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May 25, 1973

USAEC
UGC-BETHESDA

James P. O'Reilly, Director
Regulatory Operations, Region I
U. S. Atomic Energy Commission
970 Broad Street
Newark, New Jersey 07102

Re: Consolidated Edison Company of
New York (Indian Point, Unit No. 2)
Docket No. 50-247

Dear Mr. O'Reilly:

By letter dated May 23, 1973, Applicant's counsel transmitted to us a letter dated May 14, 1973 with respect to an abnormal occurrence. The abnormality involved Valve Number 204B which was discovered to be defective and must be replaced. */ Significantly this same valve not only was subject to and passed all normal quality assurance procedures set up by the Applicant, Westinghouse and the manufacturer, but also was subject to the allegedly thorough examination associated with verification that there were no thin-walled valves. Nonetheless, the defect was discovered after operation had commenced pursuant to an operating license although prior to certain hydrostatic leak tests and criticality.

By letter dated May 21, 1973 and received by us on May 24, 1973, Applicant reported another valve malfunction and subsequent valve replacement. The intermediate cause of the failure was that "several key operations personnel" assumed that a valve was open and did not actually verify that the valve was open. In fact, it was closed.

By letter dated May 21, Applicant claims the new valve meets all PSAR requirements. Obviously it should also have wall thicknesses verified as required in the Staff's June 22, 1972 letter. This should be done before installation to avoid any testing problems.

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S PDR

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PHONE 833-9070

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to O'Reilly
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Pls note

6/5/73
Korman contacted J PDR
on this and he planned to send
his answer into AEC for review
FAD

50-247
inquiry

Both of these "abnormal occurrences" clearly raise serious questions about the adequacy of Applicant's quality assurance program. The normal practice of disregarding the real underlying cause of abnormal occurrences and focusing instead only on the narrow question of whether the defect itself has been repaired must not be followed here where the quality assurance program has already been shown to have substantial defects.

The significance of the quality assurance program is underlined in the recent Appeal Board decisions in Consumers Power Company (Midland) (ALAB-106) and Vermont Yankee (ALAB-124). We urge you to require the Applicant to prepare a thorough written report disclosing what deficiencies in the quality assurance program allowed the defective valve to be installed and operated at Indian Point No. 2 and allowed several key personnel to make a serious and erroneous assumption without actual verification. Applicant should also propose specific corrective steps to eliminate the quality assurance defect and to recheck all other equipment which could have been insufficiently examined as a result of the same underlying quality assurance defect.

Until this matter has been resolved no further operation of Indian Point No. 2 should be allowed. The 50% testing license should be suspended pursuant to 10 CFR Part 2, Section 2.202. We hereby specifically request such a suspension on an emergency basis without prior hearing.

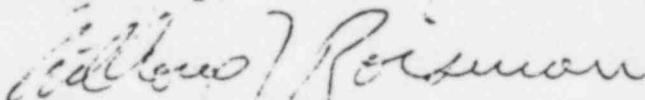
The fact that "abnormal occurrences" were at a time and place where no serious safety consequences resulted is fortuitous at best. They are clearly danger signals that there are significant defects in Applicant's quality assurance program and implementation of the program. It would be irresponsible to allow any operation of Indian Point No. 2 with the reactor critical until the problems are resolved. In ALAB-124 (Vermont Yankee) the Board stated (p. 15):

if it...appeared that an adequate program were lacking, we would likely be compelled now to reverse the decision authorizing issuance of the permanent operating license and thus to require immediate cessation of plant operation until the quality assurance matter was resolved.

Mr. James P. O'Reilly
May 25, 1973
Page three

In this case the two recently reported abnormal occurrences are abundant evidence that the quality assurance program is inadequate. There is no alternative but to suspend the license immediately, prior to criticality.

Sincerely,



Anthony Z. Roisman
Counsel for Citizens Committee
for Protection of the Environment

AZR/pq

cc: All parties of record.

cc: CPE

Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N.Y. 10003
Telephone (212) 489-5181



May 21, 1973

Re Indian Point Unit No. 2
AEC Docket No. 50-247
Facility Operating License
DPR-26

Mr. John F. O'Leary, Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, D. C. 20545

Dear Mr. O'Leary

In accordance with the requirements of Technical Specification 6.6.1.B, we wish to inform you of an abnormal occurrence which was identified on May 11, 1973 at 2230 hours. During pressurization of the reactor coolant system preparatory to starting reactor coolant pumps for the performance of a hydrostatic leak test of the Reactor Coolant System, prior to initial criticality, a leak was observed in valve number 204B which is located in the charging line to Loop 21. Subsequent investigation indicated that the leakage was apparently due to a defect in the area of the stud holes permitting reactor coolant makeup to seep into two of the stud holes and from there into the containment atmosphere.

Valve No. 204B has been replaced. The replacement valve meets the requirements of codes and standards applicable to the design and procurement of equipment as outlined in the Indian Point Unit No. 2 FSAR. A hydrostatic test of the reactor coolant system was performed to insure the integrity of the new valve and associated welds.

Mr. A. Fasano of the Region I Regulatory Operations office of the U. S. Atomic Energy Commission was notified by telephone on May 12, 1973 of the occurrence. In addition, a letter was telecopied to the Director of the Region I Office, Mr. J. P. O'Reilly, on May 14, 1973.

The valve that experienced the leakage will be subjected to analysis at the Westinghouse Research Lab. to identify the specific cause and nature of the defect. This investigation will include:

- (a) Compilation of a history of the valve after its installation in Unit No. 2.
- (b) Photographs and physical measurements of the valve.
- (c) Radiographs of the valve body.

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Mr. John P. O'Leary

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May 21, 1973

Re Indian Point Unit No. 2
AEC Docket No. 50-247
Facility Operating License
DPR-26

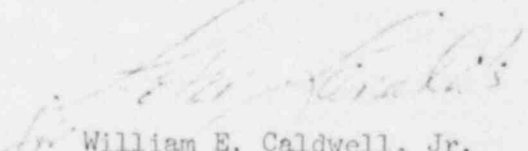
- (d) Dye penetrant inspection.
- (e) Fractography on specimens in the area where leakage occurred.
- (f) A chemical analysis of the valve body material.

Following the completing of this program, results of the investigation will be made available at the site for review by the Regulatory Operations inspector.

For a number of reasons, the safety implications of the occurrence are considered slight. The first of these considerations is that the leak was of a very minor rate and was well within the make-up capability of the Chemical and Volume Control System. Secondly, a check valve is located downstream of valve 204B and this would prevent leakage directly out of the Reactor Coolant System had the valve leakage in some way become excessive. A further consideration with regard to the safety implications is that the leakage, had it been radioactive, which it was not, was into the containment atmosphere and therefore would not have resulted in any danger to the health and safety of the public. Furthermore, the leakage would have been detected and identified by one of the four methods for monitoring leakage in containment as specified in Technical Specification 3.1.F had the plant been in operation. Finally, the plant was in a cold shutdown condition with the system pressure below 500 psig at the time of the occurrence. Consequently, the occurrence does not represent a significant hazards consideration.

Our Nuclear Facilities Safety Committee has reviewed the circumstances of this occurrence and concurs that it does not represent a significant hazards consideration.

Very truly yours


William E. Caldwell, Jr.
Vice President

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Copy to James P. O'Reilly (AEC)