Murray Selman
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May 20, 1987

Mr. William H. Russell
Regional Administrator - Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Re: Consolidated Edison Company of New York, Inc.
Indian Point Unit No. 2
Docket No. 50-247

Subject: Routine Inspection 50-247/87-08

Dear Mr. Russell:

This is in response to your letter of April 20, 1987 concerning routine inspection 50-247/87-08 conducted by Mr. Lawrence W. Rossbach and Mr. Peter W. Kelley from March 3, 1987 to April 6, 1987 at Indian Point Unit No. 2.

We acknowledge that due to circumstances and practices then in effect, the observations noted in you letter did occur. The results of our review of the two events and the measures we instituted to avoid future similar occurrences, are set forth in Attachment A to this letter.

Should you have any questions, please contact us.

Very truly yours,

Murray Selman

21.190.5.12.1

cc: Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Senior Resident Inspector
U.S. Nuclear Regulatory Commission
P.O. Box 38
Buchanan, NY 10511

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May 29, 1987

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

Attachment A

Response to Notice of Violation

Violation

A. Technical Specifications Section 6.8.1 requires that written procedures and administrative policies be established, implemented and maintained covering the requirements and recommendations of Appendix A of Regulatory Guide 1.33. Appendix A to Regulatory Guide 1.33 includes administrative procedures and procedure adherence. Station Administrative Order 204, "Work Order Procedure," requires that temporary repairs be tracked, be reviewed for 10CFR50.59 applicability and that target dates be set for effecting final repairs.

Contrary to the above, on March 5, 1987, the motor operators on service water strainer blowdown valves MOV-SWN-621, MOV-SWN-620, MOV-SWN-618, and MOV-SWN-617 had been removed and this work was not being tracked as a temporary repair, had no documented review for 10CFR50.59 applicability, did not have target dates set for effecting final repairs, nor was this work performed as a modification.

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

Response

A. Con Edison's review of the incident indicates that the motor operators for the Service Water System strainer blowdown valves failed shortly after they were placed in service. The failure has been traced to use of the motor operators in a wet environment for which they were not intended. This, led to capacitor failure. Work orders were written to replace the capacitors. However, the work orders were ambiguous and read "Replace Capcitor B/V Valves". Since Capcitor B/V valves do not exist, repairs were not accomplished.

Operation of the strainer blowdown system cleans the strainer and avoids excessive pressure buildup across the strainer. Several requests from Operations to restore the strainer blowdown system to operable status were made to the Maintenance staff. As the Strainer blowdown system had previously been operated manually (without motor operated valves), the Maintenance staff proceeded

to convert the valves back to manual operation. Due to the integral design of the motor operator with the valve, the removal of the motor operators was deemed to be routine maintenance to effect manual valve operation. The need for a temporary repair procedure, or a formal modification package, was simply not recognized.

As a result of the above events, the General Manager for Nuclear Power Generation reinstructed the principal management staff for Maintenance and Planning on the requirements pertaining to temporary repairs and plant modifications.

Violation

B. 10 CFR 50.59 requires that the licensee perform and record safety evaluations of changes to the facility as described in the safety analysis report.

Contrary to the above, on November 22, 1986, the licensee by-passed instrument air valve IA-20, shown on Figure 9.8-6 of the Indian Point 2 Safety Analysis Report, without determining if it involved an unreviewed safety question.

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

Response

B. The event cited occurred when a Temporary Procedure Change (TPC) was issued which revised the position of a valve in a by-pass line around a control and check valve in an instrument air line. The purpose of the check valve is to prevent uncontrolled depressurization of the Instrument Air System in a seismic event if the non-seismic portion of the line upstream of the check valve were to rupture. The position of the valve was changed from closed to open in order to enhance flow of instrument air.

Operations staff at the time of TPC issuance was unaware of the safety significance of the check valve: The drawings did not adequately flag the significance of the valve in question.

To avoid future similar occurrences, the use of operational TPCs is being restricted to emergency situations. In addition TPCs will require the review and concurrence of the Shift Technical Advisor. Shift Technical Advisors are on duty 24 hours per day and their function is, in part, to provide an independent safety review.