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Robert J. Barrett
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June 21, 1996
IPN-96-069

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 50-286/96-03

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 50-286/96-03.

The commitments made by the Authority with this letter are contained in Attachment II. Please note that one of the commitments submitted in the reply to Notice of Violation 96-02 on May 9, 1996 has been revised for clarity. 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

cc: See next page

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Indian Point 3 Nuclear Power Plant

Reply to Notice of Violation 50-286/96-03

VIOLATION

During an NRC inspection conducted on March 3, 1996 through April 20, 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:

Indian Point 3 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", November, 1972. Appendix A of Regulatory Guide 1.33 requires administrative procedures for procedural adherence. Administrative procedure (AP)-4, revision 16 states that "the procedure user is responsible for following approved procedures as written." Contrary to the above:

1. On March 29, 1996, the NRC noted that not all of the actions required by SOP-RC-1, revision 12, step 4.9.2.5 were performed by the operators in response to drifting rod position indications (RPI). The operators did not compare the position of the deviating RPI to the average position of the remaining rods in its bank using attachment 1 of SOP-RC-1.
2. On March 29, 1996, the NRC noted that step 4.56a of POP 1.2, revision 31, had not been completed as required prior to performing steps 4.57 and 4.58. Step 4.56a required that the operators ensure that a condenser vacuum was established prior to main steam system warmup and system walkdowns.
3. On April 2, 1996, the position of control rod B8 was logged as greater than 12 steps from group demand position on log sheet OPT-11A, revision 0. However, the required actions of technical specification 3.10 were not taken as directed by OPT-11A, until approximately 8 hours later when identified by the next operating crew.
4. On March 31, 1996, procedure SOP-SI-1, revision 16, was not used by an operator to secure the nitrogen fill lineup for the 34 safety injection accumulator. Valve SI-AOV-891D was not closed as required by the procedure until identified during the next operating shift, 3 hours after the lineup was secured.

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Response To Violation 96-03-01

The Authority agrees with this violation. The Authority has investigated these four examples of procedural noncompliance in concert with seven other examples discussed in Notice of Violation 50-286/96-02 response. These examples reinforce the need to sustain individual accountability as the cornerstone of procedure adherence. Three of the four examples illustrated an individual crew weakness. Two of these demonstrated a 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.

Response to each of the cited examples is provided in sequential order.

Response to Violation 96-03-01, Example number 1

Reason for Violation

The cause of this problem was a poorly written procedure. Contributing to this problem was a lack of attention to detail in resolving the confusing procedure issues. 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 coolant temperature. Operators responded using system operating procedure SOP-RC-1 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 indication 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.

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Corrective Actions Taken

- 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) Continuing emphasis on procedure adherence has been made through counseling and management interface with the operating crews and managers involved with this issue, and to reinforce management expectations that procedural uncertainties must be resolved prior to proceeding with any plant activity or evolution.

Corrective Actions To Be Taken to Avoid Further Violations

The corrective actions taken are expected to prevent recurrence.

Date When Full Compliance Will be Achieved

Full compliance was achieved on April 4, 1996 when SOP-RC-1 was revised.

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Response to Violation 96-03-01, Example number 2

Reason for Violation

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 inaccurate procedural direction in POP 1.2 (it was not possible to perform POP 1.2 in the specified sequence when establishing condenser vacuum using main steam). Operators are required by performance standards to change a procedure prior to accomplishing steps when procedural steps cannot be completed sequentially. The procedural use error and the procedure correction were resolved later that day when the issue was identified during shift turnover.

Corrective Actions Taken

- 1) The procedure was corrected to recognize the appropriate sequence for warming the main steam lines when using main steam for establishing condenser vacuum.
- 2) With continuing emphasis on personal accountability, the Control Room Supervisor was counseled concerning his performance. A crew standdown was conducted during which the involved crew assessed their adverse trend of human performance errors.
- 3) The Operations Manager has discussed this and other related procedural compliance issues during weekly training observations and crew interface discussions.

Corrective Actions To Be Taken to Avoid Further Violations

The corrective actions taken are expected to prevent recurrence.

Date When Full Compliance Will be Achieved

Full compliance was achieved on March 29, 1996 when POP-1.2 was revised .

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Response to Violation 96-03-01, Example number 3

Reason for Violation

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 thereby failed to take the required corrective action. The cause of this failure was a lack of attention to detail by the control room operator. The problem was identified by the control room operator on the on-coming shift. Contributing to this event was a lack of thorough log review by the Control Room Supervisor and Shift Manager. The shift involved in this procedural adherence error was the same shift involved in examples 2 above and 4 below. The control room operator involved in this error was also involved in the valve mispositioning in example 4 below and one other recent human performance error.

Corrective Actions Taken

- 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 in human performance exhibited by this crew, the crew was temporarily removed from shift rotation in order to conduct counseling and assessment of recurring performance problems.
- 3) Personal accountability was and continues to be emphasized as the principal deterrent to human performance errors. Management determined that the control room operator involved required a formal remediation program. The control room operator was assigned to staff duties during this remediation program. The involved shift was counseled and provided remedial training using their procedural adherence and attention to detail performance associated with rod misalignment and log readings as the basis. Following this "standdown" period, the crew was returned to shift rotation on April 16, 1996.

Corrective Actions To Be Taken to Avoid Further Violations

The corrective actions taken are expected to prevent recurrence.

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Date When Full Compliance Will be Achieved

Compliance was achieved on April 2, 1996 when control rod B8 was verified to be within the allowable ± 12 steps tolerance using Off-Normal Operating Procedure RC-1, "Dropped or Misaligned Rods."

Response to Violation 96-03-01, Example number 4

Reason for Violation

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 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 cause of this misposition 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 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 by several members of the off-going and on-coming shifts.

Corrective Actions Taken

- 1) The involved control room operator was removed from Control Room responsibility and enrolled in a remediation program.
- 2) The initiating crew was temporarily removed from shift duties for counseling.
- 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 principle deterrent to procedural non-compliance and human error.
- 5) As an interim measure, the Shift Manager assigns an individual each shift to conduct an independent board walkdown.

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- 6) A review of industry best-practices for the accomplishment of board walkdowns was conducted
- 7) Licensed Operator training has implemented the use of "faulted" turnover training as part of the current continuing retraining cycle. This 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.

Corrective Actions To Be Taken to Avoid Further Violations

The corrective actions taken are expected to prevent recurrence.

Date When Full Compliance Will be Achieved

Compliance was achieved on March 31, 1996 when valve NNE-AOV-891D was returned to the closed position. The other corrective action described in this reply is expected to prevent recurrence.

LIST OF COMMITMENTS

Number	Commitment	Due
IPN-96-069-01 IPN-96-057-08 REVISED SEE ABOVE	As an interim measure, the Shift Manager assigns an individual each shift to conduct an independent board walkdown. 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