

Indian Point 2

2Q/2003 Plant Inspection Findings

Initiating Events

Significance:  May 15, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

IMPROPER EMERGENT WORK PACKAGE INSTRUCTIONS FOR 22 STEAM GENERATOR LEVEL BISTABLE REPLACEMENT

On February 7, 2003, a self-revealing finding involved inadequate emergent work instructions that resulted in an electrical short during replacement of the 22 steam generator low level bistable. The electrical short caused a breaker trip on circuit 10 of instrument bus 21 and the resultant loss of electrical power to the pressurizer level and reactor coolant system pressure control channels (failed low). The inadequate work instructions is considered a non-cited violation of 10 CFR 50 Appendix B, Criterion V, since the instructions did not account for consideration of performing this replacement with the circuit de-energized or the proximity to other reactor protection system relays. The performance issue is more than minor since the operators were required to take action to restore reactor coolant system pressure and pressurizer level to preclude a reactor trip. The finding involves the initiating events cornerstone in that it increased the likelihood of upset in plant stability and it involves human error during the planning of an emergent work activity. This finding is considered to be of very low safety significance in that in accordance with NRC Manual Chapter 0609, Appendix A, the finding did not contribute to the likelihood of a secondary or primary LOCA initiator and it did not contribute to either a reactor trip or mitigation system unavailability.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Feb 03, 2003

Identified By: NRC

Item Type: FIN Finding

A failure to initiate a condition report to identify problems associated with nonsafety related steam generator level controller replacements.

Green. A failure to initiate a condition report to identify problems associated with nonsafety related steam generator level controller replacements on August 13, 2002, which resulted in a steam generator level transient and required operator action to prevent a reactor trip. This issue is more than minor because the problem could reasonably be viewed as a precursor to a significant event. Further, the controller replacement had an actual impact on feedwater flow and steam generator level control which required operator action to preclude a reactor trip. This issue affects the initiating event cornerstone objective of limiting conditions that affect plant stability. The finding was determined to be of very low safety significance (Green) because, although it affected stability of plant operating parameters, it did not increase the likelihood of a primary or secondary loss of coolant accident (LOCA), did not contribute to a reactor trip and a loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flooding condition.

Inspection Report# : [2003002\(pdf\)](#)

Significance:  Feb 03, 2003

Identified By: NRC

Item Type: FIN Finding

A self-revealing finding was identified for ineffective corrective actions to prevent main feedwater flow and steam generator level transients.

Green. A self-revealing finding was identified for ineffective corrective actions to prevent main feedwater flow and steam generator level transients during installation of a modification to replace nonsafety related steam generator system level controllers. The corrective actions from problems experienced during controller replacements on August 6 were ineffective to ensure that subsequent controllers replaced on August 9, August 13, and October 7, 2002 did not result in similar steam generator level transients and necessitate operator actions to prevent reactor trips. While this and the previous finding both concern problems with steam generator level replacements, the findings are distinct in that the previous finding identifies problems not entered into the corrective action program, while this finding concerns the ineffectiveness of corrective actions for problems that were entered into the corrective action program. This issue is more than minor because the problem could reasonably be viewed as a precursor to a significant event, since the controller replacements had an actual impact on feedwater flow and steam generator level control which required operator action to preclude a reactor trip. This issue affects the initiating event cornerstone objective to limit conditions that challenge plant stability. However, the finding was similarly determined to be of very low safety significance (Green) because, although it affected stability of some plant parameters, it did not increase the likelihood of a primary or secondary LOCA, did not contribute to a reactor trip and a loss of mitigation equipment functions, and did not increase the likelihood of a fire or internal/external flooding condition

Inspection Report# : [2003002\(pdf\)](#)



Significance: Aug 10, 2002

Identified By: Self Disclosing

Item Type: FIN Finding

CONTRACTOR WORKED OUTSIDE HIS ESTABLISHED JOB SCOPE FOR LANDSCAPING ACTIVITIES

On July 19, 2002, a contractor worked outside his established job scope for landscaping activities. The consequences of this human performance error were the accidental electrocution of the individual and an offsite power electrical transient (loss of the 138 kilovolt station auxiliary transformer for approximately seven hours). This partial loss of offsite power event was more than minor, in that it impacted the reactor safety cornerstone with respect to the initiating event objective of limiting the likelihood of an event that upsets plant stability and challenges the critical safety function of the on-site emergency diesel generators. Notwithstanding the loss of life (which the Department of Labor, Occupational Safety and Health Administration is reviewing), this electrical transient event was of very low safety significance because it did not contribute to the likelihood of: loss of coolant accidents, a reactor trip and the unavailability of accident mitigation equipment or functions being unavailable; or of a fire or internal/external flood. No violations of NRC requirements were identified.

Inspection Report# : [2002005\(pdf\)](#)

Mitigating Systems



Significance: Jun 28, 2003

Identified By: NRC

Item Type: FIN Finding

INADEQUATE OPERABILITY EVALUATION FOR THE 13.8 KV SYSTEM

The inspector identified that the licensee's operability evaluation during a 13.8 KV system reduced voltage test was inadequate. The operability evaluation did not evaluate accident load carrying capability as defined in the technical specification basis and it did not address communications and protocols between the distribution company and the

licensee to restore from the test in a timely manner. NRC Manual Chapter 9900 states that when a system's capability is degraded to a point where it cannot perform with reasonable assurance of reliability, the system should be judged inoperable. The finding was more than minor because it impacted the attribute of the mitigating system cornerstone objective. Specifically, the cornerstone objective is to ensure that the 13.8 KV system is capable of performing its safety function during a postulated loss of normal power event without undesirable consequences. This finding was determined to be of low safety significance because it did not result in the actual loss of the offsite power supply safety function.

Inspection Report# : [2003007\(pdf\)](#)



Significance: Jun 28, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

Ineffective corrective actions associated with an unauthorized modification to the No. 22 component cooling water pump.

The inspector identified a non-cited violation of 10 CFR 50 Appendix B, Criterion XVI. The licensee did not evaluate and take effective corrective actions associated with a material substitution for the 22 component cooling water pump inboard bearing oil level indication system. The bearing oil level indication system contributed to the failure of the #22 CCW pump on December 5, 2002. This finding is greater than minor since it is associated with the design control attribute of the mitigating systems cornerstone and affected the cornerstone objective. The inspectors conducted a Phase 1 SDP screening and determined that the failure to take effective corrective action on #22 CCW pump was of a very low safety significance since the redundant train components were operable and unaffected by this unauthorized modification.

Inspection Report# : [2003007\(pdf\)](#)



Significance: May 15, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

INEFFECTIVE CORRECTIVE ACTIONS ASSOCIATED WITH THE 23 EDG LOAD SWINGS BETWEEN MAY 2000 AND FEBRUARY 2003

The inspectors identified that ineffective corrective actions resulted in repetitive surveillance test failures of the 23 emergency diesel generator between December 2001 and February 2003. This finding is considered a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI. The finding is more than minor because the surveillance test failures impacted the availability of one train of emergency AC power source. This finding was of very low risk significance because the repetitive failures did not result in an actual loss of function for the emergency AC power.

Inspection Report# : [2003003\(pdf\)](#)



Significance: May 15, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

POST-WORK TEST INADEQUATE FOR 22 BORIC ACID TRANSFER PUMP BORIC ACID FILTER STOP VALVE

A self-revealing event was identified on February 26, 2003, when operators observed no boric acid flow to the reactor vessel via the No. 22 boric acid transfer pump (BATP). It was determined that during preventative maintenance activities in March 2001, the post-work test on the No. 22 BATP outlet valve to the boric acid filter stop was inadequate to identify that the valve finger plate was installed upside down. This finding is considered a non-cited violation of 10 CFR 50 Appendix B, Criterion V. This event is considered more than minor because the improperly installed valve plate affected the availability of one train of emergency boration. This is considered to be of very low

risk significance in accordance with NRC MC 0609 Appendix A, since the emergency boration function was not lost due to this performance issue.

Inspection Report# : [2003003\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: FIN Finding

UNTIMELY OPERABILITY DETERMINATION FOR THE 21 DIESEL GENERATOR

On October 9, 2002, the licensee's organization did not identify in a timely manner that the 21 emergency diesel generator was inoperable. The causes for the untimely operability evaluation were fragmented communications between Entergy departments, untimely drip tank sample results, system engineering turnover, and a lack of sensitivity to a loss of the emergency power source safety function. The time between when the non-licensed operator had reported and added inventory to the jacket water expansion tank to the time the emergency diesel generator was declared inoperable was 7.5 hours which exceeded the limiting condition for operation within TS 3.0.1 to be in hot shutdown within seven hours. In the absence of reasonable expectation that a component is operable, the component shall be declared inoperable immediately. The untimely operability evaluation affects the mitigating systems cornerstone objective. The attribute is human performance pre-event. This finding is of very low safety significance in phase 1 of the SDP since the 21 EDG was subsequently declared inoperable and actions within the TS were adhered to. This finding did not result in an actual loss of the emergency on-site power source safety function nor did it increase the risk significance for external events. No violations of NRC requirements were identified.

Inspection Report# : [2002007\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IDENTIFY THE CAUSE OF 23 EDG OUTPUT BREAKER TO CLOSE

The inspector identified that Entergy did not adequately evaluate the cause blown control power fuses on the 23 EDG output breaker cubicle on November 10, 2002, that subsequently caused the breaker from closure on November 14, 2002. On November 14, 2002, Entergy identified the cause of the breaker failure as improper operation of the inertial latch mechanism. This performance issue is being treated as a Non-cited Violation of 10 CFR 50 Appendix B, Criterion XVI. This violation is more than minor because the failure to identify the cause and preclude recurrence was considered a precursor to a more significant safety issue, in that, the plant could have started up with only 2 available EDGs - a violation of TS - and not have know it for approximately one month. The issue was determined to be of very low safety significance (Green) in accordance with MC 0609 Appendix G, since greater than three offsite and onsite power sources were available to cope with a postulated loss of offsite power.

Inspection Report# : [2002007\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

INADEQUATE POST WORK TEST ON STEAM STOP CHECK VALVE

The post work test on the 22 steam generator stop check valve (MS-41) failed to identify that the valve plug was installed upside down. This self-revealing event was identified on November 20, 2002, when operators responded to steam leak-by from this tagged closed valve that resulted in a fire alarm in the auxiliary feedwater pump room. This finding is considered a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," in that, the post work test, PT-R67A, Reverse Flow Check at MS-41 and MS-42 Alternate Test, revision 1 did not adequately verify that MS-41 was properly reinstalled after preventative maintenance. The performance finding

is considered more than minor, since the improperly installed valve plug would not have been identified prior to auxiliary feedwater system operability, had it not been identified during an unrelated tagout on the steam supply to the 22 auxiliary feedwater turbine. This is considered very low risk significance in accordance with NRC MC 0609 Appendix G since two alternate core cooling paths were available. This is an example of insufficient Entergy oversight of contractor work activities.

Inspection Report# : [2002007\(pdf\)](#)

G

Significance: Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE CONFIGURATION CONTROL FOR A SAFETY RELATED SYSTEM

The inspector identified an example of inadequate configuration control for a safety-related system. On November 20, 2002, the inspector identified that two 125 vdc circuit breakers were in their correct position (open) but administrative locking devices were not installed. The breakers are used to cross-connect the 21 and 22 125 vdc buses. This is considered a Non-Cited Violation of Technical Specification 6.8.1.a., which includes requirements for procedure adherence and operations of safety-related systems including the 125 volt DC system. Check off list (COL) 27.1.6, Instrument Buses, DC Distribution and PA Inverter, revision 18 requires the breakers to be open and locked. This performance deficiency is more than minor since more than one breaker was in the required position, but not locked. The finding impacts the mitigating systems cornerstone and is associated with pre-event human error. The finding is considered very low safety significance (Green) since the operability or availability of the 21 and 22 DC buses were not impacted.

Inspection Report# : [2002007\(pdf\)](#)

G

Significance: Sep 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

NON-CITED VIOLATION OF TS 6.8 INVOLVING DEFICIENT GUIDANCE IN PROCEDURE AOI 27.1.1

Abnormal Operating Instruction (AOI) 27.1.1, "Loss of Normal Station Power," was deficient, in that no steps were provided in the procedure to identify that the lockout relays for the component cooling water (CCW) pumps were required to be reset following a loss and restoration of power to the motor supply breakers. This deficient procedure is being treated as a Non-Cited Violation of Technical Specification (TS) 6.8, "Procedures and Programs," in accordance with the NRC Enforcement Policy. The consequence of this finding was that the pump lockout relays would have prevented the 21 and 23 CCW pumps from starting automatically on low CCW system header pressure, for 12 days and 21 days, respectively. This finding represented a partial loss of the CCW system function and would reasonably have been corrected by operator action.

Inspection Report# : [2002006\(pdf\)](#)

G

Significance: Aug 10, 2002

Identified By: NRC

Item Type: FIN Finding

OPERATORS DID NOT IDENTIFY THE APPLICABILITY OF A SHUTDOWN TECHNICAL SPECIFICATION

On July 19, 2002, operators did not identify the applicability of a shutdown Technical Specification (TS) associated with the planned removal from service of the 22 emergency diesel generator (EDG) while the 138 kilovolt off site power system was still out-of-service. This finding was associated with the reactor safety cornerstone with respect to the mitigating systems objective of ensuring the availability, reliability and capability of the EDG to respond to initiating events, such as a loss of offsite power, to prevent undesirable consequences. No violation of NRC

requirements was identified, since Entergy restored the 22 EDG prior to exceeding the allowed outage time per TS 3.0.1. This finding was of very low safety significance since it did not represent a total loss of emergency power safety function.

Inspection Report# : [2002005\(pdf\)](#)



Significance: Jul 19, 2002

Identified By: NRC

Item Type: VIO Violation

VIOLATION OF THE APPROVED FIRE PROTECTION PROGRAM/THREE-HOUR RATED WALL CONSTRUCTED TO SEPARATE THE CONTROL BUILDING FROM THE TURBINE BUILDING

WHITE - The team identified a violation of License Condition 2.K of Facility Operating License DPR-26. License Condition 2.K requires that Entergy implement and maintain in effect all provisions of the NRC approved fire protection program, which states that a three-hour rated wall will be constructed to separate the control building from the turbine building. In 1978, to meet the three-hour rating, the wall was to have been built in accordance with the design specification Underwriters Laboratories (UL) U902. Contrary to the above, in February 2002, the wall was found not to be constructed in accordance with UL U902. The combined effect of the identified deficiencies was that, as of February 2002, passages existed through both the outer brick and inner portions of the wall. If a significant amount of smoke and gasses were to penetrate the wall, this could result in the CCR becoming uninhabitable, causing the operators to resort to using the Alternate Safe Shutdown System. These conditions did not represent a three-hour fire barrier. The NRC risk assessment, using Phase 2 of the NRC Fire SDP described in MC 0609, Appendix F, considered the wall a moderately degraded fire barrier having low to moderate safety significance (White). Until repairs could be completed, Entergy established a compensatory fire watch in accordance with the IP2 fire protection program. Entergy actions in identifying original construction deficiencies in the CCR west inner wall in February 2002 were commendable. However, the corrective actions taken were not fully effective in restoring the wall to its three-hour rated design configuration. Additionally, the initial extent of condition was not sufficient to identify other degraded fire barrier walls. [Final Significance Determination and Notice of Violation docketed in NRC letter, dated November 8, 2002. Entergy response to NOV dated December 9, 2002]

Inspection Report# : [2002010\(pdf\)](#)



Significance: Jul 19, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

TURBINE DRIVEN AUX FEED PUMP OIL ISSUES

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning three issues with the control and monitoring of lubrication oil used on the turbine driven auxiliary boiler feed water pump (22 ABFP). Each issue involved incomplete evaluations that led to repeat problems and potential for pump damage. The evaluation and corrective actions following identification in February 2002 that the wrong oil was added to the turbine speed governor were not fully effective. The evaluation of this issue identified that operators were not logging the quantity or specification of oil added during rounds or operation of equipment, but no actions were taken to address the issue. Additionally, the team noted that on July 10, while preparing to run the pump, Entergy identified additional confusion regarding the specification of oil to be added to the governor, an issue that should have been resolved. Station personnel did not identify that oil analysis results in May 2002 showing a decrease in oil viscosity indicated that the wrong oil was likely added to a pump bearing and that corrective actions for a similar problem previously identified in May 2001 were ineffective. The evaluation and corrective actions following identification in October 2001 of issues with the required oil level in the pump inboard bearing were not fully effective, specifically the design drawing, the vendor manual, and operator training contained inconsistent information. These issues were evaluated using Phase I of the NRC SDP to have very low safety significance (Green), because pump operability was not directly affected. These issues are being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based

on the very low safety significance, and because the issues have been entered into Entergy's CAP. (NCV 50-247/02-010-002

Inspection Report# : [2002010\(pdf\)](#)

Significance:  Jul 19, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

SETPOINT DATABASE NOT CORRECTED FOR CIRCUIT BREAKER OVERCURRENT PROTECTION DEVICE SETPOINTS

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning the failure to promptly identify, determine the cause, and correct circuit breaker amptector setpoint database errors. The control of design setpoints is necessary to ensure the availability, reliability and capability of safety-related electrical systems. This issue was evaluated using Phase I of the NRC SDP and determined to have very low safety significance (Green), because the team did not identify any instances where a circuit breaker would not have been able to perform its safety function. This issue is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based on the very low safety significance, and because it has been entered into Entergy's CAP. (NCV 50-247/02-010-003)

Inspection Report# : [2002010\(pdf\)](#)

Significance:  Jul 19, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

SAFETY INJECTION TOPPING PUMP VIBRATION CONSEQUENCES TO SAFETY-RELATED PIPING

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criteria XVI, Corrective Action concerning the failure to identify that vibration of the non-safety-related SI accumulator topping pump caused stresses in adjacent safety-related piping that were above the code allowable values. The team evaluated this issue using Phase I of the NRC SDP, determining it to have very low safety significance (Green), because liquid penetrant examinations in the areas of high stress did not identify any piping damage. This issue is being treated as a non-cited violation, consistent with Section VI.A.1 of the NRC Enforcement Policy based on the very low safety significance, and because it has been entered into Entergy's CAP. (NCV 50-247/02-010-004

Inspection Report# : [2002010\(pdf\)](#)

Barrier Integrity

Significance:  Feb 14, 2003

Identified By: NRC

Item Type: FIN Finding

Ineffective tracking of Inservice Testing of component cooling water system relief valve.

The team identified a finding regarding the scheduled inservice test (IST) of a Component Cooling Water (CCW) system pressure relief valve that was inadvertently not performed during the last plant refueling outage. Access and testing of this valve normally requires the plant to be shutdown. This finding was not a violation of applicable technical specifications for IST because the timing of the team's questions identified this issue to Entergy personnel while the test was within the allowed test interval extension. However, the issue was more than minor because, if left uncorrected, improperly tracked relief valve tests could result in a more significant safety concern because the valves would not be

tested as required to ensure their reliable operation to provide CCW piping over-pressurization protection during accident conditions and maintain the CCW containment penetration barrier integrity. The finding was determined to be of very low safety significance (Green) because there was no actual open pathway in the physical containment structure. (Section 1R21b. 1.1)

Inspection Report# : [2003004\(pdf\)](#)

Significance:  Dec 28, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

OPERATORS DEVIATE FROM PLANT OPERATING PROCEDURES

On November 23, 2002, during a plant cooldown, Entergy deviated from the guidance of plant operating procedure (POP) 3.3, Plant Cooldown, Rev. 57. The consequence of the failure to follow the POP guidance was to exceed the operational limits on the steam generator tube sheet differential pressure of 1600 psid with a maximum value of approximately 1855 psid. Control room operators were unaware of this operational limit. Reviews of steam generator manufacturer specifications and the Updated Final Safety Analysis Report design basis accident analysis information indicated that the steam generator tubes were designed to withstand up to 2485 psid during upset and hydrostatic conditions. Therefore, the structural integrity and qualification of the steam generator tubes was maintained. Failure to document the basis of marking non-conditional steps in POP 3.3 as not-applicable is considered a Non-Cited Violation of 10 CFR 50 Appendix B, Criterion V. This issue was considered more than minor because it represented a lack of understanding of procedure requirements and awareness of plant operational limitations. This finding is considered very low safety significance (Green) in accordance with manual chapter 0609 Appendix G, in that the core cooling pathway via the steam generators was not impacted.

Inspection Report# : [2002007\(pdf\)](#)

Emergency Preparedness

Significance:  Sep 27, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO CORRECT PREVIOUSLY IDENTIFIED CONDITION IN THE JNC REGARDING THE TIMELY AND ACCURATE DISSEMINATION OF INFORMATION

During the emergency plan exercise conducted on September 24, 2002, the licensee JNC personnel proceeded with a 1:55 p.m. press conference informing the media that no release was in progress when, according to the exercise events, a release had begun just prior to the press conference. This information was not in conflict with the emergency alert system message that was in effect at the time of the briefing. However, the failure to provide updated information could cause confusion for those receiving it through the media. This failure was a previously identified weakness as documented in Drill Critique Reports and in condition reports. This is a non-cited violation of 10 CFR 50 Appendix E Section IV.F.2.g which requires, in part, that weaknesses or deficiencies that are identified during a drill or exercise shall be corrected. The risk associated with this release of incorrect information was determined to be of very low significance because it does not constitute a loss of function in meeting the applicable planning standard (10 CFR 50.47 (b)(14)).

Inspection Report# : [2002012\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Significance:  May 15, 2003

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

FAILURE TO COMPLY WITH PACKAGING PROCEDURES

A self-revealing non-cited violation of 10 CFR 71.12 was identified for failure to comply with shipping cask package procedures. On February 6, 2003, a CNS 8-120 B cask was received from the Indian Point Energy Center at a consolidation facility in South Carolina with a bolt missing on the primary lid's pressure test port in violation of the cask use and maintenance procedures. This finding was more than minor in that it was associated with the Public Radiation Safety Cornerstone's attribute of procedures for transportation packages. The finding affected the associated cornerstone objective to ensure adequate protection of public health and safety from exposure to radioactive materials contained in an NRC-approved Type B package released into the public domain. The finding was determined to be of very low safety significance in that the finding did not involve exceeding transportation radiation limits, there was no breach of the package during transit, and the issue was a Certificate of Compliance maintenance/use performance deficiency.

Inspection Report# : [2003003\(pdf\)](#)

Physical Protection

Significance:  Aug 10, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

UNIT 2 SECURITY RESPONSE FORCE MEMBER WAS FOUND INATTENTIVE TO ASSIGNED DUTIES

On July 29, 2002, a member of the Unit 2 security response force was found inattentive to assigned duties. This inspector identified finding was treated as a non-cited violation of 10 CFR 73.55(b)(1)(i), and the Indian Point 2 Physical Security Plan. The security response force officer's inattentiveness to duties was determined to have very low safety significance, using the Interim Physical Significance Determination Process. The finding did not involve a significant compromise of the Physical Security Plan; no actual intrusion occurred; and, there have not been greater than two similar findings in the past four quarters.

Inspection Report# : [2002005\(pdf\)](#)

Miscellaneous

Significance: N/A Feb 03, 2003

Identified By: NRC

Item Type: FIN Finding

Generally effective Corrective Action Program implementation

The inspectors concluded that, within the scope of the issues reviewed, overall, Indian Point 2 (IP2) personnel were identifying issues at a threshold suitable to recognize conditions adverse to quality and help ensure reliable equipment operation. Although station backlogs (corrective actions, maintenance and engineering items) remained relatively high, the inspectors observed that senior management continued to provide reasonable oversight and emphasis on accountability for corrective action program performance. Corrective action process condition reports adequately characterized and bounded the scope of the problems, and correctly assessed equipment operability. Nevertheless, the team identified instances regarding steam generator level controller replacement problems and a cable tunnel groundwater leak where problems were not identified and not entered into the corrective action process. IP2 personnel usually evaluated problems to a level of detail appropriate to its technical complexity and risk significance. Problems were adequately prioritized for resolution considering the potential safety significance of the issues and their probability for recurrence. However, in some instances (emergency diesel generator wiring termination and breaker setpoint database), the inspectors identified evaluations where the problems were not completely addressed. Corrective actions generally addressed the problems and encompassed the scope of the issues. Based on the issues reviewed, the inspectors found corrective actions were scheduled and completed commensurate with the risk significance of the issues. Formal effectiveness reviews were completed, and then reviewed by the Corrective Action Review Board to help ensure the corrective actions were effective in resolving more significant problems. Notwithstanding, corrective actions were not effective to prevent repetitive problems during a steam generator controller replacement modification. Inspection Report# : [2003002\(pdf\)](#)

Significance:  Aug 10, 2002

Identified By: NRC

Item Type: NCV NonCited Violation

FAIL TO USE THE APPROPRIATE TOOLING DEVICE FOR MOVEMENT OF FUEL ASSEMBLY G28 ON JULY 23, 2002

GREEN. On July 23, 2002, Entergy did not appropriately evaluate and implement short-term actions associated with Condition Report (CR) IP2-2002-07253. The consequence of the finding was the relocation of spent fuel assembly G-28 without the appropriate handling tools and precautions. The finding is more than minor since it could be reasonably viewed as a precursor to a significant event (dropped spent fuel assembly in the spent fuel pool). The Significance Determination Process is not modeled for a finding of this type. However, in accordance with NRC Manual Chapter 0612, this finding was reviewed by NRC risk analysts and management and has been determined to be of very low safety significance because no actual consequence existed and there was no unintended radiation worker exposure. The finding was determined to be a violation of 10 CFR 50, Appendix B, Criterion V, and is being treated as a non-cited violation. (1R20)

Inspection Report# : [2002005\(pdf\)](#)

Significance: N/A Jul 19, 2002

Identified By: NRC

Item Type: FIN Finding

Improved performance in the areas of design control, equipment and human performance, and corrective actions.

Overall, the team found that Entergy operated IP2 safely and that through implementation of the FIP, progress had been made in improving performance in the areas of design control, equipment and human performance, and corrective actions. Specifically, the team determined overall: quality of engineering products has improved, and design and licensing basis control have been strengthened; equipment performance improved (including reduced backlogs of corrective maintenance work orders, operator workarounds, CCR deficiencies, etc); station human error rate and number of equipment mis-positioning events have declined; and, improved effectiveness of corrective action program, including identification and documentation of issues at a low threshold.

Inspection Report# : [2002010\(pdf\)](#)

Significance: TBD Apr 01, 2000

Identified By: Licensee

Item Type: FIN Finding

Contamination in Storm Drains

Con Edison staff appropriately responded to the discovery of trace amounts of contamination in the Unit 1 storm drains and took proper actions to resolve the condition and to investigate the cause. The material was not associated with the Unit 2 steam generator event or any recent plant activities, and there was no radiological dose consequence due to the contamination.

Inspection Report# : [2000003\(pdf\)](#)

Inspection Report# : [2001010\(pdf\)](#)

Significance: TBD Apr 01, 2000

Identified By: NRC

Item Type: FIN Finding

Steam Generator Tube Leak Root Cause Evaluation

Con Edison completed the investigation of the plant response to the February 15, 2000 steam generator tube leak. Corrective actions to address the causes of weaknesses in the plant response to the event were in progress at the end of the inspection period and NRC review will be the subject of an AIT follow-up team inspection. The results of the root cause investigation for the steam generator tube failure were not reviewed and are being provided by Con Edison to the NRC Office of Nuclear Reactor Regulation for review.

Inspection Report# : [2000003\(pdf\)](#)

Last modified : September 04, 2003