

October 9, 2002

Mr. Fred Dacimo
Vice President - Operations
Entergy Nuclear Operations, Inc.
Indian Point Nuclear Generating Units 1 & 2
295 Broadway, Suite 1
Post Office Box 249
Buchanan, NY 10511-0249

RI-2001-A-0104

Dear Mr. Dacimo:

The Region I Field Office of NRC Office of Investigations (OI), initiated an investigation (OI Case #1-2001-029) on October 4, 2001, to determine if on August 17, 2001, members of a control room operating crew, collectively or individually, failed to provide pertinent information to licensee management in support of an initial investigation of an unplanned power increase in excess of license condition 2.c.(1). Based on the evidence developed during the investigation, OI did not substantiate that wrongdoing occurred in this instance. A copy of the synopsis of OI Report 1-2001-029 is enclosed for your information.

Please note that final NRC documents, such as the OI report described above, may be made available to the public under the Freedom of Information Act (FOIA) subject to redaction of information appropriate under the FOIA. Requests under the FOIA should be made in accordance with 10 CFR 9.23, Requests for Records, a copy of which is enclosed for your information.

Should you have any questions regarding this letter, please feel free to contact Mr. P. Eselgroth, of my staff, at (610) 337-5234.

Sincerely,

/RA/

A. Randolph Blough, Director
Division of Reactor Projects

Enclosures:
As Stated

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NAME	DVito/slj		Peselgroth Cook for		Letts/Davis		ARBlough	
DATE	10/4/2002		10/7/2002		10/7/2002		10/7/2002	

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SYNOPSIS

This investigation was initiated by the U.S. Nuclear Regulatory Commission (NRC), Office of Investigations (OI), Region I, on October 4, 2001, to determine if a control room crew, Indian Point 2 Nuclear Power Station (IP2), Buchanan, NY, Entergy Nuclear Northeast (Entergy), failed to provide pertinent information in a condition report addressing an over power event.

During the course of this investigation, information surfaced which indicated that the control room crew may have, collectively or individually: (1) caused an over power condition; (2) failed to follow IP2 procedures or directives; and (3) failed to include relevant information about the August 17th over power event in the control room log.

Based on the evidence developed during this investigation OI did not substantiate that the control room crew, collectively or individually, deliberately failed to provide pertinent information in a condition report addressing an over power event.

In addition, OI did not substantiate that the control room crew, collectively or individually, deliberately: (1) caused an over power condition; (2) failed to follow IP2 procedures or directives; and (3) failed to include relevant information about the August 17th over power event in the control room log.