

Indian Point 2

3Q/2010 Plant Inspection Findings

Initiating Events

Significance:  Mar 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

Improper Generex Isolation Caused Reactor Trip

A self-revealing finding of very low safety significance was identified because Entergy personnel did not establish procedures that were appropriate to the task, and personnel did not adequately implement the procedures that existed for isolating the generator exciter system on the main generator. Specifically, on January 11, 2010, Entergy personnel did not properly isolate one rectifier exciter bank on the exciter system of the main generator while repairing a leak in the associated cooling water line. Entergy staff did not ensure that the procedural direction was adequate to ensure that the workers could recognize when the exciter rectifier disconnect switches were in the fully open position. In addition, Entergy supervisors did not stop the maintenance in the face of uncertainty when presented with several indications that the 24 exciter rectifier bank had not been isolated, including detecting unexpected voltage in the 24 exciter rectifier cabinet and a high temperature alarm associated with the exciter rectifier. As a result, the rectifier bank was not properly isolated electrically while the cooling water to the rectifier was isolated. This resulted in overheating the exciter bank control circuits which caused a main turbine trip and a reactor trip.

This finding is more than minor because the performance deficiencies caused a reactor trip. The finding is associated with both the procedure quality and human performance attributes of the Initiating Events cornerstone and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. The inspectors performed a Phase 1 screening in accordance with Inspection Manual Chapter (IMC) 0609 "Significance Determination Process (SOP)" and determined that the finding is of very low safety significance (Green) because it did not contribute to the likelihood that mitigation equipment or functions would not be available.

The finding has a cross-cutting aspect in the area of human performance related to decision making. Entergy personnel did not make safety-significant or risk significant decisions using a systematic process, especially when faced with uncertain or unexpected plant conditions, to ensure safety is maintained (H.1.a).

Inspection Report# : [2010002](#) (*pdf*)

Mitigating Systems

Significance:  Sep 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Reactor Trip Breaker Preventative Maintenance Procedure Was Not Adequately Implemented

A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified because Entergy personnel did not adequately implement the preventive maintenance (PM) procedure for

the B reactor trip breaker (RTB). Specifically, on March 10, 2009, Entergy staff did not adequately implement PM Procedure 0 BRK 401 ELC, "Westinghouse, Reactor Trip and Bypass Circuit Breaker (DB 50)," which resulted in the inoperability of the B RTB shunt trip device function on July 5, 2010. Entergy personnel took immediate corrective actions to replace the B RTB and its associated fuse block assembly. This issue was entered into Entergy's corrective action program as condition report (CR) IP2 2010 4451.

This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems cornerstone and affects the cornerstone objective of ensuring the availability and reliability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, inadequate preventive maintenance contributed to the failure of the shunt trip device function of the B RTB. Using IMC 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," the finding was determined to have very low safety significance (Green) because the finding did not result in a loss of system safety function because the undervoltage coil was operable; there was not an actual loss of safety function of a single train for greater than its technical specification allowed outage time; and the issue was not potentially risk significant due to a seismic, flooding, or severe weather initiating event.

The finding has a cross cutting aspect in the area of problem identification and resolution associated with the corrective action program attribute of complete and accurate identification of issues. Specifically, Entergy staff performing preventive maintenance did not identify and communicate RTB conditions completely and accurately such that the B RTB conditions were fully identified in the CAP.

Inspection Report# : [2010004](#) (pdf)

Significance: SL-IV May 21, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

UFSAR Section 5.3.1.12, Cathodic Protection, Not Updated Consistent with Plant Conditions

The inspectors identified a Severity Level IV (SLIV) NCV of 10 CFR 50.71(e) because Entergy personnel did not revise the updated final safety analysis report (UFSAR) with information consistent with plant conditions.

Specifically, Entergy personnel did not remove reference to or correct information to reflect current plant conditions related to systems described as having cathodic protection consistent with UFSAR Section 5.1.3.12, Cathodic Protection. Entergy personnel identified that the UFSAR was inconsistent with current plant conditions in 2005.

However, the corrective action to resolve the discrepancy was not completed. Entergy issued CR-IP2-2010-03512 to address the UFSAR discrepancy.

This issue is considered within the traditional enforcement process because it has the potential to impede or impact the NRC's ability to perform its regulatory functions. The inspectors used the Enforcement Policy, Supplement I – Reactor Operations, to evaluate the significance of this violation. The inspectors concluded that the violation is more than minor because the longstanding and incorrect information in the UFSAR had a potential impact on safety and licensed activities. Similar to Enforcement Policy Supplement I, example D.6, the inspectors determined the violation was of SLIV (very low safety significance) since the erroneous information not updated in the UFSAR was not used to make an unacceptable change to the facility nor impacted a licensing or safety decision by the NRC.

The inspectors determined there was a cross-cutting aspect in the area of problem identification and resolution associated with the component area of corrective action effectiveness. Specifically, Entergy personnel did not implement adequate actions in a timely manner to update the UFSAR to be consistent with plant conditions. (P.1.d per IMC 0310) (Section 4OA2.1.c)

Inspection Report# : [2010008](#) (pdf)

Significance:  Apr 07, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Scenario resulting in loss of charging pump suction

The team identified a Green, Non-Cited Violation (NCV) of 10 CFR 50, Appendix R, III.G.3, in that Entergy failed to provide one train of reactor coolant system makeup free of fire damage for the control room, cable spread room, and cable tunnel fire zones for postulated fire scenarios. Specifically, Entergy failed to assure that one charging pump

would remain free of fire damage for alternate shutdown fire scenarios that could produce a spurious closure of the volume control tank motor operated outlet valve. Entergy initiated condition report CR IP2-2010-00720 for long term resolution and promptly initiated hourly fire watches in all affected fire areas except for the cable tunnel as an interim compensatory measure. The cable tunnel was evaluated as not requiring an hourly fire watch and being sufficiently protected with installed fire detection and automatic fire suppression in addition to administrative controls that limit personnel access.

This finding is more than minor because it is associated with the External Factors attribute (fire) of the Mitigating Systems Cornerstone and adversely affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage). Specifically, the availability of the charging system was not ensured for postulated fires in alternative shutdown areas. The team used Phase 1, 2, and 3 risk assessment tools of IMC 0609, Appendix F, Fire Protection Significance Determination Process, to determine that this finding was of very low safety significance (Green), with an estimated total core damage frequency in the low to mid E-7/year range. A cross-cutting aspect was not identified. (Section 1R05.01.1)

Inspection Report# : [2010006](#) (*pdf*)

Significance:  Apr 07, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fire Scenario resulting in loss of cooling water to charging pumps

The team identified a Green, Non-Cited Violation of 10 CFR 50, Appendix R, III.G.3, in that Entergy failed to provide one train of reactor coolant system makeup free of fire damage for the control room, cable spread room, electrical switchgear room, and cable tunnel fire zones for postulated fire scenarios. Specifically, Entergy failed to assure that one charging pump would remain free of fire damage for alternate shutdown fire scenarios that could produce a spurious trip of a component cooling water (CCW) pump. Entergy initiated condition report CR-IP2-2010-00751 for long term resolution and promptly initiated hourly fire watches in all affected fire areas except for the cable tunnel as an interim compensatory measure. The cable tunnel was evaluated as not requiring an hourly fire watch and being sufficiently protected with installed fire detection and automatic fire suppression in addition to administrative controls that limit personnel access.

This finding is more than minor because it is associated with the External Factors attribute (fire) of the Mitigating Systems Cornerstone and adversely affects the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the availability of the charging system was not ensured for postulated fires in alternative shutdown areas. The team used Phase 1, 2 and 3 risk assessment tools of IMC 0609, Appendix F, Fire Protection SDP, to determine that this finding was of very low safety significance (Green), with an estimated total core damage frequency in the low to mid E-7/year. A cross-cutting aspect was not identified. (Section 1R05.01.2)

Inspection Report# : [2010006](#) (*pdf*)

Significance:  Mar 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Isolation of Service Water to All Emergency Diesel Generators

A self-revealing NCV of Technical Specification (TS) Limiting Condition of Operation (LCO) 3.8.2 was identified when Entergy personnel did not maintain service water (SW) cooling to the emergency diesel generators (EDGs) when the reactor was in cold shutdown. Specifically, on March 13,2010, Entergy personnel isolated cooling water flow to the EDGs for a period of three minutes. This condition was corrected after an alarm in the control room alerted the operators to the condition and the operators promptly directed the restoration of cooling water to the EDGs.

The inspectors determined that the isolation of cooling water flow to the standby EDGs

was a violation of TS LCO 3.8.2, which requires "Two EDGs to be capable of supplying two safeguards power trains of the onsite AC electrical power distribution subsystem(s) required by LCO 3.8.10." Inadequate SW cooling to the EDGs, if left uncorrected, could have caused the EDGs to fail from a lack of cooling. This finding is more than minor because it is associated with the configuration control attribute of the Mitigating Systems cornerstone and adversely affected the objective to assure the availability, reliability and capability of systems that respond to initiating events to prevent core damage. The finding was determined to be of very low safety significance (Green) because further analysis by Entergy staff determined that the EDGs could have operated without cooling water for the period of three minutes.

The finding has a cross-cutting aspect in the area of human performance related to work practices. Entergy personnel did not incorporate actions to address the impact of work on different job activities, and did not plan work activities to support equipment reliability by limiting safety systems unavailability and reliance on manual actions (H.3.b).

Inspection Report# : [2010002](#) (*pdf*)

Significance: SL-IV Dec 31, 2009

Identified By: NRC

Item Type: VIO Violation

Incomplete Licensed Operator Medical Examinations

An NRC-identified Severity Level IV Violation of 10 CFR 50.9, "Completeness and accuracy of information" was identified because Entergy submitted inaccurate medical information for licensed operators. The inspectors identified submittals to the NRC were inaccurate due to the omission of a tactile test (test performed to ensure that operators can distinguish among various shapes of control knobs and handles by touch) from the required licensed operator medical examinations. The inspectors determined that Entergy's medical physician did not adequately test all licensed operators (both initial and renewal licensees) in accordance with 10 CFR 55.21 and 10 CFR 55.33 with respect to ANSI/ANS-3.4 1983. However, Entergy had submitted medical information, as required by 10 CFR 55 for licensed operators and applicants that stated the testing had been performed satisfactorily. Following identification of the issue, Entergy entered the issue into the corrective action program (CR-IP3-2009-04487) and completed corrective actions to develop and administer an appropriate test. The inspectors noted that all licensed operators passed this new test and no new license conditions were required.

Entergy's failure to provide complete and accurate information to the NRC could have resulted in an incorrect licensing action and is a performance deficiency because the licensee is required to comply with 10 CFR 50.9. Because this violation of 10 CFR 50.9 is considered to be a violation that potentially impedes or impacts the regulatory process, it is dispositioned using the traditional enforcement process. The finding was more than minor because documents which provided the information to the NRC were signed under oath by the company medical physician and the Site Vice President.

The applicability of cross-cutting aspects related to the performance deficiency of this finding will be determined after NRC review of Entergy's response to the Notice of Violation.

Inspection Report# : [2009005](#) (*pdf*)

Inspection Report# : [2010003](#) (*pdf*)

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Partial Loss of Control Room Indication During NI 41 Recorder Replacement

A self-revealing non-cited violation (NCV) of very low safety significance of 10 CFR 50, Appendix B Criterion V "Instructions, Procedures, and Drawings," was identified because Entergy personnel did not perform work regarding replacement of a control room digital recorder. As a result, during performance of the work, personnel inadvertently shorted a live wire resulting in a partial loss of control room indications and alarms related to the safety relief valve acoustic monitor flow indications, low range steam and feed flow indications, and inadvertent control rod movement. Entergy personnel reset the breakers to restore control room indications and entered this issue into the corrective action program as CR-IP2-2009-04860. Personnel subsequently replaced the digital recorder with the circuit breaker

opened to eliminate the electrical hazard.

The finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the grounded recorder power supply resulted in a loss of control room indications and alarms that could have impacted operations response to an event. The inspectors evaluated this finding using Phase 1 of IMC 0609, Appendix A, "Significance Determination of Reactor Inspection Findings for At-Power Situations," and determined it to be of very low safety significance (Green).

The inspectors determined that this finding had a cross-cutting aspect in the area of Human Performance related to work practices. Specifically, Entergy personnel did not follow procedures during the replacement of a control room digital recorder.

Inspection Report# : [2009005](#) (pdf)

Barrier Integrity

Significance:  Jul 01, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inoperable Control Room Ventilation System due to Damper Mispositioning

The inspectors identified a Green NCV of Technical Specification (TS) 3.7.10 because Entergy personnel did not ensure proper configuration control of a damper in the control room ventilation system (CRVS), which resulted in both trains of CRVS being inoperable for greater than the TS allowed outage time. Although the closed damper was identified by the licensee during planned testing to fulfill Surveillance Requirement (SR) 3.7.10.4, this finding is being considered an NRC-identified finding due to significant questions from the inspectors that resulted in the implementation of additional corrective actions. Entergy personnel entered this issue into their Corrective Action Program (CAP) as CR-IP2-2010-03076 and CR-IP2-2010-03564 for resolution. Planned corrective actions included reinforcement of human performance tools, utilization of operating experience during future pre-job and pre-outage briefings, revised system check-off list, and implementation of a more robust method for locking the damper in position.

This finding was greater than minor because it was associated with the Barrier Performance attribute of the Barrier Integrity cornerstone, and it impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. This finding is of very low safety significance because it impacted the radiological barrier function of the control room but did not impact other barrier functions of the control room.

The inspectors determined that the finding has a cross-cutting aspect in the area of Human Performance, Work Practices component, because Entergy personnel did not ensure that human error prevention techniques were applied to ensure work activities on the 'A' CRVS damper did not impact the nearby CCRB1 damper.

Inspection Report# : [2010003](#) (pdf)

Emergency Preparedness

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

Siren Test Failure

A self-revealing NCV of very low safety significance of 10 CFR 50.47(b)(5) was identified because Entergy personnel did not ensure the alert and notification system (ANS) sirens remained available for notification of the

populace within the plume exposure pathway emergency planning zone (EPZ). Specifically, Entergy personnel did not use procedures, step lists, or checklists while performing maintenance on the ANS siren system which caused approximately 8% of the siren system to be degraded for 56 days. The siren technicians did not use a detailed written procedure or work instruction to perform siren file updates, but instead relied on performing the task from memory. As a result, on September 16, 2009, Entergy conducted a full volume siren test during which a total of 18 sirens indicated a failure to function. Entergy entered the siren failures into their corrective action process for resolution and performed a root cause of the event to determine the short and long term corrective actions.

The finding was more than minor because it was associated with the Emergency Preparedness (EP) cornerstone attribute of facilities and equipment, and impacted the cornerstone objective of ensuring that Entergy is capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. This finding was evaluated using IMC 0609 Appendix B, "Emergency Preparedness Significance Determination Process (SDP)" and was determined to be of very low safety significance (Green).

This finding has a cross-cutting aspect associated with the area of Human Performance because Entergy did not ensure adequate supervisory and management oversight of work activities performed by siren technicians.

Inspection Report# : [2009005](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A May 21, 2010

Identified By: NRC

Item Type: FIN Finding

2010 Unit 2 PIR team summary

The inspectors concluded that Entergy was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems at a low threshold and entered them into the Corrective Action Program (CAP). For most condition reports (CRs) reviewed, the inspectors determined that site personnel screened issues appropriately for operability and reportability, and generally prioritized issues commensurate with the safety significance of the problems. The inspectors determined that causal analyses appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that corrective actions addressed the identified causes and were implemented in a timely manner. However, the inspectors identified one violation of NRC requirements in the area of effectiveness of corrective actions. The issue was entered into Entergy's CAP during the inspection.

Entergy's audits and self-assessments reviewed by the inspectors were thorough and probing. Additionally, the inspectors concluded that Entergy adequately identified, reviewed, and applied relevant industry operating experience (OE) to Indian Point Unit 2. Based on interviews, observations of plant activities, and reviews of the CAP and the Employee Concerns Program (ECP), the inspectors concluded that there was not evidence of challenges to the free

flow of information regarding safety concerns.

Inspection Report# : [2010008](#) (*pdf*)

Significance: SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Transient Combustibles Stored on the ISFSI pad

An NRC-identified Severity Level IV, NCV of 10 CFR 72.212(b)(2)(ii), was identified because Entergy personnel did not evaluate a change to the written evaluation described in its Holtec Updated Final Safety Analysis Report (UFSAR) prior to implementing the change. Specifically, inspectors identified that Entergy personnel were storing combustible material on the Independent Spent Fuel Storage Installation (ISFSI) pad which was contrary to the Holtec UFSAR and the Entergy 72.212 Evaluation Report which stated that transient combustibles will not be stored on the ISFSI pad. Following the inspectors' questions, Entergy personnel determined the required evaluation in accordance with the requirements of 10 CFR 72.48(c) was not performed. Entergy personnel entered the issue into their corrective action program and verified that all combustibles had been removed from the pad.

The Reactor Oversight Process (ROP) was not used for this finding because inspections of ISFSI activities are covered under NRC Manual Chapter 2690 and are not incorporated in the reactor safety cornerstones in the ROP's Significance Determination Process (SDP). It was determined that the failure to evaluate a change to the written evaluation required by 10 CFR 72.212 using the requirements of 10 CFR 72.48(c) was a performance deficiency that was reasonably within Entergy's ability to foresee and prevent. The finding was determined to be a Severity Level IV violation based on Supplement VI, Example D.2 of the NRC Enforcement Policy.

A cross-cutting aspect was not assigned since the performance deficiency was not applicable to evaluation in accordance with the ROP.

Inspection Report# : [2009005](#) (*pdf*)

Last modified : November 29, 2010