DCS

John D. O'Toole
Vice President

Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003
Telephone (212) 460-2533

April 12, 1984

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

Mr. Richard C. DeYoung, Director
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Mr. DeYoung:

This responds to Regional Administrator Dr. Thomas E. Murley's letter of March 13, 1984 which forwarded a Notice of Violation and Proposed Imposition of Civil Penalty resulting from your office's assessment of a significant event which we identified and promptly reported on November 29, 1983. We have determined not to oppose the imposition of the proposed civil penalty, and accordingly our payment in the amount of $40,000 is enclosed.

Upon identification of the event immediate corrective action was taken and full compliance with all requirements was achieved. An immediate review of the event identified additional actions to increase assurances that this type of event would not occur in the future. The immediate and additional actions are contained in the response to the Notice in Attachment 1.

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

Very truly yours,

John D. O'Toole

cc: Dr. Thomas E. Murley
Regional Administrator-Region I
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pa. 19406

Mr. Thomas Foley, Senior Resident Inspector
U. S. Nuclear Regulatory Commission
P. O. Box 38
Buchanan, New York 10511

IE14
1/1
014

)

STATE OF NEW YORK)

COUNTY OF NEW YORK)

)

John D. O'Toole, being duly sworn, deposes and says: That he is a Vice President of CONSOLIDATED EDISON COMPANY OF NEW YORK, INC., Licensee of Indian Point Unit 2 herein; that the foregoing Statement in Reply to Notice of Violation dated March 13, 1984 has been prepared under his supervision and direction; that he knows the contents thereof; and that to the best of his knowledge and belief said reply and the facts contained therein are true and correct.

DATED: New York, New York
13th April 1984

/s/ John D. O'Toole
John D. O'Toole

Subscribed and sworn to
before me this 13 day
April, 1984.

Conrad Tromba
Notary Public

CONRAD TROMBA
Notary Public State of New York
No. 30-4022875
Qualified in Nassau County
Terms expires March 30, 1985

UNITED STATES OF AMERICA

NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC. (Indian Point, Unit No. 2)	)	Docket No. 50-247

CONSOLIDATED EDISON'S
STATEMENT IN REPLY TO
NOTICE OF VIOLATION

In accordance with 10 CFR 2.201, and the Office of Inspection and Enforcement's Notice of Violation and Proposed Imposition of Civil Penalty dated March 13, 1984. Consolidated Edison Company of New York, Inc. ("Con Edison"), licensee of Indian Point Unit 2, submits the following response to the alleged item of noncompliance with NRC regulations set forth in the Notice.

ATTACHMENT 1

Response to Notice of Violation

and

Proposed Imposition of Civil Penalty

Consolidated Edison Company of New York, Inc.
Indian Point Unit No. 2
Docket No. 50-247
April 1984

VIOLATION

Technical Specification Limiting Condition for Operation, 3.3.B.1.b, requires that the reactor shall not be made critical unless the five fan coolers and the two containment spray pumps, with their associated valves and piping, are operable.

Contrary to the above, from October 25, 1983 until November 29, 1983, the reactor was made critical five times with both containment spray subsystems inoperable in that containment spray system isolation valves 869A and 869B were closed, resulting in a blocked flowpath for both containment spray subsystems.

This is a Severity Level III Violation (Supplement I) Civil Penalty-$40,000.

RESPONSE

The event summarized above occurred as described.

Sequence of Events

On November 29, 1983, while performing a bimonthly containment spray pump surveillance test, during normal operation, two motor operated spray header discharge valves (MOV 869A and MOV 869B) were found in the locked closed, de-energized position instead of the required locked open, de-energized position. This condition would have prevented automatic containment spray operation during the injection phase of safety injection following an accident.

A review of conditions leading to this event revealed that on October 12, 1983, during a cold shutdown, MOVs 869A and 869B were closed and tagged out of service to work on the Reactor Coolant System. On October 18, 1983 while still in the cold shutdown condition the tagout was cleared; however, these valves were specified to remain closed to block the containment spray paths while personnel continued work in the containment. Prior to plant startup, operators were assigned to perform Safety Injection System Check-off List (COL-12) which should have returned MOV 869A and MOV 869B to their proper positions prior to heating the reactor coolant system above 350 degrees. Although the facility Technical Specifications require containment spray system operability prior to making the reactor critical, our procedures require a more restrictive limit of 350 degrees.

On October 24, 1983 Safety Injection System Check-off List (COL-12), was performed to ensure the proper line-up of the Containment Spray System. The personnel who conducted this check-off did not properly verify the position of MOVs 869A and 869B. Upon discovery by plant personnel on November 29, the incident was immediately reported by telephone to the NRC Operations Center. On November 30 and December 13, 1983, written reports were sent to the Regional Administrator.

Investigation and Cause

An investigation established the cause of the event and corrective actions was implemented. The investigation included interviews with cognizant operations and test personnel, a review of the COLs (Check-off Lists), OADs (Operation Administrative Directives), Training and Operator Qualification Program, the facility Technical Specifications, FSAR, Indian Point Probabilistic Safety Study, NRC's Safety Evaluation Report and other reference documentation.

The Senior Watch Supervisor on shift on October 18, 1983 during the cold shutdown explained why valves 869A and 869B were left closed after the tagout, and why he cleared the tagout and left the valves in the abnormal position. The Senior Watch Supervisor stated that the COL would have to be performed to place the valves in the proper line-up prior to heating the reactor above 350°F.

COL-12 was performed on October 23 and 24, 1983. It required one operator to ensure the correct valve position and a second operator to verify the position. COL-12 directs the operators to the motor control centers to perform two verifications for each valve: (1) verify that the position of the valve is open and (2) verify that the breaker is de-energized. In the de-energized condition, position indication for the valve is not displayed at the motor control centers. Verifying position at the motor control center, therefore, requires energizing the breaker. This was not done, and each operator assumed the valve was open. The first assumed that the valve had been positioned by another operator. The second assumed the valve was open because the breaker was locked in the de-energized position.

Test personnel described how they found the position (line-up) of the valves and their subsequent actions. They realized the valve line-up was wrong when the "as left" position differed from the "as found" position during the spray pump test. The Senior Reactor Operator was notified when the discrepancy was identified and the valves were positioned correctly.

As a result of the investigation it was determined that:

1. Two operators failed to perform their duties correctly.
2. Nuclear Plant Operator training needed improvement.
3. Improved instructions for the performance of COLs was needed.

Immediate Corrective Action

1. Motor Operated Valves 869A and 869B were placed in the correct position (locked, open, de-energized) following the Containment Spray Pump Surveillance Test on November 29, 1983.

2. Similarly de-energized, safeguards valves covered by COL-12 and COL-51 were verified to be in the correct position on November 29 and November 30.

3. The training and qualification status of the two operators who performed COL-12 on October 24 was reviewed by the Operations Superintendent and found in order. Additionally, the operators were interviewed and a determination was made that they had improperly performed the COL for MOV 869A and MOV 869B. They were re-instructed in the proper method to determine valve position.

Permanent and Long Range Corrective Action

1. The operators involved in the incident were disciplined.

2. COL-12, Safety Injection System Check-Off List, and COL-51, Locked Valve Check-Off List, were validated by reviewing system prints, Technical Specifications, and the Final Safety Analysis Report to ensure that all valves are included that should be included. These COLs were revised to provide appropriate guidance for verifying valve position to assure each of two verifications, where required, is completely independent. The revised COLs contain a statement clearly defining that signing the COL signifies that the signer based upon his direct observation is acknowledging that the item identified in the COL has been completed. These actions for COL-51 were completed January 30, 1984 and for COL-12 February 27, 1984. We have changed OAD-6, Equipment Status Identification, which is applicable to all COLs, to include this statement. The remaining COLs will be revised as part of the ongoing operations procedure review to include a reference to the steps in OAD-6 for verifying valve position and to include the above statement.

3. Operations Section personnel were retrained by December 31, 1983 on the requirements for conducting a proper valve check-off and the requirements for maintaining equipment status control.

4. We have increased instructor participation in NPO on-the-job training in the plant.

5. Operations Administrative Directive No. OAD-19, Tag-Out Log was changed January 25, 1984 to require that all Unit 2 tag-outs normally be prepared by one of the on-watch Reactors Operators with an independent verification of tag-out adequacy by the Senior Watch Supervisor.

6. OAD-6, Equipment Status Identification, has been revised to clarify requirements, effective February 8, 1984.

7. To ensure that all necessary check-off lists are performed when coming out of an outage the Senior Watch Supervisor has been required by OAD-6 since February 8, 1984 to document on a status board used in the Foreman's Office all check-off lists that need to be performed when the need for COL becomes apparent.

8. Section 8 of the Indian Point Station Training Manual is being revised to include a qualification standard which specifies the knowledge and practical abilities that must be demonstrated to obtain each signature on the Nuclear Plant Operator Qualification Cards. This is scheduled for completion by June 1, 1984.

9. A review of valve position indication for all safety related valves has been conducted and is being evaluated to determine if changes are necessary to provide positive indication of de-energized valves. At present, we have determined that indication will be changed for valves 743 and 1870. This should be accomplished by the end of the 1984 refueling outage. The evaluation will be completed by July 1, 1984.

10. The operability of all currently installed safety related MOV position indication has been checked by reviewing current remote position indication of these valves including those covered by COL-12 and by reviewing the results of periodic Section XI valve tests. Corrective action has been taken by initiating MWRs where indicated by these reviews.

11. Quality Assurance and Reliability has included surveillance of these corrective actions into its ongoing Surveillance and Monitoring Program at Indian Point Unit No. 2.