



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

EA 95-176

October 16, 1995

Mr. W. J. Cahill Jr.  
Chief Nuclear Officer  
New York Power Authority  
123 Main Street  
White Plains, New York 10601

SUBJECT: NOTICE OF VIOLATION  
(NRC Inspection Report No. 50-286/95-12)

Dear Mr. Cahill:

This letter refers to the NRC inspection conducted from July 11, 1995, to August 7, 1995, at the Indian Point 3 Nuclear Power Plant, Buchanan, New York. During the inspection, the inspectors reviewed the circumstances associated with a violation identified by your staff involving the failure to perform a safety evaluation, pursuant to 10 CFR 50.59, prior to making a change to the facility as described in the Final Safety Analysis Report (FSAR). The specific change involved the operation of the reactor coolant system (RCS) from July 10 through July 12, 1995, with pressure lower than the minimum amount specified in your Final Safety Analysis Report (FSAR).

The violation was discussed with your staff at the inspection exit meeting on August 7, 1995, and also was described in the NRC letter, dated August 23, 1995, transmitting the inspection report. In that letter, we indicated that it may not be necessary to conduct a predecisional enforcement conference in order to enable the NRC to make an enforcement decision in this case. However, before making an enforcement decision, we provided you an opportunity to either (1) respond to the apparent violation addressed in this inspection report within 30 days of the date of that letter, or (2) request a predecisional enforcement conference. You requested a conference which was held with you and members of your staff on October 5, 1995 to discuss the apparent violation, its causes, and your corrective actions.

The violation occurred when you operated at reduced reactor coolant system (RCS) pressure (below 2205 psig) from July 10 to July 12, 1995, in attempting to seat a leaking safety valve. After discussions with operations management, operators invoked portions of alarm response procedure (ARP)-3 to allow them to reduce RCS pressure in an attempt to reseat the leaking safety valve. That procedure, which had been revised on June 20, 1995 to provide specific guidance for such pressure reduction based on a vendor recommendation, allowed the operators to reduce pressure to as low as 1900 psig to stop the leakage. That procedure was inadequate because it permitted the operation of the reactor at a pressure below 2205 psig which was not in accordance with your FSAR; therefore, it placed the reactor in a condition outside the accident analysis and design basis. Prior to reducing the RCS pressure, neither management nor staff ensured that a safety evaluation was performed, as required by 10 CFR 50.59, to provide a basis that the change from the FSAR did not involve an unreviewed safety question. In addition, operators maintained the reduced pressure for more than eight hours, which was contrary to the procedure, without evaluating the impacts of doing so.

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The NRC recognizes that a safety evaluation was performed after the violation was identified, which concluded that the safety consequences for the operating condition during the period from July 10-12, 1995, were minimal. Nonetheless, the NRC is concerned with the poor performance by your managers and staff prior to, during, and in immediate response to the event, which occurred less than a month after your startup from the extended shutdown. For example, the revision to ARP-3 did not appropriately consider that its implementation would be contrary to the FSAR. Also, although minimum RCS pressure currently is not provided in your technical specifications, senior management should have recognized, before reducing pressure, that an evaluation should have been conducted to ensure that the change did not involve an unreviewed safety question. In addition, management, the operations staff, and engineering staff should have demonstrated a technically inquisitive attitude and aggressively questioned the appropriateness of this evolution before implementing it. It was not until corporate engineering and the vendor, Westinghouse, were contacted on July 12, 1995, two days after the evolution began, that you learned that operation at reduced RCS pressure, both long-term and short-term, was outside the accident analysis for the plant as stated in the FSAR. Furthermore, after the problem was discovered, the Deficiency Evaluation Report (DER) classified the event at a lower level than it should have been. Therefore, while the actual safety significance of the violation was low, given the regulatory significance of the failures by management and staff, this violation has been categorized at Severity Level III in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy), NUREG-1600, (60 FR 34381; June 30, 1995).

In accordance with the Enforcement Policy, a base civil penalty in the amount of \$50,000 is considered for a Severity Level III violation. Because your facility has been the subject of escalated enforcement actions within the last two years, (a Severity Level III Notice of Violation was issued to you on April 26, 1994 - EAs 93-280 and 93-305), the NRC considered whether credit was warranted for identification and corrective action in accordance with the civil penalty assessment process in Section VI.B.2 of the Enforcement Policy. Credit was warranted because your staff identified the violation and conducted a detailed root cause analysis, and subsequently, you have taken significant corrective actions, as noted in the inspection report and your presentation at the enforcement conference. The corrective actions included (1) counselling of senior managers by the Chief Nuclear Officer regarding conservative plant operation; (2) communicating the initial lessons learned at a department managers' meeting; (3) timely issuance of a standing order regarding operating within normal ranges and seeking formal review if operating outside of normal ranges; (4) training of operations staff regarding lessons learned from this event, as well as enhanced training for licensed operators, site reactor engineers, and managers on certain transient and accident analysis; (5) definition of operating ranges for selected key plant parameters and incorporation into the applicable plant operating procedures; (6) planned review prior to restart from the current forced outage of alarm response procedures, plant operating procedures, and off-normal operating procedures by engineering to assure they do not permit unanalyzed operating conditions; (7) increased oversight of plant operations by the Independent Safety Engineering Group; and (8) reevaluation of the procedure review and approval process to include a more

to assure they do not permit unanalyzed operating conditions; (7) increased oversight of plant operations by the Independent Safety Engineering Group; and (8) reevaluation of the procedure review and approval process to include a more enhanced safety screening practice.

Therefore, to encourage prompt identification and comprehensive correction of violations, I have been authorized, after consultation with the Director, Office of Enforcement, not to propose a civil penalty in this case. However, significant violations in the future could result in a civil penalty.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. After reviewing your response to this Notice, including your proposed corrective actions and the results of future inspections, the NRC will determine whether further NRC enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response will be placed in the NRC Public Document Room (PDR). To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be placed in the PDR without redaction.

The responses directed by this letter and the enclosed Notice are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. No. 96.511.

Sincerely,



Thomas T. Martin  
Regional Administrator

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

Enclosure: Notice of Violation

cc w/encl:

- R. Schoenberger, President and Chief Operating Officer
- L. Hill, Jr., Site Executive Officer
- W. Josiger, Vice President - Engineering and Project Management
- J. Kelly, Vice President - Regulatory Affairs and Special Projects
- T. Dougherty, Vice President - Nuclear Engineering
- R. Deasy, Vice President Appraisal and Compliance Services
- R. Patch, Director - Quality Assurance
- G. Wilverding, Director - Independent Oversight
- G. Goldstein, Assistant General Counsel
- C. Faison, Director, Nuclear Licensing
- A. Donahue, Mayor, Village of Buchanan
- C. Jackson, Nuclear Safety and Licensing Manager (Con Ed)
- C. Donaldson, Esquire, Assistant Attorney General, New York Department of Law  
Chairman, Standing Committee on Energy, NYS Assembly  
Chairman, Standing Committee on Environmental Conservation, NYS Assembly  
Chairman, Committee on Corporations, Authorities, and Commissions, NYS Assembly
- E. Nullet, Executive Chair, Four County Nuclear Safety Committee
- R. Pollard, Union of Concerned Scientists
- The Honorable Sandra Galef, NYS Assembly  
Director, Energy & Water Division, Department of Public Service, State of  
New York
- A. Song, Assistant Secretary to the Governor
- F. Valentino, President, New York State Energy Research and Development Authority

New York Power Authority

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