

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

June 20, 1996

Re: Indian Point Unit No. 1 & 2  
Docket No. 50-003 & 50-247

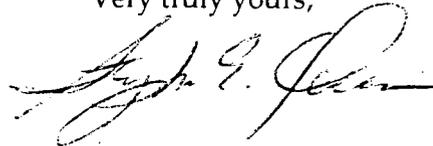
Document Control Desk  
US Nuclear Regulatory Commission  
Mail Station P1-137  
Washington, DC 20555

SUBJECT: Reply to Notice of Violation  
(Inspection Report 50-247/96-02)

The attachment to this letter constitutes Con Edison's reply to the Notice of Violation (NOV) included with your May 21, 1996 letter concerning the inspection conducted from March 3, 1996 through May 4, 1996, at the Indian Point 2 facility.

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 20<sup>th</sup> day  
of June, 1996.

  
Notary Public

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

9607010063 960620  
PDR ADOCK 05000247  
G PDR

ICSI  
1/1

Attachment

cc: Mr. Thomas T. Martin  
Regional Administrator - Region I  
US Nuclear Regulatory Commission  
475 Allendale Road  
King of Prussia, PA 19406

Mr. Lee H. Thonus  
Indian Point 1 Project Manager  
US Nuclear Regulatory Commission  
PO Box 311  
Middletown, PA 17057

Mr. Jefferey F. Harold, 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

ATTACHMENT  
REPLY TO NOTICE OF VIOLATION

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.  
INDIAN POINT UNIT NO. 2  
DOCKET NO. 50-247  
June 1996

## NOTICE OF VIOLATION

The Notice of Violation in Inspection Report 50-247/96-02 is stated as follows:

"Technical Specification section 6.8.1 requires that written procedures be implemented covering activities referenced in Regulatory (Safety) Guide 1.33, November 1972. Appendix A of Reg. Guide 1.33 identifies typical safety-related activities that should be covered by written procedures, including procedures for the control of radioactivity including operation of the liquid radioactive waste system. Reg. Guide 1.33 also requires written procedures that govern procedure adherence. Station Administrative Order (SAO) - 133, "Procedure, Technical Specification and License Adherence and Use Policy," Section 5.1.1, states that procedures shall be followed. Station Administrative Order (SAO) 206, "Jumper Log," sets forth the requirements for the use of jumpers. Per SAO 206, the alteration of a piping arrangement as defined by plant design is a jumper.

Contrary to the above, on April 10, 1996, operators drained a waste distillate storage tank to the Unit 1 chemical systems building (CSB) floor drain system without an approved procedure. Subsequently, radioactively contaminated water in the floor drains backed up, due to problems with the floor drain collection tank to which the flow was directed, and flowed out the floor drains on the 33 foot elevation of the CSB and flowed down the stairways and an elevator shaft to the 24 and 14 foot elevations of the CSB: and,

In February of 1990, the manway on Unit 1 sump tank T-26, a component described in the Unit 1 Final Safety Analysis Report that collects drainage from the Unit 1 floor drain system, was removed due to problems with the tank level and pump down systems. Removal of the manway allowed the sump tank contents to overflow through the manway, bypassing the tank normal draindown system, and resulted in the sump tank floor being used as a drainage path to the basement and drainage sump. Also, at an undetermined date, a one inch tygon line was connected to a drain point on the sump tank that directed flow to the basement and drainage sump. Neither of these modifications were controlled per the jumper requirements of SAO 206.

This is a Severity Level IV violation (Supplement I)."

## RESPONSE

We acknowledge the concerns addressed in the Notice of Violation and agree that this event could have been prevented had approved procedures and work controls been used to conduct this evolution. No procedural guidance was used to control the draining of 13 Waste Distillate Storage Tank (WDST) below the automatic pump cutout level of 30". According to SAO-206 the 1" tygon hose which drained the CSB sump tank to the floor should have been administratively handled as a jumper. This event was the result of inadequate procedural adherence by the cognizant supervisor. In addition, inadequate communication between personnel involved in this evolution and a lack of knowledge of the CSB floor drain system on the part of the personnel on duty also contributed to the event.

Immediately, following the discovery of the contaminated water spill, valve LW-667 was closed and a caution tag applied to preclude further draining of the WDST. A jumper was issued to address the presently installed 1" tygon hose that drains the CSB sump tank to the floor drain. The importance of increased attention to operational activities was emphasized by management

to all Operations personnel. The Operations Manager issued a memorandum on April 15, 1996 stressing that the operation and configuration control of systems in the plant be performed in accordance with approved procedures. The supervisor involved in this event has been counseled and appropriately disciplined.

To prevent recurrence of this event, a walkdown of the Unit 1 Integrated Liquid Radwaste system was performed to identify current field conditions. A list of discrepancies has been generated and corrective actions identified. System Operation Procedure (SOP) 5.1.2 has been revised to incorporate a method for draining 13 WDST to levels below 30". A modification that installed new CSB sump tank pumps and repaired the CSB sump tank level indication system will be completed on or before November 1996. This modification was in progress at the time of the event, having begun on November 1993. Finally, training for all operations personnel on this event will be conducted by October 1996.

Because a supervisor was involved in this event, the plant manager or VP Nuclear Power will meet with all work supervisors to emphasize conservative decision making, procedural compliance and accountability. These meetings will be completed by September 1996.

The Quality Assurance organization will complete an audit of Unit 1 systems and facilities used to support nuclear safety or waste processing activities of Unit 2. An assessment of the level of procedural adequacy, level of operator knowledge and coverage of administrative and configuration controls will be done by November 1996.

Implementation of these corrective actions will ensure continued compliance with NRC regulations applicable to this type of event to avoid its repetition.