Indian Point 3
Nuclear Power Plant
P.O. Box 215
Buchanan, New York 10511
914 736.8001

New York Power Authority

Joseph E. Russell
Resident Manager

March 9, 1990
IP3-90-017
MFP-90-055B

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

Mr. James C. Linville, Chief
Reactor Projects Branch No. 1
U.S. Nuclear Regulatory Commission
Region 1
475 Allendale Road
King of Prussia, PA 19406

SUBJECT: INSPECTION NO. 50-286/89-22 AND ASSOCIATED NOTICE OF VIOLATION

Dear Mr. Linville:

This letter and its attachment provide the Authority's response to inspection report No. 50-286/89-22 and its notice of violation (89-22-01).

Should you or your staff have any questions concerning this matter, please contact Mr. M. Peckham of my staff.

Sincerely,

Joseph E. Russell
Resident Manager
Indian Point Unit 3 Nuclear Power Plant

JER:MFP:lh

Attachment

cc: Document Control Desk (original)
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Resident Inspector's Office
Indian Point 3
U.S. Nuclear Regulatory Commission
P.O. Box 337
Buchanan, NY 10511

IE01
||

ATTACHMENT I
RESPONSE TO NOTICE OF VIOLATION
89-22-01

VIOLATION

"10 CFR 50, Appendix B, Criterion III, Design Control requires that the design basis for design changes to safety-related components shall be correctly translated into specifications, drawings, procedures, and instructions and that these design changes be independently verified to be accurate.

Contrary to the above, the design basis for a design change for steam generator pressure transmitter was not correctly translated into drawings and independently verified to be accurate, in that on October 21, 1989, the Authority identified that two steam generator pressure transmitters were cross-wired, resulting from an inaccurate installation drawing.

This is Security Level IV violation, Supplement I."

RESPONSE:

The Authority has reviewed, in detail, the notice of violation (89-22-01) outlined in Appendix A of NRC inspection report 89-22 and agrees that the event occurred as discussed. The Authority believes that this event has root causes similar to other events discussed in NRC Inspection Report 89-14. This installation error occurred at the end of the 6/7 refueling outage and was not discovered until October of 1989.

The following corrective actions have been implemented:

1. All cycle 6/7 and Reg Guide 1.97 modifications have been reviewed for similar errors.

2. A self assessment of work performed during June, 1989 to identify similar occurrences was conducted.

3. A multi-disciplinary employee involvement team to investigate the modification design, installation and testing processes to determine needed improvements was formed. The recommendations generated by this committee have been presented to station management. Several of these have been incorporated into the modification process, others are being considered. All recommendations selected for implementation will be tracked to completion.

ATTACHMENT I
RESPONSE TO NOTICE OF VIOLATION
89-22-01

4. The Authority has reemphasized to the staff the need for attention to detail.

The Authority presented these corrective actions to the NRC in detail during a NRC management meeting conducted in King of Prussia on March 1, 1990. As committed at that meeting, the Authority intends to conduct an extensive self assessment of the modification, installation and testing process at the conclusion of the current maintenance outage. The purpose of the assessment will be to determine the effectiveness of the Authority's corrective action program and whether additional changes are necessary.

The Authority is confident that substantial improvements have been made and would welcome the opportunity to share the results of this evaluation at your convenience.