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New York Power Authority

December 28, 1987
IP3-WAJ-071Z
IP3-MPC-123B

Docket No. 50-286
License No. DPR-64

Mr. William Russell
Regional Administrator, Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Subject: Systematic Assessment of Licensee Performance
Report No. 50-286/85-98

Dear Mr. Russell:

On behalf of Indian Point 3 Nuclear Power Plant and the New York Power Authority, I am writing to you concerning the recent assessment of performance presented in the subject report. Let me begin by expressing the Authority's views on the meeting held on November 13, 1987 to discuss the report. It is our opinion that the meeting was productive and afforded the opportunity for the frank exchange of ideas between our respective staffs. We also greatly appreciate your time in touring our facility and the presentation of licenses to the recent graduates of our licensed operator training program.

Regarding the SALP, we consider the evaluation to be a very positive representation of the operation at Indian Point 3. An area addressed in the report which we consider to be extremely important is Operations. The need to reduce the number of plant trips is recognized. The Authority has taken several positive steps to accomplish this. These steps include both hardware and programmatic improvements.

Due to the high frequency of plant trips initiated in the Feedwater System, the Authority commissioned a task force to review the system and recommend improvements. Hardware upgrades consisting of a new feedwater pump speed control system and trip setpoints have greatly improved the feedwater system performance and provide the operating staff with greater flexibility in response to feedwater transients.

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We also recognize that the design of certain existing systems and their testing requirements present an elevated potential for plant trips. Examples cited in the report include the instrument bus loading arrangements and turbine overspeed trip system surveillance testing. Efforts are underway to reduce or eliminate the potential for plant trips due to such system designs or testing. We are actively involved in the Westinghouse Owners Group trip reduction effort.

Programmatic enhancements are also underway. A detailed root cause analysis capability is being developed for use in evaluating in-house operating events. Improvements in shift turnover have been instituted including a revised shift relief and turnover procedure which provides for the walkdown of each control panel by the counterparts of the oncoming and offgoing shift. The practice of assembling the shift crew at the start of the watch for a comprehensive briefing of plant status and planned evolutions during the shift has also been instituted.

The Authority is concerned with the Staff's statement on page nine of the SALP report which implies the thoroughness of engineering evaluations is compromised to facilitate the plant's return to service following a trip. The policies and procedures which address post trip review and restart are clear with respect to the evaluations that must be completed before a restart decision is considered. Furthermore, the appropriate level of management is involved in all restart decisions. Plant restart decisions are based on a thorough review of the events leading up to the trip including a full understanding of the salient causes of the trip. While there are attendant economic incentives to return a plant to service, the Authority's primary motivation is the safe operation of Indian Point 3.

We want to take this opportunity to present details to clarify maintenance and operation of a main boiler feedpump cited in the assessment of maintenance on page 16 of the report. The report describes a reactor trip attributed to the failure to replace marginal parts during routine maintenance on the pump. The maintenance referred to occurred during the 1985 refueling outage during which the pump was overhauled. An oil seal to be installed was identified as being slightly out of round. The anomaly was reviewed and, since all manufacturers tolerances were met, the seal was installed. Other work was performed on the pump by an outside vendor.

During operation, water intrusion into the control oil system caused a plant trip. The preliminary assessment attributed the contamination of the oil to the oil seal. Steps were taken to mitigate the potential for recontamination during operation. During the recent refueling outage a complete overhaul of the pump was performed at which time the root cause of the water intrusion to the control oil system was identified. The water seal was determined to have been installed improperly by the pump vendor representative. This resulted in the water seal's failure to operate properly placing demands on the oil seal for which it was not designed.

Based on our review of the matter, proper decisions had been made during main boiler feedwater pump maintenance and appropriate parts replacement was conducted.

We believe one point made in the SALP report to be in error. Specifically, on page 28, "Assurance of Quality", it is noted that the Plant Operating Review Committee and Safety Review Committee (SRC) failed to uncover a problem with the implementation of a Technical Specification amendment. As was discussed at the meeting, the principal method of followup exercised by the committees is the audit process. The failure to completely implement Amendment No. 67 to the Technical Specifications was identified by an SRC directed audit.

Also, as we discussed at the meeting, we are perplexed with the SALP evaluation conclusions in the area of Training. In reviewing the report, the contribution of training in several of the functional categories is noted to be positive. With respect to the Training area specifically, the Authority has made a significant commitment including a plant specific simulator, an 80,000 square foot training facility, and accreditation. To date, all programs have been accredited including those programs dealing directly with the operations and maintenance areas.

An excellent indicator of the effectiveness of our training program is the success rate in licensed operator examinations and requalifications. We acknowledged a weakness in our emergency operating procedure training and promptly undertook an in-depth retraining program. This program was considered excellent as documented in the SALP report.

Training at Indian Point 3 will continue to advance with the maintenance of the accredited programs, delivery of our simulator and completion of the training facility.

I am available to discuss these comments should you desire.

Sincerely,

William A. Josiger
Resident Manager
Indian Point Unit 3 Nuclear Power Plant

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