December 21, 1999

Mr. A. Alan Blind
Vice President - Nuclear Power
Consolidated Edison Company of
New York, Inc.
Indian Point 2 Station
Broadway and Bleakley Avenue
Buchanan, NY 10511

SUBJECT: RESULTS FROM THE FOLLOW UP INSPECTION TO THE AUGMENTED INSPECTION TEAM, NRC INSPECTION REPORT 05000247/99013

Dear Mr. Blind:

This letter transmits the results of a safety inspection conducted by an NRC team of inspectors at your Indian Point 2 reactor facility from September 20 through October 15, 1999. The inspection was focused on your short term corrective actions and other self-assessment activities as a result of the August 31, 1999, reactor trip with complications. This inspection followed both our Augmented Inspection Team (AIT) review of the event and your initial recovery efforts as described to us at a September 14, 1999, meeting in our King of Prussia office. Interim results from this inspection were provided to you in our letter dated October 12, 1999, our site departure briefing by the team leader on October, 15, 1999, and our telephone exit on December 20, 1999. This report does not address enforcement related to the causes of the August 31 event because a separate inspection report, 50-247/99-14, has been conducted to determine the appropriate enforcement actions. This report will be issued separately at a later date.

We found that you devoted substantial resources to determine the causes of the event and the resulting corrective actions involved many aspects of the Indian Point Unit 2 facility. Department-level line managers, the quality assurance organization, the station nuclear safety committee (SNSC), the nuclear facility safety committee, a specially formed advisory group, and station senior management all had defined oversight responsibilities during the recovery effort. We considered your review and corrective actions appropriate and commensurate with the significance of the event. Your reviews included those actions specified in your initial recovery plan as well as review expansions that resulted as you implemented the recovery plan and identified additional problems. As we stated in our October 12, 1999, letter, we found that your short-term corrective actions as a result of your reviews and investigations were adequate in overall scope and priority to support the safe restart and operation of Indian Point Unit 2.

Our inspectors noted many examples of mixed performance in the your recovery efforts. For example, our probing led to the identification that a safety related breaker had been returned to service even though data obtained during testing was out of your pre-approved tolerances. Also, during training of your plant operators on your newly issued procedure for recovery of a

IE01
IE10

480 volt safety bus following loss of power, a number of discrepancies were identified that necessitated a procedure revision. Overall, we found that, despite the mixed performance, your use of multiple, diverse reviews assured quality in your recovery efforts. We consider your staff and management ability to identify and resolve conditions adverse to quality in need of longer term improvement. You had informed us that you have initiated a significant effort to improve human performance in station activities.

We also found that there were other significant areas of weak performance needing your added attention and longer term followup to assure that the improvements you initiated as a result of the August 31 event are effective. A significant finding during the recovery effort was that your plant work backlog contained issues of safety significance that persisted without timely corrective action or performing a safety evaluation. For example, the station load tap changer remained in the manual position for approximately one year prior to the event without adequate compensatory measures to assure that the function of the tap changer would be retained following a unit trip. As a result of this finding, you corrected the deficient condition that had necessitated keeping the tap changer in the manual position, and revised station procedures to limit the time that the tap changer could remain in manual to coincide with the technical specification limitations on operability of the offsite power supplies. You also initiated a broad review of station work backlogs to verify that other degraded conditions were adequately evaluated for safety impact on operations or were corrected prior to unit restart. Providing assurance that future degraded conditions are addressed in a timely manner is another area that requires further action on your part. You informed us that you intend to complete an effectiveness review of corrective actions resulting from this event.

You agreed to update your recovery plan because Consolidated Edison Company management has identified that there are a number of performance improvements to be achieved to avoid future significant challenges, such as experienced during the August 31, 1999, event. You submitted your recovery plan update on November 8, 1999. We plan to continue our close monitoring of your activities to ensure that plant operation can be conducted without undue risk to public health and safety.

Based on the results of this inspection, the NRC has determined that a number of violations of NRC requirements occurred. The violations described in the attached report are being treated as a non-cited violations (NCV), consistent with Section VII.B.1.a of the Enforcement Policy (November 9, 1999; 64 FR 61142). All of the violations relate to your activities taken following the August 31,1999 event and your subsequent corrective activities. If you contest any of the violations or severity level of the NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to the Regional Administrator, Region I, the Indian Point Unit 2 Resident Inspector, and the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555-0001. As stated earlier we will address separately, and at a later date, any enforcement directly related to the August 31, 1999, event and its causes. This report identifies these items as unresolved.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room. Should you have any questions regarding this report, please contact Mr. John Rogge at 610-337-5146.

Sincerely,

ORIGINAL SIGNED BY:
Richard V. Crlenjak for

A. Randolph Blough, Director
Division of Reactor Projects

Docket No. 50-247
License No. DPR-26

Enclosure: NRC Inspection Report No. 05000247/99013

cc w/encl:
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