

James A. FitzPatrick
Nuclear Power Plant
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Harry P. Salmon, Jr.
Site Executive Officer

November 20, 1995
JAFFP-95-0499

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
Reply to Notice of Violation
NRC Inspection Report 50-333/95-18**

Gentlemen:

Pursuant to 10 CFR 2.201, Notice of Violation, the Authority submits this response to the notice of violation transmitted with your letter dated October 20, 1995. Your letter refers to the results of the routine resident safety inspection conducted by Messrs. G. Hunegs, R. Fernandes and T. Kenny from August 6, 1995 to September 23, 1995 at the James A. FitzPatrick Nuclear Power Plant.

Attachment I provides the description of the violation, reason for the violation, the corrective actions that have been taken and the results achieved, corrective actions to be taken to avoid further violations, and the date of full compliance.

There are no commitments contained in this submittal.

If you have any questions, please contact Mr. Arthur H. Zaremba at (315) 349-6365.

Very truly yours,

Harry P. Salmon, Jr.

STATE OF NEW YORK
COUNTY OF OSWEGO
Subscribed and sworn to before me
this 20 day of November, 1995

NOTARY PUBLIC

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NANCY B. CZEROW
Notary Public, State of New York
Qualified in Oswego County No. 405911
My Commission Expires 1-26-97

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Attachments:

I - Reply to a Notice of Violation

ATTACHMENT I
Response to Notice of Violation

Violation

Technical Specification 6.8(A) states, in part, that written procedures and administrative policies shall be established, implemented, and maintained that meet or exceed the requirements and recommendations of Section 5, Facility Administrative Policies and Procedures, of ANSI 18.7-1972.

ANSI 18.7-1972, Section 5.1.2 states, in part, that procedures shall be followed, and the requirements for use of procedures shall be prescribed in writing.

Administrative Procedure AP-12.01, section 6.9 requires, in part, that operators verify the component label matches the component identified on the protective tagging record (PTR) when hanging tags and to notify the controller if a discrepancy exists.

Contrary to this, on September 5, 1995, during the hanging of PTR No. 952120, which specified the removal of fuse 16A-F8 in panel 09-5, the discrepancy between the fuse label and the PTR was not brought to the attention of the controller, and the incorrect fuse 6A-F8 was removed. This resulted in a loss of signal to both reactor feed pump control circuits with a rapid reduction in feedwater flow and subsequent reactor scram on low reactor water level.

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

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

The Reason for the Violation

This violation was the result of personnel error while hanging PTR No. 952120. Inadequate self-verification by the two licensed operators performing a dual-concurrent verification of the fuse removal resulted in removal of an incorrect fuse.

The two licensed operators confronted with a discrepancy between the fuse labelling in panel 09-5 and the PTR incorrectly reconciled the difference by concluding the panel label was printed incorrectly or faded by aging. The operators failed to recognize that the required course of action was to report the discrepancy to the controller.

The first operator (Control Room Supervisor, CRS) came to this conclusion by an erroneous comparison of the panel fuse arrangement with what was shown on the plant drawings. This operator concluded that he had performed an adequate self-verification based on his drawing research and walk-down, and was convinced that he had located the correct fuse.

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The second operator (Nuclear Control Operator 2, NCO2), after a discussion with the CRS, convinced himself that the panel fuse labelling was incorrect by concluding that the first digit "1" was either cut-off the edge of the fuse tab (the digit "6" was relatively close to the edge) or the digit "1" was worn off.

Other contributing causes were:

- a. The CRS involved in this event was very experienced in the reading and usage of plant electrical prints. His research and convincing attitude influenced NCO2 in accepting the discrepancy in the fuse tab labelling.
- b. NCO2 didn't maintain an independent thought process.
- c. PTR #952120 specified for the device to be tagged only the system fuse number (16A-F8) and not the panel fuse number (F12). If both numbers had been included on the PTR under the Device Description, there would have been a much lower probability that the wrong fuse would have been selected.

Corrective Actions That Have Been Taken

1. A critique of the tagging error was completed on September 7, 1995. The critique discusses the tagging error, its causes, significance, recommended corrective actions and lessons learned.
2. The licensed personnel who committed the personnel error were counseled regarding the failure to meet plant standards and management expectations in the area of self-verification and questioning attitude. These individuals were temporarily removed from shift and developed lessons learned from the event for presentation to other operators.
3. Operations personnel were briefed on the details of this event and the lessons learned. Plant standards and management expectations in the areas of self-verification and questioning attitude were reinforced.
4. AP-12.01 was revised to include a requirement to specify both the system fuse number and panel fuse number (if applicable) for PTR's involving fuse removal.
5. A root cause analysis of a potential adverse trend regarding PTR program performance was completed on 11/17/95.
6. Guidance was added to AP-12.01 to ensure that the preparer and independent verifier use the final hardcopy when performing checks and verifications.

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Results Achieved To Date

On October 27, 1995, a Deviation / Event Report (DER) was written identifying a potential adverse trend regarding PTR program performance. A root cause evaluation was performed which evaluated aspects of the PTR program for areas where errors have occurred. The root cause recommended corrective actions in the areas of increased supervisory oversight and additional self-verification training for operators. The root cause evaluation determined the program has adequate procedural barriers in place to detect and prevent personnel errors.

Corrective Actions To Be Taken

1. Operations management reinforce the importance of proper self checking and independent verification to all personnel involved in the PTR process. This will be completed by 11/30/95.

2. Operations department increase supervisory involvement in the PTR process as follows:

The PTR Group SRO and controller will perform spot checks of the PTR's being prepared to reinforce proper self-check standards.

Shift management will perform more field supervision to reinforce self-check standards.

Initiation of these actions will be complete by 12/31/95.

3. Self-verification training for operators will be completed by 12/31/95.

Date When Full Compliance Will be Achieved

Management expectations for self-checking practices have been and continue to be reinforced. Full compliance was achieved on 9/13/95 following completion of briefing of on-shift operators on the details of and lessons learned from the event.