DCS

APR 12 1994

Docket No. 50-213

Mr. John F. Opeka
Executive Vice President - Nuclear
Connecticut Yankee Atomic Power Company
P.O. Box 270
Hartford, Connecticut 06141-0270

Dear Mr. Opeka:

SUBJECT: INSPECTION 50-213/93-21

This letter refers to your February 15, 1994 correspondence in response to our December 30, 1993 letter, which identified two violations.

Thank you for informing us of the corrective and preventive actions documented in your letter. Both violations identified instances of improper non-licensed operator actions. In the first violation, a nuclear systems operator (NSO) did not completely open a valve following clearance of danger tag. Your corrective actions which included reinstruction of the operating crews, establishment of a "Lessons Learned" document in the Control Room, and upgrading of crew requalification training appear to be adequate. The second violation consisted of an NSO signing off the completion of a fire watch log in advance of actually performing the fire watch. However, the actual fire watch was performed when required. Your corrective actions which included disciplinary action against the NSO in accordance with company guidelines; a review of previous fire watches performed by this NSO; and, further instructions to all NSO's also appear to be adequate. The effectiveness of these corrective actions will be examined during a future inspection of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

ORIGINAL SIGNED BY:

Lawrence T. Doerflein, Chief
Reactor Projects Section 4A
Division of Reactor Projects

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cc:
S. E. Scace, Vice President, Nuclear, Operation Services
J. P. Stetz, Vice President, Haddam Neck Station
D. B. Miller, Sr. Vice President, Millstone Station
J. Solymossy, Director, Nuclear Quality and Assessment Services
J. J. LaPlatney, Unit Director
R. M. Kacich, Director, Nuclear Planning, Licensing and Budgeting

cc w/cy of Licensee's Response Letter:
Gerald Garfield, Esquire
Nicholas Reynolds, Esquire
K. Abraham, PAO (2)
Public Document Room (PDR)
Local Public Document Room (LPDR)
Nuclear Safety Information Center (NSIC)
NRC Resident Inspector
State of Connecticut SLO

bcc w/encls:
Region I Docket Room (with concurrences)
J. Stolz, NRR/PD I-4
V. McCree, OEDO
A. Wang, PM, NRR
L. Doerflein, DRP

RI:DRP	RI:DRP
Raymond	Doerflein
4/17/94	4/12/94

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NORTHEAST UTILITIES
THE CONNECTICUT LIGHT AND POWER COMPANY
WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

General Offices • Selden Street, Berlin, Connecticut

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203) 665-5000

February 15, 1994

Docket No. 50-213
B14735

Re: Response to Inspection Report
No. 50-213/93-21
10CFR2.201

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Haddam Neck Plant
Inspection Report No. 50-213/93-21
Reply to a Notice of Violations

In a letter dated December 30, 1993,(1) the NRC Staff transmitted to Connecticut Yankee Atomic Power Company (CYAPCO) Inspection Report No. 50-213/93-21. As discussed in that report, the NRC Staff cited CYAPCO for two apparent violations of the Commission's regulations.

As required by 10CFR2.201, Attachment 1 describes CYAPCO's response to the violations, including the reason for the violations, the corrective steps that have been taken and the results achieved, the corrective steps that will be taken to avoid further violations, and the date when full compliance will be achieved. Our reply is being forwarded 30 days from receipt of the Notice of Violations as granted by the Region I Staff during a recent conversation.

If you have any questions regarding the information contained in this letter, please contact us.

Very truly yours,

CONNECTICUT YANKEE ATOMIC POWER COMPANY

J. F. Opeka
Executive Vice President

cc: T. T. Martin, Region I Administrator
A. B. Wang, NRC Project Manager, Haddam Neck Plant
W. J. Raymond, Senior Resident Inspector, Haddam Neck Plant

(1) L. T. Doerflein letter to J. F. Opeka, "NRC Inspection Report No. 50-213/93-21," dated December 30, 1993.

Docket No. 50-213
B14735

Attachment 1

Haddam Neck Plant

Inspection Report No. 50-213/93-21
Reply to Notice of Violations

February 1994

Haddam Neck Plant

Inspection Report No. 50-213/93-21
Reply to Notice of Violations

Restatement of Violation 1 (VIO 93-21-01)

Technical Specification 6.8.1.a, for Haddam Neck requires that written procedures be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33 identifies equipment control as an activity that should be covered by procedures. Haddam Neck Administrative Control Procedure 1.2-14.2 "Equipment Tagging," (Rev. 15) was written pursuant to the above, and requires that tags be removed and components realigned to the position specified on the tagging clearance sheet. Tagging clearance 931229 was cleared on October 8, 1993 and specified that valve RH-V-785B be positioned to the full open position.

Contrary to the above, on December 2, 1993, the licensee determined that the residual heat removal suction valve, RH-V-785B, was not full open in that it was throttled to approximately 76% open by stem position, and that the valve had not been correctly positioned under tagging clearance 931229.

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

1. Reason for the Violation

The 'B' residual heat removal pump was removed from service on October 7, 1993, and returned to service on October 8, 1993. RH-V-785B was part of tagging clearance 931229 to support automated work order (AWO) CY-93-12811. When AWO CY-93-12811 was completed and clearance 931229 was cleared, RH-V-785B was only opened 76% versus the required position of fully open. The cause of the event was inadequate self-checking on the part of the operators performing the task. A contributing factor was the location of the valve and the length of the reach rod used to operate the valve.

2. Corrective Steps That Have Been Taken and Results Achieved

The valve was correctly positioned following identification of the violation.

As identified in the inspection report, this violation is one of several incidents of unacceptable performance which occurred during this operating period. We acknowledge an adverse trend in the area of human performance and are taking active steps to arrest and reverse this trend.

These steps include:

- The establishment of an Operations Department Instruction (ODI) entitled "Lessons Learned" to capture events in which information (such as peculiarities of valve operation) are provided to all crews. This log is maintained in the Control Room and will be reviewed monthly.

- The commencement of a formal self-checking program. This program is titled Stop Think Act and Review (STAR) and has been presented to each operating crew during the last cycle of Licensed Operator Requalification Training. This program is now an integral part of Requalification Training and is used during each operating crew's weekly and annual simulator evaluation.

In addition to the above two steps, the identified incident has been discussed with each operating crew. Clear expectations with regard to human performance have been provided to all Shift Supervisors and performance in this area is fully expected to improve. Supporting this conclusion is the fact that all of the human performance events took place in late 1993. No human performance events have taken place in 1994.

3. Corrective Steps That Will Be Taken to Avoid Further Violation

No further additional corrective actions are planned.

4. Date When Full Compliance Will Be Achieved

CYAPCO is presently in full compliance with all requirements pertinent to this violation.

5. Generic Implications

The corrective actions, as described above, will be provided to Millstone Unit Nos. 1, 2, and 3 for their review and awareness.

Restatement of Violation 2 (VIO 93-21-02)

10 CFR 50.9(a) requires that information required by the Commission's regulations be accurate in all material respects. Haddam Neck Technical Specification 6.8.1.a requires that written procedures be implemented covering the applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, February 1978. Regulatory Guide 1.33 identifies log entries as a safety related activity that should be covered by written procedures. Haddam Neck Administrative Control Procedure ACP 1.2-2.32, "Implementation and Control of Fire Protection Program Requirements" (Rev. 7) was written pursuant to the above, and requires in Step 1.4.3 the documentation of the completion of fire watch activities by denoting the person performing the watch, the date of watch, the time the watch was performed, and the initial of individual performing the watch.

Contrary to the above, the inspector determined on December 6 that records required to be maintained by Commission regulations were not accurate in all material respects. Specifically, the documentation of the completion of fire watch activities was not accurate in that, as noted by the inspector at 9:30 a.m., a non-licensed operator had signed the fire watch log for the

diesel generator fire doors indicating completion of the fire watch for 10:00 a.m. and 11:00 a.m. that day.

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

1. Reason for the Violation

The Nuclear Systems Operator (NSO) responsible for performing the required fire watch signed the fire watch log in advance of actually performing the required watch. This action was, at that time, a misrepresentation of facts. However, as stated in the violation, the fire watch was actually performed at the time required.

The NSO is required to complete two separate items to ensure completion of the required fire watch(es). The first is Administrative Control Procedure (ACP) 1.2-2.32 as stated in the violation. The second is ODI #177 "Fire Watches," which is a procedure to ensure that no fire watch is missed. The NSO performing the watch errored in believing that the more important procedure was ODI #177 and that ACP 1.2-2.32 was of lesser importance. In fact, the opposite is true. ACP 1.2-2.32 is the legal record and ODI #177 is an operator aid. The NSO's confusion with regard to the relative importance of each document prompted him to complete ACP 1.2-2.32 ahead of time, as if it were the operator aid. The NSO did not realize that he was, in fact, officially documenting the completion of a fire watch he had not yet performed.

2. Corrective Steps That Have Been Taken and Results Achieved

The NSO received disciplinary action per company guidelines. In addition, a check of previously performed work by this NSO was performed against security computer logs and no discrepancies were noted. All crews were briefed on this occurrence with the appropriate emphasis on the accurate maintenance of all records.

We wish to emphasize how seriously this incident is viewed by CYAPCO. We fully understand that the integrity of operators simply cannot be called into question. The misrepresentation of factual information, no matter how minor, will not be tolerated. This message has been unambiguously communicated to all Operations Department personnel.

3. Corrective Steps That Will Be Taken to Avoid Further Violations

No further additional corrective actions are planned.

4. Date When Full Compliance Will Be Achieved

CYAPCO is presently in full compliance with all requirements pertinent to this violation.

5. Generic Implications

The corrective actions, as described above, will be provided to Millstone Unit Nos. 1, 2, and 3 for their review and awareness.