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Vice President

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April 16, 1997

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

Document Control Desk
US Nuclear Regulatory Commission
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: Reply to Notice of Violation
(Inspection Report 50-247/96-08)

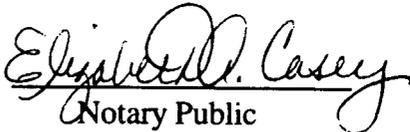
The attachment to this letter constitutes Con Edison's reply to the Notice of Violations (NOV) included with your March 12, 1997 letter concerning the inspection conducted from December 22, 1996 through February 15, 1997, at the Indian Point 2 facility.

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 16th day
of April 1997.



Notary Public

ELIZABETH A. CASEY
Notary Public, State of New York
Qualified in Dutchess County
Reg # 4878094
Commission Expires Feb 9, 19 99

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Attachment

cc: Mr. Hubert J. Miller
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Mr. Jefferey F. Harold, Project Manager
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US Nuclear Regulatory Commission
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ATTACHMENT

REPLY TO NOTICE OF VIOLATION

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
April 1997

NOTICES OF VIOLATION

The Notices of Violation in Inspection Report 50-247/96-08 are stated as follows:

- A. Technical Specification Section 6.8.1 requires that written procedures be implemented covering activities referenced in Regulatory Guide 1.33, November 1972. Regulatory Guide 1.33 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. Instrument and Control Administrative Directive IC-AD-4, Procedure for Performing Maintenance, Section 2.0 requires that procedures should be developed for all components specified in Regulatory Guide 1.33. For routine or minor maintenance, an Investigation Checklist (ICL) may suffice where detailed step by step instruction are not considered necessary due to skills normally possessed by qualified maintenance personnel. Both troubleshooting and calibrations are listed as routine, minor maintenance in IC-AD-4. In addition, SAO-405, "Modifications to Indian Point Facilities", sets forth the requirements for modifications that affect the Indian Point Station.

Contrary to the above:

1. The requirements of IC-AD-4 were not met in that the inspectors observed neither a procedure or ICL was developed for a calibration performed on components of the filter/fire deluge panel; and,
2. A modification was made to each of the BAST vent lines that reduced the vent area by approximately 94%, and SAO-405 was not used for this modification.

This is a Severity Level IV violation (Supplement I)

- B. Technical Specification Section 6.8.1 requires that written procedures be implemented covering activities referenced in Regulatory Guide 1.33, November 1972. Regulatory Guide 1.33 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. Procedure HP-3.011, Radiation and Contamination Survey Techniques, step 5.4.8 states that a sufficient number of smears, that are representative of the areas under evaluation, should be obtained for analysis.

Contrary to this requirement, insufficient smears were obtained prior to releasing contaminated area controls in the 15' RHR hallway with the result that personnel contaminations occurred.

This is a Severity Level IV violation (Supplement IV)

RESPONSE

We acknowledge the concerns addressed in this Notice of Violation and agree that the cause for these events was inadequate adherence to established plant procedures. In both events, personnel involved did not fully follow the appropriate procedures pertaining to their job responsibilities.

In the first violation, the station was experiencing problems while performing Surveillance Test, PT-2Y6 PAB Charcoal Filter Fire Deluge System, and contacted I&C for assistance. I&C personnel obtained a work order and permit to investigate the problem in support of completing this test. In the course of trouble shooting, it was identified that settings had been changed and I&C personnel needed to reset the values in the detection modules before further trouble shooting and the test could resume. This calibration was performed without the use of a procedure or an Investigation Checklist (ICL) either prepared beforehand or at the job site.

In addition, an uncontrolled jumper was installed on the 21 and 22 Boric Acid Storage Tanks (BAST) vent lines without the use of approved jumper or modification procedures.

In the second violation, insufficient smear samples were obtained in the 15' RHR hallway resulting in an inadequate survey which resulted in personnel contaminations. The technician performing the survey did not obtain a sufficient number of smear samples to meet the procedural requirements of HP 3.011, Radiation and Contamination Survey Techniques. Additionally, the supervisor who performed the review of the survey did not review the results with appropriate attention to detail to prevent releasing the posted "Contaminated" area to a "Clean" area in this case. This inappropriate down-posting resulted in personnel contaminations.

ANALYSIS

The proximate cause of these events was inadequate adherence to established plant procedures due to misinterpretation by technical personnel. It is Con Edison's policy that all workers at the Indian Point Station adhere to and comply with Station Administrative Orders (SAO) and procedures. Deviation from approved procedures is authorized where necessary, only to prevent injury to personnel, including the public, or damage to the facility. In both events, station personnel did not fully follow the appropriate procedures pertaining to their job responsibilities.

During the performance of surveillance Test PT-2Y6, PAB Charcoal Filter Fire Deluge System, I&C technicians were asked to perform trouble shooting of the Filter Fire Deluge panel. This troubleshooting resulted in identification of a need to reset alarm values. Since trouble shooting and calibrations are listed as "routine, minor" it is appropriate to use an ICL form to document the work performed. Discussions with technicians indicated that based on their understanding, an ICL was not required to be in the field during performance of the alarm value recalibration. IC-AD-4 specifies that ICLs can be used for "routine or minor maintenance" where detailed step by step instruction are not considered necessary. IC-AD-4 did not specify that an ICL be prepared before job start or be present in the field. Past practice had been to complete the ICL during or prior to job close out.

As a result of the ambiguities in IC-AD-4 the resetting of the alarm modules was performed without a procedure or an ICL prepared beforehand.

ANALYSIS (continued)

In addition, two instances were reported of tygon tube hoses being installed on the tank vent lines for 21 and 22 BASTs. In the past, the station practice was to install tygon tubing hoses on component or system vents or drains to route liquids to either floor drains or catch basins, for housekeeping, to ensure these vent and drain paths were controlled. These tygon hoses were considered temporary installations, and were not viewed as modifications or jumpers. Using the current standards in SAO-405, Modification to Indian Point Facilities or SAO-206, Jumper Log the station's temporary modification procedure, the tygon hoses were a modification to the vent lines on 21 and 22 BASTs. Consequently, this installation was contrary to the requirements provided in these procedures resulting in a temporary modification that did not receive proper engineering evaluation and control of installation and removal.

In the second violation, the technician performing the smear survey of the 15' RHR hallway and the Radiation Protection Supervisor who reviewed the survey results did not follow the guidance provided in HP 3.011, Radiation and Contamination Survey Techniques. Specifically, HP-3.011 requires either large area smears using a maslin or similar sized material or in the case of 100 cm² smears using smear papers at a sufficient number of locations to establish the condition of the area, per the Radiation Protection Manager's estimate, approximately 40 locations, prior to releasing a contaminated area as clean. The technician stated that in an effort to leave the site early for personal reasons he attempted to expedite the survey completion. Consequently he did not adequately comply with either of the procedure options. The technician's supervisor had been cautioned for a similar event where he did not pay appropriate attention to an assigned task which resulted in disciplinary action. As a result of the failure of the technician to perform a proper survey and the supervisor to perform an appropriate review, the 15' RHR hallway was down-posted from a "contaminated" to a "clean" area resulting in the contamination of personnel. Subsequent surveys performed to investigate the personnel contaminations indicated the source of contamination was located in the middle of the 15' RHR hallway.

CORRECTIVE ACTION

Violation A

Subsequent to I&C technicians performing the calibration on the filter fire deluge alarm panel, supervisors and technicians were told, by the I&C section head, that the ICL must be in the field while performing Class 'A,' 'FP' or 'MET' maintenance activities.

IC-AD-4 is being updated to provide direction for the supervisors and technicians that the ICL must be in the field while performing Class 'A,' 'FP' or 'MET' maintenance activities, this revision shall be completed by April 18, 1997.

The ICL is one of three documents that is required to support Class 'A,' 'FP' or 'MET' work orders, or calibrations; the other two are either a corrective maintenance procedure or a work step list depending on the type of work.

Supervisors have been instructed to ensure that proper documentation is included in work packages during package preparation. The proper work process has been discussed with I&C personnel at section meetings.

The revised AD will be the subject at section meetings and included in I&C continuing training after its issuance.

Violation A(continued)

The ICL has been revised from a one page document to include a specific section to document "as found" conditions, a larger "work performed" section, a section to document "as left" conditions, sections for "M&TE," "materials used," "de-term" - "re-term" of wiring and "as found" - "as left" valve positions. Also, the PAB Charcoal Filter Fire Deluge System module setpoints are now contained in the setpoint data base and I&C has generated a preventative maintenance procedure to document the calibration of these modules.

Upon notification of the installation of the unapproved jumpers on 21 and 22 BAST vent lines, the Senior Watch Supervisor immediately ordered their removal. Subsequently, station management initiated an investigation to locate any additional unapproved tygon hose installations. As a result of the above investigation, unapproved installations of vent or drain line tygon hose drains to catch basins or floor drains were either removed or reinstalled as approved Jumpers under the requirements of SAO-206.

No other cases were found that provided a restriction in the vent path similar to the BAST vent lines. An engineering evaluation of the potential effect on BAST integrity due to the restriction of the vent lines was performed using a drawdown flow rate of 150 gpm, corresponding to two pumps in operation, with no indication of adverse effects on the structural integrity of the BASTs.

The training department is preparing a bulletin for review and signature by all station personnel who could be involved in installation of tygon hoses on vents or drains, to provide a consistent message of management's expectation for adherence to SAO-206 the station's Jumper Log procedure. The review by station personnel of the above training bulletin on SAO-206 should be completed by June 1997.

Violation B

Upon discovery of the mutiple contaminations, the station initiated a resurvey of the area to discover the source of the contamination and to ensure that the contamination had not been spread to other locations. The resurvey confirmed the source of contamination of the individuals to be located in the 15' RHR hallway.

A review of the technician's survey was performed, the technician and supervisor who performed the survey review have been disciplined. The technician has completed additional on-the-job training and subsequent surveys were monitored to ensure satisfactory results prior to the technician's resumption of normal duties.

This deficiency will be used as a topic in technician continuing training and for contract technicians in preparation for future outages.

Implementation of these corrective actions are intended to prevent a repetition of these types of events.