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Indian Point 3  
Nuclear Power Plant  
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L. M. Hill  
Site Executive Officer

February 1, 1996  
IPN-96- 008

Mr. James Lieberman  
Director, Office of Enforcement  
U.S. Nuclear Regulatory Commission  
One White Flint North  
11555 Rockville Pike  
Rockville, MD 20852-2738

Subject: Indian Point 3 Nuclear Power Plant  
Docket No. 50-286  
License No. DPR-64  
**Reply to Notice of Violation And Payment of Proposed Imposition  
of Civil Penalty - \$50,000 (Inspection Report 50-286/95-15)**

Reference: NRC Letter of January 2, 1996 from Thomas T. Martin to William J. Cahill, Jr., "NOTICE OF VIOLATION AND PROPOSED IMPOSITION OF CIVIL PENALTY - \$50,000 (NRC Inspection Report No. 50-286/95-15)"

Dear Sir:

This letter provides, in Attachment I, the New York Power Authority's response to the subject Notice of Violation. The New York Power Authority agrees with the Notice of Violation contained in the referenced letter. Payment of the civil penalty is being made by the attached check in the amount of \$50,000. There are no new commitments made by the New York Power Authority in this letter.

Very truly yours,

L. M. Hill  
Site Executive Officer  
Indian Point 3 Nuclear Power Plant

Attachments  
cc: see next page

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PDR ADOCK 05000286  
G PDR

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w check

cc: Mr. Thomas T. Martin  
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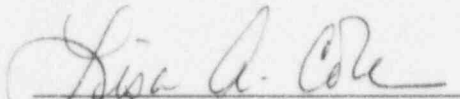
State of New York  
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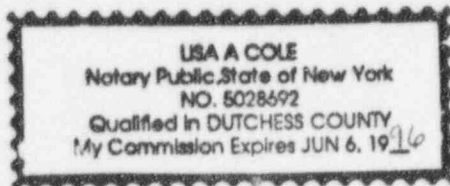
Leslie M. Hill, being duly sworn, deposes and says:

I am the Site Executive Officer of the Indian Point 3 Nuclear Power Plant of which the Power Authority of the State of New York is the owner and operator under Facility Operating License DPR-64. I have read the foregoing "Reply to Notice of Violation And Payment of Proposed Imposition of Civil Penalty - \$50,000 (Inspection Report 50-286/95-15)" and know the contents thereof; and that the statements and matters set forth therein are true and correct to the best of my knowledge, information and belief.

  
\_\_\_\_\_  
Leslie M. Hill

Subscribed and sworn to before me  
this 1<sup>st</sup> day of February, 1996

  
\_\_\_\_\_  
Notary Public



## Violation

"As a result of an NRC inspection conducted between September 19 and October 30, 1995, the exit meeting of which was held on November 2, 1995, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, (60 FR 34381; June 30, 1995), the Nuclear Regulatory Commission proposes to impose a civil penalty pursuant to Section 234 of the Atomic Energy Act of 1954, as amended (Act), 42 U.S.C. 2282, and 10 CFR 2.205. The particular violations and associated civil penalty are set forth below:

- A. The Indian Point 3 Technical Specifications, section 3.3.A.1.d, state that the reactor coolant system average temperature shall not exceed 200° F unless one recirculation pump, together with its associated piping and valves, is operable.

The Indian Point 3 Technical Specifications, section 3.3.B.1.b, state, in part, that the reactor shall not be brought above the cold shutdown condition unless two containment spray pumps, with their associated valves and piping, are operable. Technical Specifications, section 1.2.1, define the cold shutdown condition to be when the reactor is subcritical by at least 1%  $\Delta k/k$  and average temperature is less than or equal to 200°F.

Contrary to the above, on October 15, 1995, from about 11:25 a.m. to 3:33 p.m., the reactor coolant system average temperature exceeded 200°F with both recirculation pumps and both containment spray pumps inoperable. The pumps were inoperable in that the control switches for these pumps were in the trip pullout position, rather than the automatic position, and would have prevented the automatic start of the pumps.

- B. Indian Point 3 Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained covering activities referenced in Appendix A of Regulatory Guide 1.33, "Quality Assurance Program Requirements", November 1972. Appendix A of Regulatory Guide 1.33, Section 2, requires general operating procedures for cold shutdown to hot standby.

Indian Point 3 Procedure POP-1.1, "Plant Heatup From Cold Shutdown Condition", Revision 34, requires, in Attachment 3, Sections 3.4 and 3.6.3, respectively, that the Control Room Supervisor and the Shift Manager initial the procedure to indicate that at least one recirculation pump and both containment spray pumps are operable. Procedure POP 1.1 defines, in a procedural note, operable as capable of performing the intended function in the intended manner (e.g., control switches in Automatic).

Contrary to the above, between October 14 and October 15, 1995, the Control Room Supervisor and the Shift Manager initialed Indian Point 3 procedure POP-1.1 to indicate that at least one recirculation pump and both containment spray pumps were operable. However, the pumps were inoperable in that the control switches

were in the trip pullout position rather than the automatic position.

- C. Indian Point 3 Technical Specification 6.8.1 requires that written procedures shall be established, implemented and maintained covering activities referenced in Appendix A of Regulatory Guide 1.33, "Quality Assurance Program Requirements", November 1972. Appendix A of Regulatory Guide 1.33, Section 1.g, requires administrative procedures for shift and relief turnover.

Indian Point 3 Procedure OD-6, Shift Relief and Turnover, Revision 8, Section 6.2.4, requires that the tasks identified in section 3.0 of the applicable shift turnover sheet shall be completed prior to assuming the watch. Shift turnover sheet OPT-2, Control Room Supervisor Turnover Sheet, Revision 6, Section 3.0, requires the control room supervisor to walkdown the control boards prior to assuming the watch. Procedure OD-6 defines walkdown as a detailed review of the status of appropriate control panels by applicable on-coming and off-going watchstanding personnel.

Contrary to the above, on October 15, 1995, the control room supervisor did not perform a detailed review of the control panels prior to assuming the watch, as indicated by the failure to identify that the control switches for the recirculation and containment spray pumps were in the trip pullout position, and would not support exceeding the cold shutdown condition.

- D. 10 CFR Part 50, Appendix B, Criteria XVI, Corrective Actions, requires that measures be established to ensure that conditions adverse to quality, such as nonconformances, are promptly identified and corrected.

Contrary to the above, after the reactor coolant system average temperature exceeded 200°F on October 15, 1995 at about 11:25 a.m. until 3:23 p.m., measures were not established to ensure that the two reactor operators on duty identified a condition adverse to quality that existed at the time, namely, the inoperability of the recirculation pumps and both containment spray pumps. The pumps were inoperable in that the control switches for these pumps were in the trip pullout position, rather than the automatic position, and would have prevented the automatic start of the pumps.

This is a Severity Level III problem (Supplement I)."

### Response to the Violations

The Authority agrees with the violations cited in the NRC letter of January 2, 1996. The Authority evaluated the violations as various parts of a single event and the following discussions reflect this evaluation. The reasons and corrective actions have been annotated (Violations A, B, C, and/or D are indicated in parentheses) to indicate applicability to the individual violations.

## Reasons for the Violations

The circumstances leading to the violation are described in Licensee Event Report (LER) 95-022. On October 15, 1995, at approximately 1523 hours, with the plant in a hot shutdown condition, (0 power, Reactor Coolant System (RCS) temperature 230 degrees F and RCS pressure 400 psig), a Quality Assurance engineer noted that the switches for the containment spray and recirculation pumps were in trip pullout. The plant exceeded 200 degrees F at 1125 hours with the switches for the containment spray and recirculation pumps in the trip pullout position, although the pumps were required to be operable by Technical Specifications 3.3.B.1.b and 3.3.A.1.d and Plant Operating Procedure (POP) 1.1.

A root cause evaluation was completed for this event. The primary cause of the event was personnel error by the Control Room Supervisor (CRS) due to poor work practice, a lack of awareness of plant conditions (Violations A, part of B and C). The CRS knew the pump switches to be in Trip Pullout and rationalized signoff without verification. The CRS failed to understand the effect of this action. The causal factors were: the CRS demonstrated inappropriate confidence in subsequent procedural steps to establish proper control switch placement to support the mode change from the Cold Shutdown condition, the CRS demonstrated an unwillingness to ask for assistance and share responsibilities; and, the CRS demonstrated a lack of awareness of plant conditions.

There were a number of contributing causes identified for the event. These include the following:

- The failure of the Reactor Operators (ROs) to identify and take action on the abnormal switch position was personnel error due to poor work practice/error detection (Violation D). The ROs considered the CRS and Shift Manager (SM) reviews and sign-offs within POP 1.1 adequate to assure correct system alignments to support exiting Cold Shutdown. The causal factors were inadequate (passive) control board awareness and Control Room personnel failed to communicate and work effectively as a team.
- The failure of the SM to verify the pumps were operable when signing POP 1.1, Attachment 3, was personnel error due to poor work practice/error detection (Violations A and B). The SMs were not performing the same verification for signoffs as management expected. The causal factors were: inadequate review and oversight of a plant mode transition, ineffective usage of control room and shift resources to facilitate plant status verifications, and mixed communications (lack of clear communications) on management expectations.
- The failure to maintain adequate procedural barriers in POP 1.1 was personnel error due to management methods (Violations A and B). The corrective action taken in response to a similar event (LER-89-009) involved changes to POP 1.1 that were revised. Although the basis files were not developed for revisions accomplished during the 1987 time frame, the 1987

revision reflected the corrective actions committed to in LER-86-009. The causal factors were a lack of procedural guidance concerning the determination of change equivalency and absence of procedural guidance to ensure the development and retention of supporting documentation.

### Corrective Actions Taken

The following corrective actions have been completed for this event or similar events:

- The event was corrected after discovery by placing the switches for the containment spray system and recirculation pumps in the Auto position. (Violation A)
- After the event was discovered, Operations performed a board walkdown and reperformed Attachment 3 of Plant Operating Procedure 1.1. (Violations A, B, C and D)
- Event briefings have been completed and extensive interactions with senior and executive management have been completed to reinforce management expectations concerning procedure adherence, control board awareness, and the conduct of license responsibilities. (Violations A, B, C and D)
- Disciplinary action was taken that affected 6 licensed operators. The actions included suspending the Shift Manager and the Control Room Supervisor from licensed duties pending appropriate action. (Violations B, C and D)
- A temporary procedure change was made to Plant Operating Procedure 1.1 to include placing the containment spray and recirculation pump switches in automatic and an assessment verified that no other similar assumptions related to establishing system operability conditions had been made. (Violations A and B)
- The plant administrative procedure for writing procedures and the associated writers' guide had previously been revised, due to other events, to require that commitments be retained in the procedure unless justified. (Violations A and B)
- The plant organization was revised and the new Operations Department Manager (the permanent manager had been scheduled to assume responsibility on December 5, 1995) reported directly to the Site Executive Officer in order to improve communication of expectations and standards. The Site Executive Officer considered this action to have been effective in the short term and it is completed. On January 8, 1996, a new General Manager - Operations was assigned to allow the Site Executive Officer to resume a broader managerial perspective. The new General Manager - Operations has successful past experience in this position under similar

operational circumstances at the FitzPatrick Nuclear Plant. (Violations A, B, C and D).

- The integrated plant operating procedures for plant startup and shutdown were revised to include human performance enhancements (e.g., action steps specifically stated, auditable identification and completion of step performance, define performance/status attributes). These procedures were upgraded prior to using them in the plant heatup and cooldown sequence of events. (This action completes commitment IPN-95-113-01). (Violations A, B and D)
- Administrative Procedure 21 was revised on November 2, 1995 to more clearly define the roles and responsibilities of the Control Room Supervisor. Those associated with command and control and the facilitation of shift teamwork and communication, in particular, were upgraded by this revision. (This action completes commitment IPN-95-113-02). (Violations A, B, C and D)
- An assessment of post shift turnover briefing was completed. A post shift turnover briefing is now being performed in the control room to help improve communications at all levels of the operations crew. (This action completes commitment IPN-95-113-03). (Violations A, B, C and D)
- Plant Operating Procedure 1.1 was revised to ensure that deviations identified within individual check-off lists are evaluated and conclusions documented prior to the declaration of system operability. (This action completes commitment IPN-95-113-06). (Violations A and B)
- OD-6, Shift Relief and Turnover, was revised to add additional instructions for the conduct of board walkdowns. This revision helps assure greater consistency in scope and formality. (This action completes commitment IPN-95-113-07). (Violations A, B, C and D)
- A briefing with each operating crew and the operations staff was conducted prior to discuss the significance of this event and the lessons learned. (This action completes commitment IPN-95-113-08). (Violations A, B, C and D)
- The containment response to a large pipe break when the plant is at 350 degrees F was calculated to determine the effects of this low probability event. The containment pressure does not reach the containment spray setpoint with one fan cooler unit operable (Technical Specification 3.3.B requires two or more fan cooler units to be operable when exceeding 200°F). (The analysis completes commitment IPN-95-113-09). (Violation A)



### Corrective Actions That Will Be Taken

The following actions are being performed to provide corrective action and prevent recurrence of this type of event:

- An assessment of the need for a pre-mode change switch alignment check-off-list to be used just prior to mode changes is being performed. Operations is scheduled to complete this by March 2, 1996. (Previous commitment IPN-95-113-04). (Violations A and B)
- A training performance review process for licensed operators will be developed to ensure that significant performance deficiencies during simulator training that are related to nuclear safety or regulatory compliance are evaluated and corrective actions developed. Training is scheduled to complete this by February 11, 1996. (Previous commitment IPN-95-113-05). (Violations A, B, C and D)

### The Date When Full Compliance Was Achieved

Compliance was achieved on 1523 hours on October 15, 1995, when the switches for the recirculation pumps and containment spray pumps were placed in the automatic position.