

United States Nuclear Regulatory Commission PLANT ISSUE MATRIX

By Primary Functional Area / Issue Date

Region I

INDIAN POINT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
01/24/2000	1999011-01	Pri: Sec:	NRC	NCV	Pri: Sec: Ter:	Inoperable Cable Spreading Halon System
Dockets Discussed: 05000247 Indian Point 2						
01/24/2000	1999011-02	Pri: Sec:	NRC	NCV	Pri: Sec: Ter:	Failure to Test Cable Spreading Room Halon System
Dockets Discussed: 05000247 Indian Point 2						
01/24/2000	1999011-03	Pri: Sec:	NRC	NCV	Pri: Sec: Ter:	10 CFR 50 Appendix B, Criterion XI, "Test Control"
Dockets Discussed: 05000247 Indian Point 2						
01/24/2000	1999011-04	Pri: Sec:	NRC	NCV	Pri: Sec: Ter:	10 CFR 50 Appendix B, Criterion XI, "Test Control"
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: OPS Sec:	NRC	MV	Pri: 1C Sec: Ter:	Implementation of a Temporary Facility Change The inspector identified deficiencies in a temporary facility change that installed a demineralizer for the Unit 1 spent fuel pool. Although the deficiencies did not impact safety and were promptly corrected, the NRC continued to identify recurring problems implementing temporary facility changes.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: OPS Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Review of Licensee Event Reports Event reports submitted per 10 CFR 50.73 were acceptable. The control rod deviation monitor was inadvertently disabled because software changes were not properly controlled during March 1999 testing of the plant computer for Year 2000 compliance. The inspector verified that the applicable technical specification was not violated because the control rods remained properly aligned and operator logs fulfilled the technical specification requirements.
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12/07/1999	1999010	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Operational Safety Verification The inspectors verified that the facility was operated safely and in accordance with technical specification requirements. A nuclear plant operator adequately performed rounds and was knowledgeable about parameters to monitor. However, some degraded conditions required the use of supplemental logs. The auxiliary feedwater system was verified operable; components were properly labeled and material conditions were acceptable.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: OPS Sec:	NRC	POS	Pri: 5A Sec: 1C Ter:	Nuclear Facilities Safety Committee The Nuclear Facilities Safety Committee fulfilled its responsibilities in accordance with technical specifications. The committee considered initiatives to improve oversight of plant activities. The initiatives will be considered in future committee meetings.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-01	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Failure to establish and implement procedures required by TS 6.8.1 (4 examples) Because an appropriate procedure did not exist, condition monitoring of No. 24 station battery was not performed as required by Technical Specification (TS) 4.6.C.1 when No. 24 battery charger was lost. Failure to establish a procedure for performing a surveillance test required by the technical specifications was the first example of a non-cited violation of TS 6.8.1. Failures to operate the turbine-driven feedwater system in accordance with the system operating procedure when feed regulating valve FCV-405D failed open on loss of power, and to document the deviation in a condition report were the second and third examples of a non-cited violation of TS 6.8.1. Lack of procedures for responding to and recovering from loss of a single 480 Volt vital bus was a contributing factor in the untimely restoration of offsite power to the vital buses during the August 31 event. This was the fourth example of failure to establish and implement procedures as required by TS 6.8.1.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-02	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Violation of essential service water TS 3.3.F.1.b During the August 31, 1999, loss of offsite power event, operators exceeded the limiting condition for operation of TS 3.3.F.1.b concerning operability of the essential service water system. Failure to cool down the plant within the required time was a non-cited violation of the TS.
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	RECOVERY EFFORTS FOR RESTART READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. Our inspectors noted many examples of mixed performance in the your recovery efforts. For example, our probing led to the identification that a safety related breaker had been returned to service even though data obtained during testing was out of your pre-approved tolerances. Also, during training of your plant operators on your newly issued procedure for recovery of a 480 volt safety bus following loss of power, a number of discrepancies were identified that necessitated a procedure revision. Overall, we found that, despite the mixed performance, your use of multiple, diverse reviews assured quality in your recovery efforts. We consider your staff and management ability to identify and resolve conditions adverse to quality in need of longer term improvement. You initiated a significant effort to improve human performance in station activities
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12/20/1999	1999013	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Con Edison clarified the chain of command roles and responsibilities informally Following the August 31 event, ConEd clarified the chain of command roles and responsibilities for the operation manager, the plant manager, and the station vice-president. The inspectors found that this action was done informally and were concerned that ConEd had not formalized the roles and responsibilities to ensure that the corrective action would be sustained.
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Con Ed implemented Abnormal Operating Instruction AOI 27.1.13 without operator verification ConEd implemented Abnormal Operating Instruction AOI 27.1.13, "Loss of a 480V Bus," without operator verification. Subsequently, during training of operators on the procedure, a number of discrepancies were identified causing ConEd to revise and improve the procedure. The inspectors considered that the ConEd action to implement an operations abnormal procedure prior to verification by an operating crew to be an example of weak performance.
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12/20/1999	1999013	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	Con Ed had not implemented compensatory measures for operation of the emergency diesel generator make The inspectors found that ConEd had not implemented administrative compensatory measures for operation of the emergency diesel generator makeup water expansion tank when the automatic fill capability was disabled. Specifically, guidance for manual filling of the 23 EDG jacket water expansion tank was not provided to the operators.
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12/20/1999	1999013	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	The Con Ed Station Nuclear Safety Committee review was lacking in critical review The ConEd Station Nuclear Safety Committee review of the August 31 event condition report, (SL-1 report) was lacking in critical review of having the station transformer load tap changer in the manual position for an extended period of time. Specifically, the committee did not initially recognize the manual position as a potential unreviewed safety concern and did not question the operability aspects of the deficient condition during a session attended by the inspectors. The inspectors found that a critical level of quality control was not exercised in this case during review by the Station Nuclear Safety Committee.
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12/20/1999	1999013	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	MANAGEMENT'S SHORT TERM RESPONSE TO AUGUST 31 EVENT READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. We found that you devoted substantial resources to determine the causes of the event and the resulting corrective actions involved many aspects of the Indian Point Unit 2 facility. We found that your short-term corrective actions as a result of your reviews and investigations were adequate in overall scope and priority to support the safe restart and operation of Indian Point Unit 2.
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Con Ed senior management stated a commitment to improve station performance ConEd senior management stated a commitment to improve station performance, and a number of long term efforts were planned. Some of these plans were included in the revision 2 to the recovery plan. For example, ConEd stated that they would seek human performance improvements to address the various human performance deficiencies identified during the recovery effort. Further, ConEd stated that they would conduct effectiveness reviews of the corrective actions that they took for the various problems.
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12/20/1999	1999013-10	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	ConEd did not have instructions for operation of the 23 emergency diesel when the jacket water expansion t The inspector identified that a temporary procedure change should have been processed when the manual water makeup valve was closed. Station Administrative Order SAO-204, "Work Control," Section 2.8, required that a procedure or revision shall be prepared if a procedure cannot be implemented as written due to a deficiency. When identified, ConEd initiated a condition report, CR 199907756, to address the error and a temporary procedure change was added to the required guidance to SOP-27.3.1.3. Technical Specification 6.8.1 required that written procedures be established and implemented covering the recommendations covered by NRC Regulatory Guide 1.33, Revision 2. The regulatory guide included procedures for operation of emergency power sources, including diesels. ConEd not having procedures for control of EDG jacket water level was a non-cited violation of NRC requirements. This issue is in the ConEd corrective actions system as CR 199907756. (NCV 50-247/99-13-10)
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: OPS Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Implementation of Temporary Facility Changes The NRC noted continued performance lapses in the temporary facility change (TFC) process. Two errors during a TFC to supply alternate control power to safety bus 2A resulted in a condition prohibited by technical specifications 3.0.1, which was not recognized by the operators in a timely manner. Subsequent actions to complete the TFC and correct the errors were well controlled. Con Edison assured that no emergency condition was created while implementing the TFC. Procedures did not provide detailed guidance for the declaration of an emergency on the loss of control room annunciators.
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10/25/1999	1999009	Pri: OPS Sec:	NRC	NEG	Pri: 5C Sec: Ter:	Operational Safety Verification The inspectors noted several degraded conditions on Gas Turbine No. 1 (GT-1) that were not properly addressed in the corrective action process. The deficiencies did not impact the operability of GT-1. Con Edison prepared the plant for cold weather, and scheduled timely corrective maintenance on risk significant components.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1B Sec: Ter:	Reactor Startup The inspector observed that operator actions during the reactor startup were consistent with the requirements in plant operating procedure (POP) 1.2, "Reactor Startup." The pre-job briefings for the reactor startup were consistent with the station expectations. Reactor engineering provided good support to operations during the startup. Equipment problems that occurred during the reactor startup were appropriately addressed.
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10/25/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Operations Self Assessment Activities Operations self-assessments were critical and identified areas for improvement; however, due dates for specific goals were exceeded for improvement items.
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10/25/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 2B Sec: Ter:	Hurricane Floyd Operators properly responded to Hurricane Floyd, and management provided appropriate support. NRC inspection identified locations in which rainwater ingress potentially impacted operability of risk significant equipment. Con Edison took prompt actions to protect the safety-equipment.
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10/25/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 4B Sec: Ter:	Operability of 480 volt Safety Bus Tie Breaker 2AT3A An operability determination and safety evaluation associated with a degraded 480V safety tie-breaker were acceptable. The procedures impacted by the degraded condition were appropriately revised. In addition, the breaker is not relied upon for accident mitigation.
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10/25/1999	1999009	Pri: OPS Sec:	NRC	POS	Pri: 4B Sec: Ter:	Extent of Condition Reviews on Degraded Components Control room deficiencies were properly evaluated by Con Edison consistent with NRC guidance in Generic Letter 91-18 to justify extending the time to correct degraded conditions. Operability assessments were technically justified and timely, and compensatory measures were appropriate.
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10/25/1999	1999009-01	Pri: OPS Sec:	NRC	NCV	Pri: 1B Sec: Ter:	Operators Not Adhering to System Operating Procedure Poor work coordination challenged operators and caused an unexpected reactor coolant system pressure increase. Operators inappropriately increased seal injection flow to a value greater than allowed in a system operating procedure.
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09/06/1999	1999007	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: Ter:	Insufficient operator monitoring The NRC identified an instance of insufficient operator monitoring of air consumption to the weld channel and penetration pressurization system. Although it was later determined that the air consumption did not exceed the technical specification value, operators did not question the abnormal operation of flow integrator for zone 2 of the weld channel and penetration pressurization system. Con Edison entered this deficiency into the condition reporting system.
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09/06/1999	1999007	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: 2B Ter:	Walkdown of the component cooling water system The NRC performed a detailed walk-down of the component cooling water system. The NRC identified a long-standing deficiency in that the flowrate to the seal water heat exchanger was in excess of that specified in the system operating procedure. The inspector also noted the system engineer did not detect this deficiency during a July 1999 walkdown. In addition, the existing operator logs would not have revealed this deficiency. Although the impact on operability was minimal, it could have been more severe since adequate configuration controls had not been previously specified.
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09/06/1999	1999007	Pri: OPS Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Implementation of a temporary facility change The NRC identified an example of poor implementation of a temporary facility change in supplying fire water from a hydrant to a temporary demineralization plant. Con Edison did not perform an adequate review of the safety evaluation concerning the consequences of a fire hose rupture on the fire suppression system. Further, Con Edison's inattention to detail resulted in the identification of the wrong fire hydrant and the incorrect size of fire connections documented in the temporary facility change.
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09/27/1999	1999008	Pri: OPS Sec:	Licensee	NEG	Pri: 1B Sec: Ter:	Operator Performance During Reactor Trip Operator performance during the reactor trip on August 31, 1999 was mixed. Although operators accomplished emergency operating procedures well, performance weaknesses were noted in communications, entries into technical specifications limiting conditions for operation (LCOs), and actions related to the discharge of the 24 battery.
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09/27/1999	1999008	Pri: OPS Sec:	NRC	NEG	Pri: 1B Sec: Ter:	Management Oversight of and Response to the Reactor Trip Management oversight of and response to the reactor trip on August 31, 1999 and recovery actions were weak in several respects. Actions during and following the event were not focused on understanding and limiting further risk to the plant, but instead were focused on developing shutdown work plans and schedules. Senior plant management did not establish clear expectations that recovery from the degraded plant conditions was a priority over preparations for shutdown work activities.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: OPS Sec:	Self	NEG	Pri: 4B Sec: Ter:	Recovery Plans Were Poorly Coordinated After Loss of Power to Bus 6A Recovery actions were poorly coordinated. Equipment restoration plans and contingency planning were not clearly understood or fully developed. Support provided by the engineering and maintenance organizations was not fully effective. Plans to develop temporary facility changes for alternate power supply were untimely and, thus, did not prevent depletion of battery 24 and the subsequent loss of most of annunciators. In addition, troubleshooting activities for bus 6A were not well planned, preventing the timely restoration of emergency power to bus 6A.
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09/27/1999	1999008	Pri: OPS Sec:	Self	NEG	Pri: 4B Sec: Ter:	Support Provided to Plant Operators by Various Departments Was Weak The event revealed instances, both preceding and during the event, in which the support provided to plant operators by various departments was weak. The reactor protection system anomalies were not properly communicated among operations, engineering, and maintenance organizations. The 480 V degraded voltage relay reset setting was not properly translated into test procedures by engineering and maintenance organizations. The licensing bases of the load tap changer was not translated into plant procedures by licensing and engineering organizations. The emergency plan procedure was deficient because it did not contain adequate information for declaring an Unusual Event when offsite power is unavailable to the 480 V vital buses. Lastly, during the event, engineering and maintenance did not prevent the depletion of battery 24.
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08/24/1999	1999006-01	Pri: OPS Sec:	NRC	VIO IV	Pri: 2B Sec: Ter:	Temporary Facility Changes The NRC identified two examples of poor implementation of temporary facility changes (TFC) that indicate a failure to accomplish activities in accordance with instructions and procedures. The deficiencies involved a failure to initiate a temporary facility change for gas turbine-2, and a failure to fully implement safety evaluation limitation into a procedure for gas turbine-2. The corrective actions for the previous failure to initiate a TFC were narrowly focused on Unit 1 activities and failed to preclude recurrence of the violation at Unit 2. This is a Severity Level IV violation
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08/24/1999	1999006-02	Pri: OPS Sec:	NRC	NCV	Pri: 5A Sec: Ter:	Untimely LERs LER 99-011 was submitted greater than the 30 days after discovery of the event as required by 10 CFR 50.73(a)(1). Previous NRC inspection reports 50-247/98-02 and 50-247/99-03 documented LERs not issued within the 30 days of discovery of the underlying events. Con Edison identified this deficiency and initiated condition report 199905563. The repetitive failure to correct untimely LERs is considered a Severity Level IV violation of 10 CFR 50.73(a)(1) and is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy (NCV 50-247/99-006-02.)
Dockets Discussed: 05000247 Indian Point 2						
07/02/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Initial Licensing Exams Seven reactor operator (RO) applicants and one instant senior reactor operator (ISRO) applicant were administered initial licensing examinations. All RO applicants passed the examination. The ISRO failed the written portion, and passed the operating portion of the examination.
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07/02/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Operating Test Performance During the operating portion of the test, the examiners made positive observations on applicants performance as follows: strict procedure adherence; very good communications and feedback; and good crew briefings. Overall, the applicants were well prepared for the examination.
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07/02/1999	1999301	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Operator Exams Facility review of the NRC staff-developed examination resulted in an effective conduct of the generating test and no post examination changes to the written test.
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06/08/1999	1999003	Pri: OPS Sec:	NRC	NEG	Pri: 2A Sec: Ter:	PASS Evaluations Our evaluation of selected portions of the post-accident sampling system found several equipment deficiencies, plant drawing deficiencies and component labeling deficiencies which would challenge a chemistry technician's ability to acquire a sample during a postulated emergency. Your short-term corrective actions appropriately considered extent of condition for the sampling systems and each NRC observation was appropriately placed into the problem identification process.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: OPS Sec:	NRC	POS	Pri: 2A Sec: Ter:	Service Water System Walkdown The inspectors performed a detailed walk-down of the service water system. The system was determined to be capable of performing its intended safety function. Several minor deficiencies were identified and were entered into the corrective action system.
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04/27/1999	1999002-02	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Inoperable Rod Monitors An in-office review of LER 50-03/99-001 was performed. The LER documented failure to adhere to Unit 1 technical specification 2.10.2.4 on January 16, 1999. Specifically, for approximately one day, no provisions were established to promptly notify a licensed operator upon actuation of the spent fuel pool portable radiation monitor. The portable radiation monitor would not have alarmed given an unintended loss of power. This item was previously documented in NRC IR 50-247/99-01. The cause for the loss of the normal spent fuel pool radiation monitor was insufficient information available concerning Unit 1 electrical loads that were impacted by planned maintenance. Further, past experience during the performance of the daily surveillance PT-D4, "Radiation Monitor Channel Checks," did not adhere to the requirements in TS 2.10.2.4. The inspector confirmed that corrective actions including Unit 1 electrical load verifications, improvements to the work planning process, and considerations on changes to the Unit 1 technical specifications were appropriate. This failure to promptly notify a licensed operator upon actuation of an alarm on the portable radiation monitor for one day is considered a violation of Unit 1 TS 2.10.2.4. This Severity level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This violation is in Con Edison's correction action program as condition report 199900374. (NCV 50-247/99-002-02) This LER is closed.
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03/15/1999	1999001	Pri: OPS Sec:	NRC	NEG	Pri: 1A Sec: Ter:	Rod Insertion Event The inspectors reviewed Con Edison's response to a rod insertion event. The operators did not recognize the event for approximately two hours because of inadequate control board monitoring, incorrect log-keeping, and inadequate audible cues that automatic control rod motion was occurring. Con Edison's evaluation of the event was timely and thorough with good identification of causal factors and corrective actions.
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03/15/1999	1999001	Pri: OPS Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	Poor Configuration Control Involving Caution Tags The inspectors identified a poor configuration control practice involving the use of caution tags on degraded components. Specifically, Con Edison did not have a defined means of ensuring removal of the tags upon resolution of the degraded condition.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001-01	Pri: OPS Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Inadequate Control of Temporary Facility Changes A Non-Cited Violation was identified pertaining to a failure to meet requirements of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings." It requires, in part, that activities affecting quality be prescribed by appropriate procedures. Contrary to this requirement, the NRC identified that procedure RW-4.801, used for a temporary facility change (TFC) for Unit 1 spent fuel pool demineralization, was inadequate because it did not incorporate design assumptions and values specified in the supporting safety evaluation. Because of the procedure deficiency, you operated a system outside of the allowable values contained in the safety evaluation. In addition, some administrative deficiencies were noted in the review and installation of other TFCs.
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02/01/1999	1998019	Pri: OPS Sec:	Licensee	NEG	Pri: 1A Sec: Ter:	Protective Tagout Error on 21 EDG Inspector assessment of a protective tagout (PTO) error on the 21 emergency diesel generator (EDG) concluded that no violation of NRC requirements occurred. Tagout errors included failure of the independent verification process, failure of the Nuclear Plant Operators (NPOs) to consult operator aids located on the inside of each of the power and distribution panels that state the function of each breaker in the panels, an incomplete pre-job briefing, and the failure by the NPOs to question tag location which the tagout sheet stated was within the control room that in practice would require a reactor operator to attach the tag. While corrective actions from a previous violation in early 1998 involved independent verification of PTOs, the trend since that time has generally improved with respect to PTO installation and removal problems. The inspector assessed that Con Edison's short-term corrective actions for this current event were appropriate and timely. As the error was identified by a job supervisor prior to work commencing there was no actual adverse personnel safety consequence. The impact on plant systems was inconsequential as the PTO error de-energized non-10 CFR 50 Appendix R emergency lights in the EDG room for approximately 5 hours.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	NEG	Pri: 1C Sec: Ter:	RHR System Walkdown The inspector walked down a portion of the residual heat removal system. The inspector independently verified the valve positions in the field against the check off lists and found no discrepancies and material condition was observed to be adequate. Three unauthorized operator aids were identified and brought to the attention of management for resolution. The inspector also observed five deficiency tags present on components although the corrective maintenance work was complete. The concern with leaving deficiency tags in place once corrective maintenance is completed is that if a problem should occur again with the tagged component, individuals could be misled into thinking the problem has already been identified. This issue was discussed with plant management and Con Edison committed to perform a review of the implementation of the deficiency tag system.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Pre-job Briefings Pre-job briefings for various activities including containment entries and equipment tagouts were acceptable. Inspector observations of Nuclear Plant Operators during isolation of Unit 1 motor control center 10F and the 23 control rod drive fan indicated good verification of tags and equipment labeling. However, both the briefing and work planning failed to identify a loss of meteorological instrumentation that would occur when the tagout was applied. Shift turnover briefings provided an accurate account of plant conditions and equipment deficiencies.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	POS	Pri: 1A Sec: Ter:	Non-licensed Operators The inspectors observed that non-licensed operators appropriately adhered to instructions provided during implementation of two system operating procedures for the alignment of electrical equipment at Unit 1. Implementation of the procedure for containment at-power entry was also observed and was noted to be properly implemented. The visual inspection of containment appropriately documented minor equipment deficiencies and verified acceptable operation of safety-related functions.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	POS	Pri: 1C Sec: Ter:	Nuclear Facilities Safety Committee Subcommittees The inspectors attended portions of several Nuclear Facilities Safety Committee (NFSC) subcommittees. The inspectors noted that there have been substantial changes made in the leadership of each subcommittee as well as the makeup and leadership of the full committee. This change was implemented in response to concerns raised regarding the makeup and effectiveness of the NFSC during the Independent Safety Assessment (ISA), conducted March 1998. The inspectors observed good discussions at the subcommittee meetings including discussion on format changes to improve meeting effectiveness.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: 5C Ter:	Corrective Action Review Board Meetings The corrective action review board meetings for three Significance Level I events provided an appropriate environment for discussing proposed corrective actions and the timeliness of those actions.
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02/01/1999	1998019	Pri: OPS Sec:	NRC	POS	Pri: 5B Sec: 5C Ter:	Indian Point Program for Excellence The inspectors observed the initial set of reviews for items contained in the Indian Point Program for Excellence (IPPE) for the areas of Operations, Engineering, and Work Control and Maintenance. Individuals making presentations for closure or status update of items were noted to be well prepared, and senior management discussed and questioned the items presented for closure. A number of IPPE items were verified closed by the review panel based upon credit for procedural changes, quality assurance surveillances, or industry self-assessment visits. Critical discussions resulted in maintaining specific elements open or in extensions to the proposed due date. The inspectors noted that there was no indication of pressure to close items prematurely or with inadequate information to justify closure. The inspectors noted limited progress in the area of Work Control and Maintenance due to resource (personnel) constraints.
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02/01/1999	1998019-02	Pri: OPS Sec:	Licensee	NCV	Pri: 3A Sec: Ter:	Failure to Declare Valve Inoperable An in-office review was performed of LER 98-021-00. This LER documented that on December 19, 1998, automatic containment isolation valve 956D (pressurizer liquid sample space valve) failed to meet its TS required maximum stroke time of 10 seconds during the performance of PT-Q13, "Inservice Valve Test." Licensed operators failed to recognize that the TS time value was not met. This fact was not discovered until a subsequent review by the inservice test engineer on December 21, 1998. The failure to meet the four hour time requirement of TS 3.6.A.3 to deactivate the effected inoperable automatic containment isolation valve is a violation of NRC requirements. However, this non-repetitive licensee identified and corrected violation is being treated as a non-cited violation, consistent with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: MAINT Sec:	Self	NEG	Pri: 3C Sec: 2A Ter:	Maintenance Observations Plant material deficiencies continue to challenge the plant staff. Con Edison successfully addressed several significant deficiencies, but the total amount of outstanding work remained high and continued to challenge the operators and plant staff. Con Edison provided good control and oversight for high risk maintenance activities.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/07/1999	1999010	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Potential Water Intrusion in Diesel Generator Fuel Oil Supply The licensee was adequately trending and monitoring emergency diesel generator fuel oil samples. The fuel oil supply was verified to be not contaminated with water.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 2B Ter:	Potential Degradation of Emergency Diesel Generator Electrical Cables The material condition of emergency diesel generator electrical components and control wiring was acceptable. The inspector noted that oil had leaked into the conduit for the 23 emergency diesel generator which Con Edison evaluated and determined to be acceptable. The preventive maintenance procedure to inspect electrical components and control wiring had appropriate instructions and tests to evaluate the adequacy of emergency diesel generator components.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010-01	Pri: MAINT Sec:	NRC	IFI	Pri: 3A Sec: Ter:	Auxiliary Feedwater Pump Bearing Cooling Surveillance tests observed during the period were acceptable. Minor deficiencies identified by the inspector were properly addressed. An open item will follow Con Edison's evaluation of the use of city water to provide supplemental cooling to the 21 and 23 auxiliary feedwater pump bearings.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-03	Pri: MAINT Sec:	NRC	E EI	Pri: 5C Sec: Ter:	Criterion XVI violation - inadequate corrective action for OT Delta T instrument problems ConEd did not adequately disseminate or evaluate conditions adverse to quality associated with the over-temperature/delta-temperature instruments in the reactor protection system. Failure to implement effective corrective action for erratic operation of the channel 4 OT T instrument directly contributed to a risk-significant plant trip and loss of offsite power event, and was an apparent violation of the corrective action requirements of 10 CFR 50, Appendix B, Criterion XVI.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/20/1999	1999013	Pri: MAINT Sec:	NRC	NEG	Pri: 2B	PLANT WORK BACKLOG CONTAINED UNVESOLVED SAFETY SIGNIFICANT ISSUES Sec: READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. We also found that there were other significant areas of weak performance needing your added attention and longer term followup to assure that the improvements you initiated as a result of the August 31 event are effective. A significant finding during the recovery effort was that your plant work backlog contained issues of safety significance that persisted without timely corrective action or performing a safety evaluation. You agreed to update your recovery plan because Consolidated Edison Company management has identified that there are a number of performance improvements to be achieved to avoid future significant challenges, such as experienced during the August 31, 1999, event. You submitted your recovery plan update on November 8, 1999. We plan to continue our close monitoring of your activities to ensure that plant operation can be conducted without undue risk to public health and safety. Based on the results of this inspection, the NRC has determined that a number of violations of NRC requirements occurred. The violations described in the attached report are being treated as a non-cited violations (NCV), consistent with Section VII.B.1.a of the Enforcement Policy (November 9, 1999; 64 FR 61142). All of the violations relate to your activities taken following the August 31,1999 event and your subsequent corrective activities. If you contest any of the violations or severity level of the NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear RegulatoryCommission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region I, the Indian Point Unit 2 Resident Inspector, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001. As stated earlier we will address separately, and at a later date, any enforcement directly related to the August 31, 1999, event and its causes. This report identifies these items as unresolved. Ter:
Dockets Discussed:						
05000247 Indian Point 2						
12/20/1999	1999013-05	Pri: MAINT Sec:	NRC	NCV	Pri: 4B	ConEd did not critically review the results of the calibration package and subsequently place a safety-related Sec: The inspectors questioned the reported results of amptector setpoint verification tests that indicated identical trip points for all three phases. As a result of these questions, ConEd reviewed the documented results of all the amptector tests performed with the updated methodology and found that an amptector had been accepted although the data indicated the amptector was out-of-calibration. The breaker had been returned to service as the 21 EDG output breaker (CR 199907582). This problem resulted in a second ConEd review and some additional testing. The testing of the questioned breaker (NP-99-10907) resulted in ConEd being unable to duplicate the initially recorded results. Upon retest, ConEd found that the breaker's amptector settings were within tolerance and could not explain the deficient as-left settings recorded and accepted in the calibration package. 10 CFR part 50, Appendix B, Criterion XV, requires that measures be established to prevent the inadvertent use of non-conforming components. Failure of the IP2 staff to critically review the results of the calibration package and subsequently place a safety-related component (breaker) back in service with a deficient amptector setting was a non-cited violation of NRC requirements. This issue is in the IP-2 corrective actions program as condition report CR 199907582. (NCV 50-247/99-13-05) Ter:
Dockets Discussed:						
05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/20/1999	1999013-07	Pri: MAINT Sec:	NRC	NCV	Pri: 5C Sec: Ter:	ConEd did not correct deficiencies including the saturation temperature monitor, the 23 accumulator level in: In their summary of the review of the corrective actions extent of condition report, ConEd identified that the station did not track or resolve control room alarm conditions as an appropriate priority. ConEd planned to improve performance in this area with improved operations documentation of alarm conditions, improvements in work control, improved work completion, and enhanced engineering response to deficient conditions. To support reactor startup, ConEd took action to ensure that control room alarms would be documented in the corrective actions system and engineering and maintenance would be sensitized to the higher priority needed to resolve these problems. The apparent failure to take timely corrective actions for the identified deficiencies; namely the saturation temperature monitor, the 23 accumulator level instrument, and the power range high flux setpoint were non-cited violations of NRC requirements. These issues are in the ConEd corrective actions system as condition reports numbered (CR199906113, CR199810074, and CR199808160) and were included in the ConEd corrective actions extent of condition review. (NCV 50-247/99-13-07)
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: MAINT Sec:	Self	NEG	Pri: 2A Sec: Ter:	Containment Hydrogen Monitoring System Heat Trace Deficiencies The installed containment hydrogen monitoring system remained inoperable due to the heat trace system deficiencies. The licensee had established an alternate monitoring method within the required time period. However, the delays in recognizing that the hydrogen analyzer was inoperable and in establishing appropriate compensatory measures were performance deficiencies.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: MAINT Sec:	NRC	NEG	Pri: 5A Sec: Ter:	Component Material Conditions The NRC identified several examples of long-standing degraded conditions on safety-related and risk significant pumps, which indicate a weakness in problem identification and corrective actions. The conditions revealed deficiencies in the tracking and review of degraded conditions, in causal analysis, in understanding of the licensing basis, and corrective actions effectiveness.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: MAINT Sec:	Self	NEG	Pri: 5B Sec: Ter:	Service Water Leakage into Steam Generators A leak in a high pressure feedwater sample cooler caused service water contamination in all four steam generators and significantly increased impurity levels above normal limits. The failure to fully evaluate operating experience was a missed opportunity to prevent the event. An operability determination provided an adequate basis to conclude the steam generator tubes were not significantly affected by the secondary chemistry excursion.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Maintenance Observations The conduct of maintenance was acceptable. The actions to investigate degraded conditions and restore a gas turbine to an operable status were timely. Deficiencies were noted in the control of fuses and the conduct of breaker testing. The pre-job briefing, and communication and coordination of activities were good for risk significant maintenance on a containment isolation relay.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Surveillance Observations The conduct of surveillances was acceptable. The pre-job briefing and work coordination of activities were good for risk significant testing of the rod drive motor generator set. An example of inattention to detail was noted during a test of the diesel fire pump.
Dockets Discussed: 05000247 Indian Point 2						

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09/06/1999	1999007	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Improper planning The conduct of maintenance was acceptable. Instances of improper planning resulted in the unplanned inoperability of an emergency diesel generator due to insufficient fuel oil inventory, and multiple containment entries to address accumulator level discrepancies. Initial maintenance to address air leakage from an air regulator for the steam admission valve to the 22 auxiliary boiler feedwater pump created additional leakage and resulted in extending by five hours the unavailability of this safety-related component.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Good work practices Con Edison demonstrated good work practices while removing the "A" reactor trip breaker from service. These practices included good procedure adherence, self-checking and communications. Proper radiological practices were observed during replacement of the reactor coolant system filter.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Observed surveillances NRC observed that surveillances were conducted well. Some difficulties with performing pump testing were identified as the responsibility for test performance was shifted from the test and performance personnel to operations personnel
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: MAINT Sec:	NRC	POS	Pri: 3C Sec: Ter:	Work control critiques The NRC observed acceptable quality and participation during work control critiques. Con Edison critiques continue to identify instances of poor planning and inadequate work preparation.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: MAINT Sec:	Self	NEG	Pri: 2A Sec: Ter:	Loss of Emergency Power Emergency power was lost to vital bus 6A because the short time over-current setting for the EDG 23 output breaker was set incorrectly, significantly below the design basis setting. Contributing to the loss of bus 6A was that the timing of the sequencing relays for safety loads was not properly selected, allowing for the potential for multiple loads to attempt to load on to the emergency diesel generator at the same time.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: MAINT Sec:	Self	NEG	Pri: 2B Sec: Ter:	Station Personnel Missed a Potential Opportunity to Identify a Breaker Amptector Test Methodology Problem Station personnel missed a potential, earlier opportunity to identify a breaker Amptector test methodology problem. Corrective actions for previous breaker problems, which addressed test methodology, had not been completed by the due date listed in the corrective action report.
Dockets Discussed: 05000247 Indian Point 2						

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08/24/1999	1999006	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Ineffective planning and execution of maintenance We are concerned with instances of ineffective planning and execution of maintenance activities during the period. Examples of ineffective maintenance planning and execution involved inadequate contractor oversight during gas turbine operations, poor planning and awareness of plant equipment as it relates to central control room ventilation, ineffective planning of leakrate surveillances, inadequate pre-job briefings for Unit 1 ventilation work, and poor coordination between operations and maintenance on containment isolation valve work. The consequences of the ineffective maintenance included in an entry into an abnormal operating instruction for an unexpected temperature rise in the central control room, the spread of contamination in Unit 1, and inoperability of a containment isolation valve.
Dockets Discussed: 05000247 Indian Point 2						
08/24/1999	1999006	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Conduct of maintenance was adequate The conduct of maintenance was adequate. However, instances of poor planning and undocumented deficiencies resulted in an unexpected increase in control room temperatures and the spread of contamination.
Dockets Discussed: 05000247 Indian Point 2						
08/24/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 2B Sec: Ter:	Observations of Fix-it-Now group NRC observations of the Fix-It-Now group indicated good interactions with operations, work control, and the health physics personnel. The conduct of maintenance by the maintenance group was adequate. Minor inconsistencies were observed by the NRC on planning of various work activities.
Dockets Discussed: 05000247 Indian Point 2						
08/24/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Observed surveillances were conducted well The observed surveillances were conducted well. In one case, the NRC identified that two surveillances impacting both reactor coolant and non-reactor coolant leakage into the vapor containment were planned in parallel, which resulted in an increase loss of monitoring capability to operators. Con Edison rescheduled the surveillances in series.
Dockets Discussed: 05000247 Indian Point 2						
08/24/1999	1999006	Pri: MAINT Sec:	NRC	POS	Pri: 5A Sec: 2B Ter:	Good quality and improved followup of deficiencies The NRC noted good quality and improved followup of deficiencies identified during work control critiques.
Dockets Discussed: 05000247 Indian Point 2						
06/08/1999	1999003	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Maintenance Observations Generally, the quality of maintenance activities observed was good. However, various minor deficiencies existed such as informal tracking of incorrect plant labeling for the reactor protection system, improper contamination controls during maintenance on a pure water valve, and a surveillance procedure deficiency. None of the deficiencies resulted in improper maintenance, testing, or inoperability of safety equipment.
Dockets Discussed: 05000247 Indian Point 2						

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04/26/1999	1999002	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Work Process Problems The inspectors noted work process problems, including: the use of unauthorized operator aids by a contractor during a specialized calibration of differential transmitters; inadequate post-modification testing for a modification to the pressure relief system; and identification of procedure problems during a pre-job brief that reflected a review and approval of recent changes to the procedure that was less than thorough.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Maintenance Observations The quality of the work observed was generally good. The inspectors observed proper pre-job briefs and communications techniques, as well as the proper use of error reduction techniques, such as self-checking and peer checking.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: MAINT Sec:	NRC	POS	Pri: 5B Sec: 3C Ter:	Failure of Automatic Control Power Transfer Appropriate actions were observed in Con Edison's reporting and evaluation of a degraded condition associated with the redundant control power circuit for safety bus 2A. Risk insights were appropriately used in the analysis of the event and subsequent operability determination, and in the timeliness of corrective actions for the problem.
Dockets Discussed: 05000247 Indian Point 2						
04/27/1999	1999002-03	Pri: MAINT Sec:	NRC	NCV	Pri: 3A Sec: Ter:	Missed TS Surveillance Interval An in-office review of LER 50-247/99-003 was performed. This item involved a missed TS surveillance involving the liquid effluent monitor for service water, the component cooling water radiation monitor, the house service boiler condensate return line, and the area radiation monitor for the drumming station. The cause of the failure to perform the surveillance was attributed to human error. Specifically, that partial completions of the surveillance were not properly tracked. The failure to perform the surveillance did not impact safety as the tests were promptly performed with acceptable results. For the area radiation monitor, the surveillance was not performed; however, no source material exists in the area for which the monitor was intended to perform a function. Con Edison documented in the LER that previous actions for missed surveillances were not fully effective in preventing this event. Specifically corrective actions involving events documented in LERs 98-001 and 98-017 and that were previously assessed for enforcement actions by the NRC. This Severity level IV violation of TS Table 4.1 and is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. NCV (50-247/99-002-03) This violation was identified by Con Edison and is in their corrective action program as condition reports 199900344, 199901251, and 199901252. This LER is closed.
Dockets Discussed: 05000247 Indian Point 2						
04/27/1999	1999002-04	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Missed TS Surveillance An in-office review of LER 50-247/98-018 was performed. This item was identified by a Quality Assurance (QA) audit of the radiological effluent program. This LER documented missed samples for the sphere foundation drain sump and the north curtain drain. Con Edison concluded that no impact existed for off-site dose calculations for missing the samples since the other samples that were taken had no measurable alpha radioactivity. The cause for the missed surveillance was attributed to lack of sufficient detail in the chemistry sampling program to ensure TS requirements were achieved. The inspector verified selected corrective actions which included development of a chemistry TS specification compliance program, and a revision to the sampling procedures that require the correct frequency. This Severity level IV violation of TS Table 4.10-1 is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. NCV (50-247/99-002-04) This violation was identified by Con Edison and is in their corrective action program as condition report 199908972 and 199909322. This LER is closed.
Dockets Discussed: 05000247 Indian Point 2						

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04/27/1999	1999002-06	Pri: MAINT Sec:	NRC	NCV	Pri: 2B Sec: Ter:	TS Violation NRC concerns regarding the adequacy of the surveillance test program were addressed in Inspection 98-02. Collectively, the procedure deficiencies are considered a violation of Technical Specifications (e.g., TS 4.1 and 4.7) that require safety-related logic circuits be periodically tested. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001	Pri: MAINT Sec:	NRC	NEG	Pri: 2B Sec: Ter:	Evaluation of Work Wontrol Process NRC evaluation of selected portions of the work control process indicated that problems exist in some areas. Inconsistent planning and scheduling of activities as well as problems with tagout accuracy contributed to an increase in safety-related component unavailability. Numerous minor discrepancies were observed between check-off lists and equipment labeling that challenged effective tagout preparations. An incomplete operational plan to isolate a Unit 1 lighting bus resulted in the unexpected de-energization of technical specification (TS) required equipment. The above issues were properly entered into your corrective action program. As a result of these problems, the Vice President-Nuclear Power implemented strong short-term measures to control maintenance activities affecting TS equipment until the development and implementation of comprehensive corrective actions.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001	Pri: MAINT Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Maintenance Work Activities Generally, the quality of the maintenance work activities observed was good. However, for several activities, the inspectors observed that station guidance was not met regarding pre-job briefing instructions and proper attendance at briefings.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Turbine First Stage Pressure Transmitter On-line replacement of the turbine first stage pressure transmitter, PT-412A, was well-planned and implemented. You developed a temporary operating instruction for controlling plant conditions during the replacement and practiced the evolution on the plant simulator prior to the work. The actual replacement went smoothly.
Dockets Discussed: 05000247 Indian Point 2						
02/01/1999	1998019	Pri: MAINT Sec:	NRC	POS	Pri: 3A Sec: Ter:	Maintenance Observations Performance by maintenance personnel in support of testing and maintenance activities was observed to be proper. During performance of a time critical test in the control room, the test was appropriately stopped when questions arose as to management expectations on communications standards for which the instrumentation and controls technicians had recently received training. The test was reperformed satisfactorily one week later after test revision and revision to the communications expectations. A repair to a leaking steam generator manway was performed satisfactorily, and because of incorporation of lessons learned from a similar repair in 1996, radiation dose was significantly reduced.
Dockets Discussed: 05000247 Indian Point 2						
02/01/1999	1998019	Pri: MAINT Sec:	NRC	POS	Pri: 3B Sec: Ter:	Surveillance Tests Using Simulator The inspector observed portions of several surveillance tests performed in the simulator in preparation for their performance on-line later in the year. The goals of performing these tests in the simulator were to verify alarms received, correct problems with the tests, validate the tests, and practice the recent communications training. These goals were all achieved with the exception of the reinforcement of communications training.
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02/01/1999	1998019	Pri: MAINT Sec:	NRC	POS	Pri: 3B Sec: Ter:	I&C Technician Training The inspectors observed training given to Instrumentation and Control technicians on new communications standards and expectations. The training provided expectations for communications, peer checking, procedural adherence and pre job briefing. Questions on differing expectations by technicians and supervisors over peer checking and two and three part communications while tripping bistables in instrument racks were identified and resolved appropriately.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 2B Sec: 4C Ter:	Backlog Management and Content The number of items in the engineering, maintenance and corrective action backlogs remains high and in most areas there has not been significant progress in reducing the backlog. Additional resources have been allocated and/or planned that are intended to improve the ability to reduce backlogs. While the plant staff was aware of the need to reduce the work backlogs and some progress was noted in isolated areas, efforts to date have been ineffective. The inspectors did not identify any issues that would have an impact on equipment operability.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: ENG Sec:	NRC	NEG	Pri: 4B Sec: 5C Ter:	Lack of Thorough Operability Decisions Two examples were identified where non-conforming conditions, associated with reactor protection system testing, were found to be acceptable for continued operation without having a thorough, documented engineering evaluation to support the operability conclusions. Subsequent evaluations by engineering were acceptable.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	System Readiness/Health Review System readiness/health presentation reviews were performed consistent with station procedures. Con Edison's decision to prioritize engineering service activities to support the refueling outage were appropriate.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 5A Ter:	IP2 Recovery Plant Long-Term Corrective Actions Revision 3 of the IP2 Recovery Plan described initiatives which appear appropriate to improve performance over a broad spectrum of station activities. NRC review continued at the end of the inspection period to further understand Con Edison's more detailed plans and evaluate their effectiveness in improving station performance.
Dockets Discussed: 05000247 Indian Point 2						

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12/07/1999	1999014-04	Pri: ENG Sec:	NRC	EEI	Pri: 1A Sec: 4B Ter:	Criterion III design control violation - load tap changer and undervoltage relay pickup settings (two examples) Though not a direct cause of the event, correct 480 Vac undervoltage relay pickup settings are important to meet the plant design basis requirement to minimize unnecessary transfers of the 480 Vac buses from the normal offsite supply to the emergency diesel generators. Failure to establish appropriate undervoltage relay pickup settings when modification EGP-91-06786-E was implemented was the first example of an apparent violation of the design control requirements of 10 CFR 50, Appendix B, Criterion III. Operation of the station auxiliary transformer load tap changer in the manual mode placed the plant outside of its licensing basis and directly contributed to the loss of offsite power to the four 480 Vac vital buses. Failure to translate applicable regulatory requirements and the design basis into procedures was the second example of an apparent violation of the design control requirements of 10 CFR 50, Appendix B, Criterion III. Extended power operation with the 138 Kilovolt electrical system inoperable was an apparent violation of TS 3.7.B.3.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-05	Pri: ENG Sec:	NRC	EEI	Pri: 1A Sec: 4B Ter:	Violation of TS 3.7.B.3 - 138 KV offsite power inoperable Operation of the station auxiliary transformer load tap changer in the manual mode placed the plant outside of its licensing basis and directly contributed to the loss of offsite power to the four 480 Vac vital buses. Failure to translate applicable regulatory requirements and the design basis into procedures was the second example of an apparent violation of the design control requirements of 10 CFR 50, Appendix B, Criterion III. Extended power operation with the 138 Kilovolt electrical system inoperable was an apparent violation of TS 3.7.B.3.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-06	Pri: ENG Sec:	NRC	EEI	Pri: 3A Sec: Ter:	Violation of TS 3.7.B.1 - No. 23 EDG inoperable An inadequate calibration and test procedure resulted in miscalibration of the 23 emergency diesel generator output breaker in May 1999. During the August 31, 1999, loss of offsite power event, the breaker tripped when bus 6A loads started, resulting in loss of the bus. Power operation in excess of seven days with an inoperable emergency diesel generator was an apparent violation of TS 3.7.B.1. Failure to implement an inadequate test program to assure satisfactory operation of the breakers' amptector trip units was an apparent violation of the test control requirements of 10 CFR 50, Appendix B, Criterion XI.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999014-07	Pri: ENG Sec:	NRC	EEI	Pri: 3A Sec: Ter:	Criterion XI test control violation - Amptector trip units An inadequate calibration and test procedure resulted in miscalibration of the 23 emergency diesel generator output breaker in May 1999. During the August 31, 1999, loss of offsite power event, the breaker tripped when bus 6A loads started, resulting in loss of the bus. Power operation in excess of seven days with an inoperable emergency diesel generator was an apparent violation of TS 3.7.B.1. Failure to implement an adequate test program to assure satisfactory operation of the breakers' Amptector trip units was an apparent violation of the test control requirements of 10 CFR 50, Appendix B, Criterion XI.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
12/20/1999	1999013	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	EVENT CAUSE DETERMINATIONS AND CORRECTIVE ACTIONS READER'S NOTE" ALL 1999013 PIM ENTRIES ARE ABRIDGED. The inspectors reviewed the root cause reports associated with the August 31 event and found that the direct, root, and contributing causes were adequately identified. Sufficient corrective actions were initiated to address basic causes. ConEd implemented Abnormal Operating Instruction AOI 27.1.13, "Loss of a 480V Bus," without operator verification. The action to implement an operations abnormal procedure prior to verification by an operating crew to be an example of weak performance. Following an extensive investigation, ConEd was unable to determine the cause of the reactor protection system spurious transients that initiated the event on August 31. The inspectors observed that ConEd did not evaluate the load tap changer in the manual mode when it was placed in manual in September 1998 or prior to the August 31 reactor event. The inspectors found the ConEd activities to evaluate and correct the overcurrent trip of the 23 emergency diesel output breaker on August 31, 1999, to be acceptable for safe restart and operation of the reactor plant.
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	EXTENT OF CONDITION REVIEWS AND OTHER SHORT TERM ACTIONS READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. The ConEd extent of condition reviews in engineering, operations, and corrective actions were adequate to support the safe restart and operation of the reactor plant. While the operations extent of condition review was initially lacking in critical review of some operational aspects of the event, the operations department eventually evaluated operator activities and specified actions to improve performance. The ConEd evaluation to support a modification initiated in 1991, was poor. ConEd did not evaluate the combined affect of solid-state and electro-pneumatic starting sequence timers on diesel loading. ConEd had not evaluated the consequence on diesel loading of moving the service water pump starting time closer to the component cooling pump and auxiliary feedwater pump starting times. ConEd during their recovery efforts replaced the AFW electro-pneumatic timing relay with a solid-state timer and completed testing of the station sequencers. When the timer was replaced, ConEd engineering had not evaluated the acceptance criteria used in testing the installed relay until questioned by the inspectors. The inspectors found that appropriate adjustments were made to the sample sizes or focus areas of the ConEd extent of condition reviews. The inspectors found the sample expansions and added reviews to be appropriate. The inspectors reviewed the process used to complete the degraded condition reviews for backlogged active work orders and performed an independent evaluation of a sample of the deficiencies that remained uncorrected for plant restart. The inspectors confirmed that the extent of condition reviews were adequate in scope and method, and did not identify that any of the deficiencies resulted in an inoperable condition. The inspectors found that ConEd had not implemented administrative compensatory measures for operation of the emergency diesel generator makeup water expansion tank when the automatic fill capability was disabled. Specifically, guidance for manual filling of the 23 EDG jacket water expansion tank was not provided to the operators. ConEd engineering had not controlled relay reset values for relays with adjustable resets. This deficiency was corrected by ConEd during the recovery. During the ConEd Station Nuclear Safety Committee review of the corrective actions, the committee did not consider a basis for the selected reset value for the reactor coolant pump undervoltage relays. This oversight was an example of poor performance in the SNSC review process. Following the reactor transient on August 31, a plant operator documented a concern of not having a procedure for restoration of power to plant lighting buses. ConEd initially closed the issue, in the corrective actions system, without action. After the inspectors questioned this resolution, ConEd re-opened the issue and initiated corrective actions. The ConEd Station Nuclear Safety Committee review of the August 31 event condition report, (SL-1 report) was lacking in critical review of having the station transformer load tap changer in the manual position for an extended period of time. Specifically, the committee did not initially recognize the manual position as a potential unreviewed safety concern and did not question the operability aspects of the deficient condition.
Dockets Discussed: 05000247 Indian Point 2						

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12/20/1999	1999013	Pri: ENG Sec:	NRC	POS	Pri: 5C Sec: Ter:	LONG TERM ACTIONS TO ADDRESS ORGANIZATIONAL PERFORMANCE READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. ConEd senior management stated a commitment to improve station performance, and a number of long term efforts were planned. Some of these plans were included in the revision 2 to the recovery plan. ConEd planned to investigate a design change that would allow lowering the under voltage trip settings on the 480 volt buses to make the degraded voltage protection scheme less likely to operate on a plant trip with the station auxiliary load tap changer in manual. ConEd identified a need to improve the reliability of the pager system used in emergency preparedness. ConEd staff deferred any action on this item until July 2000 in order to resolve the engineering issues involved with pager reliability.
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013-04	Pri: ENG Sec:	NRC	NCV	Pri: 4B Sec: Ter:	ConEd had not specified and included in the applicable design documents, the current transformer ratio for s As part of the recovery effort, ConEd reviewed their breaker trip verification process, identified breakers susceptible to mis-setting, and tested amptectors to verify or correctly establish the trip settings for the various breakers. The inspectors noted that ConEd after finding breaker setting problems beyond the 23 EDG breaker, expanded their verification scope to 100% of the population of breakers with short-time overcurrent trips to confirm proper settings. The testing verified and adjusted the short-time overcurrent settings using a revised (improved) methodology. The inspectors witnessed some of the breaker testing and reviewed the results of other testing of the as-found and as-left condition of the amptector settings. The procedure (Work Step List associated with work order NP-99-11276) required the technician to verify the current transformer (CT) ratio. The inspectors identified that no CT ratio verification was performed nor was any acceptance criteria for the CT ratio provided. ConEd indicated that there was a discrepancy between the procedure wording and what was actually required and provided during the testing. This discrepancy was entered into the ConEd corrective action program as CR 199907561. Breaker operability was not affected by this discrepancy. ConEd had not specified and included in the amptector test procedure, acceptance criteria for the current transformer ratio for safety related amptectors. 10 CFR Part 50, Appendix B, Criterion III, Design Control, requires that appropriate quality standards be specified and included in design documents. Not having specified the acceptance criteria for the current transformer ratio (for work order NP-99-11276), was a non-cited violation of NRC requirements. This issue is in the ConEd corrective actions program as condition report CR199907561. (NCV 50-247/99-13-04)
Dockets Discussed: 05000247 Indian Point 2						
12/20/1999	1999013-11	Pri: ENG Sec:	NRC	NCV	Pri: 4C Sec: Ter:	ConEd had not specified and included in design documents, reset setpoints for those safety related relays wit The inspectors confirmed that the relay reset extent of condition reviews were adequate in scope to support plant restart, and that the deficiencies were either promptly addressed or did not result in any apparent inoperable condition. ConEd not having controlled reset setpoints for those safety related relays with adjustable setpoints was considered a non-cited violation of NRC requirements. This issue is in the ConEd corrective actions program via condition report CR199906643. (NCV 50-247/99-13-11)
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: ENG Sec:	Licensee	NEG	Pri: 3A Sec: Ter:	Corrective Action Effectiveness for Amptector Maintenance Con Edison identified, during charging pump breaker testing, that control wires from the amptector to the current transformer were improperly terminated. Corrective actions were adequate to preclude a recurrence of this condition.
Dockets Discussed: 05000247 Indian Point 2						

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10/25/1999	1999009	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: Ter:	Auxiliary Feedwater Pump Blackout Timer Modification The modification of the 21 and 23 auxiliary feed water pump blackout timers was consistent with the Safety Analysis Report and removed a vulnerability for the loss of the 480V emergency power supply bus.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: ENG Sec:	Licensee	POS	Pri: 4B Sec: Ter:	Operability Determination for Emergency Diesel Generators The operability determination was adequate for a design deficiency resulting in a potential diesel generator overload during a loss of offsite power, reactor trip, and concurrent loss of a 125V DC bus.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: ENG Sec:	NRC	NEG	Pri: 5C Sec: Ter:	Environmentally qualified components The NRC identified poor initial corrective actions in response to degraded sealant for environmentally qualified components. Subsequent inspections by Con Edison led to a number of additional corrective actions, including a number of formal operability determinations, development of formal inspection acceptance criteria, and numerous re-inspections of components. Although the impact on operability was minimal, it could have been more severe since adequate configuration controls had not been previously specified.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Review of modification replacing active hydrogen recombiner system with a passive system The NRC reviewed the modification that replaced the active hydrogen recombiner system with a passive system. The inspector determined that the vapor containment was properly isolated as part of the retirement of the original system. The inspector also identified that Con Edison was not tracking the development of the system surveillance test procedure needed for the next refueling outage.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	System readiness/health status The NRC attended several system readiness/health status presentations and found they were generally performed well although certain work groups did not attend all of the reviews.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: ENG Sec:	Self	NEG	Pri: 1C Sec: Ter:	Loss of offsite power Weaknesses in plant configuration control were the primary causes of the loss-of-offsite power to all four vital 480 volt (V) buses following the reactor trip. Offsite power was lost to the vital buses because the station auxiliary transformer load tap changer was not in the "Automatic" position when the trip occurred. Since September 1998, the load tap changer was not in the "Automatic" position, contrary to the plant licensing basis.
Dockets Discussed: 05000247 Indian Point 2						

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09/27/1999	1999008	Pri: ENG Sec:	NRC	NEG	Pri: 2A Sec: Ter:	Load Tap Changer Material Problem Was Not Evaluated for Operability A load tap changer material problem was not evaluated for operability and safety impact in September 1998. The repair for this problem was not completed as of the time of the event.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: ENG Sec:	Self	NEG	Pri: 4B Sec: Ter:	No Development of Root Causes for Prior Anomalies by Station Personnel Station personnel did not develop root causes for prior anomalies and deficient conditions associated with the reactor protection system Over Temperature/ Delta Temperature signal. The absence of a thorough investigation, establishment of root causes, and implementation of effective corrective actions led to the initiation of the event.
Dockets Discussed: 05000247 Indian Point 2						
09/27/1999	1999008	Pri: ENG Sec:	Self	NEG	Pri: 5C Sec: Ter:	Instances of Poor or Ineffective Use of the Corrective Action Process Instances of poor or ineffective use of the corrective action process contributed to the events leading to the plant trip with complications. Station personnel did not take prompt action or fully evaluate some equipment problems for their potential impact on plant operation.
Dockets Discussed: 05000247 Indian Point 2						
07/09/1999	1999004	Pri: ENG Sec:	NRC	NEG	Pri: Sec: Ter:	Corrective Action Program The corrective action process was acceptable to identify and evaluate deficiencies , but the engineering workload remained high due, in part, to the large backlogs in the corrective action process.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	NEG	Pri: 3B Sec: Ter:	50.59 Training The documentation of the 10 CFR 50.59 training and qualification for preparers and reviewers was not readily retrievable and, in some instances, not formally prescribed, creating difficulties in identifying who was qualified and what were the qualifications. Based on two assumptions in Safety Evaluation (SE) 98-035-EV not being consistent with system operating procedure SOP 10.1.2 and previously documented NRC findings, the team determined there was a potential weakness in consistently assuring that assumptions credited in the safety evaluation were implemented in the associated documents.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	NEG	Pri: 3B Sec: Ter:	System Engineering Turnover There has been relatively high system engineer turnover; in some instances, system engineers were not familiar with certain aspects of their system.
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08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	Primary System Bleed Operations System procedures, modifications and calculations appropriately supported primary system bleed operation. Interim actions were appropriate following ConEd's identification that PORV accumulators were undersized for non-power modes of operation (LER 98-06). The material condition of the safety injection system and overall plant housekeeping were good.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	50.59 Procedures The procedures supporting the 10 CFR 50.59 and Updated Final Safety Analysis Report (UFSAR) updating processes were acceptable. The licensee implemented an acceptable 10 CFR 50.59 program that produced safety impact questionnaires and safety evaluations of adequate quality, met regulations and applicable plant procedures, and provided sufficient details and references to support the conclusions drawn.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4A Sec: 4B Ter:	Temporary Changes The reviewed modification and temporary facility change packages (including calculations) were completed in accordance with applicable plant procedures, technically accurate, and supported by analysis and safety evaluations. Modification FEX-96-12241-E was supported by a thorough engineering analysis, and the safety evaluation was technically sound and in-depth. Safety evaluations provided an adequate basis for determining if the changes involved an unreviewed safety question. The implementation of processes to establish and maintain configuration control were generally acceptable.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	Operability Determinations Engineering generally provided good support to operations, and appropriately prioritized and evaluated conditions requiring technical support. Engineering was responsive to operations' priorities. Operability determinations performed for degraded or nonconforming conditions were acceptable. One operability determination associated with defective safety injection flow orifices did not completely evaluate the cumulative effect of multiple orifice failures.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: Ter:	System Readiness/ Health System engineering effectively supported overall plant operation and system performance. System readiness/health status reports appropriately reflected system performance and identified focus areas for improvement.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 1C Ter: 1C	DBD Efforts The licensee had a dedicated group for the design basis document (DBD) effort with adequate resources. The DBD program progressed in a timely manner. The component functional matrix database was a good method to validate the licensing and design basis. The 50.54(f) group had a demonstrated record of identifying licensing/design basis discrepancies that were broad in scope and in-depth.
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08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 1C Ter: 1C	EQ Self-Assessment The environmental qualification (EQ) program self-assessment was of good quality and identified several issues as well as recommendations to improve the program. The licensee initiated an appropriate upgrade plan to improve the EQ program and address identified weaknesses.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 3C Ter: 1C	Corrective Action Program ConEd demonstrated the ability to be self-critical through self-assessments and oversight findings, and the implementation of a low threshold, high volume corrective action program. The self-assessments were effective in identifying many process issues, which showed mixed performance in program implementation. The response to EQ deficiencies was appropriate to assure plant safety. While corrective actions were also good to identify the extent of discrepant conditions, progress to recognize EQ program deficiencies and address set point program weaknesses was slow.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004-03	Pri: ENG Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Hot Short Issue The licensee adequately addressed the potential for fire-induced hot short issues during a postulated control room fire as discussed in IN 92-18. The licensee planned or completed corrective actions for the 15 MOVs that are required for cold shutdown and vulnerable to hot shorts. A violation of 10 CFR 50, Appendix R, Section III.G was identified; a non-cited violation was issued based on the corrective actions taken.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004-08	Pri: ENG Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Setpoint Program The licensee had a dedicated group to improve the set point program. Although the previous corrective actions met plant restart commitments, progress in the set point program procedure development was slow. The licensee decided to increase resources to complete the validation of set point grade 1 and 2 items by December 1999. A non-cited violation of design control was identified related to the control room ventilation toxic gas monitor trip set points.
Dockets Discussed: 05000247 Indian Point 2						
08/10/1999	1999004-12	Pri: ENG Sec:	NRC	NCV	Pri: 2A Sec: 1C Ter:	PORV Limit Switches A non-cited violation was identified regarding qualification deficiencies with the power operated relief valve limit switches and acoustic monitors.
Dockets Discussed: 05000247 Indian Point 2						
07/09/1999	1999004-16	Pri: ENG Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Inadequate Toxic Gas Monitor Setpoints The licensee had a dedicated group to improve the set point program. Although the previous corrective actions met plant restart commitments, progress in the set point program procedure development was slow. The licensee decided to increase resources to complete the validation of the higher priority items by December 1999. A non-cited violation of design control was identified related to the control room ventilation toxic gas monitor trip set points.
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07/09/1999	1999004-17	Pri: ENG Sec:	NRC	NCV	Pri: 2B Sec: Ter:	EQ Deficiencies in Pressurizer Relief System The environmental qualification (EQ) program self-assessment was of good quality and identified several issues as well as recommendations to improve the program. The licensee initiated an appropriate upgrade plan to improve the EQ program and address identified weaknesses. A non-cited violation was identified regarding qualification deficiencies with the power operated relief valve limit switches and acoustic monitors.
Dockets Discussed: 05000247 Indian Point 2						
06/08/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 1C Sec: Ter:	Unit 1 Safety Evaluation The safety evaluation related to the modification of the fuel handling building pools adequately justified that no unreviewed safety question or change to the technical specification existed. Implementing procedures contained sufficient guidance and properly focused on nuclear safety.
Dockets Discussed: 05000247 Indian Point 2						
06/08/1999	1999003	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: Ter:	System Readiness/ Health Reviews The inspectors attended several system readiness/health status presentations and found they were generally performed well.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: ENG Sec:	NRC	NEG	Pri: 4C Sec: 5A Ter:	Summary of Generic Letter Actions Con Edison's response to GL 96-01 was prolonged due to licensee-identified inadequacies in the initial study that were highlighted by the 10 CFR 50.54(f) work. The resolution of 18 additional issues after plant startup was untimely; these issues should have been identified and corrected prior to startup from the outage. The root cause evaluation appropriately identified shortcomings in the original GL study. Con Edison's final actions to complete the generic letter reviews were comprehensive.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 4B Sec: 5A Ter:	RCP Bus Undervoltage/Underfrequency Trips During its GL 96-01 review, Con Edison identified inadequacies in the testing of several safety-related logic circuits and completed appropriate operability determinations for these issues. In particular, an acceptable operability determination was developed for the 6.9 KV bus underfrequency trip circuit after the NRC identified the need to test the reactor coolant pump breaker circuits. Con Edison had failed to recognize that the complete trip path included a portion of the circuit inside the RCP breaker. Subsequent actions by engineering to resolve the issue were acceptable.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: 5C Ter:	GL 96-01 Modification Good engineering support was noted in implementing a design change to correct deficiencies identified in the GL 96-01 review. In general, Con Edison appropriately evaluated and implemented corrective actions for industry issues in accordance with the operating experience program. Con Edison planned additional actions to address a growing backlog of operating experience issues awaiting review.
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04/26/1999	1999002	Pri: ENG Sec:	NRC	POS	Pri: 5A Sec: 4C Ter:	GL-96-01 EDG Testing The final response to Generic Letter 96-01 adequately addressed the testing of safety-related logic circuits. The inclusion of redundant circuit paths and systems beyond the scope of GL 96-01 indicated the thoroughness of the effort. Surveillance procedures for emergency diesel generator 21 were clear, well written and met the requirements in GL 96-01.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001	Pri: ENG Sec:	NRC	POS	Pri: 4C Sec: Ter:	System Readiness/Health Status Presentations The inspectors attended several system readiness/health status presentations and found they were generally performed well. However, in one instance the inspectors identified a narrow focus to the system health review which resulted in an incomplete assessment of equipment performance. Specifically, the system health review for the residual heat removal system did not identify repeat problems with a level transmitter on the refueling water storage tank (RWST). The inspectors determined that the system health review did not discuss this problem because it was attributed to heat trace problems and was being tracked by a different system engineer.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: PLTSUP Sec:	Self	NEG	Pri: 3A Sec: Ter:	Review of Radiological Events Con Edison responses to radiological events were acceptable. Con Edison's actions were appropriate to investigate the source of Cs-137 in a turbine building sump and to evaluate the contamination. The inspector verified that effluent releases were below NRC limits. The failure to properly control mercury resulted in the inadvertent shipment of radwaste as mixed waste. While Con Edison's actions to dispose of mercury were ineffective, the actions to evaluate and retrieve the waste were appropriate.
Dockets Discussed: 05000247 Indian Point 2						
12/07/1999	1999010	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Employee Training Radiation worker and general employee training programs were acceptable for instructing workers per 10 CFR 19.
Dockets Discussed: 05000247 Indian Point 2						
12/22/1999	1999012-01	Pri: PLTSUP Sec:	NRC	IFI	Pri: 2B Sec: Ter:	Exercise Weakness - Overall poor performance in the TSC Several repeat training and communication deficiencies were noted resulting in a poor technical support center (TSC) performance, some of which included: (1) repair teams were not prioritized; (2) the staff failed to provide needed support for event mitigation; and (3) there were instances where the staffs' expertise were not fully utilized. In addition, procedure implementation problems were noted in which both the TSC Manager (TSCM) and the plant operations manager (POM) did not fulfill their responsibilities as described in their pertinent emergency procedures. Also, the procedures describing the POM's role were confusing because the POM's attention is needed in support of two facilities simultaneously. Based on these identified problems, overall performance in the TSC was considered an exercise weakness.
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12/22/1999	1999012-02	Pri: PLTSUP Sec:	NRC	IFI	Pri: 1C Sec: 2B Ter:	Exercise Weakness - Overall poor performance in the OSC Several repeat training and communication deficiencies were noted which resulted in a poor operations support center (OSC) performance. Also, a repeat exercise weakness from the 1998 and 1994 exercises was identified with respect to a repair team dispatched during a radiological release. Specifically, procedural implementation problems identified were: (1) some repair teams were dispatched without a means to communicate; (2) teams were not selected based on expertise; (3) the OSC manager did not keep OSC personnel informed of the emergency classifications or the progression of the mitigating activities; and (4) there was an inadequate demonstration of the use of repair teams. Based on these identified problems, overall, performance in the OSC was not effective.
Dockets Discussed: 05000247 Indian Point 2						
12/22/1999	1999012-03	Pri: PLTSUP Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Inadequate corrective actions and inadequate exercise critique Overall, several performance, communication, training and procedural deficiencies were noted during the exercise. There were two repeat findings in the TSC (paragraph b.2) and two repeat findings and a repeat exercise weakness in the OSC (paragraph b.3), along with repeat findings with respect to inadequate critiques (paragraph b.5) from previous NRC-evaluated exercises. In addition, the licensee's formal critique was considered poor in that it was not sufficiently self critical and many of the findings noted above were not found. In the last two emergency exercises, the NRC staff also assessed the licensee as conducting poor exercise critiques. Based on these findings, the inspectors determined, collectively, that the licensee did not adequately identify and correct these repetitive findings and weaknesses.
Dockets Discussed: 05000247 Indian Point 2						
12/22/1999	1999012-04	Pri: PLTSUP Sec:	NRC	IFI	Pri: 2B Sec: Ter:	ERO qualifications lapse During the inspection, it was determined that ERO qualifications had lapsed for one individual in a key ERO position listed on the E-Plan's current emergency responders' list. The licensee immediately removed the individual. This was a repeat issue from a program inspection conducted in December 1996.
Dockets Discussed: 05000247 Indian Point 2						
12/22/1999	1999012-05	Pri: PLTSUP Sec:	NRC	NCV	Pri: 2B Sec: Ter:	Failure to use the EAL technical basis document during the August 31, 1999 event and not declaring an Unusu The emergency operations facility (EOF) staff was activated and operated in accordance to the emergency plan and its implementing procedures. However, the emergency director prematurely declared a Site Area Emergency based on an incorrect assessment of plant conditions; and not utilizing the expertise of the TSC staff to review all the information available for meeting the classification. These two issues appeared to be due to training, procedural, and communication deficiencies. The shift manager (SM) maintained an appropriate oversight of the central control room (CCR) staff and the CCR supervisor directed operator activities based on emergency and abnormal operating procedures. However, an EAL training problem was noted when the SM did not properly implement the EALs for the Alert classification when sufficient information was available. During the August 31, 1999 Loss of Offsite Power event, the licensee's EAL scheme for this type of event did not contain the adequate information for declaring an unusual event and the shift manager did not review the available technical basis document from which to make a proper classification. This was a similar problem that was again observed during the exercise.
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12/20/1999	1999013	Pri: PLTSUP Sec:	NRC	POS	Pri: 5B Sec: 5A Ter:	EMERGENCY PREPAREDNESS IMPROVEMENTS READER'S NOTE: ALL 1999013 PIM ENTRIES ARE ABRIDGED. ConEd took appropriate action to address the emergency planning problems identified during the August 1999 event. The reviews in this area were reasonable and identified a number of short-term and long-term corrective actions. The short-term actions involved correcting procedural and training problems, which were completed prior to restart of the reactor. Long-term actions involved specific actions for improving exercise critiques, conducting additional drills in 1999 for the operating crews, and conducting an exercise. Some of the operating crew drills will also involve emergency response facility activation. ConEd reviewed emergency action levels and identified two that needed clarification to assure reliable implementation. ConEd personnel subsequently clarified these classifications, incorporated the enhancements in an Operations Standing Order, and initiated training on the clarifications. The inspectors noted that ConEd's initial review of the action level improvements was lacking in sufficient detail to assure the changes did not reduce the level of effectiveness. ConEd initiated a corrective action report when an inadvertent change of intent was identified by plant personnel during training on the revised emergency action levels.
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10/25/1999	1999009	Pri: PLTSUP Sec:	Licensee	NEG	Pri: 1C Sec: Ter:	Emergency Planning Training Procedural deficiencies were identified during emergency preparedness remedial training. Con Edison entered the deficiencies in the problem identification system and performed adequate short-term actions to address emergency training quality.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Unit 1 Contamination Event Con Edison corrective actions in response to a radiological event were appropriate. The inspector independently determined that worker exposures as a result of the event were below NRC limits.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009-02	Pri: PLTSUP Sec:	Self	NCV	Pri: 1B Sec: Ter:	Boron Injection Outside Procedure The early injection of boric acid into the secondary system was performed outside the conditions specified by the chemistry procedure, and resulted in steam generator boric acid concentration and pH significantly outside the acceptable values.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Radiological access controls The NRC noted that radiological access controls to Unit 1 vapor containment were adequate; although some opportunities were identified for improving radiological posting through increased use of informational postings and by posting each individual high radiation area.
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Region I

INDIAN POINT

Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Radioactive liquid and gaseous effluent control programs Con Edison maintained effective radioactive liquid and gaseous effluent control programs. The offsite dose calculation manual contained sufficient specification and instruction to acceptably implement and maintain the radioactive liquid and gaseous effluent control programs.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Radioactive material/waste management and transportation programs Radioactive material/waste management and transportation programs were adequately implemented as evidenced by proper processing, packaging, storage, and shipment of radioactive wastes and materials.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Effluent /process radiation monitoring systems Con Edison maintained an effective program for effluent/process radiation monitoring systems calibration. The system engineer effectively monitored the system for operability and reliability problems and assured adequate maintenance of the system and supporting components.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Ventilation system surveillance program Con Edison established, implemented, and maintained an effective ventilation system surveillance program with respect to charcoal adsorption surveillance tests, HEPA and charcoal filter mechanical efficiency tests, and air flow rate tests.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 2B Sec: Ter:	Quality assurance audit program Con Edison quality assurance audit program for effluent control was effectively implemented. The licensee's quality control program for the radioactive liquid and gaseous effluent control to validate analytical results was effective.
Dockets Discussed: 05000247 Indian Point 2						
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 3C Sec: Ter:	Housekeeping Housekeeping in Unit 2 areas was generally good in that walkways and aisles were clear and free of debris. The licensee initiated action to address conditions in Unit 1 relative to rainwater leaking onto the Unit 1 fuel handling floor and potentially affecting contamination control of the area.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
09/06/1999	1999007	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: Ter:	Condition reporting system Con Edison quality assurance audits and the condition reporting system were effectively used to identify, evaluate, and resolve deficiencies in the area of radioactive waste management and transportation of radioactive materials.
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06/08/1999	1999003	Pri: PLTSUP Sec:	NRC	POS	Pri: 1C Sec: Ter:	Security and Safeguards Con Edison was determined to be conducting its security and safeguards activities in a manner that protected public health and safety. However the inspector observed a truck running unattended in the protected area which is prohibited by the security plan. This deficiency was promptly corrected and placed in the Con Edison corrective action program.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 3C Sec: Ter:	QA of Analytical Measurements The environmental laboratory continued to implement effective QA/QC programs for the REMP and continued to provide effective validation of analytical results. The laboratory demonstrated the ability to accommodate and incorporate difficult media and geometries into the program.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 4C Sec: Ter:	Environmental Monitoring Program Con Edison effectively performed sample collection activities according to the Memorandum of Understanding with New York Power Authority (Unit 3) and according to the REMP procedures, conducted the land use census and maintained and calibrated the automatic sampling equipment. Con Edison, together with the NYPA, effectively conducted a line-by-line comparison of the Units 2 and 3 environmental TSs in response to a QA audit. Con Edison effectively provided program oversight and met the reporting requirements in the TSs. The radiological environmental monitoring program was effectively implemented in accordance with regulatory requirements.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 4C Sec: Ter:	QA of Environmental Lab Con Edison provided effective program oversight by monitoring the progress and quality of the environmental laboratory. The quality assurance program was effectively maintained and implemented in accordance with regulatory requirements.
Dockets Discussed: 05000247 Indian Point 2						
04/26/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 4C Sec: 2A Ter:	Meteorological Monitoring Program The meteorological monitoring program was effectively maintained and implemented in accordance with regulatory requirements. NYPA's Instrument and Controls Department, with the support of the Radiological and Environmental Services Department, calibrated and maintained the meteorological monitoring instrumentation in accordance with the appropriate procedures.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
04/26/1999	1999002	Pri: PLTSUP Sec:	NRC	POS	Pri: 5A Sec: 5C Ter:	QA Audit Program The technical depth and level of detail of each audit were sufficient to effectively evaluate the performance and implementation of the REMP and MMP. The scope of each audit was comprehensive. The recommendations for improvement were appropriate. Corrective actions were appropriate to prevent recurrence.
Dockets Discussed: 05000247 Indian Point 2						
04/27/1999	1999002-01	Pri: PLTSUP Sec:	NRC	NCV	Pri: 1C Sec: Ter:	Improper Facility Change Controls During a review of Unit 1 radioactive waste processing, the inspectors identified a failure to follow procedures governing temporary facility changes. Specifically, the Unit 1 rinse water tank and the water storage pool were connected without the connection being controlled as a temporary facility change. The inspectors' finding resulted in Con Edison issuing a stop-work order for all Unit 1 waste processing, a review of all Unit 1 activities and subsequent initiation of a Significance Level I root cause evaluation to determine why differing standards were allowed to exist between Unit 1 and 2 work activities.
Dockets Discussed: 05000247 Indian Point 2						
04/27/1999	1999002-05	Pri: PLTSUP Sec:	NRC	NCV	Pri: 4C Sec: Ter:	Inaccurate Information Con Edison also documented a notification on October 29, 1998, of their conclusion that certain information provided to the NRC was not accurate in all material respects as required by 10 CFR 50.9. Specifically, the 1996, 1997, and 1998 Annual Effluent and Waste Disposal Reports for IP1 and 2, Section A.4.d, "Liquid Effluents and Samples of Continuous Discharge," have been taken and analyzed in compliance with TS Table 4.10-1. Con Edison concluded that the dose calculations reported in the annual report would not have changed due to lack of detection of alpha and other isotopes. This Severity Level IV violation of 10 CFR 50.9 is being treated as a Non-Cited Violation, consistent with NUREG/BR-0195 section 7.8 of the Enforcement Policy.
Dockets Discussed: 05000247 Indian Point 2						
04/30/1999	1999005	Pri: PLTSUP Sec:	NRC	MISC	Pri: 4C Sec: Ter:	IP-2 and IP-3 Emergency Plans On April 30, 1999 at 11 am, a public meeting was held in the Region I office with representatives from IP2 and IP3 to discuss issues regarding the proposed combining of the two emergency plans. Representatives from the NRC and the Federal Emergency Management Agency (FEMA) attended the meeting in person or via tele-conference. The NRC staff has no objection to the proposed action of combining the emergency plans for both units assuming the required 10 CFR 50.54(q) review of the final plan change concludes that there is no decrease in the effectiveness of the respective emergency plans.
Dockets Discussed: 05000247 Indian Point 2						
03/15/1999	1999001	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: Ter:	Routine Primary Sample/Analysis for Boron and Lithium The inspector observed a routine primary sample and analysis for boron and lithium. The watch chemist accurately analyzed the sample in accordance with procedure; however, proper contamination controls were not always practiced during the sample analysis.
Dockets Discussed: 05000247 Indian Point 2						

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Date	Source	Functional Area	ID	Type	Template Codes	Item Title Item Description
03/15/1999	1999001	Pri: PLTSUP Sec:	NRC	STR	Pri: 3B Sec: Ter:	Inspection of Security Program Security facilities, equipment, and personnel met your commitments and NRC requirements and provided an effective security program. (S2) Security and safeguards procedures and documentation were being properly implemented. Event Logs were being properly maintained and effectively used to analyze, track, and resolve safeguards events. (S3) Security force members adequately demonstrated that they had the required knowledge to effectively implement the duties and responsibilities associated with their positions. (S4) Security force members were being trained in accordance with the requirements of the training and qualification plan. Training documentation was properly maintained and accurate and the training provided by the training staff was effective. (S5) The level of management support was adequate to ensure effective implementation of the security program, as evidenced by adequate staffing levels and the allocations of resources to support programmatic needs. (S6) The review of your audit program indicated audits were comprehensive in scope and depth, that audit findings were reported to the appropriate level of management, and that the program was being properly administered. In addition, a review of the documentation applicable to the self-assessment program indicated that the program was being effectively implemented to identify and resolve potential weakness.
Dockets Discussed: 05000247 Indian Point 2						
02/01/1999	1998019	Pri: PLTSUP Sec:	NRC	NEG	Pri: 3A Sec: Ter:	RHR System Walkdown The inspector performed a walkdown of a portion of the residual heat removal (RHR) system. The majority of the portion walked down was in a contaminated area. The walkdown brief the inspector received from health physics did not reflect actual radiological conditions in the 21 RHR pump room. Health Physics postings for egress from the steam generator blowdown room were inadequate and allowed the inspector to walk through a contaminated area without appropriate protective clothing; however, this did not result in the spread of contamination or in personnel contamination. The incident was not documented in a timely fashion in the site or health physics corrective action program.
Dockets Discussed: 05000247 Indian Point 2						
02/01/1999	1998019-03	Pri: PLTSUP Sec:	NRC	NCV	Pri: 4A Sec: Ter:	Fuel Storage Building Projected Doses In 1982 and 1991, Con Edison made changes to the fuel storage building air filtration system design which decreased the ventilation flow rate that was assumed in the accident analysis for a fuel handling accident. These changes were evaluated and appropriately submitted to the NRC for review as TS amendment requests. However, Con Edison failed to update the FSAR to reflect the impact of the changes on the projected doses to personnel in the FSB during a fuel handling accident, which constituted a violation of 10 CFR 50.71(e) that requires periodic updating of the FSAR. This violation was treated as a non-cited violation in accordance with Section VII.B.1 of the NRC Enforcement Policy.
Dockets Discussed: 05000247 Indian Point 2						
10/25/1999	1999009	Pri: OTHER Sec:	NRC	POS	Pri: 4C Sec: Ter:	Review of Licensee Event Report (Closed) LER 99-017 Con Edison actions to address a fire protections design deficiency for postulated seismic events were prompt and demonstrated a good regard for preserving safety system operability (LER 99-017). The NRC noted a need to improve an assessment of postulated events when making reports under 10 CFR 50.73.
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Legend

Type Codes:

BU	Bulletin
CDR	Construction
DEV	Deviation
EEI	Escalated Enforcement Item
IFI	Inspector follow-up item
LER	Licensee Event Report
LIC	Licensing Issue
MISC	Miscellaneous
MV	Minor Violation
NCV	NonCited Violation
NEG	Negative
NOED	Notice of Enforcement Discretion
NON	Notice of Non-Conformance
OTHR	Other
P21	Part 21
POS	Positive
SGI	Safeguard Event Report
STR	Strength
URI	Unresolved item
VIO	Violation
WK	Weakness

Template Codes:

1A	Normal Operations
1B	Operations During Transients
1C	Programs and Processes
2A	Equipment Condition
2B	Programs and Processes
3A	Work Performance
3B	KSA
3C	Work Environment
4A	Design
4B	Engineering Support
4C	Programs and Processes
5A	Identification
5B	Analysis
5C	Resolution

ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

Functional Areas:

OPS	Operations
MAINT	Maintenance
ENG	Engineering
PLTSUP	Plant Support
OTHER	Other

EEIs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.