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October 4, 1999

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

Document Control Desk
US Nuclear Regulatory Commission
Mail Stop P1-137
Washington, DC 20555

SUBJECT: Reply to Notice of Violation, Inspection Report No. 50-247/99-06-01

Attachment A to this letter constitutes Con Edison's reply to the Notice of Violation (NOV) included with the Nuclear Regulatory Commission September 2, 1999 letter based upon the inspection conducted from June 8, 1999 through July 19, 1999 at the Indian Point Unit No. 2 facility. Commitments in response to the NOV are contained in Attachment B to this letter.

Should you have any questions regarding this matter, please contact Mr. John McCann, Manager, Nuclear Safety and Licensing.

Very truly yours,

A. Alan Blind

cc: Mr. Hubert J. Miller
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ATTACHMENT A

REPLY TO NOTICE OF VIOLATION
INSPECTION REPORT NO. 50-247/99-06-01

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
OCTOBER 4, 1999

NOTICE OF VIOLATION

Notice of Violation 50-247/99-06-01 is stated as follows:

Technical Specification (TS) Section 6.8.1 requires that written procedures be implemented covering activities referenced in Appendix A of Regulatory Guide 1.33, Revision 2 (February, 1978). Appendix A of Regulatory Guide 1.33 recommends written procedures that govern bypass of safety functions and jumper control. Station Administrative Order (SAO)-206, "Temporary Facility Changes," provides written instructions for implementation of temporary changes to the facility including bypassing safety functions and installation of jumpers. SAO-206 requires, in part, that a temporary facility change involves an alteration to a particular circuit, and that the shift manager documents any operating procedures which may require temporary procedure changes as a result of the temporary facility change.

Contrary to the above, on July 6, 1999, Con Edison failed to implement the requirements of SAO-206, "Temporary Facility Changes." Specifically, a temporary facility change (TFC) was not implemented when required, and a procedure that required a change as a result of a TFC was not changed. The following examples are provided:

1. On July 6, 1999, an alteration to the control circuitry of Gas Turbine 2 (GT-2) was made without using a TFC to control and evaluate this activity. Specifically, the journal bearing thermocouple was removed from service which resulted in removal of the associated high journal bearing temperature trip from the GT-2 trip circuitry.

2. On July 6, 1999, TFC 99-091 did not completely implement the constraints of a supporting safety evaluation. The specific constraints involved monitoring gas turbine starting diesel jacket water temperature during gas turbine startup. This requirement was placed in the system operating procedure used to start Gas Turbine 2. However, the constraints were not implemented in abnormal operating instruction (AOI) 31.2, "Gas Turbine #2," which is also used to start the gas turbine.

This is a Severity Level IV violation (Supplement I)

RESPONSE

Con Edison acknowledges the concerns addressed in the NOV and provides the following information:

On July 6, 1999, a maintenance supervisor was investigating a previous trip of Gas Turbine 2 (GT-2) which occurred while the gas turbine was being run to provide system load. The supervisor, working under a troubleshooting work permit and Work Order 99-09817, noted failed leads at a bearing thermocouple; the leads were broken and shorted to ground. Maintenance wired the leads together to prevent the grounding of the leads, which resulted in the thermocouple reading ambient temperature. Work Order 99-09865 was issued to replace the thermocouple and thereby restore the component to the original condition.

Following this maintenance activity, Operations attempted to run GT-2 for testing. The start of the GT was unsuccessful, with a trip generated by the starting diesel on "High Jacket Water Temp" occurring on two start attempts. Since the jacket water temperature was well below the proper trip setpoint, a CRS Item was initiated (CRS Item 199905262). The immediate corrective action was to defeat the High Jacket Water Temp trip and document same with a Temporary Facility Change (TFC). The System Operating Procedure (SOP) was changed to support the TFC. The Watch Engineer failed to consider that the gas turbine was also operated in emergency conditions via Abnormal Operating Instruction (AOI) 31.2. After further discussions with Operations Management, the AOI was changed with a TPC.

ANALYSIS

Maintenance personnel assigned to repair GT-2 discovered a degraded condition on the bearing thermocouple and properly documented the as found condition. The broken thermocouple leads were wired together to ensure that temperature signal spikes from intermittent grounding of these leads did not affect GT-2 operations. This effectively created a false temperature indication (room temperature) and a TFC should have been issued to memorialize the installation. The failed thermocouple would then be repaired in accordance with the maintenance process. Maintenance and Operations personnel were not cognizant of the implications of creating a false signal for the failed thermocouple in the absence of a TFC or of the requirement to address this issue through the TFC process. Following discussions with the Resident Inspector, a TFC was prepared to document and control the change.

The failure to incorporate the procedure changes required by the TFC into AOI 31.2 is attributed to personnel error. The requirement to review the operating procedures to ensure that the change was properly incorporated was recognized but not adequately met. The on-duty Watch Engineer (WE) reviewed the two System Operating Procedures (SOPs) for the operation of GT-2 but was not aware of the existence of AOI 31.2, which is utilized to run GT-2 under emergency conditions. The WE who initiated the TFC was subsequently contacted, and acknowledged that the AOI had not been reviewed due to an oversight on his part.

On 8/25/99, another failure of the TFC process occurred when TFC-99-109 was installed to provide a portable water treatment truck with a water supply from the Fire Protection System water supply. Several of the requirements of the Safety Evaluation, SE-97-029TM, were not incorporated into the TFC and were not met in the installation. SAO-206 requires the incorporation of all precautions and limitations from the safety evaluation into the TFC. This incident, together with the previous TFC issues, suggests some cross-departmental insensitivity to the importance of thoroughly implementing the TFC process.

CORRECTIVE ACTION

In response to these implementation inadequacies for SAO-206, "Temporary Facility Changes", the following corrective actions were initiated:

1. TFC 99-94 was installed to document the twisted leads on the GT-2 bearing thermocouple. This action was completed on July 9, 1999.

2. The Operations Manager directed the issuance of a TPC to AOI 31.2. The responsible Watch Engineer was counseled. These actions were completed on July 9, 1999.

3. The Operations Manager issued a statement on 8/25/99 that clearly placed the responsibility for proper implementation of the TFC process on the WE. This directive spans the entire installation, from the incorporation of the safety evaluation comments into the TFC through the physical installation of the TFC. This elimination of any transfer of ownership in the TFC process will ensure that the requirements of installation are documented and met. All Watch Engineers have received and read the 8/25/99 TFC process statement.

4. An extent of condition review was conducted from August 25, 1999 through August 31, 1999 to ensure that all installed TFCs fully comply with the requirements in SAO-206, "Temporary Facility Changes". No additional significant discrepancies were found to exist.

5. Operations, Maintenance and Site Engineering personnel will be briefed on this violation, and the examples of the recent failures to properly implement the TFC process. The importance of proper installation of Temporary Facility Changes will be stressed. This action will be completed by November 4, 1999.

ATTACHMENT B

REPLY TO NOTICE OF VIOLATION
INSPECTION REPORT NO. 50-247/99-06-01

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
INDIAN POINT UNIT NO. 2
DOCKET NO. 50-247
OCTOBER 4, 1999

LIST OF COMMITMENTS

The following list identifies those actions committed to by Con Edison in this document. Any other actions discussed in the submittal represent intended or planned actions by Con Edison. These actions are described to the NRC for the NRC's information and are not regulatory commitments.

Commitment	Due Date
Operations, Maintenance and Site Engineering personnel will be briefed on NOV 50-247/99-06-01, the examples of the recent failures to properly implement the TFC program, and the specific implementation requirements of SAO-206.	November 4, 1999