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U. S. Nuclear Regulatory Commission
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Perry Nuclear Power Plant
Docket No. 50-440
Reply to a Notice of Violation

Gentlemen:

Attached is the Perry Nuclear Power Plant's reply to the Notice of Violation contained in NRC Inspection Report 50-440/95008 dated December 14, 1995. If you have questions or require additional information, please contact Mr. James D. Kloosterman at (216) 280-5833.

Very truly yours,

for D. C. Shelton

DCS:krj

cc: NRC Project Manager
NRC Resident Inspector Office
NRC Region III

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REPLY TO A NOTICE OF VIOLATION

Violation 95008-01

Restatement of the Violation

Perry Plant Technical Specifications Section 6.8.1 requires that written procedures be established, implemented, and maintained to cover applicable procedures recommended in Appendix A of Regulatory Guide 1.33, Revision 2, 1978. Perry System Operating Instruction SOI-N27 Feedwater System is one of the procedures included in the general category of Plant Operating Procedures provided under Regulatory Guide 1.33, Appendix A. Step 4.11.2.b of SOI-N27 required that the operator verify the Reactor Feed Pump Turbine Flow Control was in manual and set at minimum.

Contrary to the above, on September 2, 1995, the operator failed to verify that the Reactor Feed Pump Turbine Flow Control was in manual resulting in an unplanned reactor protection system trip and scram (50-440/95008-01(DRP)).

Reason for the Violation

As stated in Licensee Event Report (LER) 95007, the cause of this event was operator error; failure to follow procedure. System Operating Instruction SOI-N27, "Reactor Feed Pump A(B) Startup to 1100 RPM," requires the turbine driven feedwater pump flow controller to be placed in MANUAL and set at "minimum" prior to opening the discharge valve. This step was not performed as required. The flow controller was allowed to remain in AUTO, with the operators not recognizing this improper configuration prior to performing the procedural steps which led to the reactor scram.

A Human Performance Enhancement System (HPES) evaluation concluded that this event was caused by operator error. Specific causal factors identified included failure to properly apply existing self-checking practices, and inadequate shift and panel turnovers.

Corrective Steps Taken and Results Achieved

The two operators primarily responsible for this event were removed from licensed duties and have been counseled with respect to their improper actions. They have received remedial training, and one of the operators has been returned to licensed duties. The other operator is currently assigned to an offshift position.

A videotape depicting the errors and the system response was made using the plant simulator immediately following this event. It was presented to each oncoming shift crew prior to their taking the shift, with emphasis on management's expectations for utilizing existing self-checking practices. During this training, management reiterated its expectations with regard to reviewing and understanding control board status prior

to beginning an evolution, anticipating results of control actions about to be taken, and confirming the results of control actions just taken.

Additional specialized training for licensed operators was conducted during the normal requalification cycle following this event. This consisted of a lecture on the feedwater control system followed by various feedwater control manipulations on the simulator. These manipulations were performed such that the operators not only demonstrated procedural compliance, but also an understanding of the expected system and plant response. Manipulations were repeated if any weaknesses were identified.

Corrective Steps That Will Be Taken To Avoid Further Violations

In addition to the corrective actions already taken, and to provide a second line of defense beyond the normally accepted self-checking practices, management is reinforcing its expectation with both Shift and Unit Supervisors that information obtained during shift turnover be validated prior to proceeding with an evolution. Management is also reinforcing its expectation with operators that when supplementing the normal crew, the designated panel operator must be kept informed of key operational activities. This expectation includes conducting a turnover prior to leaving the "horseshoe" (i. e., the "at the controls" area) informing the designated panel operator of the most recent control actions performed. . The delineation of these expectations is being conducted as part of the current events training and will be completed by February 10, 1996.

Date When Full Compliance Will Be Achieved

Full compliance was achieved on September 2, 1995, when feedwater control was properly regained in accordance with procedural requirements.