

May 14, 2003

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

SUBJECT: SPECIAL TEAM INSPECTION OF OPERATIONS TRAINING PROGRAMS

Dear Mr. Dacimo:

On April 23, 2003, the NRC completed a Special Team Inspection at Indian Point Station, Units 2 and 3. The enclosed report documents the inspection findings, which were discussed with you and members of your staff on April 23, 2003.

The inspection examined activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of your license. The inspectors reviewed selected procedures and records, and interviewed personnel associated with your operations training programs.

In Fall of 2001, the NRC assessed the Unit 2 licensed operator crew performance pass/fail results from the annual operating test. The high crew failure rate resulted in a Yellow finding in accordance with the NRC's significance determination process. Subsequently, the NRC augmented the site resident inspector staff to enhance observations of control room activities (which included a period of around the clock coverage), and reviewed licensee immediate corrective actions related to control room operations. Further, NRC training specialists conducted operational evaluations prior to individuals being returned to shift.

In response to the Yellow finding, Entergy conducted high intensity operator training during the first half of 2002. NRC staff observed portions of that training and also observed selected facility-conducted crew evaluations. NRC's inspection efforts included a supplemental inspection team, which reviewed the training and operations area in accordance with Inspection Procedure 95002. Further, the NRC reviewed the Unit 2 licensed operator requalification examinations administered in the Fall of 2002, and operator performance during the Fall 2002 and Spring 2003 outages.

During March 2003, the NRC administered initial license operator examinations for Units 2 and 3 (NRC Examination Reports 50-247/2003-301 and 50-286/2003-301). Additionally, in March and April 2003, the NRC performed this special inspection of selected operational events and training issues. The team determined that the training issues were primarily historical in nature and have been substantially corrected. The team also noted that the Entergy training department is actively engaged in identifying and resolving operational events and performance issues. The inspectors did not identify any examples, or group of examples, that challenged the

corrective actions related to the Yellow finding root causes. Accordingly, the Yellow finding is closed. However, as discussed in our Annual Assessment Letter of March 4, 2003, we note that cross-cutting issues in the areas of human performance and corrective actions continue to be open. NRC oversight of these areas will continue through 2003.

Based on the results of this inspection no findings of significance were identified. However, a licensee-identified violation, which was determined to be of very low safety significance, is listed in Section 4OA7 of this report. If you contest this non-cited violation, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN,: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at Indian Point, Unit 2.

In accordance with 10 CFR 2.790, the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Website at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

***/RA/***

Brian E. Holian, Deputy Director  
Division of Reactor Projects

Docket Nos.: 50-247, 50-286  
License Nos.: DPR-26, DPR-64

Enclosure: Inspection Report 50-247/03-008, 50-286/03-007

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**U.S. NUCLEAR REGULATORY COMMISSION**

**REGION I**

Docket Nos.: 50-247, 50-286

License Nos.: DPR-26, DPR-64

Report Nos.: 50-247/03-008, 50-286/03-007

Licensee: Entergy Nuclear, Northeast

Facility: Indian Point Station, Units 2 and 3

Location: Buchanan, NY

Dates: March 24-28, 2003 and April 22-23, 2003

Inspectors: T. Fish, Sr. Operations Engineer (Team Leader)  
J. Caruso, Sr. Operations Engineer  
S. Barr, Operations Engineer

Accompanied by: D. Jackson, Operations Engineer (in Training)  
G. Usova, Training and Assessment Specialist (Rockville, MD)

Approved by: Richard J. Conte, Chief  
Operational Safety Branch  
Division of Reactor Safety

## SUMMARY OF FINDINGS

IR 05000247/03-008 and 05000286/03-007; 3/24-28/03 and April 22-23; Indian Point Station, Units 2 and 3; Special Team Inspection of Operations Training Programs

This report covered an announced inspection by the Operational Safety Branch Chief, four region-based inspectors, and one Headquarters-based training and assessment specialist. One Green, non-cited violation (NCV) was identified. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 3, dated July 2000.

### A. NRC-Identified and Self-Revealing Findings

No findings of significance were identified.

### B. Licensee-Identified Violations

Cornerstone: Mitigating Systems

Violations of very low safety significance, which were identified by the licensee have been reviewed by the inspectors. Corrective actions taken or planned by the licensee have been entered into the licensee's corrective action program.

- 10 CFR Part 50.120 requires that the facility implement a training program derived from a systems approach to training (SAT) as defined in 10 CFR 55.4. 10 CFR 55.4 defines SAT as a training program that includes five elements, one of which - element 3 - is training design and implementation. Contrary to the above, from about August 2001 through October, 2001, aspects of Unit 2 initial license training design and implementation were deficient. Specifically, lesson plans contained inadequate detail and content, instructors demonstrated weak technical knowledge, and the quality of training presentations was poor. These findings are documented in the licensee's corrective action program as a Level 1 Condition Report, No. IP2-2001-11001. The findings are of very low safety significance because the conditions affected students who could not be assigned control room watchstanding duties, the licensee corrected deficiencies in lesson plans, and replaced instructors with poor instructional skills and/or who lacked Unit 2 technical knowledge.

## Report Details

### **4. OTHER ACTIVITIES (OA)**

#### 4OA2 Problem Identification and Resolution

##### 1. Problem Identification and Resolution Samples

###### a. Inspection Scope

In accordance with the guidance provided in Inspection Procedure 71152, Identification and Resolution of Problems, the inspector received input from the resident inspectors assigned to Indian Point Station and reviewed 32 condition reports (CRs) from year 2002 that described plant issues. The issues and their associated corrective actions were reviewed for causal analysis and evaluated for the appropriateness of the corrective actions taken. For several of the issues, the licensee presented the corrective actions to their Corrective Actions Review Board (CARB), which provided a final review of corrective action completion. When corrective actions were assigned to the operations training department, the inspector selectively reviewed the associated lesson material. In addition, meeting minutes from the Operations Training Review Group (OTRG) were reviewed to determine whether the licensee used operations training to address human performance errors.

###### b. Findings and Observations

No findings of significance were identified.

The inspector noted improvement in the licensee's ability to ensure the Operations Training organization responded to human performance errors. Nevertheless, the inspector identified four instances where the licensee did not thoroughly utilize their processes to respond to performance errors. These instances, judged by the inspector as missed opportunities to engage the training organization, are summarized below:

- IP2 2002 07159 was generated on 7/19/2002 to resolve an issue where operators were late identifying a Technical Specification Limiting Condition for Operation (TSLCO). The corrective action document directed that operations staff review the issue with all operating crews. However, the corrective actions did not include briefing the Operations Training staff, in particular any of the instructors involved with initial operator training and licensed operator requalification (LOR) training.
- IP2 2002 02503 was generated on 3/6/2002 to document a Resident Inspector observation that Technical Specification Limiting Condition for Operation times were not being entered properly in operator logs. The corrective action resolution included briefings to each operating shift on the issue. However, the training organization was not referenced on the corrective action and no discussions occurred at the OTRG meeting to include this issue as a part of operator training. As in the issue discussed above, the inspector determined that other target populations such as initial operator license candidates as well as instructors involved with initial operator training and LOR training would have benefitted from information on this issue.



- IP2 2002 01778 was generated on 2/15/2002 to document that operators missed a required 10CFR50.72 notification for a condition when two emergency diesel generators were inoperable. Although this issue was presented to the OTRG, the members judged the issue as “no training required”. Again, the inspector believed the issue warranted review with operations training instructors and students.
- IP2 2002 11003 was generated on 11/23/2002 to document an instance where operators exceeded the differential pressure limit across the steam generator U-tubes during a plant cool down. The issue was not discussed at a subsequent OTRG. This issue was, however, presented at the CARB meeting on 3/26/2003, where CARB members appropriately added an action item for the OTRG to review the issue. The CARB review prevented this issue from being lost to the training process. Even so, the inspector noted there had been an earlier opportunity - that is, during the OTRG meeting - for the licensee to recognize a potential training need.

In addition to the above corrective action problems, the inspector also noted examples where the OTRG missed opportunities to address human performance problems. For example, the February 2003 OTRG meeting convened following a quarter that included at least three instances of performance errors. These events, as documented in facility CRs, included: 1) operator failure to maintain required differential pressure across SG tubes; 2) a valve mis-positioning event that led to loss of cooling water to a containment fan coil unit; and 3) a valve mis-positioning event that caused chemicals to be diverted to an incorrect tank. These human performance errors represented opportunities for the OTRG members to engage the training organization such that training might be modified to prevent recurrence of these issues. Nevertheless, OTRG members did not identify any of these issues as warranting discussion or attention.

The inspector did note, however, that licensee management recently adopted a new performance indicator (PI) associated with valve mis-positionings. This PI, which indicated a recent negative trend, prompted the licensee to write a CR to address the instances of mis-positionings.

### Summary

The licensee has developed processes that have addressed human performance shortfalls in the plant, and has used operations training as part of the solution for these issues. These processes, such as operations training organization involvement in corrective action resolution, and Operations Training Review Groups have assigned training activities to areas that needed human performance improvements. Although early performance history (i.e., early 2002) indicated these processes were being inconsistently applied, recent licensee performance indicated improved process adherence.

#### 4OA(2) Training Systematic Self-evaluation and Corrective Actions

##### a. Inspection Scope

The inspector reviewed licensee procedures and self-assessments related to operations training, and considered external evaluation reports, to determine if Entergy had used a systematic process to evaluate the effectiveness of training and qualification programs and to determine and direct any needed revisions to those programs. The inspector assessed the scope and depth of the training assessments or procedures, and Indian Point Energy Center (IPEC) responsiveness to any identified need for corrective action. The inspector sampled corrective action item closure packages for completeness and adequacy, and interviewed licensee staff and management responsible for those corrective actions. Specifically, the inspector reviewed the following documentation:

- Training Improvement Plan (TIP). In June 2001, as a result of a comprehensive self-assessment, the previous plant owner, ConEd, determined that insufficient management oversight had resulted in several recurring weaknesses in the operations training program. When Entergy purchased IP2 in September 2001, they initiated a formal root cause evaluation to identify the underlying causes for the weaknesses in Operations Training and developed the TIP. The TIP was a comprehensive recovery program which incorporated corrective action activities in six broad categories: training organization and staffing; operator knowledge and skills; operator training materials; training processes and procedures; training corrective action program; and, training facilities. The TIP scope was eventually expanded to consider operations training programs at both IPEC units.
- Condition Reports (CRs) LO-IP2LO-2002-00029 and LO-IP3LO-2002-00010. These two CRs directed the performance of self-assessments on "Operations Training" for the respective units, to include the issuance of a report and corrective actions and the verification of corrective action completion and follow-up. The IP2 CR was issued in September 2002, and the IP3 CR in May 2002. Both CR's identified a number of areas for improvement which Entergy tracked as separate corrective actions required under the originating CR. Both units' reports were used as input for the respective unit's Operations Training Accreditation Self-Evaluation Reports.
- Accreditation Self-Evaluation Reports (ASERs). IP2 completed an ASER in September 2002, and IP3 completed one in January 2003, with both evaluations done to support the National Nuclear Accrediting Board accreditation renewal process. The ASERs evaluated their respective unit's operations training program in a manner similar to the accreditation team visit, providing assessment in six areas: training for performance improvement; management of training processes and resources; initial training and qualification; continuing training; conduct of training and trainee evaluation; and, training effectiveness evaluation.

- Accrediting Board Team Reports. Accreditation teams visited IP2 in October 2002 and IP3 in February 2003. These visits were intended to provide an independent evaluation of the IPEC operations training programs against the industry standards. These reports evaluated the programs across the same six areas as the IPEC ASERS and included both team-identified and IPEC-identified findings.
- Operations Department and Training Department Performance Indicators (PIs). IPEC maintains and tracks several dozen PIs covering various attributes of the operations and training departments' performance. The PIs distinguish between the different unit's performance levels, where necessary, and trend performance over the previous rolling year, comparing performance results against pre-established action level thresholds.
- NRC Supplemental Inspection Report 50-247/02-09. The NRC performed this supplemental inspection to assess Entergy's evaluation associated with crew high failure rates during facility-administered annual licensed operator requalification examinations in September-October 2001. The original performance issue had been characterized as Yellow in NRC Inspection Report 50-247/01-13. In Report 02-09 the NRC determined that Entergy had identified appropriate causes for the Yellow finding and that reasonable corrective actions had been included in the Training Improvement Plan.

b. Findings and Observations

No findings of significance were identified.

The inspector observed that the IPEC TIP was a comprehensive approach to improving the training programs at IPEC. The TIP included hundreds of specific corrective action activities, the large majority of which had been closed out by the end of calendar year 2002. The corrective actions initiated as a result of the NRC Yellow finding related to operator requalification testing had been substantially completed. The inspector's sampling of the closure packages for a number of TIP corrective actions indicated that Entergy had satisfactorily addressed the identified issue and had involved the proper level of management oversight. The few remaining open actions related primarily to the continuation of the developed corrective action processes and to the development of the Unit 2/3 Training Business Plan for 2003.

The review of condition reports (LO-IP2LO-2002-00029 and LO-IP3LO-2002-00010) and the two ASERs indicated that the IPEC training department had approached this set of self-assessments with the same rigor that had been applied to the TIP. The inspector noted that Entergy had been open and self-critical in the assessment of their own training programs and applied reasonable corrective actions. The licensee's effort was reflected in the two accreditation renewal visits, in which the accreditation teams recognized Entergy's self-identified findings and identified no new ones of their own. By the time of this inspection, Entergy had addressed and closed out all of the findings associated with the accreditation reports.

From the review of the IPEC Training Department Integration Project Plan and the IPEC Performance Indicators, and from discussions with IPEC management, the inspector determined that Entergy had the measuring tools and processes in place to successfully transition from the TIP as a primary guidance document to the Unit 2/3 Training Business Plan.

### Summary

Entergy has combined the two, previously-separate, training programs. The inspector found that the Entergy self-assessment processes, and the corrective action programs developed from them, had identified and substantially addressed long-standing problems in the existing training programs, and had provided for continuing improvement in the combined Training Department. Although some corrective action items remain open, and the transition to one training program for both units is not yet complete, the inspector concluded that the Entergy staff was effectively implementing training program evaluations and making improvements along the way.

#### 40A5 Other Inspection Activities

##### a. Scope

Inspectors interviewed approximately sixty-five personnel involved with the Unit 2 and Unit 3 operations training programs. This number included instructors (involved with the initial licensed operator class and requalification class), license holders (senior reactor operators, reactor operators, and watch engineers), shift technical advisors, students that had either just completed the initial license operator (ILO) class or had been in the ILO class at one time, and non-licensed plant operators.

The interviews, and where appropriate followup inspections, focused on specific attributes of the training rule described in parts 10 CFR 50.120 and 55.4, and included: whether certain aspects of the operations training programs, e.g., lesson plans, system descriptions, scenario exercises, operating procedures (including those used for normal, abnormal, and emergency operations), quality of instruction and course presentation were acceptable and up-dated; whether training management fostered an atmosphere where students and instructors were free to raise issues; whether students enrolled in the ILO class were prepared for the subsequent NRC license examinations; and whether the training programs for ILO and licensed operator requalification training had sufficient numbers of qualified instructors who possessed adequate, plant-specific technical knowledge.

##### b. Findings and Observations

No findings of significance were identified.

However, the results of the interviews indicated that from about August 2001 through October 2001 the Unit 2 ILO program exhibited deficiencies in the area of course design and implementation. In particular, lesson plans, instructor technical knowledge, and instruction quality were deficient. The following observations were based on inspections

and also feedback from interviews with IP2 trainees and instructors involved with the Unit 2 ILO program.

#### Deficient Lesson Plans

The IP2 ILO class began in May 2001, under the direction of ConEd staff. From May to July, the class concentrated on generic reactor fundamentals. However, during the plant specific systems phase of the class, which began in August 2001, students noted lesson plans for some systems and administrative portions of the program were technically incorrect. Outdated material was either corrected on the spot in class or put aside for further research and then corrected. The results of the research were shared with the class at a later date and also used to update training material for future use. In mid-August, a student in the ILO class generated Condition Report (CR) IP2-2001-07934 that documented this problem. In early November, the new licensee, Entergy, combined this CR with other training-related CRs into a Level 1 CR, IP2-2001-11001. Subsequently, the licensee suspended ILO training for 3 months (from November 2001 to January 2002) while the training staff corrected course material.

#### Deficient Instructor Technical Knowledge and Material Presentation

Several instructors who initially taught the systems and administrative training portions of the program exhibited weaknesses in their knowledge level and plant specific experience. Also, some instructors simply read to the students from the lesson plans. Entergy addressed these issues when they replaced instructors who exhibited poor instructional skills and/or lacked Unit 2 technical knowledge with more knowledgeable and skilled staff.

#### Summary

The inspectors determined the deficiencies associated with the Unit 2 initial license class training constituted a violation of regulatory requirements as discussed below in Section 4OA7. The inspectors also noted the deficiencies are historical in nature, were addressed in the response to the Level 1 CR, and have been essentially corrected.

Also, as documented in NRC Examination Report 50-247/2003-301, recent initial exam results for Unit 2 indicated that two of six applicants were denied licenses. This information did not represent a deficiency in the initial license operator program for several reasons. First, independent information indicated the program has improved and continues to improve. Second, the two applicants passed the written exam and two of three sections of the operating test. Third, the total number of applicants was small so any inference based on the failure rate is inappropriate and the use of pass/fail rate statistics for initial exams does not apply to MC 0609 Appendix I SDP analysis.

#### 40A6 Meetings, including Exit

On April 23, 2003, the team presented inspection results to Mr. F. Dacimo and other members of his staff who acknowledged the findings. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

#### 40A7 Licensee-Identified Violations

The following violation of very low safety significance (Green) was identified by the licensee and is a violation of NRC requirements which meet the criteria of Section VI of the NRC Enforcement Policy, NUREG-1600 for being dispositioned as a Non-Cited Violation (NCV).

10 CFR Part 50.120 requires that the facility implement a training program derived from a systems approach to training (SAT) as defined in 10 CFR 55.4. 10 CFR 55.4 defines SAT as a training program that includes five elements, one of which - element 3 - is training design and implementation. Contrary to the above, from about August 2001 through October, 2001, aspects of Unit 2 initial license training design and implementation were deficient. Specifically, lesson plans contained inadequate detail and content, instructors demonstrated weak technical knowledge, and the quality of training presentations was poor. These findings are documented in the licensee's corrective action program as a Level 1 Condition Report, No. IP2-2001-11001. The findings are of very low safety significance because the conditions affected students who could not be assigned control room watchstanding duties, the licensee corrected deficiencies in lesson plans, and replaced instructors with poor instructional skills and/or who lacked Unit 2 technical knowledge.

## Attachment 1

### KEY POINTS OF CONTACT

#### Licensee Personnel

L. Cortopassi Training Manager  
F. Wilson Superintendent, Operations Training  
T. Jones Licensing  
S. Joubert Unit 3 Initial License Training  
P. Griffith Licensing  
J. McCann Manager, Nuclear Safety and Licensing  
F. Dacimo Site Vice President  
C. Schwarz General Manager, Plant Operations

### LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

#### Opened

None

#### Open and Closed

None

#### Closed

FIN 50-247/01-013-01 Yellow Finding At Indian Point 2: Crew High Failure Rate During Licensee-Administered NRC Annual Operating Tests

#### Discussed

None

**LIST OF ACRONYMS**

ConEd	Consolidated Edison
IPEC	Indian Point Energy Center
SDP	significance determination process
NCV	non-cited violation
PI	performance indicator
CFR	Code of Federal Regulations
NRC	Nuclear Regulatory Commission
OTRG	Operations Training Review Group
CARB	Corrective Action Review Board
LOR	licensed operator requalification
ILO	initial licensed operator
CR	condition report
TIP	training improvement plan
ASER	accreditation self-evaluation report