Stephen E. Quinn
Vice President

Consolidated Edison Company of New York, Inc.
Indian Point Station
Broadway & Bleakley Avenue
Buchanan, NY 10511
Telephone (914) 734-5340

November 1, 1994
Re: Indian Point Unit No. 2
Docket No. 50-247

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

SUBJECT: Reply to NRC Inspection Report No. 50-247/94-13

REFERENCE: NRC Letter dated October 6, 1994, "NRC REGION I RESIDENT INSPECTION REPORT No. 50-247/94-13, C. J. Cowgill to S. Quinn

Attachment A to this letter responds to the referenced inspection report.

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

Very truly yours,

Stephen E. Quinn

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
US Nuclear Regulatory Commission
PO Box 38
Buchanan, NY 10511

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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION
INSPECTION REPORT 50-247/94-13

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
November 1, 1994

REPLY TO NOTICE OF VIOLATION

VIOLATION

During an NRC inspection conducted from July 24, 1994 through September 3, 1994, 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, the following violation was identified:

Technical specification (TS) 6.8.1 requires that written procedures shall be established and implemented covering the activities referenced in ANSI N18.7 - 1972 and Regulatory Guide 1.33, Appendix A, November 1972. Operations Administrative Directive (OAD)-15, "Policy for Conduct of operations," section 5.6, requires that an operator's signature on operation documents indicates that the individual has either performed or visually witnessed the activity.

Contrary to the above, on August 12, 1994, an operator signed a surveillance test record that indicated he had checked and/or repositioned eleven valves in the service water system Zurn strainer room when in fact the operator only checked ten valves. As a result, service water system valve SWN 594 was left open when it was required to be-shut during performance of the test.

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

RESPONSE

Con Edison has completed its review of the incident involving a Service Water Pump test which is referenced in the NOV issued on October 6, 1994. In addition, we have reviewed recent personnel performance, including the tagging and equipment deficiencies referenced in your cover letter to IR 50-247/94-13, to determine the underlying root causes and generic implications. Our conclusion is that these incidents, with one exception described below, were attributable to human factors performance related to inadequate procedural use and review. More specifically, established procedural controls proved ineffective, when not properly implemented by the individual performing the procedure. We attribute these incidents to individual deficiencies in work performance, and believe that they are not generally indicative of an unwillingness to adhere to procedures, nor reflect a lack of understanding of station policy and management expectations for strict procedure adherence. The one exception involved a violation of our Company-wide tagout procedure by an individually not normally assigned to the site; this was addressed through prompt and significant disciplinary action for that individual.

The individual involved in the Service Water Pump test was counselled by his supervisor and manager on proper procedure use as well as our expectations for strict procedure adherence and strong personal performance. Because the error was identified and immediately brought to management attention by the individual involved, further disciplinary action was deemed inappropriate.

Our review also indicated that the actions taken following the event were appropriate and timely. The error was identified by the operator who committed it, and communicated to the Senior Watch Supervisor (SWS). The operators performance in immediately identifying the discrepancy to his supervisor is exactly the response expected and encouraged by management. The pump was then re-tested on the same shift without further incident. The SWS had an Open Item Report issued to document the event, which resulted in a root cause evaluation by the Human Performance Engineer, with appropriate corrective actions. There was no safety impact as a result of this incident.

OAD-33, "Procedure Adherence and Use", has been revised to further emphasize and clarify requirements for strict procedure adherence and use. All Operations personnel will be trained on this revision, the Service Water Pump test and other recent performance deficiencies; this will be completed by December 20, 1994. Upon completion of this training, formal "Field Observations" by Operations management personnel will concentrate on strict procedure adherence, active procedure use, and proper attention to detail, to ensure that our corrective actions have been effective.

Additionally, the importance of strict procedure adherence and aggressive attention to detail will be re-emphasized during a station wide campaign. The campaign is intended to reach all station personnel through various means such as training, "tailgate" sessions, and via plant posters and handouts over the next several months.