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March 1, 1993

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: Reply to a Notice of Violation - NRC Inspection
Report No. 50-247/92-22

Reference: NRC Letter dated January 29, 1993, "Notice of
Violation - Inspection Report No. 50-247/92-22",
C. W. Hehl to S. Bram.

This letter is in response to the Notice of Violation (NOV)
pertaining to the Technical Support Center (TSC) ventilation
system contained in the referenced letter. Our reply to the
NOV issues raised in the referenced letter pursuant to the
instructions set forth in Appendix A is contained in
Attachment A. Our response to the Notice of Deviation
pursuant to Appendix B instructions is contained in
Attachment B.

The referenced letter requests assurance that other emergency
response facilities are properly maintained. For the offsite
facilities consisting of the Emergency Operations Facility
and the Alternate Emergency Operations Facility, full
responsibility for facility readiness, including maintenance,
resides in Emergency Planning within the Site Protection
organization. Measures have been in place, and proved
effective, in maintaining these facilities. We believe our
maintenance and inspection program will be sufficient to
assure that the offsite facilities will perform their
emergency functions. For the on-site facilities, including
the Technical Support Center and Operational Support Center,
we believe that the reviews now being conducted by the Daily
Management Review Group, as part of our improved corrective
action process, will assure proper management attention and
prioritization of needed activities to respond to identified
issues.

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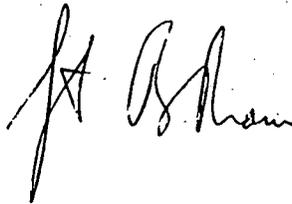
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To further assure that the emergency response facilities are in full compliance with NRC Requirements, a comparison of the "as-built" facilities to the existing facility descriptions in the Emergency Plans and Procedures will be performed and the Emergency Plans and Procedures will be compared to the requirements of the NUREGs 0696 and 0737 Supplement 1. The intent of this assessment is to reconcile any deviations that are identified. This effort will be performed by the Emergency Planning group and completed by December 31, 1993.

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

Very truly yours,



cc: Mr. Thomas T. Martin
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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
MARCH, 1993

REPLY TO NOTICE OF VIOLATION

VIOLATION

During an NRC inspection conducted from September 27, 1992 to November 7, 1992, a violation of NRC Requirements was identified. In accordance with the General Statement of Policy and Procedure for NRC Enforcement Actions, 10 CFR Part 2, Appendix C (1992), the violation is listed below:

Section 50.47(b)(8) of 10 CFR Part 50, requires that adequate emergency response facilities and equipment to support the emergency response be provided and maintained.

Contrary to the above requirements, the technical support center (TSC) ventilation system was not adequately maintained as shown by the repeated TSC ventilation system test failures between August 1986 and October 1992. In addition, the carbon filter unit fan was tagged out from November 1991 to April 1992 without adequate compensatory actions.

RESPONSE

The cover letter transmitting the NOV as well as NRC Inspection Report No. 50-247/92-22 identifies the following areas as the principal contributors to issuance of the NOV. These are:

- 1) TSC ventilation testing;
- 2) TSC habitability, in particular temperature control;
- 3) Improper clearance of a stop tag on the charcoal filter train.

These are addressed as follows:

- 1) TSC Ventilation testing.
Periodic testing of the TSC ventilation system, including charcoal absorbency, has been conducted since the facility was built and declared operational. Over the years problems were encountered with the ventilation system. These included auto start of the charcoal filter train, maintenance of an 1/8" W.G. differential pressure between the TSC and adjacent areas, together with repeated failures of the flow test. As each of these problems occurred they were addressed, however responsiveness in terms of prompt corrective actions was admittedly untimely and occasionally incomplete.

A contributing factor to the less than adequate corrective action response was the recognition that the conceptual design of the ventilation system was more complex than required, and that elimination of such complex features as the auto start function would reconcile the observed flow test failures. Furthermore, based upon the successful charcoal absorbent tests, it was believed that placing the charcoal train in the incident mode would render the TSC ventilation system functional in terms of meeting applicable NUREG standards. Charcoal filter train fan operation in the manual mode was in fact verified, but not documented. Past test data, based upon available records, of the charcoal and its replacement history is as follows:

<u>Date</u>	<u>Measured Efficiency</u>	<u>Required Efficiency</u>
9/21/87	99.9%	90%
2/2/89	99.71%	90%
2/25/90 Carbon filters replaced.		
11/7/90	99.11%	90%
9/23/92	90.39%	90%
1/30/93 Carbon filters replaced		

With respect to the 1/8" W.G. criteria, this requirement was well recognized and differential pressure data was taken at the time of each conducted test since 1989. However, this portion of the testing protocol was not formally incorporated into the test procedure acceptance criteria. Senior Plant Management understood that the procedure had been revised in 1989. Variances in flow, such as the high flow of 4250 SCFM noted in 1989, were evaluated and found to be acceptable in terms of the ability of the ventilation system to provide radiological protection in accordance with GDC 19 of Appendix A to 10 CFR 50.

TSC ventilation system performance issues were addressed on a case-by-case basis. Followup, in terms of corrective action and documentation, was admittedly slow. The slow response was in large part attributable to the knowledge that the TSC ventilation system would remain functional if the charcoal train was placed in the incident mode, and the fact that the Emergency Plan provided a compensatory action of relocation of required personnel to the EOF should the TSC become inhabitable.

TSC ventilation system maintenance short comings leading to this violation can be attributed to less than satisfactory implementation of the Indian Point Corrective Action Program. However, we believe notable improvements have been made in this area with the revised Station Administrative Order 132 and the creation of the Daily Management Review Group. Its effectiveness in the area of TSC ventilation was most noticeably demonstrated in the April 1992 review of the Significant Occurrence Report stemming from the failed TSC ventilation test in March of 1992. As a result of this Committee's efforts and work order prioritization, a successful retest of the TSC ventilation system was performed in September, 1992. We believe that implementation of the Daily Management Review Group in December, 1991, will preclude the slow response times that have occurred in the past. Furthermore, we believe that the outstanding maintenance issues pertaining to the TSC ventilation system have now been resolved, as evidenced by the successful system test performed in September, 1992.

2) TSC Habitability

The potential conflict of maintaining conditioned air to the TSC for temperature control versus maintaining the charcoal filter train plenum at a positive pressure with respect to adjacent areas was recognized and addressed by Con Edison as documented in a Con Edison Engineering memorandum issued November 14, 1990. Due to the time required to formally issue a plant modification to resolve the conflict, compensatory actions were instituted which would permit introduction of conditioned air to the TSC from the plant computer room if temperatures within the TSC became excessive. The original concept, which included structural modification (erection of masonry walls) in the vicinity of the TSC charcoal filter train plenum was rejected. It became obvious that diversion of 720 cfm originally intended for an office area, which was not part of the TSC, would be the optimum means of pressurizing the TSC charcoal filter train plenum. This process has, admittedly, consumed more time than necessary. Assignment of a higher priority to implementation of this modification was not done due to an over reliance on the compensatory measure. It was also recognized that the probability of exercising the compensating measure, which would only become necessary under extreme weather conditions during the summer months, was somewhat remote. In addition, the Emergency Plan provided the contingency action of evacuation to the EOF should the TSC become uninhabitable.

The temperature issue was not addressed in our assessment of IEN 92-32 as steps had been taken to provide an optimum solution to the temperature problem. This modification will be implemented by December 31, 1993.

3) Improper clearance of a stop tag on the carbon filter unit fan.

On November 4, 1991, the TSC Carbon Filter Unit Fan was removed from service and a tagout issued (i.e., a stop tag applied) in preparation for maintenance. On November 12, 1991, a Work Permit was issued for maintenance work. On November 25, 1991, the Work Permit was returned. On November 27, 1991, the Tagout Restoration was issued to remove the stop tag; however, due to a communications error between the Support Facility Supervisor (SFS) and the field operator, the stop tag was not removed. The SFS initialed the tagout restoration, indicating that the stop tag had been removed. On March 18, 1992, a TSC ventilation test was performed with unsatisfactory results; a Work Order was then issued. On April 2, 1992, during troubleshooting of this deficiency, the stop tag was found in the field. The tagout was verified as having been cleared, the stop tag was removed, and proper fan operation was verified.

Operations management reviewed the situation in November, 1992 and attributed the error to inadequate performance by the SFS. Corrective action included appropriate disciplinary action for the individual involved. To provide further assurance against recurrence, an OIR was issued on January 29, 1993, with corrective actions that included reviewing the event with all Operations personnel to reinforce the standards for communications and signatures on operations documents, and to review (and revise, if necessary) the periodic audits that are currently performed by Operations on Tagouts that are both in effect and those that have been cleared. All corrective actions are scheduled for completion by April 1, 1993.

ATTACHMENT B

NOTICE OF DEVIATION

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
MARCH, 1993

REPLY TO NOTICE OF DEVIATION

DEVIATION

Final Safety Analysis Report (FSAR), section 12.7 references a June 1, 1981 letter as the basis for the conceptual design of the emergency response facilities. The June 1, 1981 letter to the NRC states in part: "The ventilation system in the TSC will function in a manner comparable to and compatible with the control room ventilation system. The system will be redundant and automatically activated HEPA and charcoal filters are included in the design". Further, it states: "The TSC will be connected to the control room by an enclosed bridge designed so that no radiation protection is needed to ensure safe travel between the TSC and the control room."

Contrary to the above, the current design of the TSC ventilation system is such that it is neither redundant nor automatically activated, and the passageway from the TSC to the control room does not allow for personnel travel without radiation protection.

RESPONSE:

We believe the issuance of the Notice of Deviation is inappropriate on the following basis:

The 1981 letter states that the TSC ventilation system will "be comparable" to the CCR ventilation system. In this respect, the TSC system does contain elements of redundancy similar to the CCR; however, the CCR ventilation system is not completely redundant nor is the TSC system. Both systems have a single charcoal bed. Although the CCR system does have redundant blowers, the emergency power supply, until recently, was from one diesel. The TSC ventilation system also has one diesel as a backup power supply. Both the TSC and the CCR have redundant air conditioning systems. Thus, the TSC does reflect the redundant elements contained in the CCR design except in the instance of redundant charcoal filter blowers where the single emergency power supply obviates the need for hardware redundancy.

The conceptual design provided for two means of travel from the CCR to the TSC. The first, on elevation 53 foot, was exiting from either door of the CCR (one through the watch supervisor's office), and crossing the hall to either of two adjacent TSC entrances. The second was by exiting the CCR to the watch supervisor's office, climbing a ladder to a connecting bridge to the TSC. The connecting bridge was pressurized on the TSC side by the TSC ventilation system, and on the watch supervisor's office side by CCR ventilation system. Thus, the bridge provided a means of going from the CCR to the TSC without protective clothing.

In 1984, modifications of the CCR ventilation system were implemented in the interest of enhancing the integrity of the CCR ventilation system. This same modification isolated the watch supervisor's office from the CCR ventilation system, which also eliminated the pressurization of the watch supervisor's office.

In 1989, after difficulties had been experienced with the auto start feature of the TSC ventilation system, a decision was made to delete this feature. Overall, this change enhanced the reliability of the system by making its operation simple, not complex.

These changes were made in the realization that the original conceptual design reflected ideas that were not necessary to meet the functional criteria in NUREGs 0696 and 0737 Supplement 1 as mandated by the 1983 order. Since compliance with these functional criteria was maintained, it was determined that no "substantial" changes necessitating NRC notification were made.

In terms of benefit, the change in the CCR ventilation system enhanced its integrity and reliability. In addition, the value of maintaining a bridge free of contamination was questioned, since the NUREGs required anti-contamination clothing and GDC-19 requirements could be met by use of the alternate count-room pathway. Similarly, deletion of the auto start feature, which enhanced system reliability, was thought to be an improvement. We believe that the controlling NUREGs provide design flexibility as long as compliance with the functional criteria is maintained.

The reference in the FSAR is to a conceptual design which was appropriate at the time the reference was included in the FSAR. However, the facilities are now constructed and "as built" changes occurred. To preclude further confusion concerning this reference it is being deleted as the FSAR should reflect final design information and not conceptual design information. Furthermore, the deletion is being made since detailed information concerning the Emergency Response Facilities should be contained in the Emergency Plan and Procedure. The NRC's guidance (NUREG 0800) does not require this information to be in the FSAR. A safety evaluation has been prepared justifying this deletion which will occur in the next annual update of the FSAR.

To ensure that the "as-built" facilities are in accord with the NUREGs, a comparison of the existing facilities will be made to the existing descriptions in the Emergency Plan and Procedures and reconciliations made where appropriate. In parallel, the Emergency Plan and Procedures will be compared with the NUREGs to ensure compliance. This effort will be completed by December 31, 1993.