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

July 6, 1992

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 Inspection Report No. 50-247/92-09

This letter is in response to subject inspection conducted by Messrs. G. Hunegs, D. Stampfli, et. al., of NRC Region I office during the period from April 5, 1992 to May 9, 1992, at Indian Point Nuclear Power Plant Unit No. 2.

Your June 5, 1992 letter outlines a Notice of Violation. Con Edison's reply to this violation is contained in Attachment A to this letter.

With regard to the assessment of watch standing practices involved with the April 13, 1992 reactor trip, we believe the trip revealed that in some specific areas, such as log keeping, watch turnover and watch standing practices in conventional plant field operations, improvements made have not yet been uniformly and consistently achieved. We intend to improve field operations with training and coaching that reinforces our expectations.

Should you have any questions regarding this matter, please contact Mr. Charles W. Jackson, Manager, Nuclear Safety and Licensing.

Very truly yours,

IE01
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Attachment

cc: Mr. Thomas T. Martin
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Francis J. Williams, Jr., Project Manager
Project Directorate I-1
Division of Reactor Projects I/II
US Nuclear Regulatory Commission
Mail Stop 14B-2
Washington, DC 20555

Senior Resident Inspector
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ATTACHMENT A

REPLY TO A NOTICE OF VIOLATION IN INSPECTION REPORT 92-09

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
JULY, 1992

REPLY TO A NOTICE OF VIOLATION

Violation

As a result of an NRC inspection conducted by NRC Region I from April 5, 1992 to May 9, 1992, and in accordance with the NRC Enforcement policy (10 CFR 2, Appendix C), the following violation was identified:

> 10 CFR 50, Appendix B, Criterion XVI, requires, in part, that in the case of significant conditions adverse to quality, measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.
>
> CI-240, Quality Assurance Program for Operating Nuclear Plants, Section XIII, "Conditions Adverse to Quality and Corrective Actions," establishes measures to assure that significant conditions adverse to quality are promptly identified and corrected, that the cause of the condition is determined, and corrective action is taken to preclude its recurrence.
>
> Contrary to the above, between September, 1988 and April, 1992, the corrective action process failed to determine and correct the adverse interactions which existed between the auxiliary feedwater system and the condensate system. This resulted in the malfunctioning of both motor-driven auxiliary boiler feed pumps on April 13, 1992, following a reactor trip.
>
> This is a Severity Level IV violation (Supplement I).

Response:

The four events preceding the April 13, 1992 motor-driven auxiliary feed pumps (MDAFWP) anomaly, as noted in the inspection report, involved interactions between the condensate and auxiliary feedwater system (AFWS) that were different in nature. The events of September 1988 and January 1990 can be characterized as high pressure fast transient events (existing in milliseconds). None of these events would have tripped the MDAFWPs because they involved pressures above the MDAFWPs low suction pressure switch setpoint. The succeeding events of September, 1990 and November, 1991, on the other hand, can be characterized as low pressure fast transient events also of milliseconds duration, except that these events caused tripping of the MDAFWPs. For the November 1991 event, we re-verified the low suction trip setpoints for the MDAFWPs and duplicated the event that caused the pump to trip. Although we understood the cause of the MDAFWP trip, we proactively established a corrective action to investigate other potential adverse AFWS and condensate system hydraulic interaction. The April 13, 1992 MDAFWP anomaly occurred prior to the closeout of the November 1991 event corrective action. The immediate corrective action taken in response to the April 13, 1992 event was the installation of a jumper to block close condensate level control valve LCV-1128. Tests were subsequently conducted prior to restart which verified system capability to deliver required flow with condensate level control bypass valve LCV-1128A open under the most limiting condition, as well as MDAFWP functional capability subsequent to its rapid cycling.

Also, in addition to our existing improvements in the trending of significant occurrence reports and open item reports and their review after each occurrence in our daily management review meeting, we have initiated a proactive quarterly review of outstanding corrective actions to assess progress towards completion, as well as to reassess the priority of those items. We consider that this action, as well as the jumper installation, will avoid further violations. We also consider their implementation to be the time when full compliance was achieved. A computer hydraulic model of the system was developed to better understand AFWS and condensate system interactions. A permanent change to preclude recurrence is currently under review. Changes being considered include possible modification to the MDAFWP low suction pressure switch setpoint or leaving LCV-1128 in the closed position. The permanent change will be implemented during February, 1993 refueling outage.