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Vice President

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February 4, 1985

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

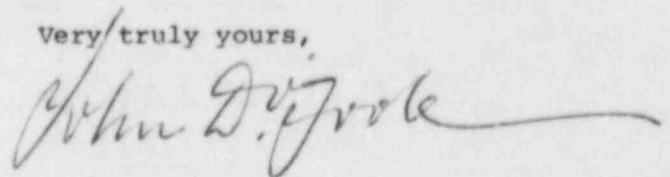
Mr. Samuel J. Collins, Chief  
Division of Project and  
Resident Programs  
U. S. Nuclear Regulatory Commission  
Region I  
631 Park Avenue  
King of Prussia, Pa. 19406

Dear Mr. Collins:

This refers to I.E. Insection 50-247/84-32 conducted by Mr. T. Kenny of your office on November 1-30, 1984 of activities authorized by NRC License No. DPR-26 at Indian Point Unit No. 2. Your January 4, 1985 letter stated that it appeared that certain of our activities were not conducted in full compliance with NRC requirements, as set forth in the Notice of Violation enclosed therewith as Appendix A. Our response to the items of non-compliance is presented in Attachment A to this letter.

Should you or your staff have any questions, please contact us.

Very truly yours,



cc: Senior Resident Inspector  
U. S. Nuclear Regulatory Commission  
P. O. Box 38  
Buchanan New York 10511

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ATTACHMENT A

RESPONSE TO NOTICE OF VIOLATION

APPENDIX A

VIOLATION 1

Technical Specification 6.8.1 requires that written procedures and administrative policies be established, implemented and maintained that meet or exceed the requirements and recommendations of Sections 5.1 and 5.3 of ANSI N18.7-1972 and Appendix A of Regulatory Guide 1.33. Section 1.h of Appendix A to Regulatory Guide 1.33 includes procedures addressing log entries, record retention and review. Administrative Directive OAD-3, Revision 6, "Plant Surveillance and Log Keeping" requires specific licensee log keeping technique, and actions to be taken when measured parameters exceed normal or maximum/minimum values. OAD-3 also requires proper administrative review of completed logs.

Contrary to the above, on November, 1984, the inspector identified that measured parameters of control room logs and conventional area logs for the period of October 31 to November 6, 1984 are not being logged in accordance with OAD-3, Revision 6, in three separate areas.

- a. Technical Specification parameters, which had been logged out of normal operating bands were not addressed as required by OAD-3, Revision 6.
- b. Out of specification readings were not circled in red as required, nor were they delineated in the remarks section as required by OAD-3, Revision 6.
- c. Administrative reviews of the logs were inadequate because the reviewers failed to identify the examples delineated in 1 and 2 above.

Collectively, this is a Severity IV Violation (Supplement 1)

RESPONSE

Administrative Directive (OAD-3), Revision 6, entitled "Plant Surveillance and Log Keeping", has been revised as of January 25, 1985 to further clarify log keeping requirements. Those

individuals involved in the inadequate log keeping identified by this violation have been reinstructed in their responsibilities. In addition, they have been informed that disciplinary action may be imposed if additional discrepancies persist.

Supervisory and staff personnel involved in the administrative review of the logs have been directed to be more thorough in their review of completed logs.

VIOLATION 2

2. 10 CFR 50, Appendix B, VI, "Document Control" states, in part, "Measures shall be established to control the issuance of documents...which prescribe all activities affecting quality."

Station Administrative Order SAO-120, "Nuclear Plant Operating and Safety Information Handling System," Part "C", Technical Specifications states that, "Reviewers of the amendment changes should assure the status of the plant, drawings and procedures, and training, are consistent with, and comply with amendment requirements in their area of responsibility."

Contrary to the above, the licensee made the necessary changes, for Technical Specification Amendment #74 in the appropriate procedures, but failed to change the status of the plant in that setpoints of certain 480 volt relays as delineated in the amendment, were not reset to the new value.

This is a Severity IV Violation. (Supplement 1)

RESPONSE

On December 10, 1981, when Technical Specification Amendment No. 74 was issued, the setpoints of certain 480 volt relays were not reset to the specified values. The responsibility for revising plant parameters to be in accordance with changes to the Technical Specification was implied in various Station Administrative Orders (SAO's) such as SAO 102 "Procedure/Procedure Change Approval Policy" but not explicitly set forth in any one SAO, such as SAO 120 "Nuclear Plant Operating and Safety Information Handling System." This weakness, acknowledged by Con Edison, was among the bases for Revision 2 to SAO 120, issued August 4, 1983. This revision explicitly addresses the responsibility of reviewing parties concerning Technical Specification Amendments and reasonably assures that the above violation will not recur.

### VIOLATION 3

10 CFR 50.73(a) requires a Licensee Event Report be submitted for any event described in the paragraph within 30 days after the discovery of the event.

Contrary to the above, on September 1, 1984, the licensee identified a plant condition that was contrary to prescribed parameters, but failed to report it in the form of Licensee Event Report 84-14 until November 7, 1984.

This is a Severity Level V Violation (Supplement 1)

### RESPONSE

The Station has established procedures for the internal review of significant occurrences for reportability per the requirements of 10 CFR 50.73.

These procedures call for the review of Significant Occurrence Reports and Test Reports for the purpose of determining reportability by personnel other than those directly involved in the work itself. This permits review by staff knowledgeable in the background required for reportability decisions. This reportability process recognizes a 30 day period for the submittal of LER's after an event is discovered to be reportable. In this instance, plant personnel had identified data from which reportability could be assessed, however staff responsible for making reportability determinations were not apprised of this information until October 7, 1984, at which time the period for submittal of the LER was promptly commenced. The failure to make a timely report was therefore inadvertent.

To reduce the time between recognition of an event and the date it is discovered reportable and to reasonably insure LER's are submitted within 30 days of the reportability date, the process for determining reportability has been better defined and the report preparation process has been streamlined.