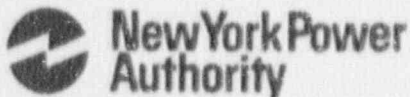


James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
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November 19, 1990
JAFP 90-0835

William Fernandez II
Resident Manager

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
RESPONSE TO NOTICE OF VIOLATION
INSPECTION REPORT 50-333/90-06

Reference: a. NRC letter, C.J. Cowgill to W. Fernandez,
dated October 18, 1990 transmits Inspection
Report 50-333/90-06.

Dear Sir:

In accordance with 10CFR2.201, Attachment 1 responds to the
Notice of Violation included with NRC Inspection Report 50-
333/90-06 (Reference a). This inspection was conducted by
Messrs. W. Schmidt and R. Plasse during the period from August 12
to September 22, 1990.

If you have any questions regarding this matter, please contact
Mr. D. Ruddy of my staff.

Very truly yours,

William Fernandez II
WILLIAM FERNANDEZ II

WF:DAR:bnr

CC: see next page

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CC: Records Management (WPO)
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Attn: C. J Cowgill, Acting Chief
Division of Reactor Projects

Certified Mail - Return Receipt Requested

ATTACHMENT 1 TO JAFP-90-0835

NOTICE OF VIOLATION

New York Power Authority
James A. FitzPatrick Nuclear Power Plant

Docket No. 50-333
License No. DRP-59

As a result of the inspection conducted on August 12 thru September 22, 1990, and in accordance with NRC Enforcement Policy (10CFR2, Appendix C), the following violation was identified.

10 CFR 50, Appendix B, Criterion XVI, Corrective Action, requires, in part, that conditions adverse to quality are promptly identified and corrected, such that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, NYPA did not determine and correct conditions adverse to quality regarding a June 28, 1990 unplanned isolation of the reactor water cleanup system, which was reported in LER 90-21. Specifically, the only cause identified and corrected was a drawing error, despite the existence of non-adherence to tagout procedures, poor work practices regarding instrument isolation, inappropriate use of design drawings, and poor communication.

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

RESPONSE TO NOTICE OF VIOLATION

The Authority does not agree with the Notice of Violation. The exact words of Appendix B to 10 CFR 50, Criterion XVI, Corrective Action, state, "In the case of significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition."

The Authority agrees that a more detailed investigation or critique at the time of the event may have identified some of the additional weaknesses presented in the inspection report. However, the Authority determined that the principle cause or significant condition adverse to quality was a drawing error. The measures employed to make this determination included the preparation and review (by senior plant management) of LER 90-21. In the review of the draft LER, the possible causes of the event were discussed, including some of the items identified in Inspection Report 90-06. It is the conclusion of the Authority that the principle cause was correctly and accurately identified, in accordance with Criterion XVI of Appendix B. A drawing change request has been issued to correct the drawing error.

ATTACHMENT 1 TO JAFP-90-0835

The following paragraphs address each additional item identified in the Notice of Violation, including the justification why the item was not a cause of the event, and the corrective steps taken to improve future performance.

1. Tagout procedure

A protective tag was issued for the subject work activity of June 28, 1990. As noted in LER 90-021 the circuit breakers for the outboard supply containment isolation valve (12MOV-18) and return containment isolation valve (12MOV-69) were opened. Per the Work Activity Control Procedure No. 10.1.2, "Equipment and Personnel Protective Tagging" it is the responsibility of both the tag holder (worker) and the controller (operator) to determine adequate protection of equipment and/or personnel. It has been the policy of the plant to allow maintenance activities to be performed without protective tags provided; (a) the worker has direct control of the means of isolation (e.g. breaker, valve, lifted lead) and (b) the worker does not leave the work area unattended before restoring the equipment to its normal condition. In the case of lifting leads, additional measures shall be taken to control and document the reconnection of the leads. Therefore, lifting energized leads using proper tools and personnel protective equipment is an acceptable practice.

After the protective tags were in place the technician proceeded to remove the switch using Instrument and Control Standing Order No. ICSO-12, "Generic Troubleshooting and Maintenance Procedure." This procedure complements the plant protective tagging procedure and is consistent with plant policy. The procedure provides a means of documenting lifted leads and jumpers and requires a discussion with the Control Room Operator and the Shift Supervisor before work begins.

2. Work practices

As noted in the Inspection Report, the technician did not perform a voltage frisk after lifting a lead to deenergize the temperature switch. The Authority recognizes this as a poor practice and the workers involved have been counseled on this matter. Further, the Authority will conduct training for all technicians on this subject and related work practices. Procedure No. ICSO-12 will also be revised to reinforce the need to properly check for results when isolating or trouble shooting equipment. However, had the technician performed the frisk and reconnected the lead the event would still have occurred.

ATTACHMENT 1 TO JAFP-90-0835

As noted in the Inspection Report, the technician chose to lift leads rather than pull fuses to deenergize the temperature switch. In many cases lifting leads is the preferred method because it can limit the amount of equipment taken out of service for a maintenance activity. However, had the fuses been removed and restored, the event would still have occurred.

The inspection report stated the technician apparently did not notice that he lifted leads in the Division 1 portion of panel 09-22, while the switch he replaced was in the Division 2 portion. It should be noted that each portion of this panel contains components connected to the opposite division, although they are separated by metal enclosures. As such, the symptoms of the drawing problem available to the technician were subtle rather than clear-cut.

3. Design drawings

A loop diagram is an appropriate drawing for identifying connections to an instrument. Loop diagrams are used industry-wide as the principle drawing for depicting an instrumentation circuit. Properly drawn, they provide the power supply, as well as, the inputs and outputs of each instrument and all other component interfaces. The loop diagrams are used by the operations and engineering personnel as well as technicians. The drawing used during the subject event was not properly drawn. It did not indicate that other components were connected to the power supply terminal points. Recognizing this, the Authority is standardizing the loop diagram format and will add new and revised diagrams to the drawing system beginning in 1991.

4. Communications

There was a miscommunication between Operations and I&C concerning exactly which leads were to be lifted and at what location. The workers involved have been counselled on the need to discuss the specifics of a work activity with the operations personnel. This subject will also be discussed in training for all technicians in connection with item 2 above. The leads were not lifted at the device due to a lack of accessibility; rather the leads were lifted at an appropriate accessible terminal block. Even if proper communications had occurred between Operations and I&C personnel as to the exact location of the determination, the event would not have been avoided due to the drawing error.