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August 13, 1998

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 (98-06-04, 98-06-05, 98-06-06), Inspection Report 50-247/98-06

The attachment to this letter constitutes Consolidated Edison Company of New York, Inc.'s (Con Edison) Reply to the Notice of Violation included with your June 26, 1998 letter, as revised by your July 9, 1998 letter, which transmitted the results of the NRC special inspection conducted on March 30 through May 21, 1998 at the Indian Point 2 facility. Your inspection focused on the review of our corrective actions regarding a number of plant restart issues, which were identified in Confirmatory Action Letter No. 1-98-005, dated March 26, 1998.

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

Very truly yours,

A. Alan Blind

Attachment

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c:

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ATTACHMENT

REPLY TO NOTICE OF VIOLATION

INSPECTION REPORT 50-247/98-06

Consolidated Edison Company of New York, Inc.
Indian Point Unit No. 2
Docket No. 50-247
August 1998

NOTICE OF VIOLATION

The Notice of Violation enclosed in Inspection Report 50-247/98-06 contained three violations of NRC requirements listed as paragraphs A through C, stated as follows:

- A. 10 CFR 50, Appendix B, Criterion XV, "Nonconforming Materials, Parts, or Components," states in part: "Measures shall be established to control materials, parts, or components which do not conform to requirements in order to prevent their inadvertent use or installation."

Contrary to the above, in September 1997, a defective fuel tube that had been identified in a 10 CFR Part 21 notification was installed on emergency diesel generator 22 during the 6-year preventive maintenance work on the diesel.

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

Response to Violation A

We acknowledge the concern addressed by this violation and agree that the review conducted by Con Edison personnel was not sufficient to prevent the inadvertent use of a fuel tube which had been determined to be defective by the vendor (Coltec Industries) per 10 CFR Part 21. Notification of the existence of this defective component was first received by Con Edison on July 18, 1997. Information was recorded in the Condition Identification Tracking System (CITRS) and disseminated to the appropriate sections for review on July 18, 1997. On August 15, 1997 the system engineer responsible for the emergency diesel generators (EDG) verified that none of the fuel tubes reported by the vendor to be defective were installed on the EDGs. Also, on August 15, 1997, the materials group responded that no action was necessary unless a requisition to procure new material was received. This response was interpreted to imply that no defective fuel tubes had been procured and stored in the warehouse. Maintenance acknowledged receipt of this notification and distribution for information. Based upon these reviews conducted and recorded in CITRS, all parties involved believed that there were no defective fuel tubes either installed in the field or handled or stored in the warehouse.

It was not known that on August 15, 1997, the same date that the system engineer performed a field verification, maintenance planners had withdrawn fuel tubes from stock. On December 26, 1997 it was determined that a fuel tube reported to be defective per 10 CFR Part 21 had been installed on 22 EDG in September 1997.

The cause of this event was the initial investigation omitting examination of the warehouse stock availability or transactions. Had a review of previous material requests or transactions for the fuel tube been performed and reported in CITRS, operating experience review procedures would have alerted Maintenance to a potentially defective component.

The immediate action taken following the discovery of the defective fuel tube on 22 EDG was to

determine the operability of the EDG. Per discussions with Coltec Industries, it was determined that no immediate operability concern existed since the nature of the defect (i.e., fracture) is attributed to long-term EDG operation and its associated engine vibrations. For standby nuclear applications, such as at Indian Point 2, the potential defect had no immediate consequence. Therefore, it was concluded that the EDG operability was acceptable. The defective fuel tube was subsequently replaced on January 8, 1998.

To prevent a recurrence of this type of event, Material Procurement was required via CITRS to examine the reasons for the initial incomplete investigation. Personnel responsible for such investigations were instructed to be more thorough in performing investigations of warehouse stock by reviewing previous transactions. All sections (i.e., system engineering, material procurement, and maintenance) affected by this event are aware of the significance of maintaining complete communications when entering input and/or responses in CITRS.

- B. 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," states in part: "Measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment are promptly identified and corrected."

Contrary to the above, as of May 21, 1998, prompt corrective actions were not taken regarding conditions adverse to quality as evidenced by the following examples:

1. Responses for at least seven items in Quality Assurance Audit Report 94-11, which documented a service water (SW) system self assessment conducted in late 1994, were either overdue or unacceptable. One overdue item involved the lack of a detailed SW system single failure analysis.
2. The inconclusive test results of a thermal performance test for the 21 component cooling water (CCW) heat exchanger (HX) conducted in 1995 were not evaluated for corrective action until the NRC identified this issue.

Response to Violation B

We acknowledge the concern addressed by this violation and agree that responses to audit items contained in the Corrective Action Monitoring Program Report (CAMP) relative to Quality Assurance Audit Report 94-11 were overdue. As noted in the inspection report, the most significant item was the lack of a single failure analysis of the service water system as requested by Generic Letter 89-13. As noted in the inspection report, a contractor (Altran) familiar with the service water system was engaged to perform this single failure analysis. This analysis has been completed. No physical and/or administrative changes are anticipated as a result of the analysis results.

We agree that inconclusive results of a thermal performance test for the 21 component cooling

water (CCW) heat exchanger (HX) conducted in 1995 were not evaluated within a reasonable time period. The test results had been evaluated at the time; however, since they were deemed questionable, no conclusion could be made regarding the heat exchanger performance. The heat exchanger was subsequently cleaned, thus establishing a new baseline for future monitoring of heat exchanger performance. Although, Generic Letter 89-13 allows frequent regular maintenance of a heat exchanger as an acceptable alternative to testing, that was not the intent of the test/inspection program as committed to in our response to the generic letter. Thus, the root cause for the questionable test results was not determined within an acceptable time period.

These events are attributed to the unusually high level of outage-related critical activities during the 1997 through 1998 time period. The high workload had an adverse affect on the level of support engineering provided to the plant, in that it placed an emphasis on the near-term critical issues. This resulted in an inadvertent delay in addressing other items which were of a less critical nature (i.e., non-outage work). This weakness was noted in the recently documented, "Indian Point 2 Independent Safety Assessment (ISA)" report dated May 1998. The immediate action initiated to address these overdue audit items was to review the nature of the outstanding audit items and expedite their resolutions. One item is associated with the design basis documentation program and is not expected to be completed prior to December 31, 2000. Three items involve setpoint changes which will be addressed by plant modifications to be implemented prior to startup from the current outage. The last item involving the service water system single failure analysis has been closed. Our longer-term programmatic corrective actions and/or recommendations have been summarized in our response to the ISA report.

- C. 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," states in part: "Activities affecting quality shall be prescribed by documented instructions, procedures, or drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions, procedures, or drawings."

Contrary to the above, in May and June 1997 during inspections of the 21 and 22 CCW HXs, ConEd personnel failed to record the as-found conditions on the heat exchanger/pipeline inspection report as required in accordance with Attachment 1 of System Engineering Standard SE-330.

Response to Violation C

We acknowledge the concern addressed by this violation and agree that Con Edison personnel did not document the "as-found" conditions of 21CCW and 22CCW heat exchangers during inspection and maintenance activities conducted in 1997. Indian Point System Engineering Procedure SE-330, "Heat Exchanger/Pipeline Inspection Standard" requires that the system engineer visually inspect the internals of heat exchangers whenever they are opened and that the "as-found" conditions (i.e., biological fouling, corrosion, tubesheet plugging, etc.) be documented on Attachments 1 and 2 of the procedure. The reason for this violation is attributed to an oversight by the system engineer. The system engineer was cognizant of his responsibility

to document the visual inspection of the "as-found" conditions of 21CCW and 22CCW heat exchangers; however, the subject documentation was not provided as required by SE-330.

At the present time, it is impractical to complete the required "as-found" heat exchanger documentation. Therefore, no immediate corrective actions were taken. A review of past maintenance work records involving heat exchangers was conducted to determine if any other similar events have occurred. A number of work orders associated with various safety-related heat exchanger inspections were also discovered to be unacceptable with missing "as-found" documentation. To prevent the recurrence of this event, maintenance work packages which involve the "opening" of any heat exchangers cooled by Service Water system, will require both "as-found" and "as-left" inspection documentation to be completed. The maintenance work package will contain a hold point to ensure that the system engineer is notified of the need to perform the required inspection. This corrective action has been entered into the station's corrective action system (CITRS) and will be completed by October 31, 1998.