Stephen B. Bram
Vice President

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

October 11, 1989

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

Document Control Desk
US Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

SUBJECT: Response to NRC Region I Inspection Report No. 50-247/89-16

This is in response to your letter dated September 11, 1989 concerning a routine inspection conducted by Mr. Lawrence W. Rossbach, and Mr. Peter W. Kelley, Resident Inspectors, and Mr. Hai-Boh Wang from NRR, from July 11, 1989 to August 28, 1989.

Our detailed response to each violation set forth in your September 11, 1989 letter is contained in Attachment A.

With regard to the concern expressed in your cover letter relating to effective communication of technical support guidance to operations personnel, we acknowledge the need to improve communications of written information and provide the necessary tools to enhance recall of this information. To improve communications, Standing Orders are issued and placed in the night order book to insure they are read and followed by each on-coming watch. They are also placed and maintained in a separate "Standing Orders" book, which must be periodically reviewed by all operators. This review is documented.

Should you or your staff have any questions regarding this matter, please contact Mr. Jude G. Del Percio, Manager, Nuclear Safety and Licensing.

Very truly yours,

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8910250206 891011
PDR ADOCK 05000247
Q PNU

cc: Mr. William Russell
Regional Administrator - Region I
US Nuclear Regulatory Commission
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King of Prussia, PA 19406

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ATTACHMENT A

RESPONSE TO NOTICE OF VIOLATION

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
OCTOBER, 1989

ATTACHMENT A

RESPONSE TO NOTICE OF VIOLATION

Violation

A. Technical Specification 3.0.1 requires that the licensee take action to place the unit in hot shutdown within 7 hours in the event a Limiting Condition for Operation (LCO) and/or its associated action requirements cannot be satisfied because of circumstances in excess of those addressed in the specification. Technical Specification LCO 3.7 allows only one inoperable emergency diesel generator during power operation.

Operations Administrative Directive 15, Policy for Conduct of Operations, Section 4.2, requires the Operations Manager to develop and implement orders to ensure safe and reliable operation of plant equipment and systems. The Operations Manager's November 15, 1988 standing order mandating specific power reductions to ensure that Technical Specification 3.0.1 shutdown requirements are met requires that the unit load be reduced to 50% power within three hours of entering this limiting conditions for operation (LCO).

Between 8:40 a.m. and 1:30 p.m. on August 1, 1989, the unit was in a condition which resulted in two emergency diesel generators being inoperable thereby requiring entry into Technical Specification 3.0.1 due to an inability to meet Technical Specification LCO 3.7 requirements.

Contrary to the above standing order, on August 1, 1989, the licensee did not reduce load to 50% power within three hours due to inoperable diesel generators.

This is a Severity Level IV Violation. (Supplement 1).

Response

Our internal evaluation of the abovementioned events identified that the non-essential service water system was inoperable concurrent with Emergency Diesel Generator 23 being inoperable. The plant was found to be in a condition which was in excess of those prescribed by Technical Specifications 3.7.B.1 and 3.3.F.2.b and therefore required application of Technical Specification 3.0.1. An initial one hour notification was made in accordance with requirements. The scope of the Technical Specification 3.0.1 conditions applicable to this event were not fully recognized, however, and a premature exit of Technical Specification 3.0.1 was made. Upon recognition of the additional applicability later that same day, a second hotline notification was made.

LER 89-11 submitted on September 1, 1989 (included in Attachment B) documented the particular event discussed above, its causes, and corrective actions, which included development of an additional operator aid (i.e., a "cause and effect" matrix), addressing equipment conditions and impacted LCOs. This is in trial use by the operators. A Standing Order - "Technical Specification Clarification Aid" was also issued on September 5, 1989 by the Operations Manager to detail particular LCO status for equipment out of service. No further corrective actions are needed.

We believe the actions we have taken in response to the event described above, demonstrate the licensee initiative for self identification and correction encouraged under 10CFR Part 2 Appendix C Section V.G.1 and conform to the specific criteria contained therein. We therefore request that consideration be given to withdrawal of this violation consistent with the discretionary authority provided in that section.

Violation

B. 10 CFR 50, Appendix B, Criteria XVI states, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition. The Consolidated Edison Quality Assurance Program, Section 5.2.11, Corrective Actions, requires verification that corrective actions are implemented.

Contrary to the above, effective corrective actions were not implemented to preclude repetition of failures to meet Generic Letter 82-12, Nuclear Plant Staff Working Hours, noted in previous Inspection Reports 87-25 and 88-19 even though overtime audits by the licensee continued to identify failures to comply with Generic Letter 82-12. Deficiencies identified by NRC included missing or incorrect overtime documentation and untimely or unauthorized overtime approval.

This is a Severity Level IV Violation. (Supplement 1).

Response

The applicable Station Administrative Order (SAO) has been strengthened to further support compliance and foster accurate and complete documentation. Changes include:

- Development of a standard form for use by affected station sections when excessive work hours will or have been worked. The form clearly identifies the time period of the discrepancies, the specific reasons and whether prior approval was given.

- Requirement that responses to internal audit findings be made at the level of the General Manager or his designee who is responsible for ensuring that discrepancies found are corrected and that the action taken is in accordance with the SAO.

- Inclusion of contractor personnel within the scope of the SAO.

The above changes will strengthen our internal audit process by allowing inspection against a standard format and ensuring an increased management awareness and involvement. Guidance is also being developed which will require prior approval by the respective General Manager or the Vice President, in all but extreme circumstances, whenever the responsible Manager is not available. It should be noted that we recognize certain extreme circumstances may arise where the overtime pre-approval process cannot be exercised. For example, a delay of an incoming watch person and the unavailability of the Operations Manager and superiors to pre-approve the overtime of the outgoing watch person that covers the delayed individual to maintain minimum shift complement would cause us to exceed the overtime guidance. We do not expect these instances to occur but when it does post overtime approval will be granted.

ATTACHMENT B

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
OCTOBER, 1989

10 30

NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): Indian Point Unit No. 2

DOCKET NUMBER (2): 0 5 0 0 0 2 4 7

PAGE (3): 1 OF 0 4

TITLE (4): Emergency Power Supply and Service Water Header 0.0.5.

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 8	0 1	8 9	8 9	— 0 1 1	— 0 0	0 8	3 1	8 9		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME: Bruce Shepard

TELEPHONE NUMBER: AREA CODE 9 1 4 — 5 2 6 - 5 6 7 8

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
B	B I	S T R	Z 0 1 0	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

[ ] YES (If yes, complete EXPECTED SUBMISSION DATE) [X] NO

EXPECTED SUBMISSION DATE (15): MONTH | DAY | YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

LER 89-11

On Tuesday, August 1, 1989, IP-2 was operating with Emergency Diesel Generator #23 and Service Water Pump #23 removed from service. At approximately 0815, the differential pressure for the remaining two non-essential service water pump strainers increased above the allowable value. An evaluation by the operators began, and at 0840 the entire non-essential service water system was declared inoperable placing the plant into Technical Specification (TS) 3.0.1, and requiring a 1 hour notification and subsequent plant shutdown to hot shutdown within 7 hours.

At 0940 non-essential service water pump #23 was made operable by strainer cleaning, and at 1330 a second non-essential service water pump (#22) became operable. TS 3.0.1 was incorrectly interpreted to be satisfied at 0940 although it was actually satisfied at 1330, 4 hours and 50 minutes after TS 3.0.1 was entered. The health and safety of the public were not affected by this event.

NRC Form 366 (9-83)

~~8909190057~~ A-1 4 pp.

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor, Auxiliary Electrical System (Emergency Diesel Generators) and Service Water System (Designated Non-essential Header).

IDENTIFICATION OF OCCURRENCE:

The evaluation identified that the non-essential service water system was inoperable concurrent with Emergency Diesel Generator #23 inoperable. The plant was found to be in TS 3.0.1 condition, which is applicable to plant conditions in excess of those prescribed by TS 3.7.B.1 and 3.3.F.2.b. The scope of the TS 3.0.1 conditions applicable to this event were not fully recognized and a premature exit of TS 3.0.1 was made, prompting a followup hotline notification.

REPORTABILITY DETERMINATION DATE:

August 1, 1989

REPORT DUE DATE:

August 31, 1989

REFERENCES:

SOR 89-458 and SOR 89-458A

PAST SIMILAR OCCURRENCE:

LER 88-015

DESCRIPTION OF OCCURRENCE:

On Tuesday, August 1, 1989, IP-2 was operating at 100% power with Emergency Diesel Generator(EDG) #23 removed from service for repairs to its jacket water cooler. The designated non-essential service water header was served by #21, 22 and 23 service water pumps(SWP). At approximately 0815, the differential pressure for all the non-essential service water strainers increased above the allowable value because of debris from the Hudson River. Initial troubleshooting by the operator began, by switching pumps and attempting to reduce differential pressure across strainers. At 0840 (approximately 25 minutes later) the operators declared the non-essential service water system (all three non-essential SWP) inoperable, a condition in excess of TS 3.3.F.2.b.

Upon the declaration of inoperability, TS 3.0.1 was entered, requiring a 1 hour notification starting at 0840, and subsequent plant entry into hot shutdown within 7 hours.

DESCRIPTION OF OCCURRENCE: (continued)

While the NRC was being notified at 0940, non-essential service water pump #23 became operable (the plant was still in a 24 hour LCO for TS 3.3.F.2.b and, although not recognized, TS 3.0.1 was still applicable since the plant was outside TS 3.7.B.1). Shutdown of the plant was not begun, nor was an NUE declared, since the SWS, SRO's and Watch Engineer/STA prematurely exited TS 3.0.1 at that time not realizing the plant was still in a TS 3.0.1 condition. The emergency diesel generator loading analysis performed in the Spring of 1989 determined that EDG #21 could be overloaded when EDG #23 and SWP #22 are inoperable. Under these conditions, EDG #21 must also be considered inoperable and along with the continued inoperability of EDG #23, this represented a condition requiring that TS 3.0.1 be applied. At 1330 non-essential SWP #22 became operable. TS 3.0.1 should have been exited at that time, 4 hours and 50 minutes after TS 3.0.1 was entered (the 7 day LCO for EDG #23 out of service would still have been in effect).

ANALYSIS OF OCCURRENCE:

When EDG #23 was removed from service to perform maintenance, the LCO specified in TS 3.7.B.1 was properly entered and a 7 day LCO was declared. The removal from service of non-essential SWP #23 for maintenance did not result in any additional LCO since TS 3.3.F.2 only requires two SWPs on the nonessential header. The removal from service of non-essential SWP #21 & 22, due to debris collection in the strainer, caused the operators to recognize the plant was in a TS 3.0.1 condition since no operable SWPs remained on the designated non-essential header, thereby exceeding TS 3.3.F.2.b conditions.

SWP #23 was returned to service at 0940, supplying the non-essential header (the plant was still in TS 3.3.F.2.b since only one non-essential SWP was operational). Later in the day it was determined that placing SWP #23 in service with SWP #22 still out of service was not sufficient to satisfy the requirement of TS 3.7.B.1 pertaining to one inoperable EDG. That LCO permits one EDG to be inoperable for seven days provided off-site power sources are available and the two remaining EDGs and their associated engineered safety features are operable. The non-essential SWP on EDG #23 is designated a TS pump due to the potential for overloading EDG #21 during the switchover sequence of a design basis loss of coolant accident. Therefore, the EDG LCO was not satisfied because circumstances in excess of those addressed in TS 3.7.B.1 continued to exist, and TS 3.0.1 was therefore still applicable.

TS 3.0.1 should have been exited when SWP #22 became operable at 1330, 4 hours and 50 minutes after entry. In any case, entries into 3.0.1 are reportable pursuant to 10 CFR 50.73(a)(2)(i)(B) because the plant is operating with a condition outside the limits specified in the Technical Specifications.

CAUSE OF OCCURRENCE:

The unscheduled removal from service of SWPs #21 and 22 (due to high differential pressure across their strainers) during ongoing maintenance on EDG #23, resulted in the inability to comply with the requirements of the EDG LCO. This necessitated entry into TS 3.0.1. The non-essential header system could not be immediately restored, also necessitating entry into TS 3.0.1.

The inability of plant personnel to fully interpret the requirements of TS 3.7.B.1 resulted in the plant remaining in a TS 3.0.1 condition without the proper action (starting to proceed to hot shutdown and declaring an NUE) being taken.

CORRECTIVE ACTION:

The strainer for SWP #22 was repaired and returned to service which restored compliance to the EDG LCO and the non-essential service water header requirements. Additionally, as part of our ongoing plant improvements program, we will be replacing the existing travelling screens during 1991 (long lead time for equipment). This is expected to improve the river water quality prior to suction into the SWP strainers.

The need to enhance the ability of plant personnel to diagnose TS 3.7.B.1 conditions (twice in 10 months, see LER 88-015) is recognized. Corrective actions involve reinstruction of necessary plant personnel with regard to the full scope of conditions which impact this Technical Specification. An additional operator aid (e.g., a "cause and effect" matrix) addressing these conditions has been developed and is being used on a trial basis for evaluation.