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July 25, 1988

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

Document Control Desk  
U.S. Nuclear Regulatory Commission  
Mail Station P1-137  
Washington, DC 20555

SUBJECT: Response to Inspection Report No. 50-247/88-19

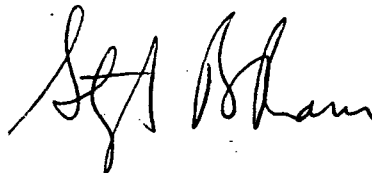
This responds to your letter of June 24, 1988 concerning inspection 50-247/88-19 conducted by Messrs. Lawrence W. Rossbach and Peter W. Kelley during the period May 3, 1988 through May 30, 1988 at Indian Point Unit No. 2. Attachment I to this letter provides our response to the Notice of Violation transmitted in the inspection report.

Additionally, your June 24, 1988 letter requested that we provide our assessments of 1) the adequacy of our corrective action programs and those additional actions needed to assure effective implementation, and 2) the quality of our implementation of system line-ups and those actions necessary to assure that a high quality independent verification program is implemented. Those assessments are provided in Attachment II to this letter.

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

Very truly yours,

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Attachments

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Attachment I

Response to Notice of Violation  
Inspection Report 50-247/88-19

Consolidated Edison Company of New York, Inc.  
Indian Point Unit No. 2  
Docket No. 50-247  
July 25, 1988

1. Violation A Summary:

"Technical Specification 6.2.2.(g) requires that administrative procedures shall be developed and implemented to limit the working hours of unit staff who perform safety-related functions (e.g. licensed senior operators, licensed operators, health physicists, auxiliary operators and key maintenance personnel.)

Operations Administrative Directive (OAD) 9, Revision 8, 'Operations Section Organization' states in part that planned deviations from these guidelines, (e.g. individuals should not be permitted to work any more than 16 hours in any 24 hour period, nor more than 24 hours in any 48 hour period, etc., as stated in section 5 of the procedure) require advance approval of the Operations Manager who shall keep the General Manager informed of all deviations, by memorandum which justifies the cause for the deviations.

Contrary to the above, on May 11, 1988, it was determined that deviations from the guidelines as stated in Section 5.3 of OAD 9, Revision 8, involving licensed senior operators and licensed operators had occurred on at least two occasions during the period of March 7 to May 7, 1988 and no memoranda from the Operations Manager to the General Manager were provided for justification and approval of the deviations."

Response:

We acknowledge that deviations from the guidelines of OAD-9 occurred in the period noted in that exceedance of work hour guidelines occurred without the required written memoranda on record from the Operations Manager to the General Manager to demonstrate approval and justification of such deviations.

Although this instance represents a recurrence of circumstances which had previously occurred on September 25, 1987, it is important to point out that our practices and policies in this area have been enhanced. Subsequent to our November 25, 1987 letter to you, which provided our response to the previous occurrence, we issued Nuclear Power Policy Statement No. 10, entitled "Nuclear Power Policy for NRC Schedule Guidelines," with an effective date of March 24, 1988. The purpose of this policy statement was to identify in detail positions applicable to the NRC Policy Statement set forth in Generic Letter 82-12 (also covered by the IP-2 technical specifications), and to assure that proper documentation is prepared in accordance with Generic Letter 82-12.

One requirement of Nuclear Power Policy Statement No. 10 is the performance of quarterly audits of working hours for applicable positions by the Personnel Section, so as to ensure that deviations from the work-hour guidelines are properly documented. We believe that this audit process, in addition to the specific actions taken as a consequence of the May 11, 1988 event, will further assure compliance in the future.

As a consequence of the May 11, 1988 event, certain corrective actions have been implemented to preclude recurrence of a similar event:

- o Overtime authorization forms are now required to be sent to the Operations office affixed to the variation sheets. Operations staff will verify that a form approving overtime exists for each instance requiring documentation.
- o Unit No. 2's Senior Watch Supervisor shift turnover log sheet DCR-2 has been revised to remind the Operations staff of their obligation to complete any necessary overtime justification documentation. The turnover log sheet now states "Deviations from overtime scheduling guidelines logged and Operations Manager informed."
- o The Senior Watch Supervisors and Support Facilities Supervisors have been re-instructed on the need for this documentation through an entry in the Indian Point Unit No. 2 Night Order Book.
- o An evaluation of the Operations Section working hours and scheduling practices will be performed.

2. Violation B Summary:

"Technical Specification 6.8.1 requires that written procedures be implemented as recommended by Regulatory Guide 1.33, Appendix A, (November 1972). Appendix A of Regulatory Guide 1.33 (November 1972) requires procedures for startup, operation and shutdown of safety-related systems including containment cooling systems. Operations Administrative Directive 6, Rev. 8, states that equipment status documentation can be in the form of completed checkoff lists, current tag-outs, status boards, status sheets, current shift turnover checklist or procedures currently in use. Checkoff list (COL) 10.2.1, Revision 3, Containment Spray System states that the breaker for valve 869A shall be open and locked.

Contrary to the above, on May 10, 1988 the breaker handle for Containment Spray System valve 869A was not locked in accordance with COL 10.2.1."

Response:

On May 8, 1988, breaker position for Containment Spray System valve No. 869A had been double-verified using Check-off List ("COL") 10.0, entitled "Locked Safeguard Valves." The performance of this COL established that the breaker handle was in the correct position. Subsequent to the May 10, 1988 discovery that the breaker handle for valve No. 869A was not locked in accordance with COL 10.2.1, entitled "Containment Spray System," interviews were conducted with those individuals who had performed COL 10.0 on May 8, 1988 to determine the facts surrounding this event. These interviews were unable to determine how this situation occurred, whether the COL had been correctly executed on May 8, 1988, or whether the valve position had been altered between May 8 and May 10. Nonetheless, a memorandum was sent to all Senior Watch Supervisors requiring them to review locked-valve criteria with personnel assigned to them, and requiring them to re-read OAD-6, entitled "Equipment Status Identification," and OAD-19, entitled "Stop Tagout and Caution Tag Program." We believe that these actions will heighten awareness on the part of the personnel as to the importance of the locked status of equipment required to be locked.

In addition, the feasibility of initiating a sealed-valve program is being considered at IP-2. Such a sealed-valve program, if implemented, would enhance administrative control and criteria for safeguards and non-safeguards sealed-valves. Color-coded plastic seals, as well as locks and chains for certain equipment, would be used. If a final decision is made to implement such a program, a draft sealed-valve program procedure is expected to be issued in August, 1988.

3. Violation C Summary:

"10 CFR 50, Appendix B, Criterion V requires that activities affecting quality shall be prescribed by documented procedures and shall be accomplished in accordance with these procedures. Post maintenance test procedure 38231, issued May 18, 1988, required the use of a calibrated stopwatch.

Contrary to the above, on May 19, 1988 a calibrated stopwatch was not used in performing post maintenance test 38231."

Response:

The test consequences of using an uncalibrated stop watch to time the soap-leak test were evaluated on June 1, 1988 by Operations and Test Engineering. A determination was made that the Post-Maintenance Test as performed was acceptable for purposes of assuring operability, and consequently full compliance with our Post-Maintenance Test program was achieved for this particular test on that date.

Although the test duration was not a critical parameter for the soap-leak test, and consequently had no safety significance, the inspection report did raise the issue of procedural adherence.

Procedural adherence is a key ingredient in fostering excellence in operations, and consequently procedural adherence is strongly and repeatedly emphasized to personnel. Station personnel have become further sensitized to the importance of procedural adherence and, therefore, we fully expect this enhanced awareness to be reflected in practice.

Procedural adherence in certain cases requires more than just personnel awareness, but requires high quality procedures. We believe our procedures are of high quality. However, personnel have been reminded and will continue to be reminded, as required, that when a situation arises in which a procedure revision becomes necessary or a procedural step requires certain actions to be taken which are impossible to achieve, inappropriate to follow or unsafe, the only accepted course of action is to revise the procedure in accordance with approved station practices. Procedural noncompliance on the part of station personnel will not be tolerated.

Attachment II

Response to Request for Assessments  
Inspection Report 50-247/88-19

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Consolidated Edison Company of New York, Inc.  
Indian Point Unit No. 2  
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1. Assessment of Corrective Action Programs:

There are examples of effective corrective action that demonstrate an effective program is in place and that the program continues to improve. However, we recognize that any repetition of an action identified as a noncompliance with requirements or identified as unacceptable for other reasons may indicate that corrective actions have not been fully effective in those instances.

We had recognized for some time the importance of unifying the existing corrective action tracking systems in a single corrective action program. It was essential for management to have readily available a single focal point for all corrective action items so they could be efficiently tracked, prioritized and coordinated, and overlap eliminated. Decision makers are then more fully informed, particularly when setting priorities for escalated overdue action. To assure development, tracking and management oversight of the corrective action tracking program a formal goal was established, a program coordinator was appointed, and support resources were committed. Since April 1988 unified corrective action program reports have been submitted to management. These reports include descriptive analysis of corrective action trends in each of the program's corrective action systems. System trends and progress of individual items are easily observed. The program will be governed by a formal station procedure. Quality Assurance provides independent support by verifying, on a sampling basis, that item closeouts meet the original intent of the corrective action.

For a corrective action program to be effective, it is necessary to have a high degree of assurance that the corrective action undertaken truly addresses the underlying cause. Root cause analysis provides this assurance by correctly identifying the underlying deficiency leading to an unacceptable condition. Development of the corrective action program will include development of root cause analysis capability. This capability will lead to appropriate resolution of deficiencies and, where problems are generic, to the initiation of programmatic solutions.

Training on corrective action program implementation will be required. A formal course to provide this training is currently being developed.

Corrective action program development is proceeding as planned and results to date indicate improved corrective actions. For example, overdue items in each of four corrective action tracking systems show a downward trend in 1988.

The newly instituted System Engineer program performs an important role in implementing corrective actions for plant systems. One of the major functions of any System Engineer is to be cognizant of system "concerns," and based on the significance of a concern, to resolve it or to assign it to appropriate personnel for resolution.



An example of corrective action effectiveness in a programmatic or system area is evident for the Service Water System. The Service Water System Engineer has gathered "concerns" affecting this system. These concerns are items for which no Work Order had been generated, and include audit and surveillance findings, inspection report findings, Field Engineering Requests, Open Item Reports, and other miscellaneous input.

The concerns were prioritized by the System Engineer based on relative ranking as to impact on safety. The initial action was to obtain documentation necessary to issue a pertinent Work Order. Once the Work Order is issued, necessary work will be performed by appropriate personnel in accordance with station priorities, which take into consideration the System Engineer's prioritized ranking of concerns.

Since January 1988, approximately 80 concerns associated with the Service Water System have been identified and an action plan has or will be established for each item. Currently 18 items have either been totally resolved or have Work Orders written. The balance are under technical analysis.

Until technical analysis results in a Work Order or in a formal engineering resolution, the status of any concern remains open in one of the tracking systems in the corrective action program. In this way its progress is tracked and, if unsatisfactory, escalated up to and including the executive level until the concern is resolved.

2. System Line-ups:

The present administrative controls for ensuring that systems are properly aligned consist of check-off lists which are performed by a single qualified operator and then independently performed by a second qualified operator who records the "as-found" condition. (The "required" position is intentionally not listed on the second checker's list.) When check-off lists require independent verification, a third qualified individual reviews and compares the two check-off lists to ensure there are no discrepancies or differences. The items checked include: 1) valve, switch or breaker positions; 2) component locked (if required), and 3) the presence of a tag or label. Any discrepancies between the "as left" state and the desired state of a component, as indicated on the check-off lists, must be documented in the remarks section of the check-off list, and must be approved by the Senior Watch Supervisor.

The elements of this administrative program are considered adequate to ensure proper equipment alignment when they are properly implemented. However, the fact that the handle of the circuit breaker for Valve 896A was found unlocked on May 10, 1988 after the recent performance of Check-off List 10.2.1, which required double verification that the breaker was locked open, is indicative of a problem (though apparently isolated) in the implementation of these administrative controls or of equipment controls. Although the results of an investigation of this event were inconclusive, it is possible that the lock was removed after the check-off list was properly completed.

As noted in the response to Violation B in Attachment I, a system of serialized component seals is being considered to provide added auditable assurance that manipulations of locked equipment performed after the check-off list is complete are properly controlled.