

James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
Lycoming, New York 13093
315 342-3840



**New York Power
Authority**

January 13, 1994
JAFP-94-0028

Harry P. Salmon, Jr.
Resident Manager

Director, Office of Enforcement
U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555

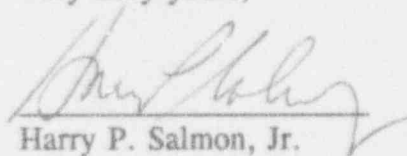
**SUBJECT: James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
Reply and Answer to Notice of Violation
NRC Inspection Report 50-333/93-24**

Dear Sir:

This letter provides the Authority's Reply to the Notice of Violation in accordance with the provisions of 10 CFR 2.201. The reasons for the violations, the corrective actions that have been taken and the results achieved, the corrective actions to be taken to avoid further violations and the date when full compliance will be achieved for the violations is included in Attachment 1.

If you have any questions, please contact Mr. Mike Colomb.

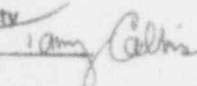
Very truly yours,


Harry P. Salmon, Jr.

STATE OF NEW YORK
COUNTY OF OSWEGO

Subscribed and sworn to before me
this 13th day of January, 1994

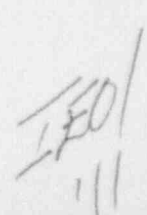
TAMMY L. CALKINS 4985563
Notary Public, State of New York
Qualified in Oswego County

Commission Expires 8/19/95 
Notary Public

cc: see next page

9401310238 940113
PDR ADDCK 05000333
G PDR

32



cc: Regional Administrator
U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, PA 19406

Office of the Resident Inspector
U.S. Nuclear Regulatory Commission
P.O. Box 136
Lycoming, NY 13093

Mr. Brian McCabe
Project Directorate I-11
Division of Reactor Projects-I/II
U.S. Nuclear Regulatory Commission
Mail Stop 14 B2
Washington, DC 20555

Response to Notice of Violation

Attachment 1

Violation

- A. Technical Specification 6.8.A states, in part, that 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.

Contrary to the above, a number of instances were identified where procedures were not followed. The following examples were cited:

- 1) Operating Procedure 34, Resin Transfer, Regeneration and Cleaning, Step G.2.7 states close spent resin tank inlet valve, 20 AOV-311. However, during a resin transfer on November 13, 1993, 20 AOV-311 was not closed and resulted in a resin spill during a subsequent resin transfer operation.
- 2) Instrumentation Maintenance Procedure (IMP)-12.6, Reactor Water Cleanup High Temperature (12 TIS-99) Test/Calibration, Step 9.2.28 states, in part, request operation to reset the PCIS isolation. However, on October 28, 1993, during the performance of IMP-12.6, the PCIS isolation signal was not reset and resulted in an inadvertent valve closure.
- 3) Administrative Procedure 12.01, Equipment and Personnel Protective Tagging, Section 7.2.1 states, in part, review impact of instrumentation valving which may cause a plant trip or system initiation. However, on November 5, 1993, the impact of instrumentation valving was not adequately reviewed and an unplanned PCIS isolation and scram occurred when tags on the reactor vessel refueling level instrument test drain valves were released.
- 4) Administrative Procedure 10.01, Problem Identification and Work Control, Section 8.2.7 states, in part, work request approvers shall approve work requests before the required date and ensure step texts are accurate. However, on October 28, 1993, Work Request 93-02261-00 was performed using unapproved work instructions.

This is a Severity Level IV violation (Supplement 1).

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

Response to Notice of Violation

Attachment 1 (cont.)

The Reason for the Violation

Failure to follow the procedures was the cause of this violation. The individuals involved had been trained on these procedures and have satisfactorily used these procedures in the past. A contributing cause for example A.3, Equipment and Personnel Protective Tagging, was a breakdown in communications between the tag holder and the Operations Department on the status of the instrument after the hydrostatic test.

Corrective Steps Taken to Avoid Further Violation

The steps taken to avoid further violations are categorized as short-term and long-term.

The short-term actions for A.1, Operating Procedure 34, Resin Transfer Event include:

- 1) The individual involved in the resin transfer has been disciplined for failure to follow procedure.
- 2) Operating Procedure 34 has been revised to include valve 20AOV-311 in the standby panel checklist (Attachment 2 of OP-34). This will provide an additional verification that the valve is shut.

The short-term actions for A.2, Instrument Maintenance Procedure IMP-12.6 Event include:

- 3) The Instrument and Control (I&C) individuals involved who failed to have Operations reset the PCIS isolation per the procedure were counseled for failure to follow procedure. I&C individuals involved had incorrectly decided to mark a procedure step not applicable (N/A) after discussing amongst themselves the need to perform this step with the plant shutdown. This event was reviewed and discussed at the weekly Instrument and Control group staff meeting.

The short term actions for A.3, Administrative Procedure 12.01, Equipment and Personnel Tagging Event include:

- 4) AP-12.01 has been revised to have Instrument and Control technicians perform valving on instruments unless the Shift Supervisor determines that valve operations will not result in inadvertent actuation signals to systems such as RPS, PCIS, or ECCS.

Response to Notice of Violation

Attachment 1 (cont.)

- 5) An attributes list to focus the operator on the key process tasks has been developed for use in protective tagging and tag restoration, including the potential for safety system actuation.

The short term actions for A.4, Administrative Procedure 10.01, Problem Identification and Work Control Event include:

- 6) The work crew involved with the work instruction, which was reviewed and signed by a chief journeyman but not approved by the first line supervisor, were instructed to be more attentive to work package reviews/approvals and the critique for this event was reviewed with all first line supervisors and chief journeymen.
- 7) A review of the present method of assigning QA inspectors to follow work activities identified in Administrative Procedure 10.01, "Problem Identification and Work Control" was conducted. The present method was determined to be adequate.

Additional short-term actions:

- 8) Management continually monitors the Deviation and Event Reports (DERs) generated, this includes human performance events. As the outage work activities increased between October 24th and November 4, 1993, an increase in human performance events was identified. As a result of this increasing trend, management stopped work and initiated special meetings (standowns with their staff) to review the problems that had occurred since the start of the outage. The review focused on lessons learned from human performance events including the importance of quality (procedure adherence) over quantity (pressure to complete the work). It was re-emphasized that employees are to contact their supervisor when questions arise concerning procedures or work implementation.
- 9) Subsequent to the above action, on November 29, 1993, departments held a second standown meeting to review the four (4) Deviation and Event Reports which correspond to examples A.1 through 4 of this violation. The description of the procedure violation, how it happened (i.e. inaccurate understanding of plant status, repetitive nature of work and inadequate document details), why it happened (i.e. lack of questioning attitude and lack of self-checking), the event consequence (i.e. near misses and challenges to safety systems), and the corrective actions were reviewed.

The long-term actions to assure continued improvement include the following:

- 10) An evaluation was performed to identify any patterns related to recent procedural errors.

Response to Notice of Violation

Attachment 1 (cont.)

The method used to evaluate and to identify patterns, focusing on INPO SOER 92-01 "Human Performance" recommendations for procedure errors, was to categorize the Deviation Event Reports (DERs) issues by the following:

- Procedure Type
- Procedure Level of Use
- Departments Involved
- Was Procedure Changed Recently
- Was Procedure Upgraded Recently
- Communications as a Contributing Cause
- Supervision/Pre-Job Briefing as a Contributing Cause
- DER Significance (Level A, B, C, D)
- Type of Deviations

As a result of the evaluation, a pattern was identified that many of the DERs were written against administrative procedures which are categorized as informational use.

Based on this evaluation, the following actions will be taken:

- 11) A task analysis will be completed and the training program revised for the Equipment and Personnel Protective Tagging Process (Administrative Procedure 12.01) with emphasis on improving human performance. This will be completed by March 1, 1994.
- 12) Develop a training module for improving work practices, including the area of procedure adherence, attention to detail and self-verification. The training will be an enhanced work practice workshop with multi-discipline participation stressing management expectations and the responsibilities of each staff member in the process. Management and all levels of supervision will participate. The module will be developed by January 28, 1994. The training is scheduled to start on February 7, 1994.
- 13) Due to the intense work load during outages, a focused staff briefing will be conducted prior to scheduled outages. The intent of the briefings will be to re-emphasize lessons learned from past events and management expectations regarding procedure compliance and safety first attitude. Briefings will commence beginning with the April, 1994 scheduled maintenance outage.
- 14) Administrative procedures 10.01, Problem Identification and Work Control, and 12.01, Equipment and Personnel Protective Tagging, are being revised to include a reference use section that will ensure key elements of the procedure are not overlooked during the evolution. This will be completed by April 1, 1994.

Response to Notice of Violation

Attachment 1 (cont.)

The Date When Full Compliance was Achieved

Full compliance was achieved on November 29, 1993, when the second department shutdown meetings were held to review the examples which lead to this violation. Management is continuing to monitor trend data to ensure that corrective actions taken and planned are effective in preventing recurrence of problems.

Violation

- B. Technical Specification Table 4.12.3, Manual Fire Hose Station Tests, requires a flow/hydrostatic test to be performed every three years.

Contrary to the above, a flow test has never been performed on the manual fire hose stations.

This is a Severity Level IV violation (Supplement 1).

Admission or Denial of the Alleged Violation

The Authority agrees with this violation.

The Reason for the Violation

The failure to conduct flow testing of individual fire protection hose stations as required by Technical Specification Table 4.12.3 was the result of incomplete development of the Surveillance Test Program upon implementation of Technical Specification Amendment 34. The cause was failure to distinguish the difference between testing requirements of the sample Technical Specifications and the testing performed in accordance with the applicable NFPA code in the development of Technical Specification Amendment.

Corrective Steps to be Taken to Avoid Further Violation

The surveillance test procedure for this specification was revised and the hose station flow testing performed. This action was satisfactorily completed on November 17, 1993.

Date When Full Compliance was Achieved

Full compliance was achieved on November 17, 1993.