



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

May 13, 1997

Mr. Robert J. Barrett
Site Executive Officer
New York Power Authority
Indian Point 3 Nuclear Power Plant
Post Office Box 215
Buchanan, NY 10511

Dear Mr. Barrett:

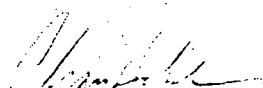
SUBJECT: NRC INSPECTION REPORT NO. 50-286/96-12 AND NOTICE OF VIOLATION

This letter refers to your April 24, 1997 correspondence, in response to our March 18, 1997 letter, which documents your response to three violations in NRC Inspection Report 50-286/96-12.

We acknowledge your denial of the violation of 10 CFR 70.24 involving the installation of criticality monitors in the IP-3 new fuel storage area. Since this enforcement position involves multiple licensees and is currently being reevaluated by the NRC Office of Enforcement on a generic basis, we will inform you in the future regarding our position in this matter. We also noted your comment regarding the entry of Deviation Event Reports (DERs) into your computer tracking system by technicians/operator level personnel and believe that it is consistent with our observations in this matter.

Regarding the other two violations, we appreciate you informing us of the corrective and preventive actions documented in your letter. These actions will be examined during a future inspection of your licensed program.

Sincerely,


Charles W. Hehl, Director
Division of Reactor Projects

Docket No. 50-286

IEO/



Mr. Robert J. Barrett

3

Distribution w/cy of Licensee's Response Letter:

Region I Docket Room (w/concurrences)
Nuclear Safety Information Center (NSIC)
PUBLIC

Inspection Program Branch, NRR (IPAS)

D. Screnci, PAO (1)

NRC Resident Inspector

DOCDESK

W. Dean, OEDO (WMD)

S. Bajwa, NRR

G. Wunder, NRR

J. Harold, NRR

R. Correia, NRR

D. R. Taylor, NRR

L. Cunningham, NRR

D. Barss, NRR

M. Campion, RI

C. Cowgill, DRP

J. Rogge, DRP

R. Barkley, DRP

R. Junod, DRP

cc: Mr. Hubert J. Miller
Regional Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

Mr. Curtis J. Cowgill III, Chief
Projects Branch No. 1
Division of Reactor Projects
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

U.S. Nuclear Regulatory Commission
Resident Inspectors' Office
Indian Point 3 Nuclear Power Plant

Reply to Notice of Violation 50-286/96-12

3. AP-10.1, section 3.4.7, states that the clearance holder shall agree by personal observation that the protection for the work activity is satisfactory prior to commencement of work.

Contrary to the above, on February 4, 1997, the clearance holder did not personally observe that the protection was satisfactory for the 32 charging pump packing replacement.

4. SPO-SD-01, section 4.6.1, states that a problem identification description (PID) review committee consisting of department representatives including engineering, shall meet daily to review PIDs.

Contrary to the above, on February 7, 1997, A PID review committee met to review PIDs without an engineering representative.

This is a Severity Level IV violation."

C. Violation (50-286/96-12-03)

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

Contrary to the above requirements, from October 21, 1996, to January 16, 1997, the field support supervisors documented deficiencies on operations/work control feedback forms, which indicated that the work control center did not adequately develop protective tagouts and operational impact sheets, and that this barrier to ensuring that work was conducted safely was ineffective. However, measures were not established to assure that this ineffective barrier was identified and corrected.

This is a Severity Level IV violation."

Reply to Notice of Violation 50-286/96-12

Conclusion

The Authority believes that it should not be cited for violating NRC requirements for the following reasons:

1. The Special Nuclear Material license issued for Indian Point 3 exempted the licensee from the requirements of 10 CFR Part 70.24;
2. No changes occurred to Indian Point 3 upon conversion of the construction permit to an operating license that would have invalidated the previously granted exemption;
3. The Indian Point 3 operating license (Section 2.B.(2)) permits the receipt, possession and use of special nuclear material in accordance with the facility's SAR;
4. The SAR describes activities and equipment required for fuel handling. The SAR does not require criticality monitors;
5. The Authority's interpretation that the exemptions granted under the Part 70 license were carried forward into the operating license is consistent with that of the NRC, at least as of May 1988, when an NRC Acting Assistant Director for Projects, TVA Projects Division, stated that the staff considers that exemptions from the requirements of 10 CFR 70.24 granted as part of the Part 70 license are still in effect even though the specific provisions of the Part 70 license were not incorporated into the Part 50 license granted to TVA.

The Authority further believes that the cited violation does not meet the threshold of a Severity Level IV violation as defined in the NRC's enforcement policy. As stated in NUREG-1600, General Statement of Policy and Procedures for NRC Enforcement Actions, "Severity Level IV violations are less serious but are of more than a minor concern; i.e., if left uncorrected, they could lead to a more serious concern." There was no serious condition that needed to be corrected to prevent a more serious concern from developing. The NRC recognized this fact when it granted Indian Point 3 an exemption in part from the requirements of 10 CFR 70.24. In its letter dated March 27, 1997, the NRC states "Fuel movements are procedurally controlled and designed to preclude conditions involving criticality concerns."

Reply to Notice of Violation 50-286/96-12**B. Response to Violation 96-12-02**

The Authority agrees with this violation. Work packages were issued without a clearance. A work package was issued without an adequate Operational Impact Statement (OIS). An authorized clearance holder was not the person who walked down a protective tagging order (PTO) for adequacy. A problem identification description (PID) meeting was held without an engineering representative present.

Reason for Violation

The cause of this violation was human performance errors. The cited instances of procedural non-compliance were caused by work practices that resulted in the improper use of procedural guidance, a lack of attention to detail, and supervisory methods. Although these examples challenged various barriers in the work control process the associated work was performed safely.

The cause of work packages being authorized for issuance without a clearance, and a PTO being walked down by someone other than the clearance holder were work practices that resulted in procedure AP-10.1, Protective Tagging, not being followed correctly. The first non-compliance occurred when work packages were authorized for issuance prior to a clearance being issued. This would have allowed the work to be performed prior to meeting the procedure AP-10.1 requirement that a clearance be issued when required. The requirement for preparing a clearance prior to authorization of the work for issuance was verified by the Field Support Supervisor (FSS) following prompting by an NRC inspector. Clearances were subsequently prepared for these work packages prior to being issued. The second non-compliance was with the Procedure AP-10.1 requirement that the "clearance holder" agree by personal observation that the protection was adequate. While a thorough walk down of 32 Charging Pump packing replacement was performed, it was not performed by the clearance holder. Due to inconsistencies in procedure AP-10.1, it was believed by maintenance personnel that performance of the walk down by personnel other than the clearance holder was acceptable.

The cause of an inadequate OIS was a lack of attention to detail. An inadequate review of the scope of work in a work package resulted in the inadequate OIS. As a result, a clearance was prepared that did not include the proper electrical protection. A proper review would have identified the proper electrical protection required for the subject work activity; a megger of the Fan Cooler Unit (FCU) motors. The lack of an adequate OIS and clearance was identified as part of the normal work control process and corrected prior to issuance of the work packages.

The cause of not having an engineering representative present at the PID review committee meeting was supervisory methods. Procedure SPO-SD-01, Work Control Process, requires a PID review committee consisting of representatives from Site Planning and Outage Services, Operations, Central Planning, Maintenance, I&C, and Engineering meet to review PIDS. The chair of the PID review committee, the Work Control Supervisor, did not verify that the required members of the PID review committee were present during the PID review committee meeting.

Reply to Notice of Violation 50-286/96-12

C. Response to Violation 96-12-03

The Authority agrees with this violation. The use of Operations/Work Control feedback forms was ineffective and measures were not established to assure that this ineffective barrier was identified and corrected.

Reason for Violation

The cause of this violation was that the feedback process in the Work Control Center was informal. The use of the operations/work control feedback forms was not controlled through written instruction. Work Control addressed feedback issues using memorandum and/or verbal communications. The forms used for feedback and the process for addressing feedback were not designed to allow easy tracking of the analysis of problems, which in turn made it difficult to identify trends. Additionally, formal training was not provided on the use of feedback forms and the process that governs the use of the feedback forms.

A contributing cause was a lack of an assessment of the effectiveness of the feedback process in the Work Control Center.

Corrective Actions Taken

An Operations Shift Order was issued on February 8, 1997 communicating the expectation for use of feedback forms to Operations personnel.

Memoranda were issued by the Work Control Supervisor on February 12 and 13 of 1997, communicating the expectation for use of feedback forms to Work Control Personnel.

The Work Control Supervisor began processing and maintaining a log of feedback forms on February 12, 1997. Operations currently processes forms relating to operational issues (e.g. PTO, OIS, etc.) Work Control currently processes feedback forms relating to scheduling issues. This is an interim measure until the process is proceduralized.

Corrective Actions to be Taken to Avoid Further Violations

The feedback process, including requirements for deficiency identification, deficiency evaluation, corrective action and trend analysis with regard to protective tagging orders, operations concerns, operational impact sheets and required limiting conditions for operation will be proceduralized. To be completed by July 15, 1997.

A training session will be held, covering the proceduralized operations/work control feedback process. To be completed by July 30, 1997.

A self assessment process will be developed for the Work Control Center. To be completed by June 15, 1997.

Date When Full Compliance Will Be Achieved

Compliance was achieved on February 12, 1997, when the Work Control Supervisor began processing and maintaining a log of feedback forms. Other listed actions should help prevent further recurrence.