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Vice President

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December 2, 1988

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

Edward C. Wenzinger, Chief
Projects Branch No. 2
Division of Reactor Projects
U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406-1498

SUBJECT: Response to Inspection Report No. 50-247/88-26

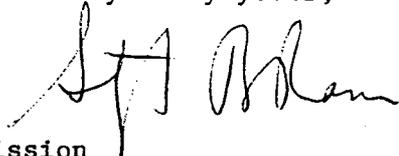
This is in response to your letter of November 2, 1988 concerning routine inspection No. 50-247/88-26 conducted by Mr. Lawrence W. Rossbach and Mr. Peter W. Kelly from August 16, 1988 to October 3, 1988 at Indian Point Unit No. 2.

While no violations were noted, you requested that we respond to several concerns (identified as unresolved Item 247/88-26-02) relative to the September 24, 1988 incident in which the Refueling Water Storage Tank level indicating device was discovered to be not in place. The Attachment to this letter provides our response to that request.

Note that this incident was also the subject of LER 88-14 submitted on October 24, 1988.

Should you have any questions, please contact us.

Very truly yours,



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ATTACHMENT

Section 3.1.3 of Inspection Report No. 50-247/88-26 refers to the occurrence in which the Refueling Water Storage Tank (RWST) level indicating device was discovered to be not in place and initially considered to be a potential loose object in that tank. The report states that, since the device was subsequently found to have been out of place since October, 1987 when maintenance was performed on the RWST, Con Edison might have acted in a more timely manner to have identified the occurrence. The report notes three factors that may have contributed to that observation: (1) a lack of personnel sensitivity to the effect of foreign materials on safety related equipment, (2) inadequate troubleshooting in response to plant alarms, and (3) the large backlog of plant maintenance.

With regard to an apparent insensitivity to the effect of foreign materials on safety related systems, we point out that, on learning that the device was not in place, an immediate and conservative decision was made to enter Technical Specification 3.0.1, resulting in a plant shutdown. This was immediately followed by an intensive effort to locate that device in the tank and in associated piping systems. It was subsequently determined that the device did not constitute a loose part or foreign material in the RWST but had been removed by contractor personnel during cleanup of the tank prior to plant restart from the Refueling Outage. This is addressed in LER 88-14 submitted to NRC on October 24, 1988.

Additionally, we are currently preparing a Conduct of Maintenance procedure to enhance control of contractor personnel. This procedure will specifically require loose part evaluation and observation, tank closeout and a cleanliness inspection, leading to appropriate corrective action thereafter. Quality Assurance Specification QA-8212, "Cleanliness Control" is being revised to reflect this. We are also in the process of revising the work procedure for removal of the RWST mushroom vent cap (to which the displacer is attached) in order to provide proper protection of the alarm device as well as proper testing.

Were this event to occur today, the analysis of the cause of the problem would be undertaken with the aid of our Operations Planning group which was inaugurated in 1988. The Operations Planning group reviews all new work orders, prioritizes them employing nuclear safety as the prime consideration, and assesses all safety related aspects of each open work order. Replacement of the device has been assigned a very high priority and is dependent on acquisition of material, anticipated to be delivered during February, 1989.

We believe that the procedures, policies and programs already discussed with you and safety awareness training currently scheduled provide reasonable assurance that this type of event will not recur. These policies, procedures and programs are aimed at increasing our safety awareness, improving procedural compliance, stressing aggressive suspicion with respect to problems and reduction in work order backlog. We note that IPAT, in their Inspection Report No. 50-247/88-20 dated July 21, 1988, acknowledged the effective prioritization of our backlog and the fact that it is trending downward.

In summary, we believe that initiatives undertaken over the past year have been effective in significantly reducing the likelihood of occurrence of concerns such as those raised in the Inspection Report.