BREAKER SNAPPED PRIOR TO LATCH 8.3.26A - ARC CHUTE HAS CRACK ON BACK OF CASING 8.3.22A - C "PHASE G-GAP OUT OF SPEC. 8.3.45C - CONTROL RELAY APPEARS TO HAVE A CRACK ON BACK LEFT SIDE, AND A CHIPPED ARC CHUTE.</p>
<p>200100303 System: N/A TagNumber: N/A</p>	<p>ConEd correspondence to the NRC dated June 5, 2000 (NL-00-067) contains the following two commitments. These commitments were previously identified in CR 200004342 which was prioritized as SL-4 and consequently closed to track and trend. It is imperative that this condition report remain open to ensure the timely and effective completion of the commitments. It is therefore recommended that this CR be administratively assigned a Significance Level of 3, and that an FCA for it be assigned to Configuration Management. Commitment NL-00-067-C01 1. Update and/or develop design basis documents to include current design and licensing bases information. (Reference Attachment 1, Section A.4) (Note the referenced section presents a staggered schedule with a final due date of 12/31/2002.) Commitment NL-00-067-C02 2. Verify the accuracy of the FSAR to enhance the availability of the facility design and licensing bases. (Reference Attachment 1, Section A.4) (Due date 3/31/2001.)</p>
<p>200100304 System: N/A TagNumber: N/A</p>	<p>This condition may require implementation of a revision to operator training or a revision to NRC commitments in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Environmental Health and Safety Department with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following discrepancy was discovered. NRC Commitment PD-78-046-C01 was made in a Environmental Protection Plan Report. The commitment reads as follows: "Windsor Farms, like Strawtown Dairy, is located outside of the 15 mrem/yr isodose line, so that a monthly milk sample will be collected from there will beginning in October 1978." Indian Point 2 Technical Specifications and the ODCM currently specify that an annual Land Use Census be taken to determine if any milk producing animals are within the prescribed 5km area and samples taken accordingly. RECOMMENDATION: It is recommended that a revision to the NRC commitment be prepared in accordance with NSLAD-7, Guidance for Managing Commitments. This is not considered an operability issue.</p>
<p>200100305 System: N/A TagNumber: N/A</p>	<p>The 2000, DC System, Safety System Functional Assessment (SSFA) Team identified that critical Engineering calculation analyses (electrical, mechanical and seismic) were either inadequate, could not be retrieved in a reasonable amount of time, or were nonexistent. This same issue was previously identified by the 1999, Auxiliary Feedwater System, SSFA Team as "A Major IP 2 Weakness." Condition Report (CR) Number 200002431 (SL-2) was written to address this issue. Specific recurring examples of the above issue has been identified in the 2000 SSFA, in Condition Report Numbers 200008983, 200008984, 200008990, 200009870, 200009871, 200009872, 200009876, 200009877, 200009882, 200009883, 200009900, 200009908, 200009909, 200009910, 200010004, 200010387, 200010559, 200010560, 200010571. This NQA recommendation provides suggestions, not requirements. The assigned Owner (line management) is responsible for correction as well as actions to prevent recurrence. 1. CR Number 200002431 needs to reference this CR. This CR can then be closed to CR 200002431, however both CRs should reflect that this CR is being closed to CR Number 200002431. 2. Design Engineering needs to assure that the corresponding CRs generated during the 2000 SSFA (listed above) with respect to additional Engineering calculation issues is resolved as part of the resolution of CR Number 200002431. 1/10/01</p>
<p>200100306 System: N/A TagNumber: N/A</p>	<p>The 2000, DC Systems, Safety System Functional Assessment (SSFA) Team identified that in the past two years, disposition of DC System and related Condition Reports (CR) has not always been effective with respect to: 1. Condition Prioritization 2. Adequacy of supporting technical evaluation 3. As well as appropriateness and timeliness of closure. This observation is similar to CR 200002439 (SL-2) identified during the 1999, Auxiliary Feedwater System, SSFA. Examples substantiating this observation: 1. The 1999 SSFA Team identified insufficient evaluation of an AFW Pump Room "Winterization Configuration" ( blocking of inlet louvers with plywood). The CR initiated for this concern had been inappropriately closed. The 2000 SSFA Team identified similar concerns with the blocking of the Cable Spread Room inlet louvers with plywood. 2. A CR initiated during the 1999 SSFA identified issues pertaining to the USI A-48 Program and the use of Seismic Qualification Users Group (SQUG) criteria prior to updating the licensing basis. The SSFA Team determined that that CR was inappropriately closed prior to NRC issuance of the SER. In response to the SSFA Team's concern this year, the station re-opened that CR. 3. During the 2000 SSFA, team reviews of DC System CRs indicated that some failures of the Battery Room Ventilation System, for the past two years, might not have been adequately investigated. The team was thus concerned with the present configuration's ability to adequately control hydrogen concentration when the non-safety</p>

<p>200100307 System: N/A TagNumber: N/A</p>	<p>related battery room HVAC is not available. The team concluded that these failures could challenge the existing compensatory measures under this condition. The Team's concern was not shared by Station System Engineering.</p> <p>The 2000, DC System, SSFA Team identified that the identification and translation of design and licensing basis information into plant configurations, calculations, drawings, operating procedures, and training materials were not always correct, complete, or consistent. NQA's concern is, "Is this below the required level of detail required or is it an issue of not having the details? Some examples include: 1. The effect of degraded AC input voltage to the Battery Chargers as limited by existing degraded voltage setpoints had not been analyzed. To address this concern, during the assessment the vendor performed a successful test of a spare charger at reduced voltage conditions. 2. The design inputs for Station Blackout (SBO) battery loading were not auditable or clearly translated in the associated calculation. The basis for size and timing of loads and consideration of multiple diesel start attempts was questionable; the loads in the SBO calculation did not agree with the calculations associated with battery load studies, battery sizing, or voltage analysis. 3. There was no basis for the questionable lack of internal separation of the voltage sensing and transfer control circuits connected to the preferred and alternate sources for the automatic transfer switches between redundant preferred and alternate 125 Vdc sources. 4. No analysis was retrievable of the effects on redundant DC buses and loads of continual cycling of a DC automatic transfer switch from the preferred to alternate (redundant) source and vice versa. 5. Existing compensatory actions for controlling hydrogen concentration below 2% when battery room HVAC is inoperable were considered inadequate by the team; the station did not agree with this conclusion, but to address the team's concern, the station is changing the compensatory procedures to provide continuous exhaust flow and will prepare an analysis of hydrogen pocketing under conditions of HVAC failure. 6. The operation of the substantially larger capacity cable spreading room/electrical tunnel ventilation exhaust fans results in a reduction of the ventilation of the battery rooms up to and including ventilation failure. The issue of the adverse impact of the electrical tunnel ventilation on the battery room ventilation was also identified in a 1994 audit; however, the impact on hydrogen concentration had not been addressed. 7. A commitment to Generic Letter 91-06 (Generic Issue A-30, Adequacy of Safety-Related DC Power Supplies) to achieve safe shutdown with any one DC source was not substantiated by analysis. 8. The design basis for output current limitations on the battery chargers appeared to be misunderstood with respect to operator training. 1/10/01</p>
<p>200100308 System: N/A TagNumber: N/A</p>	<p>The 2000, DC Systems, SSFA Team identified that there were instances that indicated either potential for bypass of design change control procedures (for example, by performing technical evaluations within a Condition Report rather than within an MSAP or other formal process) or inadequate rigor in the evaluation of the change. Examples include: 1. A 10 CFR 50.59 safety evaluation for the "Winterization configuration" (blocked ventilation louvers) of the Cable Spread Room ventilation system (which interfaces the Battery Room ventilation system) did not exist; this appeared to be a plant-wide issue for "Winterization configuration." 2. For two CRs, the requirement for MSAP evaluations was waived and the evaluation documented solely in the CR; these involved a circuit breaker and a battery cell, based on the part or critical characteristic being "below the level of detail shown on design drawings." The changes involved replacement of a breaker part and changes in the material of a battery case, internal plate support, and cover. The team concluded that the changes appeared technically adequate, but should have been documented via a design control document rather than solely in the CR. The team also concluded that the level of detail shown on design documents was not a valid basis for waiving an MSAP. 3. Repair work to the linkage of an automatic transfer switch may have bypassed the plant modification process; changes to the linkage relative to the original equipment design involved use of a longer screw, an additional nut, and a flat washer. These changes to the design were done under a work order without a modification package. The team concluded that the changes appeared technically adequate, but should have been documented via a design control document rather than solely in the CR. 4. An MSAP for replacement of the DC Ground Detection Circuits did not identify or evaluate changes to critical electrical characteristics such as sensitivity (which was reduced by the change) and device ratings. 01/10/01</p>
<p>200100309 System: FP TagNumber: FPN</p>	<p>Transformer Deluge Fire Detection Panel has a 'printer trouble alarm.'</p>
<p>200100310</p>	<p>A computer outage was planned affecting two IP2 servers (Midya1 &amp; Midya2). An outage email notification was sent to all</p>

System: COMP TagNumber: COMPN	IP2 plant personnel with regards to the servers, systems/applications affected, and duration of the outage. Although IP2 plant personnel were properly informed of the outage, the network support group (downtown IR) was not notified via the WAN/LAN change form of the scheduled outage. Although the failure of the notification was not intentional it was not in accordance with LAN/WAN Change procedure. This CRS is being written for IPCA self-assessment and self track/trend.
200100311 System: MS TagNumber: MS-789	The Primary Air Ejector nozzle flange up stream of MS-789 for 21B (bottom) Steam Jet Air Ejector set is actively leaking steam and water, minor in nature. This could be a source of air leakage, please torque flange or replace gasket as required. Water marks are visible on the flange and surrounding piping.
200100312 System: MS TagNumber: FCV-1155	FCV-1155, HP Turbine Steam header drain valve is passing flow to 23 Condenser with valve in the closed position. This is a long standing item and should be corrected, the valve is located under the HP Turbine.
200100313 System: FW TagNumber: N/A	22 Main Boiler Feed Pump Sealite sleeve is pulled from the connector on the Turbine outboard bearing vibration monitor, west side of pump, repair as required.
200100314 System: OPS TagNumber: OPSA	While performing PT-V14 (Overpressurization Protection System Analog Channels) found step 7.3.17c for channel 1,2, and 4 the " Saturation Temp Margin Approached " alarm did not come up when sliding links were open. However channel 1 came up when decade box was reconnected (step 7.4.4) and channel 2 came up when sliding links were closed (step 7.8.2c) and channel 4 never came up. This is not part of the test criteria and test was SAT as found and as left.
200100315 System: ILWH TagNumber: CT971-FRE	Upon taking the 2000 set of logs found discharge flow chart recorder(CT 971-FRE) reading ~38 GPM, for approximately 2 1/2 hours, immediately following the release of 13 WDST. Also, the distillate integrator counter was advancing, integrator reading following release of 13 WDST was 197390, current reading is now stopped at 202505.
200100316 System: COMP TagNumber: COMPA	The EDDS/ERDS system is currently reporting the wrong time. All parameters being reported each minute are consistent with current plant indications however the time stamp on the page is one hour behind.
200100317 System: N/A TagNumber: N/A	An untrained and unqualified chemistry technician was assigned to restart and make operational the old Dionex Series 8200 On-Line Analyzer (monitors the CPD, HPPW and the former WTP for ionic impurities). A new on-line analyzer is awaiting installation. There is no "X" in this individuals Chemistry Technician Qualification Matrix box for this task, Number 403002. A second untrained and unqualified chemistry technician, who is not even listed on the Qualification Matrix, and is not qualified on a single task, caused the Condensate Salinity High Alarm in the CCR to alarm. Reportedly while he was working on it alone.
200100318 System: RMS TagNumber: FI-1247	While taking rounds I found FI-49 [ 23 S/G B/D sample flow indicator] reading low. The bypass valve used to adjust flow is open full please investigate.
200100319 System: GEN TagNumber: GENN	Hydrogen Cooler #22 south section outlet service water piping on 38" elevation has a through wall leak at weld on line to PI-5002.
200100320 System: FP TagNumber: N/A	During a Simulator Training session @ approximately 7:50 AM a Computer Room Ceiling Smoke Detector alarmed and would not reset.

1. ✕ Back To Top ' List include all CRs closed in the last 24 hours except Employee Concerns Program.

Below is a list of 36 CRs<sup>1</sup> created in the last 24 hours. (1/11/01 9:38:07 AM to 1/12/01 9:38:07 AM)

Condition Number	Condition Description
200100322 System: LGHT TagNumber: LGHTN	While changing lights on 33' unit 1 turbine bldg area noted that 8 fluorescent fixtures in light & power room are inoperative, and 8 standard light fixtures are inoperative in various areas of 33'.
200100323 System: SIS TagNumber: LI-935A	During an Engineering Quality Review, it was noted that, the corrective actions and basis of operability descriptions for Operability Determination 99-036, and associated Condition Reports were considered to be weak since it does not appear that all appropriate issues were discussed. The Operability Determination was written in October 1999 to address drift problems with two Accumulator level transmitters that were occurring over a long period of time (on the order of a year). Accumulator 21 level transmitter LT-935A was noted to be drifting on several occasions and was re-calibrated in March and August of 1999. The Operability Determination corrective action did not completely address why it was out of calibration in a relatively short period of time, or what the corrective action was to address the drifting concern. There was no discussion on any need to increase the calibration frequency or if the amount of drift in the time period was consistent with the instrument uncertainty calculation. The Operability Determination was closed out without identifying if the drifting problem associated with LT-935A was resolved. Condition Report 200010884 written in December 2000, identified a drifting concern with the same transmitter (LT-935A). In the second issue, Accumulator 23 level transmitter LT-935C was noted to be deviating from its redundant transmitter on numerous occasions (at least five times in a year). The problem was attributed to gas binding in a sensing line due to a piping run that did not allow for proper venting of the instrument line. This allows nitrogen gas to be trapped in the line. The ultimate solution was to re-route one of the sensing lines to prevent trapping the gas. However, interim compensatory action until the modification was installed was weak, since it allowed drifting to proceed to the limit of the operator log sheet without discussing if the nature of the suspected drift phenomenon of nitrogen gas accumulation was included as a variable in the uncertainty calculation. The evaluation stated that the allowable instrument error was 15 to 18 percent, and therefore allowed drifting to proceed to the limits identified in the operator log. Further, the response placed reliance on the transmitter that appeared to be working properly to routinely identify a problem with the other transmitter, and did not address potential failures of this transmitter that was not identified with a drift problem. Additional compensation should have been specified in the Operability Determination, such as more frequent venting, until a permanent solution was implemented. A modification was done as part of the corrective action to address this problem.
200100324 System: IA TagNumber: IA-1281	22 Instrument Air dryer dewpoint for monthly test was -21 degrees F. Action level is greater than -30 degrees F. System Engineer to be notified.
200100325 System: N/A TagNumber: N/A	12:26- Received notification of a mechanic with chest pains, dispatched FSS and SM, EMT already dispatched. 12:36- Requested ambulance on site for mechanic who is complaining of chest pains. Notified security. 12:48- Notified by security that [redacted] is on site. 12:52 - Ambulance departed the site. Notified [redacted] to expect the arrival of a non-contaminated individual complaining of chest pains.
200100325 System: N/A TagNumber: N/A	A maintenance mechanic complained of chest pains while doing light work.
200100327 System: RPS TagNumber: N/A	CRS 200010125 identified discrepancies between design drawings and the as-built configuration of the Reactor Protection System. The investigation prompted by this CRS led to the identification of other CRS's that identified similar inconsistencies between design drawings and RPS wiring. A review of the corrective action associated with these CRS's revealed that the CRS actions were typically closed by revising plant drawings to reflect the as found configuration without performing a safety evaluation to determine the impact of the change on the design and licensing basis. In some cases the as-found condition affected the system design as depicted in the UFSAR text and/or figures. A summary of the subject CRS's and associated corrective action follows. The potential impact of these issues on system Operability is addressed under "Conclusions" below. • CRS199803574 identified a discrepancy between the RPS wiring configuration and a description in section 7.2.2.9 of the UFSAR of isolation between safety signals and annunciator and/or computer signals.

Contrary to the UFSAR statement that "The center and front decks (of RPS logic relays) are used for annunciator and computer signals respectively", 22 RPS logic relays were found to violate this criterion. The response to this CRS provided technical justification for a UFSAR wording change to support the as-found configuration. This technical justification included the statement that "The contacts of these (RPS logic) relays involve only one train. Therefore there is no potential for any interaction between redundant safety trains". CRS 199904968 (see below) identified additional RPS wiring that did not conform to design drawings. This as-found condition included contacts from both an "A" train and "B" train RPS relay (P10-2) connected to a common circuit. This configuration appears to invalidate a portion of the justification for allowing computer, annunciator, and RPS logic functions to be wired to a single deck of a RPS relay. • CRS 199902835 identified three distinct discrepancies between plant drawings and the as-built condition. These discrepancies involved: RPS logic relays used to block the "Source Range High Flux at Shutdown" annunciator, drawings showing RPS relay contact configuration different from the as-built condition, and incorrect RPS relay nomenclature on plant drawings. The corrective action for this CRS was limited to revising the affected drawings to agree with the as-found condition. No safety evaluation or review of UFSAR impact was performed. • CRS 199903445 was initiated because the drawing revisions prepared in response to CRS 199902835 (see above) were in error. CRS 199903445 also identified an additional drawing error in which the drawing showed the incorrect RPS relay contacts used for the Source Range High Flux at Shutdown annunciator block. Again, the drawing were revised with no accompanying safety review or UFSAR impact review. • CRS 199904968 identified another discrepancy between design drawings and the as-found configuration of RPS. This discrepancy involved contacts from RPS relay P10-2 that are used to defeat the Source Range Loss of Detector Voltage annunciator above 10% reactor power which are not shown on plant drawings. The corrective action for this CRS involved a field verification of the configuration and revision of the affected drawing to reflect the as-found condition. No safety evaluation or UFSAR impact review was performed even though a re-examination of these corrective actions as part of the SL3 investigation of CRS 200010125 determined that this change has a potential impact on the UFSAR, plant test procedures, and DBO. This SL3 investigation also identified a potential nuclear safety concern with the as-found configuration; however, this is based on a scenario in which a wiring error causes a wrong contact to be connected in the RPS logic circuit. An intensive search for documentation that approved the as-found configuration was unsuccessful in identifying a modification to the affected circuit. • CRS 200007597 identified a number of potential internal wiring related discrepant conditions in the reactor protection racks. Isolated cases of wire routing and/or terminations were observed to be inconsistent with routing/separation requirements stated in the UFSAR. In response to this CRS, Operability Determination 00-018 was issued to address the wiring routing/separation issues. The OD determined that the RPS was Operable. • CRS 200009499 identified additional conditions in which the wiring in the RPS racks violated statements in the UFSAR. The CRS stated that "Wires (in RPS Racks 4 and 5) were carelessly strewn through multiple wire ways" and "Had the original design been followed, there would not only have been no mixing (of circuit functions) there would also be half as many new wires to mix". This issue raised in this CRS were also addressed with Operability Determination 00-018 (See CRS 200007597 above). • CRS 200009641 identified six (6) issues related to RPS wiring deficiencies or discrepancies, three of which were similar to or a repeat of issues identified in previous CRS's. The new issues identified in this CRS include: a wire associated with an NRS power range logic relay with a splice that is not represented on plant drawings, and a single cable containing both 125 VDC logic protection power and 118 VAC instrument bus power. Both of these issues were addressed in Operability Determination 00-018; however, no documentation could be found to confirm that the identified splice was prepared and approved in accordance with applicable procedures. • CRS 200010125 identified errors made on drawings as part of the corrective action for CRS 199904968. It also identified discrepancies between drawings and the as-found RPS wiring that had not been previously identified. The SL3 investigation for this CRS has not yet been approved. Conclusions: The confluence of the issues identified in the CRS's that are summarized above represent design control concerns with the reactor protection system that have not been fully addressed in the responses to the CRS's individually, nor have the implications when considering these CRS's collectively been addressed. A review of these issues has led to the following conclusions: 1. Resolution of discrepancies between as-found plant conditions and design drawings have often been resolved by revising drawing to match the as-found plant condition. These "design changes by default" have been made without the required quality assurance requirements such as design verification or ensuring preservation of the licensing basis through a documented safety evaluation. Although not explicitly stated in the CRS responses, differences between as-built conditions and drawings are assumed to be the result of drawing errors. Discussions with Engineering personnel involved with RPS drawings reveal a lack of confidence that drawings accurately reflect field conditions and difficulty in working with and understanding the information shown on these drawings. 2. Several of the discrepancies identified in the above CRS's appear to have been the result of modifications that were not authorized (i.e. not conducted in accordance with procedures

or regulatory commitments). An extensive search for an approved modification that led to the defeat of the Source Range Loss of Detector Voltage annunciator above P10 was unsuccessful in identifying a modification. This as-found condition was also found to be inconsistent with the Indian Point 3 configuration. Although experienced and knowledgeable personnel have judged these changes to be acceptable, bypassing of the quality assurance requirements for implementing these changes calls into question their validity. 3. The impact of the RPS wiring discrepancies identified in CRS's 200007597, 200009499 and 200009641 has been addressed in Operability Determination 00-018. This operability determination included a detailed and thorough evaluation of the impact of the wire routing and separation discrepancies on each of the five RPS design criteria. However, it was not within the scope of this operability determination to address functional design changes that some of the as-found conditions represent. Instead, it took credit for investigations performed under other CRS's that determined the as-found conditions to be acceptable. However, the scope of these "investigations" was limited to confirming the as-built condition and revising the drawings accordingly. Notwithstanding the limited scope of the previous operability determination, the implication of these issues on Operability of the reactor protection system has been discussed extensively within Design Engineering. Although I (initiator of this CRS) have concerns relative to the Operability and potential nuclear safety impact of these issues, my supervisor has considered these concerns and determined that the identified discrepancies are limited to configuration control (i. e. documentation) issues and involve no Operability or nuclear safety issues. 4. As part of the search for modifications that would explain the as-found configuration of the RPS, other approved modifications were found that affected the same or similar circuits in which discrepancies were found. These modifications were apparently developed based on circuit configurations shown on plant drawings. Because these drawings do not accurately reflect as-built conditions, previous modifications to the RPS circuits may have impacts that were not considered. 5. Conversations with individuals involved in development of RPS testing have confirmed that supplemental testing has been performed to address the as-found conditions described above. Recommendations: Based on the above conclusions, the following corrective actions are recommended: 1. Verify that previous system walkdowns of the RPS collectively provide a high degree of certainty as to the as-built configuration of the system. Conduct additional system walkdowns as necessary. 2. Evaluate each discrepancy between the as-built configuration of the RPS and design documentation and determine whether the design needs to be changed or whether a physical plant change is required. In cases where design changes are required, perform the required design reviews/verifications and safety evaluations. 3. Review each required design document and/or physical change against the licensing basis and make necessary revisions to the UFSAR. (The SL3 investigation of CRS 200010125 has already identified a UFSAR impact). The RPS DBD, test procedures, and system description will also likely require revision. 4. Perform an Operability Determination to supplement Operability Determination 00-018 which has already addressed the wire routing/separation issues associated with the identified discrepancies. This OD should address the functional changes that were not part of an approved modification and approved modifications that may have been impacted by the identified discrepancies. 5. Further evaluate the need for a major overhaul of the RPS drawings to improve readability and accuracy. This initiative appears to be a necessary part of the actions required to prevent recurrence of problems similar to those addressed in this CRS.

200100328  
System: FW  
TagNumber: N/A

During the SG Replacement Project ultrasonic calibration blocks were borrowed from IP-3. At the conclusion of the project Calibration Block # IP-3, which is a 3.5' T X 14" L X 7" W carbon steel block, was identified as contaminated. SGT brought it to the Unit 2 Decon area and was supposed to transport it to Trailer 68 once decon had been completed. After taking the block to decon, it was apparently mislaid. Despite numerous tours of the Unit 1 & 2 decon, storage, and tool rooms the block could not be located. If this block is not located, SGT needs to take steps to procure a replacement block for IP-3. This block may be need for the April outage at IP-3.

200100329  
System: ILWH  
TagNumber: 13 WDST

13 and 14 WDST EMT Chromolox controllers have a history of failures due to control cabinet water intrusion during periods of rain. Water is detrimental to the Chromolox controllers which are composed of solid state/digital components. Replacement of the Chromolox controllers is a short term solution since subsequent rain will again damage the controllers. For a permanent resolution, water intrusion into the control cabinets must be prevented. The following are some of the areas that require enhancement to prevent control cabinet water intrusion: 1. The control cabinet screw clamps that are designed to keep the door tightly closed should be secured at all times to prevent water intrusion via the door seal. 2. The conduits which connect to the control cabinets are rusty at the connections and may allow for water intrusion. 3. The Chromolox controllers do not appear to make a water tight seal protruding through the door. In addition, the Chromolox controller face is removable which may not be designed to prevent water intrusion. All these areas (and more as required) are to be enhanced to prevent water intrusion. Prevention of control cabinet water intrusion should prevent failure of the Chromolox controllers other electrical components existing in the cabinets during periods of rain.

<p>200100330 System: FW TagNumber: N/A</p>	<p>During the SG Replacement Project ultrasonic calibration blocks were borrowed from IP-3. At the conclusion of the project Calibration Block # 86-32550, which is a 5" T X 16.5" L X 7" W carbon steel block, was moved to the SGT warehouse on Kenny Lane, to await delivery to Trailer 88 along with calibration block # IP-3. When the SGT warehouse closed, block # IP-3 still had not been located and SGT requested permission to transport Block 86-32550 to IP-3 Plant Stores. Permission was granted as it was believed the block would be stored more securely back at Indian Point 3. Today, when IP-3 ISI personnel attempted to retrieve the calibration block, IP-3 Stores personnel said that they were not familiar with the block and could not locate it. If the block cannot be located, SGT needs to take steps to procure a replacement block as this block may be needed for the IP-3 spring outage.</p>
<p>200100331 System: N/A TagNumber: N/A</p>	<p>Received a signed employee concern from an Employee Concerns Drop Box. The concern states: Ice buildup presents an unsafe working condition in the Condenser tube pull pit. This is a lay down area for the tube lock scaffold poles, and metal planks. During plant heat up, steam from the Gland Steam Exhaust Pipe condensed on the structural iron frame. This was used for the heat exchanger replacement, forming large icicle. Ice also formed in the pit on the floor and stairway, also on the material stored in the area. On 12/28/00 Williams Power Safety informed the One Stop Shop and the Safety Department of the ice build up. On 12/30/00 we had a snowstorm on top of the ice. Operations informed us that steam would be venting constantly during normal operations. The solution may be to contain and divert the steam over the pit. Or move the lay down area for scaffold to a place where ice build up will not cause a safety concern. (Concern inputted by [REDACTED])</p>
<p>200100332 System: N/A TagNumber: N/A</p>	<p>During resolution of Condition Report 199809226 60 project files were not retrievable by both Records Management resources as well as project engineers. It is recommended that the project engineers reconstitute the project files and send them for project file closeout. The following is a list of the aforementioned project files and their respective revisions. CGX-92-08058-C R4 EGP-91-06786-E R2, R4, R5 FCX-94-10721-C R2, R3 FCX-95-10910-C R0, R1 FCX-96-11572-C R0 FCX-98-12891-C R0 FCX-98-12892-C R0 FCX-98-13078-C R1, R2 FEX-98-11715-E R1 FEX-96-12241-E R0, R1 FEX-97-12808-E R0, R1, R2 FIX-97-12467-I R0 FMX-00-12345-M R0 FMX-93-09273-M R1, R2, R3, R4, R5 FMX-94-10478-M R2 FMX-95-10820-M R1, R2, R3, R4 FMX-95-10912-M R0, R1 FMX-95-11302-M R0 FMX-95-80244-M R0 FMX-97-12451-M R0 FMX-97-12533-M R0, R1 FPX-91-08757-F R2, R3 FPX-95-11385-F R0 FPX-95-11453-F R3 FPX-96-12151-F R1 FPX-96-12169-F R0 FPX-96-82586-F R0 FPX-97-12715-F R1 FPX-97-12746-F R7 FPX-97-12791-E R0, R1 FPX-98-00002-F R0 FPX-98-12833-F R0 FPX-98-12965-F R0 FPX-98-13012-F R0 FPX-98-13073-F R2 FPX-98-83038-F R0</p>
<p>200100333 System: RCS TagNumber: FC-414</p>	<p>CONDITION DESCRIPTION The Setpoint Information Network (SPIN) data field display for the RCS low flow trip bistable As-Left tolerance is given as +/- 2 mv. However, the implementing procedure, PT-Q53, uses a value of +/- 3 mVdc. The tolerance information on the Setpoint Device Data Form (SPDDF) was incorrectly interpreted for the following bistables: 1) Channel I - FC-414; -424; -434; -444 2) Channel II - FC-415; -425; -435; -445 3) Channel III - FC-416; -426; -436; -446 The original SPDDFs do not have As-Left tolerance in signal units (mVdc) but rather in process units ( +/-0.6% of process range, i.e. % flow). This situation is apparently a result of not having readily retrievable scaling calculations for these loops. The SPIN entry person took the nominal +/- 0.5% tolerance specification value and scaled it across an erroneously assumed 400 mVdc bistable span to yield +/- 2 mV. It has been confirmed with Westinghouse that the rack uncertainty for this variable used +/- 3 mVdc as the As-Left tolerance, thus there is no operability concern and the as-installed tolerance as per procedure PT-Q53 is correct. RECOMMENDATIONS Assign this condition report to the Setpoint Control Group for resolution.</p>
<p>200100334 System: N/A TagNumber: N/A</p>	<p>The processing of DOEs should be evaluated to ensure that all the affected documents e. g. vendor manuals, drawings, and OE database changes are being accounted for and correspondingly updated. The process for closeout of DOEs is covered in DE-SQ-12.512 and SAO-405. In Design Engineering, however, a backlog needing review for drawing impacts has accumulated and that backlog is not being addressed. It is expected that the impact on drawings from a DOE standpoint is, in all likelihood, minimal. This issue should nevertheless be addressed. The timely handling of DOE updates in departments responsible for the OE database and the Vendor Manual program should be confirmed to ensure that similar problems don't exist.</p>
<p>200100335 System: N/A TagNumber: N/A</p>	<p>During an Engineering Quality Review, several generic deficiencies were noted with Condition Report responses. The deficiencies appear to be human-performance based and are described as follows. 1. The responses failed to discuss whether the problems have been corrected or how they may have been corrected. 2. The responses do not always address the specific issue. 3. There is, in general, a lack of information provided in the CR responses, which makes it difficult to</p>

	<p>determine what actions were taken. There were fifty-three condition reports reviewed. Of this total, eight were judged Unacceptable and twenty-four were judged Acceptable with Weaknesses. The Engineering Document Quality Review report, to be issued January 12, 2001, provides detailed reviews for all of the CRs. This information should be used to supplement Condition Report response deficiencies identified by others (CAG, etc), and utilized to develop CR-specific training for technical staff.</p>
<p>200100336 System: N/A TagNumber: N/A</p>	<p>During an Engineering Quality Review of Operability Determinations, Safety Evaluations, and Calculations, the following generic weaknesses were noted Operability Determinations Conclusions often have no supporting basis or the basis is not clear or thoroughly presented. Research by the review team was typically required to determine what the design basis was, and why it was not compromised. Safety Evaluations Relevant design bases are often not discussed. Potential consequences and the basis for the safety evaluation conclusion are often not discussed. References that support the conclusion are not always identified. Calculations Design inputs and references are often not identified. Calculation format is not consistent. The Engineering Document Quality Review report, to be issued January 12, 2001, provides detailed document reviews. It is recommended that this information be utilized to develop training for technical staff.</p>
<p>200100337 System: N/A TagNumber: N/A</p>	<p>E-Plan Procedure, IP-1012, Rev. 8 text is missing pertinent information and several words and tasks are inconsistent with descriptions in the FSAR, Section 11 and Health Physics Procedure HP-SQ-3.801, Personnel Decontamination. 1) IP-1012, Rev. 9, Sec. 4.0, Equipment and Material says "NONE" yet the following equipment is specified in the procedure: a) Radiation Protection Plant, Medical Emergency Kit (5.4.1) b) First Aid / Decon Suite (5.4.3) c) Plastic bags for contaminated material (5.4.3.a) d) Dosimeters and TLDs (5.4.3.m, o) e) Radiation Protection Hospital Medical Emergency Kit (5.4.3.o) f) RM-14/HP-210 (5.4.4.a) g) Anti "C" clothing (5.5.2) h) Decontamination Agents in the Decontamination Room (5.6.9) 2) FSAR, Fig. 11.2-6 identifies a Medical Facility consisting of a Decontamination and Examining Room. 3) HP-SQ-3.801, Rev. 14 refers to "decontamination kits" ...and ... "sample collection kits" in the Decontamination Room. 4) IP-1012, Rev. 9, 5.4.3 refers to the "First Aid / Decon Suite" ...5.6.4, 7 and 8 to the "Decontamination Suite" 5) IP-1012, Rev. 9, 6.0 does not refer to HP-SQ-3.801 which is the decontamination procedure which will be used by Health Physics personnel in the Decontamination Room. 6) IP-1012, 5.4.3.b prescribes Form 31a to record an individual's contamination levels, HP-SQ-3.801, 2.7 prescribes Attachment 8.2</p>
<p>200100338 System: LWH TagNumber: LWHN</p>	<p>On 1/28/99, TFC-99-018 was installed to allow for liquid effluent removal with potential PCBs from the Unit 1 annulus sump and north curtain drain. This TFC has been modified via change of scope to allow discharge to various pools as well as the trac truck. This was done to accomodate periods of significant precipitation. The number of modifications made indicates that an operating procedure (SOP perhaps) is in order to govern all possible permutations and proper operations of the system installed by this TFC. This is a very substantial TFC and it has been in place for nearly two years. A procedure is called for as well as permanent system. This TFC as it is now is widely regarded as a permanent plant installation.</p>
<p>200100339 System: COND TagNumber: FCV-1120</p>	<p>THIS IS A TECHNICAL QUESTION. During the "Training" Stand Down associated with the CR 200100048, "Main Turbine Trip On High Steam Generator Level", the following was noted in the Event Response Team Handout; i.e., in "Contributing Factor", Item 1, the Statement is made, "Less than adequate questioning attitude regarding the low main boiler feed pump suction pressure failed to identify the off-normal secondary system condition. (ICA # 9, 12, 13)" ICA #7 (Operations) of the "Procedure Revisions" Section of the Event Report Recommendations, reminded me of a CR that was prepared in 1998 (CR 199806073), addressing specifically, one particular possible operator work-around, but also noting "Manual Operation of FCV-1120" as another possible work-around (See OAD 41). The Manual Operation of FCV-1120 has been mandated, in SOP 20.2, P&amp;L 2.7, since a MOD replaced the valve. See also CR 199806073, page 3 of 10, and 6 of 10, Item 2, for the particulars associated with FCV-1120. This is of particular concern, since FCV-1113, the valve used in conjunction with FCV-1120, was plagued with operational, and material deficiencies, during this Startup.</p>
<p>200100340 System: FP TagNumber: N/A</p>	<p>The inspection of the Vapor Containment Pressure Relief Charcoal filter Solenoid valves SOV-7689 and SOV-7683 under Work Order NP-01-19615 revealed that these valves do not exist. The technicians opened the plenum and observed that the piping down stream of FP-833 enters the plenum and spills then enters the charcoal bed region and does not exit. This condition is contrary to that indicated by drawings DMD227551-AQ as well as A185616-10, which indicate that the valves exist. This is however, consistent with that indicated in drawing 227551 which shows the split of the line. This configuration indicates that water is discharged into the charcoal bed region through two open spray nozzles. There is no drain line associated with this part of the deluge system. Although as indicated above this contradicts the drawings, this condition</p>

does not hinder the operation of the system in any manner. Upon detection and verification of a fire in the Vapor Containment Pressure Relief Charcoal filter the fire brigade will respond by opening the valve FP-595 then ensure that FP-594 is open by manually opening FP-597. This will allow full flow to the affected area. The main solenoid valve FP-833 is open on the pre-alarm and allows water to flow directly to the fire. Without the solenoid valves this happens immediately without need for an additional step to open the discharge solenoid valve. This is an acceptable configuration and has no adverse impact on the system function. However, the test procedure (PT-2Y 6) is written as if the solenoid valves exist. This contributes to the problem with the test procedure outlined in CR 199904107 where the air pressure could not be reestablished following the pre-alarm. With the pre-alarm present FP-833 opens and air discharges to the Vapor Containment Pressure Relief Charcoal filter bed region. The pre-alarm opening the SOV-FP-833 is documented on drawing A185616-10 (D-5). Once the SOV-FP-833 is opened the full flow capability of the system is in effect. Under these conditions it is not reasonable to expect that the air manifold connected to the system at the FP-1226 location is capable of maintaining the system pressurized. Based upon further review of the PMT-08740 it is seen that the hypothesis associated with FP-833 is correct. Once the resistor is removed (Step 14) the pre-alarm is released and the system returns to 80 psig as is evidenced by the signoff on each of these items (Step 15). The return of the system to 80psig without any action other than removing the pre-alarm (closing FP-833) demonstrates that the open SOV is the cause of the procedure conflict. This CRS condition is the result of a weakness in the configuration control system. The drawings and test procedure do not agree with the actual plant configuration. To resolve this it is recommended that the drawings listed above be revised as required to reflect this actual configuration. In addition, the test procedure PT-2Y 6 should be revised to reflect the condition that the solenoid valves do not exist and the system pressure will drop once FP-833 is open. Since this does not impact the operation of the fire suppression system there is no safety concern. The review of this condition does not lead to a conclusion that this problem extends beyond this portion of the deluge system. The system is considered to be fully operational. (This CR and evaluation was prepared by [redacted] of Enercon) This CR should not be assigned as an SL2, but should be assigned back to System Engineering to assign corrective actions. (PJS).

200100341  
System: SIM  
TagNumber: N/A  
THIS IS A SIMULATOR CONDITION. While on IC-07, noted that on panel FD, 22 RCP seal leakoff recorder pen failed low, and that recorder plexiglas cover does not stay shut.

200100342  
System: SIS  
TagNumber: 856B  
Labeling on SB-2 for valves MOV-856B & 856F says 'STOP' for the 'OPEN' position. The procedure referenced calls for the valves to be opened. Please correct labeling as the final solution, in the interim please correct procedure to agree with plant labeling.

200100343  
System: SIS  
TagNumber: PT-922  
Labeling on Pressure Indicators PI-923 & PI-922 does not agree with the actual function of the gauges. These Gauges monitor SI Pump Discharge pressure as indicated: PI 922 - 23 Cold Leg Current label - 21 & 23 Hot Leg Press 21 Cold Leg 23 Hot Leg PI 923 - 22 Cold Leg Current label - 21 & 24 Cold Leg Press 24 Cold Leg 21 Hot Leg Please correct labeling to reflect actual function

200100344  
System: GEN  
TagNumber: N/A  
on 1/12/01 during the midnight shift we received 8 gen. diagnostic trouble alarms in the ccr. Each time when we went to acknowledge the alarm at the fluke points 501-508, 510-518 and 540-546 came up as no measurement..these are stator wedge thermocouples per sop 26.8 rev 7. This a CCR DI. please investigate and repair.

200100345  
System: SW  
TagNumber: TI-7057  
Gauge face is filled with water, all other gauges of this type in the area are dry.

200100348  
System: N/A  
TagNumber: N/A  
During the Training Audit 00-04-A/B, the following Finding (01) was identified. A number of the duties and responsibilities of the Operations Training Records Assistant required by TRAD 203 were not being fulfilled. As a result, some records were not being maintained as required by TRAD 203. Contributing to the above, there was no documentation of training on Station Records Management for the Training Records Assistant in accordance with SAO 521. Discussion: 1) TRAD 203 and SAO 521 describe the duties and responsibilities of the section records custodians (Training Records Assistant) and the training to be given them. The Operations Training Records Assistant received less than adequate training on TRAD 203 and SAO 521 and thus was not familiar with the duties and responsibilities as delineated in TRAD 203. As a result some of the duties and responsibilities delineated in TRAD 203 were not being fulfilled. TRAD 203, Section 3.6, delineates specific Training Records Assistant Responsibilities, among them are: Tracks qualification training documentation that is received

and sends cumulative a monthly report to program training coordinators. Reviews records for completeness prior to filing. Ensures and maintains organized and current filing of training materials and Training Records. Contrary to the above, The operations Training Records Assistant was not tracking qualification training documents and sending a cumulative monthly report to the program training coordinators. Records were not being properly reviewed for completeness. Operations training records were not easily retrievable. 2) TRAD 203 requirements for maintenance of specific Training Records was not met. TRAD 203, Section 4.2.3 and 4.2.5 lists specific requirements for the content of Instructor Training Files and for Contract Instructor Files. Contrary to these requirements, three instructor files did not have the required qualification documents or the file was not found. Additionally, training and qualification documents were incomplete or had missing data. For example, documents were missing the following: signatures or initials, dates, course number, instructor name, and course duration. 3) SAO 521, Section 2.2.2 states that "Managers shall assign one person in their organization to be the Section Records Custodian and ensure as appropriate that Section Records Custodians receive training on the Station Records Management SAO,.... The requirement of SAO 521, Section 2.2.1 was not met. There is no documentation for training on the Station Records Management SAO for both the technical and operations Training Records Assistants. Although there is documented training for the operations Training Records Assistant on the requirements of TRAD 203, this training was ineffective, as indicated by the lack of fulfillment of TRAD 203 requirements and responsibilities. Note that the issues discussed in this finding are repeats of similar deficiencies identified in the previous training audit, namely Finding 1999-04-B-F02 and CR 199908632. Specifically the need for explicit details of the responsibilities and training for Records Assistants and deficiencies in the Instructor Qualification files. The implication is that problems identified in Technical Training are not appropriately evaluated for extent of condition, i.e., the application to Operations Training. Recommended Corrective Action: a) The Training files found deficient, specifically the Instructor Training Files and Contract Instructor Files should be reviewed for completeness and correctness. b) The operations and technical Training Records Assistants should receive thorough training on SAO 521 and TRAD 203 requirements and responsibilities, and this training should be documented. c) Operations Training Records should be reviewed for orderliness and for retrievability. d) Training management should review how training deficiencies are analyzed for extent of condition, particularly how deficiencies identified in one discipline or area are reviewed for applicability to other areas. Technical Training deficiencies should be assessed for applicability to Operations Training and vice-versa.

200100347  
System: N/A  
TagNumber: N/A

This condition report is intended to document conditions noted during observations of IP-2 maintenance and I&C training by a PSE&G Auditor. These observations occurred during the Training Audit 00-04-A/B and were fully discussed with Training personnel and management at that time. During the Circuit Breaker Testing Course : Trainee's identified that training equipment, equipment referenced in a student handout, test parameters and number of test required were different than in the plant. • Personal Protective Equipment was not being worn during training in the lab setting. • Lesson plan material was not covered in sequence or not covered. • Students were given copies of Job Performance Measures that included oral questions with responses. • A Contract instructor was used who was not a Subject Matter Expert. In addition to the observations described above, the following recommendations were made by the PSE&G auditor.. • TRAD 103 should be revised to include instructions in Section 4.6 to require the results (of Instructor Observations) be debriefed with the instructor at the earliest opportunity. • TRAD 103 should be revised to require that comments should be required to support an excellent rating, since excellent denotes performance in a highly effective way. • Due dates should be assigned for Curriculum Review Committee action items, and the status of all items should be reviewed at the next CRC meeting. This would ensure closure of all items. • TRAD 104 should be revised to include direction to give the corrected test back to the trainees and to review all incorrect responses with the trainees. • TRAD 103 requirements that "all learning objectives should be tested by either a written, oral or performance test" should be adhered to.

200100348  
System: HVAC  
TagNumber: 21CCRF

As part of the Engineering Quality Review, Calculation No. FCX-00097-00, "Control Room Air Conditioning", dated 11/03/98 was evaluated and found to contain discrepancies with respect to the UFSAR Sections 7.2 and 9.9. The calculation input data involved variations in design outdoor temperature, air supply fan capacity, reliance on Unit 1, and omitted reference to vendor data for equipment ratings. While providing a reasonable assurance that the desired cooling performance could be achieved for the calculated heat load, it could not be determined if this analysis was the Calculation of Record for the CCR. The calculation indicated there was no modification involved with the analysis or if it supplemented or superseded any previous calculation. This condition report is prepared to reconcile the specified technical differences between the calculation basis and UFSAR. Also needed is a clarification to identify what analyses and documents form the calculations of record for the CRAC system.

200100349 System: N/A TagNumber: N/A	The temperature in the Hitmen Skid room are bordering on freezing. In the past, pipes in the room have exploded because they were frozen. The heaters in the room need to be hooked up to prevent this from happening again.
200100350 System: COMP TagNumber: N/A	Unable to perform a keyword search via 'Crystal Report Viewer' due to a failure of the computer system. This is an ongoing problem which has an adverse affect on answering Condition Reports.
200100351 System: ESFA TagNumber: N/A	As part of the Engineering Quality Review, Calculation No. FMX-00085-01, "RWST Minimum Submergence Level" dated 1/5/98 was reviewed and found to contain technical discrepancies and omitted reference to applicable data contained in the UFSAR. The calculation did not reference design basis pump flows or FSAR information in determining if the RWST suction arrangement would be susceptible to vortexing. There is an unjustified assumption made for the inverted weir arrangement to maintain full pipe flow at lower tank levels. Data used for tank volumes were not referenced by source. The conclusion does not directly relate to the calculation objective to state the minimum acceptable tank level to prevent vortexing. The body of the calculation must be searched to locate this information. This condition report is initiated to resolve these discrepancies, emphasize the need for attention to detail, and provide a clearer conclusion which satisfies the objective. These changes will reinforce the calculation methodology and are not expected to alter the outcome of the existing analysis.
200100352 System: N/A TagNumber: N/A	Chemistry's respirators, that are stored in the 42' conventional lab, had not been inspected nor sanitized for some time. At present, they do not appear on any station procedure or check-list. Maintenance records for these devices are kept in the Doelmeier issue area, and shows that the last time that any of were serviced was February, 2000. Additionally, numerous devices are missing from the inventory. Furthermore, it has been learned that Chemistry has been supplementing the missing inventory by obtaining respirators from the 15' tool room. These undocumented respirators are present in the lab storage area.
200100353 System: 480V TagNumber: SWPA-2050-003	While preparing to swap breakers to perform the PM on 21SWP breaker, it was discovered that the spare breaker was not available for installation in the cubicle due to CM work order NP-00-19302.
200100354 System: BG TagNumber: N/A	Atlantic Westchester (Vendor) was called in to investigate loss of heat found that the fire system panel kept the system from being in service. On 1/10/01 Fire Systems Inc. came on site to install fire notification system to the fire alarms in Energy Education Center and the New Simulator. On completion of the installation the system was returned to service with one exception is that the HVAC units were not reset inside the panel.
200100355 System: N/A TagNumber: N/A	This CR is written, to find out why this job took so long to be scheduled, because, it should have been very simple to do it while the plant was shut down, and now it became a safety issue, we have to deal with radiation dose, heat stress and high noise levels to have this accomplished in 2 or 3 hours, when it could've been accomplished in 1.
200100356 System: N/A TagNumber: N/A	Fire door found open. The piston controlling. The door closure is out of adjustment. The door is near stairway #9 on the 53' elevation in Unit #1.
200100357 System: 480V TagNumber: RHRP-2012-003	During As Found testing of the spare RHR breaker, step 8.3.7 failed. The acceptance criteria for meggering phase to ground is 100 megohms minimum. The readings achieved are 75 megohms for all three phases.

1.  Back To Top  List include all CRs closed in the last 24 hours except Employee Concerns Program.

Below is a list of 15 CRs<sup>1</sup> created in the last 24 hours. (1/12/01 2:09:33 PM to 1/13/01 2:09:33 PM)

Condition Number	Condition Description
200100375 System: FCS TagNumber: RC5A	<p>Per RFE-S-18.022 if power operations occur for . 2 calendar weeks at power less than 85% p and or reduced power operation at power levels less than 95%p is limited to 4000 mwd/mtu. Westinghouse wants to advise operations at reduced power. We have not exceeded two weeks of reduced power operations however for the potential of reaching this guideline Westinghouse and operations were notified.</p>
200100376 System: CVCS TagNumber: 21CIX	<p>The UFSAR contains inaccurate information that cannot be revised until a modification is implemented as described in this CR. Furthermore, IP2 is committed to completing verification of the configuration and plant operations portions of the UFSAR by March 31, 2001. This condition was previously documented in CR 200005095 which was inappropriately closed. It is imperative this condition report tracking this imminent modification and UFSAR change remain open to ensure their timely and effective completion. It is therefore recommended that this CR be administratively assigned a Significance Level of 3, and that an FCA for it be assigned to Design Engineering. BACKGROUND: UFSAR Section 9.2.2.5.1 states "Series operation (of the evaporator feed ion exchanger) is recommended to ensure prevention of breakthrough of cesium in the event of evaporation with 1-percent fuel defects." Boric acid evaporation/recycling is no longer performed at IP2, and most of the equipment has been retired or physically removed from service. Therefore, the UFSAR information is no longer accurate as it related to the evaporation process, although there is still a question about the need for series operation for HUT cleanup. CRS 200003806 was generated to investigate whether or not series operation of the evaporator feed ion exchangers was still required. In addressing the CR, Systems Engineering held discussions with Chemistry. Chemistry noted that the Evaporator Feed Cation Ion Exchangers are no longer used for Recirculation Cleanup of the CVCS HUT, and assigned an action to Operations to revise SOP 3.6, Section 4.3.2 to reflect this in the procedure. Operations rejected this assignment because the Evaporator Feed Ion Exchangers are not retired, and therefore, until a modification is performed to retire or remove the equipment, the SOP would remain as is. In the end, a request for engineering services (RES 12383-00) was generated by Systems Engineering to retire and remove this equipment, and the CR was then closed. Until the proposed modification is implemented, the UFSAR contains information which does not reflect the actual as-built plant, and the SOP contains information which does not reflect the actual as-operated plant. REQUIRED ACTIONS: - Implement modification per RES 12383-00 - Revise affected plant drawings - Revise affected operating procedures (including SOP 3.6) - Revise UFSAR This CRS MUST REMAIN OPEN until the subject modification is implemented, and all plant documentation, including the UFSAR, is updated to reflect this change.</p>
200100377 System: FP TagNumber: SOV-7661	<p>The is to document the repetitive need for doing a hard reset of the PAB fire deluge system for the charcoal filter system. Pab Exhaust outlet 4 was alarmed and would not reset. Ohmic output from PAB4 thermistor was verified as well as the required 28 volts to the solenoid. There was no alarm condition present and alarm would not clear . PAB-4 Control module had the be "bootstrap" restarted by powering down the panel and restoring power. The alarm was then reset by pressing the "stop water" switch on the console which cleared the alarm and the reset the output to the solenoid. This is a repeat activity, from a repeat complaint, and should be researched to see if this is in fact the engineered design as to the function of this particular aspect of the alarm panel. Secondly an alarm response procedure should be implemented to allow the operators to clear this particular alarm without generating a work order each time the alarm comes up.</p>
200100378 System: HVAC TagNumber: N/A	<p>The UFSAR contains inaccurate information that cannot be revised until a modification is implemented as described in this CR. Furthermore, IP2 is committed to completing verification of the configuration and plant operations portions of the UFSAR by March 31, 2001. This condition was previously documented in CR 200007270 which was inappropriately closed. It is imperative this condition report tracking this imminent modification and UFSAR change remain open to ensure their timely and effective completion. It is therefore recommended that this CR be administratively assigned a Significance Level of 3, and that an FCA for it be assigned to Design Engineering. While incorporating UFSAR Change Request 815 into the UFSAR, a discrepancy was discovered. UFSAR Change Request 815 was generated in support of Technical Specification Amendment 208, which removed the limiting conditions of operation of the CCR Toxic Gas monitors from the TS, and added them to the UFSAR (Section 9.9.3 and 9.9.4). The on-line living UFSAR was updated per the UFSAR Change Request, however, while in the process of verifying the statements in the UFSAR Verification Database, it became apparent that plant procedures had not been revised to reflect the removal of the LCOs from the TS. A review of ARP AS-1 (Window 4-7) reveals that the "Technical Specifications/Station Administrative Order" section still refers to TS 3.3.H.3, which is no</p>

	longer applicable. The ARP directs the user to go to AOI 29.13. The AOI does not list LCOs, and in References Section 5.4 (UFSAR) the AOI states that there is no reference to the UFSAR. It does not appear that any controlled plant procedure has been updated to reflect the LCOs of the CCR toxic gas monitors being moved from the TS to the UFSAR, and as such, the statements in the UFSAR can not be verified. RECOMMENDATIONS: Normally, the recommendation would be to update plant procedures to reflect the fact that the Toxic Gas Monitor LCOs are now contained in the UFSAR, not the TS. However, this may not be necessary as safety evaluation 00-529-EV has approved the removal of the toxic gas monitors from service. IF the modification cited in the safety evaluation IS implemented, AND an SAO-139 is generated to remove the discussion from the UFSAR, THEN ensure that all appropriate plant procedures are revised as part of the modification process to reflect the removal of the CCR Toxic Gas Monitors from IP2. IF the modification cited in the safety evaluation to remove the Toxic Gas Monitors from service IS NOT implemented, THEN appropriate plant procedures must be revised to reflect the relocation of the CCR Toxic Gas Monitors from the TS to the UFSAR.
200100379 System: IA TagNumber: 21IADD	while performing PT-M30 found 21 instrument air desiccant dryer in the fixed mode
200100380 System: N/A TagNumber: N/A	OPS PM W12, PMT Review, could not be performed since the the "W" drive report titled "PMT Report" has not been updated since 7/17/00. Either we need to update the report or remove the requirement to perform this Ops PM.
200100381 System: 440V TagNumber: 11RW1-3T	During the restoration of Tagout # 14383 "Unit 1 Dock Rectifier and Supply Breaker PM", 11RW1-3T, the supply breaker for MCC-10M, would not stay in the closed position.
200100382 System: MS TagNumber: MS-883-X4	Steam leak on line to 883-X4 on west side of MSR 21A reheater drain tank. Additionally, the yarway associated with MSR-21A has water leaking out of it.
200100383 System: MS TagNumber: N/A	Received email on 1/12/01 from NQA with additional information regarding water hammer event that occurred on 12/25/00: " I talked to the NPO who wrote this CR, and he said that the entire East header moved. It was loud enough to scare individuals working on 53'. As a result of this water hammer the header moved and struck a hand wheel on a drain valve of one of the HP dumps, and a CR was written as well. I am going to try and find this other CR. I asked the NPO if anybody has talked to him about this condition report and he said, "NO". The original c/r (200010719) did not describe the event in this nature. Rather it noted that we had a water hammer event (no severity noted) and that perhaps some asbestos fell in a few areas. The screening committee closed the c/r to track and trend and asked that the asbestos cleanup be investigated via an RFI. With the new information now available - it would be prudent to try to figure out what caused the water hammer (obviously - this was a larger "hammer" than described on the original c/r). Suggest SL3 for evaluation to the system engineer and FYIs to [redacted] (to note that we did not have enough information in the description of the original c/r to make a good call) and to [redacted]
200100384 System: RMS TagNumber: R-5	During the performance of PT-M10B it was noticed that the drawer label on R-5 has the elevation listed as 45'. This should probably actually be 95'.
200100385 System: COMP TagNumber: N/A	Came into work hoping to get some CRS work done but the reports will not run. Customers are calling CAG wondering how they too, can get work done. Called help desk and left message that we need to reset CITRUS. Suggest SL4 to Computer Apps for track and trend however, we note that this problem is reoccurring and sooner or later we have to improve reliability of this system.
200100386 System: RMS TagNumber: R-7	During the performance of PT-M10B it was found that the retaining clips for the screws holding the drawer closed are missing. The drawer closes, but the screws cannot be screwed in.
200100387	C/R 200007795 appears to have been closed out with less than adequate quality. The original c/r text reads as follows: This

<p>System: N/A TagNumber: N/A</p>	<p>condition may require a Technical Specification Amendment, generation of a procedure, or revision of an NRC commitment in accordance with NSLAD-7, Guidance for Managing Commitments. It is recommended that this condition report be assigned to the Steam Generator Replacement Project with an FYI to NS&amp;L and to the 50.54(f) group. While reviewing IP2 regulatory commitments as part of the Commitment Verification Project, the following issues were identified. Con Ed Correspondence to the NRC dated 4/5/95 (NL-95-040), states: "Consolidated Edison commits to perform post-weld heat treatment of installed laser welded sleeves." (Commitment NL-95-040-C02) NRC Correspondence to Con Ed dated 5/19/95 (RA-95-092), states "Con Ed has committed to the use of postweld heat treatment (PWHT) and to performing additional confirmatory testing to determine the design life of the sleeves and to confirm that leakage detection requirements are met." (Commitment RA-95-092-C01) "Con Ed has committed that for any tube indication in this area [span between sleeves in which there is reduce "fil-factor"], a further inspection will be performed by an alternate technique, such as a surface riding probe, in order to determine the acceptability of the sleeved tube for further service." (Commitment RA-95-092-C04) "In addition, Con Ed has committed that, for any change in the eddy current signature of the sleeve or sleeve/tube joint region, a further inspection will also be performed by an alternate eddy current technique in order to determine the acceptability of the sleeved tube for continued service." (Commitment RA-95-092-C05) Technical Specification 4.13 describes the use of laser welded sleeving for steam generator tube repair, but does not provide the level of detail provided in these above four mentioned commitments. No controlled plant procedures could be located which verifies that these commitments are implemented at IP2. This topic was discussed during the October 6, 2000 meeting of the Steam Generator Management Committee and the sleeving repair method will not be applicable to the replacement steam generators. A Technical Specification change is pending which will remove this option from the IP2 Technical Specifications. RECOMMENDATION: IF the Technical Specification Amendment is approved, THEN this condition report may be closed. IF the Technical Specification Amendment is not approved THEN either GENERATE a procedure which implements the four commitments listed above OR REVISE the NRC commitment in accordance with NSLAD-7, Guidance for Managing Immediate Action: Notified immediate supervisor (redacted), discussed with (redacted) and generated this report. Suggest SL-3 and adequate close out so that this document is a stand alone document with no gaps.</p>
<p>200100388 System: MS TagNumber: LC-1192S</p>	<p>RCL 21A Yarway Level Indicator, LC-1192S has failed high. The Yarway gage is leaking at a drip every 5 seconds.</p>
<p>200100389 System: IACC TagNumber: CC-61-1</p>	<p>22 IA closed cooling suction strainer is leaking. The leak is currently about one drop per minute and it is captured by a container.</p>

1. \*Back To Top \* List include all CRs closed in the last 24 hours except Employee Concerns Program.

# IS - Condition Detail Report

[Click here for the SL Report](#)

Condition Number: 200010719

<u>Occurrence Date</u>	<u>Operability Concern</u>	<u>Location</u>	<u>Detection Method</u>	<u>Significance</u>	<u>Reportable</u>	<u>Tag Number</u>	<u>System</u>	<u>Originator</u>
12/25/2000 08:37:25	Originator: Uncertain Watch: Confirmed No	Turbine	OA	4	No	N/A	MS	[REDACTED]

### Condition Description:

This morning after bypassing the MS-1's, at about 0530 observed water hammer on east main steam header. This resulted in potential asbestos containing material on the south east end of 36' and from MCC 25 to MCC 24 on 15' and the entire tube removal pit.

### Immediate Action:

Control room, SM, FSS informed during water hammer event, bypassed traps open further, monitored for cold traps. Taped off the affected areas.

### Operability Review Note:

The amount of insulation that has fallen is well below the reportable amount for asbestos. All required actions were taken to ensure the area was secured. There are no further issues.

### Narrative:

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<u>IS</u>	<u>Assignor</u>	<u>Assignee</u>	<u>Reviewer</u>	<u>Due Date</u>	<u>Last Update</u>	<u>Date Closed</u>	<u>Status</u>
	[REDACTED]	CRS e-CAPTain	CRS e-CAPTain	12/26/2000	12/26/2000		Open

### Action Requested:

Please Process Condition Report.

### Response:

Per CASC Review, assign to [REDACTED] ( ).

### Reviewer Note: