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October 6, 1999

Mr. Jefferey F. Harold
Project Directorate I
Division of Licensing Project Management
Office of Nuclear Reactor Regulation
United States Nuclear Regulatory Commission
Washington, D.C. 20555

SUBJECT: Consolidated Edison Company of New York, Inc., Response to Request for Additional Information Regarding Preliminary Review of the Union of Concerned Scientists Petition dated October 1, 1999.

Dear Mr. Harold:

The purpose of this letter is to provide the information requested in your October 1, 1999 request for additional information. After evaluating these topics in the content of our Recovery Plan, we have concluded that they are appropriately being addressed in the Plan, and that our continuing full implementation of the Plan will provide reasonable assurance that Indian Point will be returned to service and operated safely in accordance with all pertinent licensing requirements. The basis for this conclusion with respect to each of the three requests identified is provided below.

Issue 1: The Union of Concerned Scientists petition discusses a number of examples of past problems with circuit breakers. In your September 24, 1999, letter in response to the issues raised in the petition, you state that the recent problem is significantly different from the historical mechanical problems previously encountered and corrected with the DB-50 circuit breakers. However, you did not address your measures to correct problems with the implementation of your post calibration test procedure that were revealed during the August 31, 1999, event. During our ongoing inspection process we learned that your current root cause evaluation has identified corrective actions from a prior root cause evaluation of DB-50 breaker problems that remain open and overdue. Provide any additional information to update your September 24, 1999, response that affects the petitioner's issue 2.

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Response:
The post calibration Procedure PC3Y5, "DB-50 and DB-75 Circuit Breaker Amptector Calibration", was revised to incorporate a specific check of the amptector setting at 8 percent below its desired value to ensure the breaker will not trip sooner than expected. This will preclude the potential for mis-calibration of an amptector as occurred in the 8/31 event.
There were five (5) corrective actions from the DB-50 breaker root cause evaluation that remained open and overdue at the time of the 8/31 event. Four (4) of these were related to the setting of amptectors. The fifth corrective action was associated with factory testing to verify breaker design and had no potential bearing on the 8/31 event. Two corrective actions required the development of procedures and training for primary current testing and two required the review and revision of procedures for secondary current testing. The intent of the primary current test corrective action was to verify current sensor ratios as a result of incorrect wiring of a current sensor on an RHR pump breaker. At that time this was considered to be required since secondary current testing would not detect this type of wiring error. Subsequently, in addition to a visual examination of terminal connections, an alternative and simpler technique was developed to verify the current sensor operation by measuring the current on the secondary side of the current sensor under normal load. This fully addressed the root cause of the RHR pump breaker event. Additionally the primary current testing envisioned as part of this corrective action would probably not have detected the problem associated with the 8/31 event since the intent of the primary current test was to exercise the complete amptector circuit, not to check the calibration of the amptector.
The intent of the secondary current procedure review was to clarify the required tolerances associated with the long delay trip time repeatability. Since the trip on 8/31 was associated with the settings on the short delay pickup, completion of this corrective action would not have prevented this event.

Issue 2: Provide the 2-year rolling average reliability values for the EDGs and state if these values include the output breakers in the scope of the reliability determination.

Response: The 2 Year rolling average reliability values for the Emergency Diesel Generators as of October 1, 1999, which do include both failure to start and output breaker reliability data, are as follows: 21EDG 96.83% (1 failed start - March 29, 1998; 1 breaker failure - July 1998); 22EDG 100%; and 23EDG 98.48% (1 breaker failure - August 31, 1999).

Issue 3: In your preliminary response you did not address what actions that you have taken which describe the controls that will be used when the tap changer control is not in automatic and what mitigation strategies will be put in place to preclude any unnecessary transfers to the onsite emergency power supply during normal power operation, unit trip, or accident condition should the need arise while the tap changer control is in manual.

Response: As a consequence of the August 31 event, significant licensee attention and resources have been directed to tap changer status in carrying out the Recovery Plan. If the automatic control capability of the tap changer were to be compromised, necessitating manual status, Station Administrative Order SAO-112, Corrective Action Program, requires a Condition Report (CR) be issued and a Deficiency Identification (DI) tag would be placed on the control switch. A CR for a deficient component requires that a work order be issued to commence repairs. The failure of the tap changer to control in automatic would be a significant operator work around which would expedite the repair.

Pending development of a more permanent solution, the following interim actions will be taken if the tap changer can not be maintained in automatic :

1. The degraded tap changer will be reviewed according to the guidance provided in NRC GENERIC LETTER NO. 91-18, REVISION 1.
2. A dedicated qualified individual will be stationed in the control room to manually control voltage on the 480V busses to prevent unnecessary transfer to the onsite emergency power supply.
3. A specific plan to address the tap changer failure to control in automatic will be generated based on the tap changer failure mechanism and existing plant conditions.
4. The appropriate procedure(s) will be revised to include the actions stated in the above items.

Very truly yours,

A. Adam Blind

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