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New York Power Authority

Robert J. Barrett
Plant Manager

November 14, 1996
IPN-96-117

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

Subject: Indian Point 3 Nuclear Power Plant
Docket No. 50-286
License No. DPR-64
Reply to Notice of Violation 50-286/96-08

Dear Sir:

This letter provides, in Attachment I, the New York Power Authority's response to the subject Notice of Violation. The Authority agrees with the Notice of Violation contained in NRC Region I Inspection Report 50-286/96-08.

The commitments made by the Authority with this letter are contained in Attachment II. If you have any questions, please contact Mr. K. Peters at (914) 736-8029.

Very truly yours,

Robert J. Barrett
Plant Manager
Indian Point 3 Nuclear Power Plant

Attachments I & II

cc: See next page

IE01

cc: Mr. Hubert J. Miller
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Indian Point 3 Nuclear Power Plant

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VIOLATION

During an NRC inspection conducted on July 29, 1996 through September 15, 1996, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995), the violation is listed below:

A. Indian Point 3 (IP3) Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained covering activities referenced in Appendix A of Regulatory Guide 1.33, "Quality Assurance Program Requirements (Operations)," November, 1972. Section A of Appendix A to Regulatory Guide 1.33 requires that administrative procedures be established for equipment control. IP3 Administrative Procedure (AP)-10.1, Revision 13, "Protective Tagging," states that the shift manager or designee shall review the protective tagout form for operability requirements.

Contrary to the above, on July 28, 1996, protective tagging order 96-1030, which isolated the turbine driven auxiliary boiler feed pump steam supply trap (MS-64), was not adequately reviewed by the shift manager prior to issuance to assure system operability.

This is a Severity Level IV violation. (Supplement I)

Response To Violation 96-03-01

The Authority agrees with this violation. The Protective Tagging Order (PTO) was not adequately reviewed to ensure system operability requirements.

Reason for Violation

The principal causes of this problem are that a Control Room supervisor failed to adequately assess the operability impact, to use an appropriate mechanism to control the effect of the tagout, and to effectively communicate the status and required actions on Auxiliary Boiler Feed Pump (ABFP) operability.

The 32 ABFP steam trap was added to the station schedule at the end the week of July 21st. However, the schedule input sheet for the ABFP steam trap work was never signed by the Work Control Center (WCC) Supervisor. In addition, the Operational Impact Sheet (OIS) was not filled out by the WCC as a result of the compressed time schedule. In order to support work on the morning of July 29th, this work package was turned over to the Operations swing shift Control Room Supervisor (CRS) on July 28th from the day shift Field Support Supervisor (FSS) and the CRS advised that a PTO had to be applied. The CRS reviewed the work package and signed for the independent verification of the work package. The CRS also authorized the PTO, which includes a review of operability. The PTO was applied at 0650 hours on July 28th.

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The CRS performed an operational review of this activity. The CRS determined by operational experience, review of plant drawings and system walkdown, that the steam trap work did not affect the operability of 32 ABFP. The CRS considered that other redundant traps would compensate for the trap being tagged out and also; decided as an additional measure, that the clearance should be turned in at the end of each shift so the trap could be blown down. The CRS failed to confirm the assessment of redundancy, the technical basis for the periodicity of requiring the steam trap to be blown down, and the impact on the operability of 32 ABFP. The CRS placed a note on the work request that required the clearance to be returned to operations at the end of each shift. The note on the front of the PTO was not adequate to ensure the trap was blown down every shift. The CRS left a list of all PTOs applied on the FSS desk; however, there was no FSS watch on the mid shift. The CRS mentioned this PTO during shift turnover, but did not advise that the clearance was to be returned at the end of each shift so that the compensatory measures could be applied.

On July 29th, the mid watch performed a temporary lift of the PTO at 0715 hours because it was not aware of the details regarding the 32 ABFP work activity and PTO. An operability determination was then performed by System Engineering which stated that the system would remain operable if the trap was blown down approximately every 12 hours. The trap was tagged out for a total of 12 hours and 25 minutes.

The inadequacies noted above will be addressed by the following corrective actions:

Corrective Actions Taken

1) A shift order was issued to all the operating crews describing this event and the associated problems.

2) A shift order was issued which specifically addressed the issue of the watch filling out an operational impact sheet if Work Control personnel are not available.

3) An operability determination was completed for the time the trap had been tagged out which concluded that the system remained operable.

4) A senior member (usually the Assistant Operations Manager) of Operations Management now attends the 0630 and 1400 daily planning meetings and the 12-week scheduling meetings that are held weekly to improve the operational input for upcoming activities.

5) The Operations Manager has discussed the need for improving the quality of the Operational Impact Sheet content with the Planning and Scheduling Manager and the Work Control supervisor.

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6) The Operations Manager had a meeting with Operations personnel in Work Control, along with Work Control supervisors to discuss the importance and increased level of expectations with regard to operational review of work activities.

7) Work Control provided written instructions/expectations on the completion of the Operational Impact Sheet by the WCC.

8) The Operations Manager met with each operating crew to increase operator sensitivity to the effects of work activities at various plant conditions, to reinforce the importance of a questioning attitude and to stress the importance of the turbine driven aux boiler feed pump with respect to work activities associated with it.

Corrective Actions Taken to Avoid Further Violations

Training will be conducted with all licensed operators concerning how to validate continued operability. This is scheduled to be completed by December 18, 1996.

Date When Full Compliance Will be Achieved

Compliance was achieved approximately July 29, 1996 when the PTO was lifted and the trap was blown down. The other corrective actions described in this reply are expected to prevent recurrence of this type of condition.

LIST OF COMMITMENTS

Number	Commitment	Due
IPN-96-117-01	Training will be conducted with all licensed operators concerning how to validate continued operability.	December 25, 1996