

April 2, 2004

MEMORANDUM TO: William D. Travers
Executive Director for Operations

THRU: James E. Dyer, Director /RA/
Office of Nuclear Reactor Regulation

FROM: Hubert J. Miller /RA/
Regional Administrator

SUBJECT: DEVIATION TO THE ACTION MATRIX TO CONTINUE HEIGHTENED
NRC OVERSIGHT OF INDIAN POINT NUCLEAR GENERATING UNIT 2

This memorandum requests your approval to deviate from the Reactor Oversight Process (ROP) actions for Indian Point Nuclear Generating Unit 2 (IP2) for the purpose of continuing NRC heightened oversight throughout calendar year 2004 (ROP5). This action involves a higher level of NRC management involvement and assessment than currently required at IP2 by the Action Matrix. The deviation is needed to closely monitor Entergy's performance following the station's recovery from longstanding problems. Our proposed approach, albeit requiring your specific approval, is consistent with the underlying concept of Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," in which the NRC, through its assessment process, has recognized that longstanding performance issues at a plant may require more tailored, plant-specific, follow-up over an extended period of time.

Background

In October 2000, the NRC concluded that IP2 performance was in the Multiple/Repetitive Degraded Cornerstone column of the NRC's Action Matrix. Per the ROP, this required significant additional oversight. In early 2001, a broad scope supplemental inspection (Inspection Procedure 95003) determined the plant was operating safely and that overall performance was acceptable. However, the team identified problems similar to those that had been previously identified, particularly in the areas of design control, human and equipment performance, problem identification and resolution, and emergency preparedness.

Following the 95003 inspection, Consolidated Edison made limited progress as they focused on the pending plant sale. In September 2001, Entergy purchased IP2, performed an in-depth self-assessment in the Fall of 2001, and subsequently implemented its improvement program.

IP2 remained in the Multiple/Repetitive Degraded Cornerstone column through calendar year 2001. Additionally, a Yellow finding was opened in late 2001 due to operator requalification examination failures. In August 2002, the NRC determined that IP2 had made sufficient progress to justify closure of the Red finding associated with the February 2000 steam generator tube failure. This action resulted in moving the facility to the Degraded Cornerstone column of the Action Matrix at the beginning of the fourth quarter 2002. However, as a result of longstanding weaknesses in corrective action effectiveness, along with a number of human errors, we documented substantive cross-cutting issues in both problem identification and resolution (PI&R) and human performance.

The Yellow finding associated with the Fall 2001 licensed operator requalification examination failures was reviewed during the 2002 assessment period and early 2003. NRC not only evaluated the licensee's broad scope of corrective actions, but also assessed operator performance over a range of activities. At the end of the second quarter 2003, we concluded that IP2 had made sufficient progress to close the Yellow finding. We moved the facility from the Degraded Cornerstone column to the Regulatory Response column of the Action Matrix, consistent for a plant with one White finding (see Attachment).

Consistent with the planned actions in the March 18, 2003, Deviation Memorandum, Region I maintained heightened oversight of inspection and assessment activities at Indian Point through ROP4. The April 28, 2003 Annual Assessment meeting was chaired by the Regional Administrator. A number of senior managers, including Chairman Diaz (observed the Pilot Force-on-Force Exercise) and the Regional Administrator, visited the site. The Deputy Division Director and Branch Chief averaged monthly (or more frequent) visits to the site. Drop-in meetings with local elected officials were also conducted. The Indian Point Technical and Communications Teams evaluated emergent issues at the site, ensured proper inspection effort, and responded to correspondence involving Indian Point through 2003, ensuring the accuracy of the content and clarity of the messages to Entergy and our external stakeholders. As outlined in the March 18, 2003 memorandum, the Region I staff completed the 41500 inspection of the licensed operator training program in April 2003. Region I also focused additional inspection resources in the areas of: problem identification and resolution; design basis initiative; security and safeguards; and emergency preparedness. Additionally, a special inspection at both units was completed during the fourth quarter 2003 to review the high number of offsite electrical disturbances at the site.

Deviation Basis

Overall, performance continued to slightly improve at IP2 during 2003. However, the rate of progress has been slow, largely due to the scope and nature of several large projects challenging the site. Entergy chose to accelerate the pace of site integration in 2003. This transitional "work" posed an additional burden on licensee staff and management, which continues into 2004. Other significant IP2 and site projects (e.g., Design Basis Initiative, IP2 power up-rate, Independent Spent Fuel Storage Installation, and the June 8, 2004 emergency preparedness exercise) also pose a challenge to the plant staff and warrant close NRC oversight.

Additionally, IP2 continues to carry relatively high backlogs of work, particularly in elective maintenance, engineering, and corrective actions. The significant number of longstanding (backlogged) deficiencies at IP2 and the re-prioritization (priority down-graded) of some emergent work at IP3 (often done to support IP2 workloads), continue to challenge Entergy. An example of an adverse consequence of this situation was the failure of both units' Technical Support Center back-up diesel generators on August 14, 2003. The site's work control process and implementation have had difficulties in both lowering the backlogs and improving equipment reliability.

Further, IP2 has maintained its substantive cross-cutting issue in PI&R for over two years. Accordingly, the annual assessment letter requests Entergy to respond in writing regarding actions taken or planned to address the effectiveness of their corrective action program. Additionally, IP2 continues to make slow progress on several multi-year design basis initiatives that were left open from their 2002 Fundamental Improvement Program. Recent issues with electrical cable routing and separation requirements have arisen driving this design initiative. Due to the heightened interest in the plant, and the above issues, we feel it is prudent to continue a heightened management involvement.

Planned Actions

Both units are currently in the Regulatory Response column of the Action Matrix, and could move to the Licensee Response column by the second quarter 2004. Similar to last year's deviation memorandum, the region requests your approval to deviate from the ROP Action Matrix to provide the following additional oversight of the Indian Point Nuclear Generating Station throughout calendar year 2004:

- Periodic management meetings and site visits focused on reviewing Entergy's continuing improvement initiatives, particularly in the areas of reducing corrective actions and maintenance backlogs and improving the overall effectiveness and timeliness of corrective actions. This would include Regional Administrator (RA) and/or Deputy RA involvement in mid-cycle and annual assessment public meetings and, potentially, other periodic or special meetings/site visits to address issues of heightened public interest. This level of NRC management involvement is consistent with the Degraded Cornerstone column of the Action Matrix.
- Continued senior management review and approval of assessment letters and other routine and special correspondences with the licensee and external stakeholders, consistent with the Degraded Cornerstone column of the Action Matrix.

We also plan the following actions, in accordance with the ROP and other agency guidance, to continue our heightened oversight of Indian Point 2 and 3 through calendar year 2004. These actions, although not requiring approval as a deviation, are included for your information:

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	CY 2000				CY 2001				CY 2002				CY 2003			
Corner-stone	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
IE		White PI	Red ¹	Red	Red	Red	Red	Red	Red	Red	Red ²					
MS	Yellow ³ White PI	Yellow White PI	Yellow White PI	Yellow White PI	Yellow	Yellow	Yellow	Yellow Yellow ⁴	Yellow Yellow	Yellow Yellow	Yellow ⁵ Yellow White ⁶	Yellow White	Yellow White	Yellow ⁷ White ⁸	White	White ⁹
BI	Yellow PI															
EP	White	White ¹⁰ White ¹¹ White White	White White White	White White White	White White White	White White White	White ¹² White White									
Matrix Column	N/A	consider MDC	MDC	MDC	MDC	MDC	MDC	MDC	MDC	MDC	MDC	DC	DC	DC	RR	RR

¹Red Finding associated with the February 2000 steam generator tube failure.

² Red Finding closed (reference ROP-3 Mid-Cycle Letter, dated 8/28/02).

³ Yellow issue associated with August 1999 reactor trip with electrical distribution problems (Pre-ROP issue benchmarked as Yellow per SECY-99-007A and SECY-00-0049.)

⁴ Yellow Finding associated with 2001 licensed operator requalification examination failures.

⁵ Yellow issue closed along with the Red finding (see Note 2).

⁶ White Finding associated with degraded Control Building to Turbine Building fire barrier.

⁷Yellow Finding closed (reference ROP-4 Mid-Cycle Letter)

⁸ White Finding left open an additional quarter, reference the 95001 inspection and recent PI&R sample inspection results associated with review of DBI initiative.

⁹ White finding closed by PI&R team (IR 2004-03).

¹⁰ White Finding associated with September 1999 EP Exercise, closed

¹¹Three White Findings associated with February 2000 steam generator tube failure and previous exercise observations involving ERO augmentation, accountability of onsite personnel, and JNC effectiveness.

¹² Three White Findings closed following 95002 and remedial EP Exercise in June 2001.