

Stephen E. Quinn
Vice President

July 12, 1995

Consolidated Edison Company of New York, Inc.
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Re: Indian Point Unit No. 2
Docket No. 50-247

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

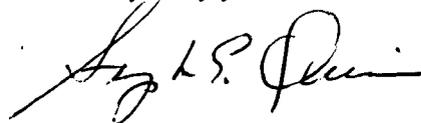
SUBJECT: Reply to NRC Inspection Report No. 50-247/95-08

REFERENCE: NRC Letter dated June 12, 1995, "NRC Region I Resident
Inspection Report No. 50-247/95-08," 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,



cc: Mr. Thomas T. Martin
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ATTACHMENT A

REPLY TO A NOTICE OF VIOLATION
INSPECTION REPORT 50-247/95-08

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
JULY, 1995

REPLY TO NOTICE OF VIOLATION 95-08-01

VIOLATION

Technical Specification section 6.8.1 requires that written procedures are implemented covering activities referenced in Regulatory Guide 1.33, November 1972. Regulatory Guide 1.33 requires written procedures for activities related to equipment control (e.g. locking and tagging). Indian Point 2 Station Administrative Order (SAO)-105, "Work Permits" specifies that tagouts are used to direct the manipulation of plant equipment for the express purpose of providing protection to workers, other equipment and plant reliability.

Contrary to the above, on March 9, 1995 while starting the 22 containment spray pump, water was discharged to the pipe penetration area of the PAB. Subsequent investigation revealed that a temporary jumper installed was not addressed in the tagout for work on valve 869A, which had been disassembled for maintenance. Further, on April 8, 1995 during maintenance and subsequent testing of the Condensate Storage Tank, no tagout was used to identify plant conditions which were required for providing protection to plant equipment, such as ensuring an adequate vent path was maintained.

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

RESPONSE TO NOTICE OF VIOLATION

The March 9, 1995 event involved water being discharged to the pipe penetration area of the PAB while starting Containment Spray Pump No. 22 (22 CSP). The reason for this event was a combination of configuration control, inadequate system tagout, and a lack of appreciation of the system interaction effects with the headers cross connected. The tagout package should have included 22 CSP as a potential source of water after the cross connect of the two headers for the purpose of reactor cavity fill.

Immediate corrective action was taken by securing 22 CSP and closing motor operated valve 866C. A walkdown of the area was conducted which verified that all proximately located equipment was unaffected and operable. The protection for the tagout was reviewed and modified to include 22 CSP and the pump discharge valves.

In order to prevent recurrence, SAO-206, entitled "Jumper Log," has been revised to ensure that configuration controls are established so that protection generated for maintenance is based upon current and correct information.

The April 8, 1995 event involved effects on the Condensate Storage Tank (CST) associated with failure to maintain adequate vent path. The reason for the event was insufficient managerial oversight which in this instance adversely affected communications and control programs. There are existing control programs available (caution tags, jumpers) which could have been used to communicate the technical requirements for certain system vent path openings.

Immediate corrective actions began with field inspections of the CST and repairs made as needed. Portions of the tank's internal surfaces were re-coated. Structural inspections and evaluations were performed to ensure continued operability. A hydrostatic test pursuant to ASME Section XI was performed. Finally, the breather valves were reinstalled and the CST returned to service.

Both of these events occurred with the plant shut down for major maintenance and refueling. During this period neither the CST nor the Containment Spray System were required to be operable to perform any safety functions. Thus the safety impact of these events were minimal.

Nevertheless, improvements in the control of work activities during shutdown periods are necessary in order to prevent recurrence. The following corrective actions are therefore planned to assure that such improvements are made prior to our next refueling outage in 1997:

1. A process to control foreign material exclusion (FME) barriers which are required at system openings for vent purposes will be evaluated and implemented. (February 1996)
2. The outage scheduling system will be expanded to include activities of important components within the secondary side of the plant with additional detail similar to that currently provided for the primary side components. (June 1996)
3. Operating procedure SOP 20.4 will be reviewed and enhanced as necessary to provide appropriate precautions and limitations with respect to the CST breather valves and the nitrogen system. (September 1995)
4. The responsibilities of project managers and system engineers concerning the criteria for returning systems to operability following the completion of outage projects will be refined in accordance with criteria to be developed following a review of current system operability guidance. (July 1996)
5. Formal training given to appropriate station personnel will be expanded to specifically include these events, their causes, and steps to be taken to prevent recurrence. (June 1996)

REPLY TO NOTICE OF VIOLATION 95-08-02

VIOLATION

Station Administrative Order SAO-304, "Radiological Boundary Controls", requires that each High Radiation Area (HRA) access point shall be posted with a conspicuous sign bearing the standard radiation symbol and written warning. SAO-304 also specifies that entrance to HRAs and Locked HRAs shall be in accordance with Technical Specification 6.12. Technical Specification Section 6.12 requires that each High Radiation Area in which the intensity of radiation is greater than 100 mrem/hr but less than 1000 mrem/hr shall be barricaded and conspicuously posted as a high radiation area and entrance into the area shall be controlled by issuance of a radiation work permit. In addition, High Radiation Areas in which the intensity of radiation is greater than 1000 mrem/hr shall have locked doors to prevent unauthorized entry.

Contrary to the above, on April 25, 1995 Con Edison Health Physics (HP) personnel identified a Locked HRA barrier in the Vapor Containment (VC) that had been cut allowing access to plant personnel. Further, from the period of April 25, 1995 to April 28, 1995 five HRA barriers were found partially blocked open or on the ground, partially obscuring the posting in the Vapor Containment and one HRA boundary posting insert was found missing in the Primary Auxiliary Building (PAB).

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

RESPONSE TO NOTICE OF VIOLATION

The April 25, 1995 event involved the apparent cutting and/or tearing of a barricade of a properly posted and barricaded area to complete containment floor painting activities. Con Edison Health Physics personnel identified that the barrier had been damaged. Immediate corrective action was taken to restore the barricade. Personnel involved with the painting activities were interviewed. These personnel were found to have been cognizant of station Locked HRA requirements, and were counseled on the need to check with an HP Technician immediately prior to the start of work per their radiation work permit. A contributing factor was the use of the same barricade material for this HRA as was being used to control access to wet paint areas. Subsequent corrective actions included procuring unique colored fencing for high radiation area barriers, enhanced discussion of the safety significance of high radiation/locked high radiation area controls in worker training, using self-closure gates wherever practical, and upgrading existing signs to highlight that the areas are postings required by technical specifications.

The April 27, 1995 event involved the 46' Containment South Recirculation Pump door being open for a period of about 1 hour. Immediate corrective action was taken to close the door. In our personnel interviews, we found strong worker knowledge of the rules for Locked HRA controls. However, we did identify a weakness in their understanding of HRA requirements, which we attribute to the recent de-posting of the area. Our present radiological work practices were developed over a period of 20 years with Locked HRA requirements for many plant areas, including the inside cranewall (ICW) areas of containment. As a direct result of the success of the Full Reactor Coolant System Decon National Demonstration Project, the station was successful in de-posting the ICW area from a Locked HRA to a HRA about one week prior to this event. In anticipation of problems associated with this change, the frequency of HP surveillances was increased to permit the timely identification and resolution of any expected HRA issues. Subsequent to the event, interviews with personnel indicated a lack of knowledge associated with the need to properly barricade (vs. lock) the less safety significant high radiation areas.

Actions listed above for strengthening radiation worker training and the use of swing gate closures are expected to prevent recurrence of this event.

In both events described above, full compliance with applicable radiation control requirements was achieved upon their original day of discovery.

Con Edison does not agree that a prior event which occurred on February 7, 1995 and which was documented in Radiological Occurrence Report (ROR) 95-02 is similar to the April 25 and 27, 1995 events because that event was not caused by a lack of personnel knowledge of the requirements for HRA controls. Our interviews with the Security Guard involved with this prior event indicate that he had a thorough knowledge of both Locked HRA and HRA controls. The event was caused by inattention to detail and had no bearing on the events listed above.

Several other items were documented by Con Edison as a result of augmented surveillance activities following the RCS Decon. We investigated each event and have determined that either an adequate barrier was present or that the failure of the barrier was due to a mechanical related equipment failure, not to a deficiency in personnel knowledge of station radiological controls.

1. 95' Vapor Containment - Stairs to Bedsprings - 4/25/95
The area was properly posted and barricaded. The rope to the area was found draped across the entry point by Con Edison HP personnel during a surveillance. It had become unhooked from one end of the stanchion due to failure of the rope and was immediately secured upon discovery during the routine surveillance.
2. 46' Vapor Containment - North Recirculation Pump Room - 4/25/95
The area was properly posted and barricaded. Con Edison HP personnel, during a surveillance, found the door open approximately one foot to allow the passage of a HEPA ventilation trunk into an ICW work area. The door and HEPA trunk provided sufficient barricades, such that, in order to gain access to this area, the door would have had to be opened further.
3. 95' 24 RCP Door - 4/27/95
The area was properly posted and barricaded. Con Edison HP personnel, during a surveillance, found that the door had been manually opened beyond the capacity of the self-closure device to function. The door was opened for a period of less than five minutes with no personnel in the immediate work area.
4. 46' Vapor Containment - North Recirculation Pump Room - 4/26/95
The area was properly posted and barricaded. Con Edison HP personnel, during a surveillance, found the door open. Access to the area was completely blocked by a ladder that was being used to repair a support above the pump room door, as authorized by other HP personnel.
5. 51' Service Water Chase - 4/28/95
The area was properly barricaded. Con Edison HP personnel, during a surveillance, found that the high radiation area sign insert had been flung out of the swing gate sign due to centrifugal acceleration caused by the swing gate spring. We have no database of any prior related events to forecast such an equipment related occurrence.

The five items mentioned above represent good examples of personnel showing a questioning attitude and documenting their observations. It is management's expectation that such a questioning attitude be part of daily activities at Indian Point 2.