

Stephen E. Quinn
Vice President

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October 18, 1995

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 Inspection Report 50-247/95-18; Notice of
Violation

This is in reply to your letter dated September 18, 1995 concerning the inspection conducted from July 10-14, 1995, at the Indian Point 2 facility.

Attachment A to this letter constitutes our reply to the Notice of Violation (NOV) included with your letter as Enclosure.

We consider this to be a serious event and have undertaken extensive corrective actions. We believe our corrective actions to be timely and appropriate to the event and circumstances surrounding it.

We respectfully request however, that the classification of the event as Severity Level III be reconsidered. The causal circumstances were not repetitive. While this event relates to high radiation area access, as do the referenced prior events, their similarity appears to end at that point. The prior events stemmed from circumstances where certain elements of the HRA access program were ineffectively implemented. In this instance, the facts do not suggest failures in the implementation of the program (or incomplete prior corrective actions) but rather a lack of adherence to clearly delineated procedural requirements by two individuals (in which ample training had been provided) that merely happened to arise in the context of HRA access.

Personnel lapses in procedural adherence were not significant elements of the prior events. We therefore believe that the disciplinary action taken against the personnel here involved and reinforcement of the message of need for procedural adherence to all station personnel is likely to be the most effective single and enduring element of our corrective action. Accordingly, the determination of a Severity Level III would appear to be at some variance with prior use of the Enforcement Policy for such events, where repetitive violations are generally keyed to perceived lack of complete implementation of corrective action programs stemming from prior events.

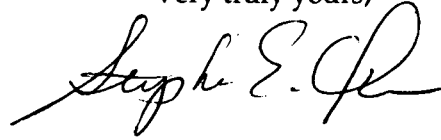
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Should you have any questions regarding this matter, please contact Mr. Charles W. Jackson, Manager, Nuclear Safety and Licensing.

Very truly yours,



Subscribed and sworn to
before me this 18th day
of October, 1995.

Karen L. Lancaster
Notary Public

KAREN L. LANCASTER
Notary Public, State of New York
No. 60-4643659
Qualified in Westchester County
Term Expires 9/30/97

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
OCTOBER, 1995

REPLY TO NOTICE OF VIOLATION

VIOLATION

Technical Specification 6.11 specifies that procedures for personnel radiation protection shall be prepared consistent with the requirements of 10 CFR Part 20 and shall be approved, maintained and adhered to for all operations involving personnel radiation exposure.

Procedure OAD-14, Rev. 8, "Key Control", Step 3.1.2., specifies that "All Operations Section personnel requiring entry to LHRA [Locked High Radiation Area] shall contact the HP LHRA Key Custodian except for those personnel listed in step 3.1.1. who may use the LHRA Key for EMERGENCIES ONLY".

Procedure HP-SQ-3.109, Rev. 18, "Control of High Radiation, Locked High Radiation, Special Locked High Radiation and Very High Radiation Areas," Section 5.3. specifies the requirements for locked high radiation areas. Section 5.3.2.a, requires that any individual entering an LHRA shall be provided with or accompanied by either (a) for self-monitoring personnel, a radiation monitoring device that continuously indicates the radiation dose rate in the area; (b) a radiation monitoring device that continuously integrates the radiation dose rate in the area and alarms when a preset integrated dose is received (entry into such area with this monitoring device may be made after the dose rates in the area have been determined and personnel have been made knowledgeable of them); or (c) an individual qualified in radiation protection who possesses dose rate radiation monitoring device. Section 5.3.4.3 requires that prior to exit of the LHRA, an individual from the work party must assure that all members of the work party are out of the area, and after exiting, the door is locked, and a HP technician has been notified. In addition, Attachment 7.1 to Procedure HP-SQ-3.109, Rev. 18, Instruction 1.d, specifies that the individual controlling access to an LHRA shall notify the key custodian or HP key holder promptly upon exiting the area.

Contrary to the above, on July 7, 1995, during an entry into an LHRA, procedures required by Technical Specification 6.11 were not adhered to for certain operations involving personnel radiation exposure, as evidenced by the following examples:

1. a nuclear plant operator (NPO) (a member of the work party and operations section) utilized an LHRA key, which was designated for EMERGENCY USE ONLY as required by Procedure OAD-14, Rev. 18, for a non-emergency entry into the 14-foot elevation Chemical Services Building Drainage Sump Tank Room (an LHRA), without contacting the HP LHRA Key Custodian.
2. the NPO entered the 14-foot elevation Chemical Services Building Drainage Sump Tank Room without a continuously indicating dose rate monitoring device or without being accompanied by an individual qualified in radiation protection; although the individual did possess a continuously integrating dose rate radiation monitoring device, he was not made aware of the dose rates in the area prior to entry.

3. the NPO did not secure the LHRA upon exiting the area, and the radwaste supervisor (also a member of the work party and who functioned as the door guard controlling access for the area) did not ensure the door was locked after exiting and did not notify the Key Custodian or HP key holder upon exiting the area.

This is a Severity Level III Violation and is a repetitive violation (Supplement IV).

Reply to a Notice of Violation

Con Edison agrees with the licensee-identified violation as stated. It was caused by a lack of attention and failure to follow procedures by the two involved personnel. The corrective actions listed in page 2 of the September 18, 1995 letter transmitting the NOV accurately reflect actions that we have taken with the following clarifications. Alarming swing gates and self-closing doors (Item 3) are being used where ever practical. In some situations, plant health physics personnel may choose to continue using the alternative controls of NRC Regulatory Guide 8.37 (e.g., flashing lights, cocooning, video coverage, door guards, etc.), consistent with the Plant Technical Specifications. Also, Item 6 specifies that one day of safety training will be conducted for every employee that will include safety issues and coaching in safety practices. In order to enhance effectiveness, station management has elected to incorporate this commitment into the broader based "Outreach Program" listed under Item 5. All of these actions have been completed with the exception of the Outreach Program, and full compliance has been achieved. The Outreach Program will be completed by December 31, 1995.

In the cover letter to the NOV, it was suggested that our previous corrective actions may have been insufficient to prevent this event because they emphasized engineering controls and were not broad in scope. Specifically, these prior corrective actions were said not to have taken into account key access, nor reinforced adherence to required procedures for access to HRAs and LHRAs. We offer the following additional information on this topic. Key access had been previously addressed in a temporary procedure change (TPC) to Operations Administrative Directive 14, Key Control. This TPC was implemented in early February 1995 at the start of the 1995 Refueling Outage. Prior to this change, Operations Section personnel who were qualified for self-monitoring were allowed to enter HRAs and LHRAs unaccompanied by health physics section personnel. The change to OAD-14 was made to test the concept of single group key control, yet continue to allow Operations personnel unimpeded access to the plant for emergency response until an alternate means for expedited access could be worked out. This change resulted in better documentation of and accountability for key control. Thus, key control had been previously addressed and was being processed as a permanent change prior to this event. Our expectations had been clearly communicated to the involved personnel. The radiation protection program procedures and training were sound. For these reasons, we elected to take significant disciplinary action against the personnel involved in this event.

The importance of strict adherence to station procedures is communicated and reinforced to plant personnel through a variety of mechanisms; these include: General Employee Training, Radiation Safety Talks, tailgate meetings, and in outage work stand-downs initiated by the VP, Nuclear Power. Radiation Safety Training has been revised to included a discussion for the Radiological Occurrence Reports (RORs) for the Containment and Chemical Systems Building violations. The Practical Factors work area was enhanced to include a High Radiation Area scenario as well as a Locked High Radiation Area scenario, and the exam is heavily weighted in these areas. Procedure adherence will continue to be stressed in the Outreach Program and in our normal daily course of business. To date thirteen (13) outreach meetings have been performed. Approximately 180 people have participated in this program to date.