Entergy

Entergy Nuclear Northeast
Entergy Nuclear Operations, Inc.
Indian Point Energy Center
295 Broadway, Suite 1
P.O. Box 249
Buchanan, NY 10511-0249

December 14, 2001

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 2001-004-00
NL-01-146

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Stop O-P1-17
Washington, DC 20555-0001

Dear Sir:

The attached Licensee Event Report 2001-004-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Sincerely,

Fred Dacimo
Vice President - Operations
Indian Point 2

Attachment

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

Mr. Patrick D. Milano, Senior Project Manager
Project Directorate I-1
Division of Licensing Project Management
U.S. Nuclear Regulatory Commission
Mail Stop O-8-C2
Washington, DC 20555-0001

Senior Resident Inspector
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PO Box 38
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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-1998)

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Indian Point, Unit 2	05000247	1 OF 3

TITLE (4)
Human Performance error resulted in missed Technical Specification requirement.

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
10	15	2001	2001	-004-	00	12	14	2001		05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9)	N
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)

	20.2201(b)		20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
	20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
T. R. Jones, Licensing Engineer	914-734-5190

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO				

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

On October 15, 2001, at approximately 1512 hours with the unit at 100 percent power the Steam Generator Blowdown Flow Instrument [EIIS:WI:FI] (FI-1241) was declared inoperable. Per Technical Specification Section 3.9 and Table 3.9-1, with the number of channels operable less than required by the Minimum Channels Operable requirement, effluent releases via this pathway may continue provided the flow rate is estimated at least once per four hours during actual releases. The Watch Engineer considered the requirements of Technical Specification Section 3.5 and Table 4.1-1 and System Operating Procedure (SOP) 15.1 Heat Balance, both focused on the impact on the heat balance calculation. The Watch Engineer did not consider the requirements of Technical Specification Section 3.9 or Table 3.9-1. The Instrumentation and Control (I&C) Technicians informed the Shift Manager-in-training of the failed surveillance Test. The Shift Manager (SM) on duty delegated signature authority to the Shift Manager-in-training, a qualified Control Room Supervisor. Per Operations Administrative Directive (OAD) 15 Revision 51 Section 4.5.2 the SM is responsible for signing all documentation specifying SM. This responsibility may be delegated to any management Senior Reactor Operator qualified as the Field Support Supervisor, Watch Engineer, SM or Control Room Supervisor. The SM may NOT delegate this responsibility when signature indicates authorization as Emergency Director. The Shift Manager-in-training recognized the impact on heat balance but not on the Technical Specification Section 3.9 and Table 3.9-1. On October 15, 2001, at approximately 2015 hours the oncoming watch crew identified the missed Technical Specification and took the appropriate actions. The four-hour time requirement for estimating flow was missed by approximately 30 minutes. During the time when compensatory actions were not in effect, primary to secondary reactor coolant leakage was zero and no changes to blowdown flow occurred. Based on this, no unmonitored release occurred and the safety significance was determined to be minimal.

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

PLANT AND SYSTEM IDENTIFICATION
Westinghouse 4-Loop Pressurized Water Reactor

EVENT IDENTIFICATION
Human Performance error resulted in missed Technical Specification requirement.

EVENT DATE
October 15, 2001

REFERENCES
Condition Reporting System Number: 200109887

PAST SIMILAR EVENTS

None

EVENT DESCRIPTION

On October 15, 2001, at approximately 1512 hours with the unit at 100 percent power the 21 Steam Generator Blowdown Flow Instrument (FI-1241) was declared inoperable. The inoperability was discovered when Surveillance Test (PT-Q70) Steam Generator Blowdown Flow Functional was completed unsatisfactory due to low power supply voltage. Per Technical Specification Section 3.9 (Radioactive Effluents) and Table 3.9-1 (Radioactive Liquid Effluent Monitoring Instrumentation) with the number of channels operable less than required by the Minimum Channels Operable requirement, effluent releases via this pathway may continue provided the flow rate is estimated at least once per four hours during actual releases. The Watch Engineer considered the requirements of Technical Specification Section 3.5 (Instrumentation Systems) and Table 4.1-1 (Minimum Frequencies for Checks, Calibrations and Tests of Instrument Channels). The Watch Engineer also considered System Operating Procedure (SOP) 15.1 (Heat Balance). Both of these procedures focused on the impact on the heat balance calculation. Based on these procedure sections the Watch determined there was no operability concern. The Watch Engineer failed to recognize the requirements of Technical Specification Section 3.9 and Table 3.9-1.

The Instrumentation and Control (I&C) Technicians informed the Shift Manager-in-training of the failed Surveillance Test. The Shift Manager (SM) on duty delegated signature authority to the Shift Manager-in-training, a qualified Control Room Supervisor. Per Operations Administrative Directive (OAD) 15 Revision 51 Section 4.5.2 the SM is responsible for signing all documentation specifying SM. This responsibility may be delegated to any management Senior Reactor Operator qualified as the Field Support Supervisor, Watch Engineer, SM or Control Room Supervisor. The SM may NOT delegate this responsibility when signature indicates authorization as Emergency Director. The Shift Manager-in-training recognized the impact on heat balance but not on the Technical Specification Section 3.9 and Table 3.9-1. The surveillance paperwork contained a specific reference to Technical Specification Section 3.9. The Shift Manager-in-raining noted that during the first review of the paperwork he failed to note the Technical Specification reference in the surveillance procedure. On October 15, 2001, at approximately 2015 hours the oncoming watch crew identified the missed Technical Specification and took the appropriate actions. The four-hour time requirement for estimating flow was missed by approximately 30 minutes.

The apparent cause of this event was insufficient attention to detail in the review of the failed surveillance procedure by the Shift Manager-in-training. This coupled with an inadequate operability determination performed by the Watch Engineer resulted in a failure to institute compensatory action associated with Technical Specification Section 3.9 and Table 3.9-1 in a timely manner.

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

EVENT ANALYSIS

This event is reportable in accordance with 10CFR50.73(a)(2)(i)(B), which requires a Licensee Event Report (LER) for any operation or condition prohibited by the plant's Technical Specifications except when: 1) The Technical Specification is administrative in nature; 2) The Event consisted solely of a case of a late surveillance test where the oversight was corrected, the test was performed, and the equipment was found to be capable of performing its specified safety functions; or 3) The Technical Specification was revised prior to the discovery of the event such that the operation or condition was no longer prohibited at the time of discovery of the event. Since none of the exceptions were met an LER is required.

Both the Watch Engineer and Shift Manager-in-training reviewed this surveillance test 100 percent independently. The Watch Engineer reviewed this as part of the operability review when Instrumentation and Control (I&C) issued the condition report. The Shift Manager-in-training reviewed the paperwork completed by I&C for signoff on the failed test.

As two Senior Reactor licensed operations personnel had performed an independent review of this surveillance and had the same error (not identifying Technical Specification impact) a review for common cause was performed. Both licensed operators had recently graduated from the same initial license training course. Training reviewed the training material content and determined that Technical Specification Section 3.9 is covered in three classroom lesson plans. No other events associated with this Technical Specification were identified in the condition reporting system.

EVENT SAFETY SIGNIFICANCE

The compensatory action required by Technical Specifications is to estimate blowdown flow (for the failed blowdown line) every four hours. The basis for requiring this device to be operable (pursuant to Technical Specification 3.9.A.2) is to monitor and control, as applicable, the releases of radioactive materials in liquid effluents during actual or potential releases. In this instance, steam generator blowdown flow is measured based on monitoring and control if primary to secondary reactor coolant leakage is present. The compensatory action required if the steam generator blowdown flow meter is inoperable is to estimate flow rates every four hours. The four hour time requirement for estimating flow was missed by approximately 30 minutes. In this instance, primary to secondary reactor coolant leakage was zero. In addition, no changes to blowdown flow occurred during the time period when the compensatory action of flow estimation was required. Based on this, no unmonitored release occurred and the safety significance was determined to be minimal

CORRECTIVE ACTIONS

1) Reviewed the event with the Shift Manager-in-training and Watch Engineer to reinforce expectations for attention to detail.