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Robert J. Barrett
Plant Manager

May 9, 1996
IPN-96-057

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 50-286/96-02

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 50-286/96-02, dated April 2, 1996.

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,

A handwritten signature in cursive script that reads 'Robert J. Barrett'.

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

Attachments

cc: See next page

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Indian Point 3 Nuclear Power Plant

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VIOLATION

During an NRC inspection conducted on January 25, 1996 through March 1, 1996, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," (60 FR 34381; June 30, 1995), the violations are listed below:

A. Violation (96-02-01)

10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings, requires in part that activities affecting quality shall be prescribed by documented procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these procedures.

Contrary to the above, between January 14, 1996, and February 28, 1996, activities affecting quality were not accomplished in accordance with procedures in that:

- 1) On January 14, 1996, operators during one shift failed to take hourly Zurn strainer differential pressure readings while Zurn strainer blowdown was out of service, as required by Temporary Operating Procedure (TOP)-116, "Operation of Service Water During 123 Header Zurn Strainer Piping Repair."
- 2) On January 31, 1996, eight term procedure changes for plant operating procedure (POP)-1.1, "Plant Heatup from Cold Shutdown" were not distributed in accordance with Administrative Procedure (AP)-3, "IP3 Procedure Preparation, Review, and Approval."
- 3) On February 5, 1996, NYPA identified that Operations Directive (OD)-14, "Equipment Layup," was only partially implemented and required management reviews were not performed.
- 4) On February 6, 1996, the NRC identified 15 plant-identified deficiencies (PIDs) classified as control room non-deficiencies (CCR.ND) that were hung on control room panels, contrary to requirements in station Directive OPS-SD-01, "Work Control."
- 5) On February 7, 1996, NYPA identified that operators had failed to complete Operations Directive (OD)-37, "Cold Weather Preparation," after initiating the procedure in September 1995.
- 6) On February 7, 1996, NYPA identified that numerous periodic self assessment tasks specified in Operations Directive (OD)-3, "Operations Periodic Task Directive," were not completed. These included assessments of operator overtime, Appendix R equipment inventories and cold weather preparations.

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- 7) On February 28, 1996, Nuclear Plant Operators were not routinely touring the boron injection tank room, the waste holdup pit and the vapor containment as required by Operations Directive (OD)-36, "Operator Rounds and Log Sheets."

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

B. Violation (96-02-02)

10 CFR 50, Appendix B, Criterion XVI, Corrective Actions, requires in part that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected.

Contrary to the above, effective corrective actions were not taken to resolve continuing problems with the administration and control of operator overtime. Review of time and attendance records for the operations department between January 20, 1996 and February 10, 1996 revealed that some operators exceeded the overtime limits of Indian Point 3 Technical Specification 6.2.2.g without prior approval. This condition was similar to problems identified in the NRC's Restart Assessment Team Inspection (NRC Inspection Report 50-286/95-80). NYPA's Quality Assurance department also identified similar problems in August 1995 (NYPA QA surveillance report 5-85).

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

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A. Response To Violation 96-02-01

The Authority agrees with this violation. The Authority has reviewed the seven examples cited in the violation both individually and collectively. In addition, the Authority has investigated four other recent examples of procedural noncompliance. Although the immediate consequences of the two groups of procedural noncompliance issues are different, the causal factors remain consistent. These causal factors reinforce the need to sustain individual accountability as the cornerstone of procedure adherence. Our efforts have focused on addressing the impediments to procedure compliance in a comprehensive and integrated manner and therefore forms the basis for considering additional experience beyond the seven examples cited in the notice of violation.

Collectively, these eleven examples highlight continuing weaknesses in management oversight and involvement; weaknesses in the individual performance of operators, staff, and managers; and weaknesses in both procedure and process quality. Previous corrective actions in the area of management oversight and involvement have been enhanced by the following actions. To improve operations management oversight, a number of organizational changes have been initiated. A notable change is the acquisition of an INPO staff member loaned to IP3 as Manager, Operations Support. Long term plans are in place to increase the number of senior licensed individuals at the station. This action will provide a sufficient number of trained individuals to oversee and supervise operational activities more effectively. Coupled with the corrective actions discussed below in the response, these actions will enable improved management oversight and involvement with all administrative processes. Continued improvements in the area of management oversight and involvement is expected as self identified problems are evaluated through the site corrective action program and continued performance self assessment.

Several of the cited examples illustrate weaknesses in the individual performance of operators, staff, supervisors and managers. Similarly, the four recent additional examples illustrated an individual crew weakness and a continuing weakness by a specific control room operator. Personnel at all levels in the organization, managers, staff, and workers, are expected to follow the procedures they use. If they are unable to follow a procedure, they are expected to stop and correct the problem before proceeding. IP3 personnel are held accountable for these expectations as illustrated by the removal of an individual and an operating crew from shift duties after an adverse trend in procedure adherence was recognized.

Each of the cited examples is addressed individually. Response to the seven cited examples is provided in sequential order. In addition, the causes of the four additional examples and related corrective actions are provided to encompass our integrated assessment of procedural compliance.

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Response to Violation 96-02-01, Example number 1

New York Power Authority agrees that Nuclear Plant Operators failed to take certain hourly special log readings of service water Zurn strainer differential pressure.

Reason for Example

On January 15, 1996, Nuclear Plant Operators failed to take three hourly special log readings of service water Zurn strainer differential pressure. These readings were required by a temporary operating procedure used during the period that maintenance was performed on associated service water piping. The cause of the missed log readings was a failure of the Control Room Supervisor to assign the task to a specific Nuclear Plant Operator.

On January 19, 1996, Nuclear Plant Operators on a different crew failed to take one hourly special log reading of the service water Zurn strainer differential pressure. The cause of this occurrence was failure of the Field Support Supervisor to notify the Nuclear Plant Operator that a piece of equipment was secured thereby necessitating the commencement of special log readings. The Field Support Supervisor failed to ensure that this communication was accomplished.

In both instances, supervisors failed to anticipate and establish appropriate measures to verify the required readings were taken. Communication between the supervisors and the operators was deficient in both cases.

Corrective Actions Taken

- 1) After the first occurrence, a post incident critique was conducted by the Shift Manager with the involved crew. Results of the critique were discussed at subsequent shift turnover meetings with the other crews. A similar critique was held after the second occurrence.
- 2) A Deviation Event Report was initiated for each event, an investigation conducted, and lessons learned were disseminated in required reading for the operations department.
- 3) Personnel involved in the incidents were counseled during the critiques.

Corrective Actions to be Taken To Avoid Further Violations

All actions are complete.

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Date When Full Compliance Will Be Achieved

Compliance was achieved by January 19, in that Special log readings were taken immediately following the discovery of the problems on January 15 and January 19, 1996.

Response to Violation 96-02-01. Example number 2

New York Power Authority agrees that the term procedure changes were not delivered to Document Control within the required 14 day period.

Reason for Example

Eight term procedure changes associated with POP 1.1, Plant Heatup from Cold Shutdown, were not delivered to Document Control within the 14 day period required by AP-3, "IP-3 Procedure Preparation, Review and Approval." The cause of this human performance error was a cognitive decision by the Operations Technical Advisor and a lack of consideration for other potentially negative effects of holding back distribution by operations management. POP 1.1 is the procedure used by the station to integrate all station activities needed for plant heat-up and was in use at the time by the control room staff.

Once a TPC is approved for incorporation into the plant operating procedures it is entered into the control room and field support supervisor's controlled copies by the writer for use by the operating crews. TPCs are then delivered with the supporting review and approval documentation to Document Control. Document Control is responsible for the distribution of the procedure to other controlled copy holders. The process for distribution in effect at that time required the replacement of the control room copy of the procedure, even though the old and new procedures were exactly the same. For a procedure in use, this replacement then required transposing all data from the in-use copy to the new copy. The transposition of the data was an onerous and error prone task for POP 1.1 since it was 170 pages long. The operations department technical assistant recognized the potential for a control room transposition error in this situation because a similar problem had been induced recently when replacing a procedure in active use. The technical assistant recommended to operations management that the changes be held for a period of time to allow for the completion of plant heatup. When operations management concurred with the proposal, the term procedure changes were held instead of being directed to Document Control.

Plant heat-up was subsequently delayed and the term procedure changes were not delivered to Document Control within the required 14 day period. The cause of this human performance error was a cognitive decision by the Operations Technical Advisor and a lack of consideration for other potentially negative effects of holding back distribution by operations management. Contributing to the problem is a term procedure process that failed to meet user needs in the case of evolutions carried out over a long period of time.

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Corrective Actions Taken

- 1) The Technical Advisor was counseled on the decision to delay TPC distribution and the operations clerical staff was coached on the importance of prompt distribution of term procedure changes on February 1, 1996.
- 2) The term procedure changes applicable to POP 1.1 were distributed to all controlled copy holders on February 5, 1996.
- 3) Operations and configuration management initiated a TPC distribution monitoring process and AP-3 was revised on March 29, 1996 to facilitate the distribution process. Utilization of a working copy of POP 1.1 was initiated in the Control Room to eliminate vulnerability to a transposition error.

Corrective Actions to be Taken To Avoid Further Violations

Monitoring of the distribution of TPCs will continue until the effectiveness of the corrective actions to facilitate TPC incorporation and procedure distribution have been validated. This activity will be scheduled until December 31, 1996.

Date When Full Compliance Will Be Achieved

Compliance was achieved on February 5, 1996 in that the Term Procedure Changes to POP 1.1 were distributed to all control copy holders. The other corrective action described in this reply is expected to prevent recurrence of this type of condition.

Response to Violation 96-02-01, Example number 3

New York Power Authority agrees that many of the recommended layup practices included in OD-14, Equipment Layup, were partially implemented.

Reason for Example

The cause of this problem was lack of management knowledge and attention to the recommendations and requirements of the procedure. Contributing to this was the fact that the Operations Manager was new in his position and unaware of the requirements of the procedure. Instead, his focus was on improving the quality of control room operations. Other members of the operations management staff were similarly focused.

In September 1995, shortly after the plant entered the forced outage, the Assistant Operations Manager and the General Chemistry Supervisor met and discussed layup requirements. At that time the outage was scheduled for less than six weeks and therefore layup was not recommended. A heatup was commenced on October 15, 1995, followed by a cooldown to cold

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shutdown on October 21, 1995. On November 6, 1995, a meeting of chemistry, operations, system engineering, and outage management occurred to discuss the need for layup activities during the new cold shutdown period. A list of activities was agreed upon and subsequently acted upon. A plant heatup was then started on December 2, 1995 but the unit again returned to cold shutdown on December 26, 1995. In January 1996, Shift Managers raised the issue of deciding on layup requirements with management. Again a meeting of managers was held on January 25, 1996 and a list of actions agreed upon. Not all actions agreed upon were subsequently completed. The cause of this was lack of management followup to assure timely accomplishment and failure to place these activities in the outage scope.

Contributing to this problem was the nature of the outage. New issues, both equipment and human performance related, emerged throughout the outage creating an outage that was difficult to plan effectively. The startup was often just a week away by schedule, but slipped day for day as new problems were discovered. Since equipment layup decisions depend on the length of time systems will remain inactive, managers were reluctant to layup systems that appeared by schedule to be needed again in a short period of time.

The procedure inadequacies of OD-14, Equipment Layup were identified twice prior to January 1996 in DER 95-2347 and 2847. The corrective actions for these DERs were incomplete or ineffective.

Corrective Actions Taken

- 1) The need for layup activities was identified to management in January 1996 by Shift Managers. Representatives from Operations and Chemistry Departments met and decided on layup activities using the recommendations of OD-14, Equipment Layup, based upon the expected outage duration at that point. However, not all of the recommended actions were completed prior to restoring the systems to service
- 2) A Deviation Event Report was initiated on February 6, 1996 and a review of the problem completed on February 26, 1996.

Corrective Actions to be Taken To Avoid Further Violations

OD-14, Equipment Layup, is being revised to simplify the administrative requirements and require the integration of layup activities into the outage schedule. OD-14 will be made a station directive to reflect the wider involvement of station personnel needed to accomplish the recommendations. This revision is scheduled to be completed by September 4, 1996.

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Date When Full Compliance Will Be Achieved

Some layup activities and periodic administrative reviews were not completed prior to startup and are no longer applicable. The other corrective action described in this reply is expected to prevent recurrence of this type of condition.

Response to Violation 96-02-01, Example number 4

New York Power Authority agrees that problem identification tags for control room problems classified as "non-deficiencies" were hung in the control room contrary to the requirements of OPS-SD-01, Work Control.

Reason for Example

Approximately 18 problem identification description tags were hanging in the control room for problems classified as "non-deficiency". This classification denoted problems that exist within the control room that do not adversely affect the operators ability to monitor and control the plant. Station Directive OPS-SD-01, "Work Control", section 6.4.3 states that problem identification tags for this type of deficiency shall not be hung on control room panels. The operators were unaware of this requirement in the procedure and reasoned that these deficiencies needed formal identification to aid in locating the problems and to prevent duplicating the identification of the problems in the work control system. Because of this, the problem identification tags were hung. It should be noted that problem identification tags for those problems classified as control room deficiencies are allowed to be posted.

Corrective Actions Taken

- 1) The problem identification tags posted on "non-deficiency" items in the control room were removed on approximately February 8, 1996, shortly after the problem was discovered.
- 2) A draft procedure change to OPS-SD-01, "Work Control" in the works at that time was modified to delete the requirement not to post problem identification tags for non-deficiencies. The procedure was approved on April 18, 1996 and became effective May 1, 1996.
- 3) The revised procedure allowing the posting of problem identification tags for control room "non-deficiencies" became effective May 1, 1996. Tags have been rehung identifying "non-deficiency" conditions.

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Corrective Actions to be Taken To Avoid Further Violations

The operations self-assessment program will incorporate surveillances to assure compliance with administrative requirements. The operations self-assessment audit plan will be implemented by August 23, 1996.

Date When Full Compliance Will Be Achieved

Compliance was achieved approximately February 8, 1996 when tags were removed. The other corrective action described in this reply is expected to prevent recurrence of this type of condition.

Response to Violation 96-02-01, Example number 5

New York Power Authority agrees that operators failed to complete OD-37, Cold Weather Preparation in a timely fashion.

Reason for Example

Operations Directive, OD-37, "Cold Weather Preparations", was initiated in September 1995 but not completed until February 1996. The cause for this extended period was a lack of management attention to providing direction and resolving issues that prevented successful completion of the procedure. During this period, management attention was focused on the completion of high priority outage tasks and the resolution of numerous operator performance issues. Additionally, the procedure for completing cold weather preparations failed to provide adequate instructions needed to complete the tasks without extensive management oversight including the planning and scheduling of work efforts by several different groups. Equipment relied upon to provide cold weather protection, such as the house service boiler, also required substantial repair. Due to conflicting priorities, the procedure for cold weather protection did not obtain an appropriate station commitment until November 1995 with the assignment of a nuclear plant operator and an outage coordinator. Cold weather equipment deficiencies were prioritized and the high priority items received appropriate attention. However, progress faltered at this point and lower priority items were not completed until senior managers became involved in January 1996. Although the procedure states that the Operations Manager and the shift managers are responsible for implementing and completing the procedure, no individual with implementing authority and resources was assigned to accomplish the task until senior management became aware of the problem in January 1996.

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Corrective Actions Taken

- 1) Management focused additional attention on the status of the cold weather preparations beginning in January 1996.
- 2) The Operations Manager directed the Nuclear Plant Operator assigned to complete the cold weather preparation procedure to provide daily status reports.
- 3) Maintenance priorities were raised for deficient cold weather equipment to accelerate their repair.
- 4) The status of cold weather preparations was discussed during the various work planning meetings held throughout the day.

Corrective Actions to be Taken To Avoid Further Violations

The procedure for cold weather preparations is being revised to improve implementing directions. The revisions include clearer instruction for performing the required tasks, clear assignment of departmental responsibilities for those items requiring resources outside of the operations department, and specific accountability for the procedures accomplishment. Additionally, the procedure will be scheduled for implementation in late summer to allow adequate time for correction of any deficient conditions before cold weather sets in. These revisions will be completed by July 1, 1996.

Date When Full Compliance Will Be Achieved

Compliance was achieved when the cold weather preparations were completed on February 27, 1996. The procedural improvements will be completed by July 1, 1996.

Response to Violation 96-02-01, Example number 6

New York Power Authority agrees that numerous periodic self-assessment tasks specified in OD-3, Operations Periodic Task Directive were not completed.

Reason for Example

The principle cause for this performance issue has been a lack of management involvement and inadequate oversight to ensure task completion. An inappropriate assignment of responsibility for program management within the operations department was a principle contributor to the violation as stated.

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Corrective Actions Taken

- 1) During February 1996, an initial review of the Operations Periodic Task program was completed and tasks needing completion prior to startup were identified and dispositioned accordingly.
- 2) Programmatically, tasks that would be better performed by the Performance and Reliability Department were transferred from the Operations Periodic Task program.
- 3) The station's management observation program was revitalized and, as a result, those redundant periodic tasks directing observations were eliminated.

Corrective Actions to be Taken To Avoid Further Violations

- 1) The Operations Periodic Task program will be revised to assign specific operations management responsibility for program implementation and oversight, define personal accountability for specific tasks, and provide for increased formality in tracking task completion utilizing the site's Action Commitment Tracking System (ACTS). This will be completed by June 30, 1996.
- 2) An implementation plan will be developed to complete overdue tasks by July 31, 1996.

Date When Full Compliance Will Be Achieved

Monthly Operations Periodic Task for May will be completed by May 31, 1996, all the second quarter OPTs will be completed as scheduled and overdue annual OPTs will be completed by July 31, 1996.

Response to Violation 96-02-01, Example number 7

New York Power Authority agrees with the violation.

Reason for Example

Nuclear plant operators frequently did not tour the boron injection tank room nor the waste holdup tank pit. In addition, nuclear plant operators occasionally did not tour the vapor containment during cold shutdown conditions although tours of these areas are required by Operations Directive, OD -36, "Operator Rounds and Log Sheets". The cause of this problem is conflicting and unclear direction to the nuclear plant operators by operations management concerning the requirements for performing tours. These contradictions occurred between shift orders, logs sheets, and Operations Directive, OD-36. Contributing to this problem are challenging expectations for the nuclear plant operators with regard to the practical accomplishment of rounds, log keeping, and demands of supporting shutdown plant evolutions.

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For some situations the nuclear plant operators have had a difficult time completing these tasks along with such operational activities as protective tagging or the manipulation of plant systems and equipment. An assessment of this performance issue was completed during November and December 1995 by an off-shift reactor operator at the request of the Operations Manager. However, the recommendations of the assessment have not all been acted upon due to management's focus on control room performance issues.

Corrective Actions Taken

- 1) A shift order was published on February 29, 1996 affirming management's expectation to conduct rounds in accordance with OD-36, "Operator Rounds and Logsheets." All operator logsheets were changed to clearly indicate that the rounds were not optional.
- 2) An action plan IOPS-APL-96-03 was developed to lay out the strategy for improving the quality and consistency of nuclear plant operator rounds. This plan was approved on March 8, 1996. Investigations carried out by the plan noted that most observable equipment problems were identified by nuclear plant operators and documented in the work control program.
- 3) Action was taken to resolve the specific problems identified in the boron injection and waste holdup rooms including resolution of both grating and lighting issues. In addition, a general station cleanup was accomplished prior to startup to upgrade the overall housekeeping condition of the plant.
- 4) Revision 10 to OD-36, "Operator Rounds And Logsheets", was approved on March 8, 1996 which clarified procedural requirements and reduced the requirements for rounds, where justified.

Corrective Actions to be Taken To Avoid Further Violations

Further revisions concerning the conduct of operator rounds are being considered to optimize operator resources. OD-36 will be revised by June 1, 1996.

Date When Full Compliance Will Be Achieved

Management expectations for operator rounds was reaffirmed in shift orders on February 29, 1996. The other corrective actions described in this reply are expected to prevent recurrence of this type of condition.

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Recent Examples Of Procedure Adherence Weakness

The following four additional examples of procedure non-adherence occurred after inspection 96-02 and are included as part of the station's efforts to provide an integrated assessment of contributive causes and corrective actions in dealing with this important performance issue. These items were discussed by the Resident Inspectors during a weekly debrief with the station management staff on April 15, 1996.

Example number 1

Description and Reason

On March 29, 1996 while conducting procedure POP-1.2, "Reactor Startup", a procedure step to warm and pressurize the main steam lines was completed and signed off by the Control Room Supervisor prior to completing the preceding step which called for establishing condenser vacuum. The cause of this procedural non-adherence was inattention to detail by the Control Room Supervisor who failed to recognize that the procedure could not be carried out in the order written. An additional contributing factor to the problem was an inaccurate procedural direction in POP 1.2 which was not possible to accomplish in the specified sequence when establishing condenser vacuum with main steam. Performance standards, which require procedural steps to be completed sequentially and appropriate attention to detail exhibited, required a procedure change to be completed to correct the problem prior to accomplishing the steps. The procedural error and the procedure correction were resolved during the next shift when the problem was identified during shift turnover.

Corrective Actions

- 1) The procedural direction was corrected to recognize the appropriate sequence for warming the main steam lines using main steam for establishing condenser vacuum instead of auxiliary steam.
- 2) With continuing emphasis on personal accountability, the Control Room Supervisor was counseled as discussed in example 3 below.
- 3) The Operations Manager has also discussed this and other related procedural compliance issues in his weekly training observations and crew interface discussions.

Example number 2

Description and Reason

On March 31, 1996, in responding to a low pressure in 34 Safety Injection Accumulator, the nitrogen fill valve was left open at the end of the pressurization evolution. The out of position

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valve was not identified during the remainder of the shift nor by the off-going or on-coming crew members during shift turnover board walkdowns. The mispositioned switch was subsequently identified by a member of the Tactical Assessment Group and returned to its proper closed position. The principal cause of this problem was a lack of attention to detail and weak self checking practices by the involved reactor operator. Subsequent investigation revealed that the nitrogen fill procedure for the evolution was not in hand when completing the accumulator pressurization, even though this was an expected behavior by operations management. Additionally, the mispositioned switch remained undetected through the balance of the shift and continued to be undetected during shift turnover due to inadequate board walkdown practices by several members of the off-going and on-coming shifts.

Corrective Actions

- 1) The involved control room operator was removed from license responsibility and continues to be exempted from shift assignments.
- 2) The initiating crew was temporarily removed from shift duties for counseling as discussed in example 3 below.
- 3) All operators involved in the shift turnover walkdowns were counseled by the Operations Manager regarding their actions not meeting performance expectations.
- 4) Personal accountability has been and continues to be emphasized as the requisite deterrent to procedural non-compliance and human error.
- 5) An effort is currently underway to adopt industry best-practices relative to the accomplishment of board walkdowns in support of shift turnover. Actions to preclude recurrence will be initiated with the completion of an independent board walkdown to be completed during the shift. Responsibility for the performance of this independent walkdown will be assigned by the Shift Manager at the beginning of each shift. This action will be initiated by June 7, 1996
- 6) A review of industry best-practices for the accomplishment of board walkdowns will be conducted. This review will be completed by June 30, 1996.
- 7) Licensed Operator training has implemented the use of "faulted" turnover training as part of the current continuing retraining cycle. This recurring training commenced about April 15, 1996 and serves to reinforce attention to detail in the accomplishment of board walkdowns in support of the routine shift turnover process.

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Example number 3

Description and Reason

On April 2, 1996 during midshift, the B8 control rod was logged by a control room operator at 217 steps with a bank demand of 230 steps. The maximum allowable deviation of the rod position indication from the demand is 12 steps. The control room operator failed to recognize this condition and therefore also failed to take the required corrective action. The principle cause of this problem was a lack of attention to detail by the midshift control room operator. The problem was identified by the control room operator on the on-coming shift. Contributing to this problem was a lack of log review by the midshift Control Room Supervisor and Shift Manager who were focused on other plant activities. The shift involved in this procedural adherence error was the same shift involved in the problems described in examples 1 and 2 above. The control room operator involved in this error was also involved in the valve mispositioning in example 2 above and one other recent human performance error.

Corrective Actions

- 1) Initial actions were completed to resolve the indicated rod misalignment in accordance with SOP-RC-01, "Full Length Rod Control and RPI System Operation".
- 2) In response to the adverse trend of human performance errors exhibited by this shift crew, the crew was temporarily removed from license responsibilities for counseling and an assessment of the recurring performance problems was conducted.
- 3) Personal accountability was and continues to be emphasized as the principal deterrent to human performance errors and therefore operations management determined that the involved control room operator required a formal, long term counseling program. The control room operator was removed from the crew and assigned to staff duties during this counseling program. The involved shift was counseled concerning specific performance requirements using the procedural adherence and attention to detail concerns associated with rod misalignment and log readings as the basis for this training. Following this "standdown" counseling period, the crew was returned to shift responsibilities on April 16, 1996.

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Example number 4

Description and Reason

During the period of reactor startup, an instance occurred in which rod position indication errors existed that were believed to be induced by changing reactor temperatures. Operators used system operating procedure SOP-RHR-1 to respond to this situation in which step 4.9.2.5 directs operators to establish alternate monitoring of affected rod position indicators. The step has four bullets for accomplishing the alternate monitoring. The resident inspector noted that the last bullet in the step was not initiated while the operators were experiencing temperature induced position anomalies. This step states that an attachment to the procedure should be used to determine if an individual RPI deviates greater than twelve steps from the average position of the remainder of rod positions in the bank. The operators determined in an earlier step that the rods were within the required deviation band from bank demand, that technical specification requirements were met, and therefore felt that completing the last bullet in the step was unnecessary. Operations management reviewed these actions and concurred with the decision of the operators to go no further in the procedure (DER 96-1066).

Corrective Actions

- 1) Since the last bullet in step 4.9.2.5 of SOP-RHR-1 was imprecise and subject to interpretation, the procedure was revised to provide more specific direction.
- 2) As with other similar procedural adherence issues, continuing emphasis has been placed through counseling and operations management interface with the operating crews to reinforce management expectations that procedural uncertainties will be formally resolved prior to proceeding with any plant activity or evolution.

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B. Response to Violation 96-02-02

The New York Power Authority agrees with this violation with respect to not having taken effective corrective actions to resolve continuing problems with the administration and control of operator overtime.

Reason for Violation

NYPA has reviewed the circumstances surrounding this violation and concluded that the cause of the ineffective corrective action was insufficient focus on individual awareness and accountability.

NYPA has reviewed the circumstances surrounding this violation and concludes that the process for the administration and control of overtime requires improvement. However, our initial review of the 13 cases identified by the NRC inspection to be potential violations of the Indian Point 3 Technical Specification 6.2.2.g, could not establish that they were in violation of the Technical Specification or the plant procedure guidelines for overtime. We are continuing to evaluate these instances. However, regardless of the outcome, the extensive work effort involved in retrieving the data for the evaluation indicated that the process for documenting time worked requires improvement.

Subsequent to the NRC inspection there have been five violations of the overtime restrictions that can be attributed to inadequate control of overtime. The events were self identified, and that is indicative of a heightened awareness of the guidelines, albeit this was after the fact. The five events included seven people from four departments. The events involved personnel who unknowingly exceeded the overtime restrictions caused by a lack of emphasis on the individual's responsibility for tracking their overtime. In addition, a violation was averted when an operator began to work a scheduled shift and questioned the status of a Request for Overtime that had been previously submitted for approval in anticipation of him exceeding the overtime restrictions during the shift. It was determined that the Request for Overtime had not been approved, and arrangements were made to relieve the operator before the overtime restrictions were exceeded. In view of these conditions the prior corrective actions should have focused on the individual's accountability for working within the overtime guidelines.

It is concluded that the corrective actions taken to prevent violations of the overtime restrictions after the NRC Restart Assessment Team Inspection (NRC Inspection Report 50-286/95-80) were not effective. The cause of those violations was determined to be personnel were not applying a sufficient degree of attention to their work practices or they were not familiar with job performance standards. The corrective action included discussions with the errant individuals, and the entire station staff was reminded of the overtime restrictions and procedures in a segment of the site program for weekly departmental meetings.

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Corrective Actions Taken

The plant procedure that provides guidance on overtime restrictions was revised (AP-36 Revision 10) to provide for the Request for Overtime form to be controlled and maintained in accordance with the Indian Point 3 Records Retention Schedule.

Corrective Actions to be Taken to Avoid Further Violations

- 1) Provide for each site person's heightened awareness of the overtime restrictions, and focus on the individual's accountability for working within the overtime guidelines. This will be completed by June 1, 1996.
- 2) Provide a means for recording shift turnover time in order to distinguish it from other periods of time worked. This will be completed by July 1, 1996.

Date When Full Compliance Will be Achieved

We have been in compliance as of April 27, 1996. The corrective actions described in this reply are expected to prevent recurrence of this type of condition.

LIST OF COMMITMENTS

Number	Commitment	Due
IPN-96-057-01	Monitoring of the distribution of TPCs will continue until the effectiveness of the corrective actions to facilitate TPC incorporation and procedure distribution have been validated.	December 31, 1996
IPN-96-057-02	OD-14, Equipment Layup, is being revised to simplify the administrative requirements and require the integration of layup activities into the outage schedule. OD-14 will be made a station directive to reflect the wider involvement of station personnel needed to accomplish the recommendations.	September 4, 1996.
IPN-96-057-03	The operations self-assessment program will incorporate surveillances to assure compliance with administrative requirements.	August 23, 1996.
IPN-96-057-04	The procedure for cold weather preparations is being revised to improve implementing directions. The revisions include clearer instruction for performing the required tasks, clear assignment of departmental responsibilities for those items requiring resources outside of the operations department, and specific accountability for the procedures accomplishment. Additionally, the procedure will be scheduled for implementation in late summer to allow adequate time for correction of any deficient conditions before cold weather sets in.	July 1, 1996.
IPN-96-057-05	The Operations Periodic Task program will be revised to assign specific operations management responsibility for program implementation and oversight, define personal accountability for specific tasks, and provide for increased formality in tracking task completion utilizing the site's Action Commitment Tracking System (ACTS).	June 30, 1996.
IPN-96-057-06	An implementation plan will be developed to complete overdue tasks.	July 31, 1996

Number	Commitment	Due
IPN-96-057-07	Further revisions to OD-36 concerning the conduct of operator rounds are being considered to optimize operator resources.	June 1, 1996
IPN-96-057-08	An effort is currently underway to adopt industry best-practices relative to the accomplishment of board walkdowns in support of shift turnover. Actions to preclude recurrence will be initiated with the completion of an independent board walkdown to be completed during the shift. Responsibility for the performance of this independent walkdown will be assigned by the Shift Manager at the beginning of each shift.	June 7, 1996
IPN-96-057-09	A review of industry best-practices for the accomplishment of board walkdowns will be conducted.	June 30, 1996
IPN-96-057-10	Provide for each site person's heightened awareness of the overtime restrictions, and focus on the individual's accountability for working within the overtime guidelines.	June 1, 1996
IPN-96-057-11	Provide a means for recording shift turnover time in order to distinguish it from other periods of time worked.	July 1, 1996