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July 24, 1997

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 a Notice of Violation (Violations 97-05-01, 97-05-02, and 97-05-03), Inspection Report 50-247/97-05

This responds to your June 19, 1997 letter concerning the special inspection to evaluate the personnel actions and equipment response following a stuck open main steam safety valve which occurred during testing on May 1, 1997. The inspection was completed on May 22, 1997 and was conducted by a team headed by Mr. J. Shedlosky. The attachment to this letter constitutes our reply to the Notice of Violation attached as Enclosure 1 to your letter.

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

Very truly yours,

Attachment

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PDR ADOCK 05000247
Q PDR

IE01

cc: Mr. Hubert J. Miller
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ATTACHMENT

REPLY TO A NOTICE OF VIOLATION (97-05-01, 02, and 03)
INSPECTION REPORT 50-247/97-05

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

Reply to a Notice of Violation (97-05-01, 02, 03)

NOTICE OF VIOLATION

The Notice of Violation in Inspection Report 50-247/97-05 is stated as follows:

"During an NRC inspection completed on May 22, 1997 , violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the following violations were identified:

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 surveillance tests for main steam safety valve tests. 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 PT-R6, Main Steam Safety Valve Set point Determination, requires that the control room be notified prior to testing a safety valve in order for the operators to verify that the average reactor coolant temperature has recovered from the previous valve test.

Station Administrative Order (SAO)-202, Conduct of Infrequently Performed Tests or Evolutions, paragraph 4.1.2.c, requires that procedures be prepared to control infrequent evolutions and that those procedures should delineate individuals' responsibilities, the lines of authority, and provide for contingency actions and termination criteria. Surveillance test PT-R6, Main Steam Safety Valve Set point Determination, was deemed by Consolidated Edison Company of New York, Inc. to be an infrequently performed evolution subject to SAO-202 requirements.

Contrary to the above, the following are two examples of failure to follow station procedures that occurred on or prior to May 1, 1997:

1. Test personnel failed to notify the control room prior to testing three main steam safety valves for set point verification. One of the three main steam safety valves (MSSV-46C) stuck open for approximately five and one half minutes.

2. Procedure PT-R6 did not provide for test termination criteria which described how test personnel should react to a failure of a MSSV to lift at the expected pressure.

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

B. The Code of Federal Regulations Title 10 Part 50 Appendix B criterion XVI requires that measures be established to ensure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, the 23 containment recirculation fan motor breaker failed to meet the acceptance criteria for PT-R13 when tested on February 9, 1995, and this deficiency was not identified during the post test review and no corrective actions were taken.

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

RESPONSE TO A

Violations 97-05-02 and 97-05-03 are directly associated with the May 1, 1997 event. This event was the subject of a comprehensive, detailed root cause analysis by a multidisciplinary team of plant personnel. The responses to A1 and A2 contain information from the final report prepared by that team.

RESPONSE TO A1 (Violation 97-05-02)

Surveillance test PT-R6, "Main Steam Safety Setpoint Determination," contains requirements to obtain permission from the Senior Watch Supervisor (SWS) to commence the test, to inform the Senior Reactor Operator (SRO) that the test is going to be performed, and to notify the Central Control Room (CCR) prior to lifting the safety valve. There is also a requirement to check that T-average has recovered from the previous lift.

Permission to commence the test was given at approximately 0245 hours and communications with the CCR was established. The first valve (MS-49C) tested satisfactorily and the control room was contacted to ascertain the impact on the plant. At approximately 0300 hours, the second valve (MS-48C) tested satisfactorily and the control room was again contacted. At this point, the control room requested that the communications be stopped as the plant response to the first two valve lifts was satisfactory. The third and subsequent valves were then tested with no communication with the CCR.

We agree that full notification of the CCR was not complied with in accordance with the test procedure. This is contrary to station requirements and management expectations for procedural compliance. The corrective action for this situation is to review the event with Operations personnel during operator requalification training to emphasize the need for procedure adherence and good communications. This is scheduled to be completed by October 31, 1997.

RESPONSE TO A2 (Violation 97-05-03)

SAO-202, "Conduct of Infrequently Performed Tests or Evolutions," paragraph 4.1.2.c states:

> "Procedures prepared to control the evolution. The procedures delineate individuals' responsibilities, the lines of authority, provide for contingency actions and termination."

Surveillance test PT-R6 does contain a specific termination criterion in regard to prompt removal of air pressure after a safety valve opens (step 3.2.8). Further, a "Test Instruction Sheet" issued with every test contains the requirement in step 8 to obtain SWS permission to continue testing if the test cannot be accomplished, any data cannot be obtained, is suspended, is in conflict with another procedure, or unexpected results are found. However, we agree that termination criteria were inadequate for this test evolution since no guidance is provided to abort an attempt to open a valve if it does not open at or near the expected set pressure. As a corrective action for this occurrence, test PT-R6 was revised to provide an upper limit criterion for each safety valve which prohibits continuation of the test if the valve does not lift at less than or equal to 104 percent of the setpoint. Precautions and limitations required for this infrequently performed test were also added to the test procedure. This revised test procedure was successfully used during restart from the 1997 refueling outage to test the main steam safety valves.

It should be noted that the test rig does have an upper limit to the air pressure that can be applied to the valve, so valve lift cannot occur at more than 16 percent above the lowest setpoint of a safety valve.

RESPONSE TO B (Violation 97-05-01)

The recorded test results indicate that 23 containment recirculation fan (CRF) failed the test acceptance criterion for start time in response to the train A safety injection actuation signal. We agree that this deficiency was not identified, therefore no corrective actions were taken. It should be noted that the response time of 23 CRF to the train B safety injection actuation signal was within specification. All other equipment response times in the 1995 test procedure PT-R13, "Safety Injection System," were reviewed for indications of the failure of other equipment and no unacceptable results were found. Four other tests conducted during the 1995 outage involving expected responses from 23 CRF were reviewed to assure there were no other response anomalies. Tests conducted during the 1997 refueling outage indicated no response deficiencies for 23 CRF. Therefore, it is believed that 23 CRF was fully capable of performing its safety related functions in a timely manner.

The personnel who signed for the test review were interviewed. Although they confirmed that the test data was reviewed they could not recall that this deficiency existed. The deficiency is considered to be an unintentional oversight. However, to reinforce management expectations for the conduct of testing and test review, this occurrence will be reviewed and discussed with personnel from the Test and Performance, Instrument and Control, Chemistry, and Operations groups who are responsible for the entry and review of test data in surveillance tests. This review will emphasize the importance of attention to detail when recording data to prevent initial data entry errors. This corrective action is currently scheduled to be completed by September 15, 1997.