Murray Selman
Vice President

Consolidated Edison Company of New York, Inc.
Indian Point Station
Broadway & Bleakley Avenue
Buchanan, NY 10511
Telephone (914) 737-8116

September 15, 1986

Re: Indian Point Unit No. 2
Docket No. 50-247

Mr. Samuel J. Collins, Chief
Projects Branch No. 2
U.S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

Dear Mr. Collins:

This refers to inspection 50-247/86-23 conducted by Mr. Lawrence W. Rossbach and Mr. Peter W. Kelley of your office on July 8, 1986 through July 31, 1986 at Indian Point Nuclear Generating Station, Unit 2.

Your August 14, 1986 letter stated that it appears that certain of our activities were not conducted in full compliance with NRC requirements, as set forth in the Notice of Violation enclosed therewith as Appendix A. Pursuant to the provisions of 10 CFR 2.201, our response to the notice is presented in Attachment A to this letter.

Should you or your staff have any questions, please contact us.

Very truly yours,

John C. Basile

cc: Senior Resident Inspector
U.S. Nuclear Regulatory Commission
P.O. Box 38
Buchanan, New York 10511

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ATTACHMENT A

RESPONSE TO NRC INSPECTION 86-23

VIOLATION A

10 CFR 50.72 specifies immediate notification requirements. 50.72.b.1.i requires that the initiation of a plant shutdown required by Technical Specifications be reported in one hour. 50.72.b.1.v requires that any event that results in the loss of a significant portion of the offsite notification system be reported in one hour. 50.72.b.2.ii requires that any event or condition that results in the actuation of any Engineered Safety Feature be reported in four hours.

Contrary to the above, the inspector identified that no immediate notifications were made for the following events:

1) The July 31, 1986 shutdown initiated at 2:15 p.m., as required by Technical Specifications;

2) The June 4, 1986 failure of 17 offsite sirens during a test (fourteen of the sirens failed due to a common mode failure); and,

3) The May 28, 1986 actuation of train B of the Safety Injection System which occurred at about 4:10 p.m.

This is a Severity Level V Violation (Supplement I).

RESPONSE

1) and 3) The following corrective actions have been taken to ensure that notification requirements are met in the future:

a) All Control Room operators and Watch Supervisors have been personally reinstructed on notification requirements by the Vice President, Nuclear Power.

b) To insure increased supervisory attention, compliance with notification requirements has been made a criterion in each Watch Supervisor's annual salary review.

c) The Station Administrative Order governing reporting requirements is being reviewed and rewritten to reduce the possibility of misreading a reporting requirement. This effort is expected to be completed by November 1986.

2) It is not apparent to us that a 10 CFR 50.72 section (b)(1)(v) notification is required for these failures. However, SAO-124 is being revised to give minimum quantitative guidance for notification related to siren failures of which the licensee becomes aware. The revision will specify that notifications should be made if 7 of 77 sirens in Westchester County, 5 of 50 sirens in Rockland County, 2 of 9 sirens in Putnam County, 2 of 16 sirens in Orange County or a total of 15 of 152 sirens fail when the system is activated. Finally, any common-mode failures will be reported. Since the June 4, 1986 violation, one-hour notifications were made to the NRC when the Orange County and Westchester County repeaters malfunctioned on August 8 and September 2, 1986 respectively.

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VIOLATION B

Technical Specification Table 4.1-3, Item 2, requires that all control rods be moved every 2 weeks during critical reactor operations to verify operability of the control rods and control rod drive mechanisms. The maximum time interval allowed between tests is 20 days.

Technical Specification Table 4.10-4, Item 4a, requires that the plant vent noble gas activity monitor, R-14, be source checked on a monthly basis.

Contrary to the above: (1) between June 10, 1986 and July 8, 1986, a period of 29 days, control rod K-6 was not tested for operability; and, (2) R-14 was not source checked for operability between January 18 and March 18, 1986.

This is a Severity Level V Violation (Supplement I).

RESPONSE

1) Rod K-6 was determined operable using the incore moveable detection system on July 8, 1986 since the rod position indicator for rod K-6 was still inoperable. At this time full compliance with Technical Specification requirements was achieved. The inoperable rod position indicator will be repaired when it can best be accomplished under ALARA principles. In addition, the test procedure has been changed to require notification of Reactor Engineering prior to commencement of the rod exercise test. This will ensure the use of the incore moveable detector system, as required by the test, if any rod position indicator is inoperable. The result of this corrective action has been compliance with the rod exercise test requirements.

2) Periods of various types of precipitation, including freezing precipitation, occurred intermittently making access to R-14 unsafe. The technician entered "N/A" in the appropriate data sheet, which later caused the test results to be interpreted as though the test criterion had been successfully met. The test was thought to have been completed on time and to have satisfied all operability criteria.

   On March 18, 1986 the next monthly surveillance test including the plant vent noble gas activity monitor, R-14, was satisfactorily completed. At this time full compliance with Technical Specification requirements were met.

   The cause of this missed surveillance was personnel failure to strictly adhere to a procedure step. During the review of this event, and the interviews that were conducted with personnel involved, the correct completion of this type of test procedure was reinforced.

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To further prevent recurrence, the general instruction issued with each surveillance test, which previously permitted discretionary use of an "N/A" entry, has been withdrawn. The use of an "N/A" entry continues to be on a case by case basis in surveillance tests. Additional administrative guidance is being given to personnel with test-related responsibilities concerning situations that require the attention of and action by the SWS.