

EA No. 92-135
Docket No. 50-286

AUG 07 1992

Mr. Joseph E. Russell
Resident Manager
New York Power Authority
Indian Point 3 Nuclear Power Plant
Post Office Box 215
Buchanan, New York 10511

Dear Mr. Russell:

At an enforcement conference on April 10, 1992, New York Power Authority (NYPA) made a number of presentations of fact to the NRC which were not accurate. On May 7, 1992, the NRC Office of Investigations interviewed members of your staff with respect to these inaccuracies and subsequently determined that there was no apparent attempt to deceive the NRC and no apparent willfulness with respect to the inaccurate presentations made at the conference.

However, the number of inaccuracies that were presented at the conference is of concern. An enforcement conference between the NRC and a licensee is a formal forum for the presentation of information by licensee management that is subsequently used in the determination of appropriate regulatory action pursuant to apparent violations of NRC requirements. It is imperative that licensee management make factual presentations at these conferences on matters pertaining to licensed activities. Inaccuracies presented by NYPA on April 10, 1992, are detailed in the enclosure to this letter.

NYPA's inaccurate statements have been identified as an apparent violation of NRC requirements and are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), 10 CFR Part 2, Appendix C (1992). Accordingly, no Notice of Violation is presently being issued. In addition, please be advised that the number and characterization of apparent violations described in the enclosure may change as a result of further NRC review.

We will contact you shortly to schedule an enforcement conference to discuss this apparent violation. The purposes of this conference are to discuss the apparent violation, its cause and safety significance; to provide you the opportunity to point out any errors in our enclosure; to provide an opportunity for you to present your proposed corrective actions; and to discuss any other information that will help us determine the appropriate enforcement action in accordance with the Enforcement Policy. In particular, we expect you to address the apparent short-coming in NYPA's conduct of licensed activities that lead to incomplete and inaccurate information being presented.

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New York Power Authority

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In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be placed in the NRC Public Document Room.

Sincerely,

Original Signed By:

Charles W. Hehl, Director
Division of Reactor Projects

Enclosure:
As stated

cc w/encl:

J. Brons, President

R. Beedle, Executive Vice President - Nuclear

G. Goldstein, Assistant General Counsel

P. Kokolakis, Director, Nuclear Licensing - PWR

G. Begany, Mayor, Village of Buchanan

C. Jackson, Nuclear Safety and Licensing Manager (Con Ed)

C. Donaldson, Esquire, Assistant Attorney General, New York Department of Law
Director, Power Division, Department of Public Service, State of New York

K. Abraham, PAO-RI (2)

Public Document Room (PDR)

Local Public Document Room (LPDR)

Nuclear Safety Information Center (NSIC)

NRC Resident Inspector

State of New York, SLO Designee

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- bcc w/encl:
- Region I Docket Room (with concurrences)
- T. Martin, RA
- W. Kane, DRA
- K. Smith, RC
- D. Holody, EO
- B. Letts, OI
- W. Hehl, DRP
- J. Wiggins, DRP
- C. Cowgill, DRP
- P. Eselgroth, DRP
- R. Urban, DRP
- J. Tappert, DRP
- G. Tracy, SRI - IP-3
- G. Hunegs, SRI - IP-2
- W. Cook, SRI - FitzPatrick
- W. Hodges, DRS
- R. Lobel, OEDO
- J. Lieberman, OE
- R. Capra, NRR
- N. Conicella, NRR

RI:DRP
 JTappert/mjc
M.J.
 8/4/92

RI:DRP
 PEselgroth
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ENCLOSURE

At the enforcement conference on April 10, 1992, regarding Boric Acid Heat Trace and other issues, NYPA management presented information for NRC consideration in making enforcement conclusions which was not accurate as detailed below.

1. NYPA's enforcement conference response handout stated:

"On March 19, 1992 the midnight shift recorded two alarm conditions on the boric heat trace logs. One alarm was for circuit 42, emergency boration pathway, which was reading low with circuit status energized. The other alarm was for circuit 63, normal blended path, which was reading high and de-energized. These alarms indicated to the nuclear plant operator that the circuits were operating correctly." (page 28)

"The nuclear plant operator (NPO) logs taken at 0030 hours indicated circuit 63 was recorded as high temperature with the heat trace de-energized. Circuit 42 was recorded as low temperature and the heat trace energized. These readings indicated to the NPO that the circuits were functioning correctly." (page 32)

Contrary to the above, readings indicated that circuit 63 was not functioning properly. The boric acid heat trace log taken at 0030 on March 19, 1992 shows that circuit 63 displayed a high temperature alarm with the heat trace circuit still energized. This was an abnormal condition for which no remarks were noted on the log by the operator or shift supervisor upon his review.

2. NYPA's enforcement conference response handout stated:

"When the redundant circuit (circuit 63) failed to maintain temperature at 1700 hours, a plant shutdown was ordered although it was recognized at this time that circuit 42, the emergency boration path, was maintaining temperature greater than 145 degrees F, which is well above precipitation temperature for twelve percent boric acid solution. The decision to shutdown was based on the unavailability of circuit 63. We incorrectly believed, at the time, that circuit 63 was common to all three paths.

Safety Significance

At no time during this event were any of the boric acid lines unavailable due to precipitation of boron. As previously stated, circuit 42 was maintaining temperature above 145 degrees F on the emergency boration path. The plant was brought to hot shutdown and repairs to circuit 63 and circuit 42 were made over the next few days. A historical review of boric acid heat trace problems has shown no instances of boric acid blockage except for the March 16, 1992 event. At all times a path for boron injection has been available. Despite the problems noted with circuit 42 the emergency boration path has always been available." (page 29)

Contrary to the above, the temperature on the emergency boration path was below 145°F, the temperature at which operability is determined. On March 19, the inspector noted that circuit 42 was alarming in an actual low temperature condition. The temperature recorder for circuit 42 had indicated 94°F as early as January 13, 1992.

The I&C supervisor, along with two technicians, obtained the emergency boration line temperature by hand pyrometer on the night of March 19. The temperature of the emergency boration line approximately 8 feet from the charging line tee was 141°F.

In addition, the electrical engineering supervisor stated that upon troubleshooting circuit 42 on March 20, 1992, the temperature on the emergency boration line near the alarm bulb (10 to 15 feet from the charging line tee) was 141 to 142°F. It was ultimately determined that circuit 42B was, inoperable.

3. NYPA's enforcement conference response handout stated:

"On January 23, 1992, IP-3 had an event that involved a blown control power fuse that rendered the automatic initiation feature of safeguard equipment on a vital 480V bus inoperable...

The initial assessment, using Alarm Response Procedure (ARP-4) and System Operating Procedure (RPC-8) was that the failure affected only one of the vital buses; redundancy existed and therefore the event was initially considered not reportable. A complete assessment by the assistant shift supervisor was delayed while he made communications to NYPA management and the NRC resident...

The cause of the delay was a procedure deficiency and distraction of the assistant shift supervisor.

NYPA management distracted the assistant shift supervisor from completing the assessment and informing the shift supervisor. As a result, the shift supervisor's involvement in fuse replacement efforts continued and focus was not directed toward Technical Specification compensatory actions. The alarm Response Procedure directs the operator to system operating procedure RPC-8. This procedure does not specifically address loss of safeguards automatic initiation signals." (page 4)

Contrary to the above, the cause of the delay was personnel error. In addition, the alarm response procedure clearly addresses the loss of safeguards automatic initiation signals.

Alarm response procedure ARP-4 stated:

"If DC power is lost to the bus interlocking relays, the bus and associated equipment on that bus shall be declared inoperable. Evaluate continued plant operation by referring to SOP-RPC-8 and Technical Specifications."

SOP-RPC-8 clearly lists the components powered by bus 5A and provides an easy method for utilizing technical specifications. SOP-RPC-8 does not specifically address the loss of safeguards automatic initiation signals. That is not its purpose. That guidance is previously provided by ARP-4 which states that the bus and associated equipment shall be declared inoperable.

The guidance provided by the procedures are clear. The failure to shutdown the plant was the result of personnel error. The Assistant Shift Supervisor did not utilize SOP-RPC-8 effectively in order to determine the correct components affected by the loss of bus 5A.

4. NYPA's enforcement conference response handout stated:

"Errors in the NRC Report on page 5, paragraph 3:

However, since the replacement fuse did not have the necessary category I documentation, the safeguards equipment and initiation logic circuitry were still considered inoperable. The technical services department subsequently completed a commercial grade dedication on the fuses and generated the required documentation to declare the replacement fuse as category I.

This [NRC] statement is also incorrect. The commercial dedication process was completed prior to fuse installation and the conditional release was never used. We pursued the conditional release process in parallel with troubleshooting and dedication efforts so that the SI components could be functionally restored. The components could only be declared operable after the dedication and retest were complete." (page 14)

Contrary to the above, the NRC report is correct. This statement, was taken from the significant occurrence report (SOR) which was written by the licensee for the January 23 event. This statement was written by the shift technical advisor (STA) on watch during the event, and signed by the shift supervisor, operations manager and general manager of operations. In addition, the manager directly supervising the commercial grade dedication of the fuse confirmed the accuracy of the NRC inspection report and SOR 92-3-23.

5. NYPA enforcement conference response handout stated:

"During the October event, a temporary modification, which used a lower rated fuse, was installed expeditiously to prevent a plant shutdown. During the January event, a fuse was commercially dedicated and installed. The process of dedicating the fuse did not substantially add to the time necessary to effect repairs and terminate the shutdown. The entire event lasted three hours and eighteen minutes. Troubleshooting, a temporary modification to remove the faulted socket, and a retest to verify operability were not delayed by the dedication process." (page 13)

Contrary to the above, the significant occurrence report followup report dated March 30, 1992, and SOR 92-3-23 state that the event lasted three hours and forty-five minutes. In addition, as confirmed by the materials manager supervising the commercial grade dedication of the fuse, SOR 92-3-23 demonstrates that the event was delayed by the dedication process due to the lack of qualified replacement fuses.