

John D. O'Toole
Vice President

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

November 23, 1984

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

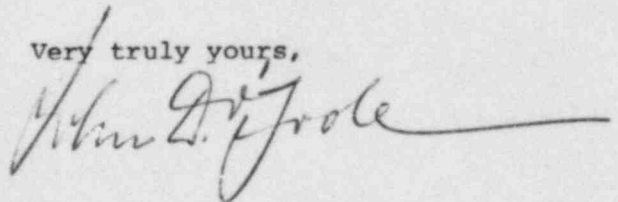
Mr. Thomas T. Martin, Director
Division of Engineering and
Technical Programs
U. S. Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, Pa. 19406

Dear Mr. Martin:

This refers to I.E. Inspection 50-245/84-17 conducted by Mr. J. R. White of your office on July 10-13, 17-20, 1984 of activities authorized by NRC License No. DPR-26 at Indian Point Unit No. 2. Your October 24, 1984 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 A

10 CFR 20.201, "Surveys", requires the licensee to perform surveys (evaluations of the radiation hazards incident to the presence of radioactive materials) as necessary to comply with the regulations of this part.

Contrary to the above, on July 14, 1984, the licensee performed sampling of airborne radioactivity to support the work of two individuals compacting dry radioactive waste in accordance with Radiation Work Permit 8217. Though the air sample analysis indicated the presence of alpha activity, the licensee failed to evaluate this radiation hazard and consequently failed to take prompt action to estimate personnel exposure due to alpha or transuranic activity in accordance with 10 CFR 20.103, "Exposure of individuals to concentrations of radioactive materials in air in restricted areas."

This is a Severity Level IV Violation (Supplement IV).

Response

Prior to this licensee identified incident, continuous breathing zone air sampling had been adequate to provide radiological control of baling station operations. In this instance, the failures of the baler door lock and ventilation system combined with the work practices employed at the time contributed to the incident.

Several actions were taken in immediate response to this incident prior to involvement by the NRC inspector. These actions included stopping all work associated with baling operations; notification of the Shift Radiation Protection Supervisor and Radiation Protection Manager; barring of the two involved individuals from areas requiring respirators; conducting a post-job critique by the Acting General Manager, EH&S with all involved personnel; decontamination of the baling station; whole body counting of the two individuals at Indian Point 2 and at non Con Edison facilities; analysis of bioassay samples; generation of an event report; issuance of a Maintenance Work Request to repair the baler door; and initiation of isotopic/gross alpha analysis of air samples.

To prevent recurrence of this incident, the following additional actions have been implemented:

- Revised EH&S procedure 4.304 to require an alarming constant air monitor, proper ventilation, operating door latch, and pre-job briefings of personnel for baling operations.
- Documented instruction of personnel in baling station operations.
- Rerouted ventilation exhaust to building exhaust plenum.
- Repaired baler door lock.

Violation B

10 CFR 19.12, "Instructions to Workers", requires the licensee to provide instructions to personnel in precautions and procedures to minimize exposure to radiation and radioactive materials.

Contrary to the above, on July 14, 1984, two individuals were directed to compact dry radioactive waste in accordance with Radiation Work Permit 8217, but were not adequately instructed in precautions and procedures to minimize their exposure to radiation and radioactive material. Consequently, the individuals conduct in the area resulted in creating an airborne radiological hazard and their unplanned intake of radioactive materials.

This is a Severity Level IV Violation (Supplement IV).

Response

Con Edison agrees with the description of the event as stated in the Notice of Violation.

In immediate response to the above event, all operations at the baling station were halted. To preclude the recurrence of such an event EH&S Procedure 4.304 "Dry Active Waste Drum Compacting Operations" was revised to require contractor personnel to receive a pre-job briefing in accordance with EH&S 2.203, "Management Controls for Contractor Decontamination Services." In addition, the individuals involved in the event were reinstructed in the precautions and procedures to minimize their exposure to radiation and radioactive material.