Long Island Power Authority

Shoreham Nuclear Power Station
P.O. Box 628
North Country Road
Wading River, N.Y. 11792

JUL 2 1 1993

LSNRC-2093

Mr. Richard W. Cooper, II, Director
Division of Radiation Safety and Safeguards
U.S. Nuclear Regulatory Commission - Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

Notification of Completion of Actions Addressed
in NRC Confirmatory Action Letter 1-93-006
Shoreham Nuclear Power Station - Unit 1
Docket No. 50-322

Ref: (1) NRC Confirmatory Action Letter 1-93-006, dated May 12, 1993 from U.S. Nuclear Regulatory Commission (R. W. Cooper) to Long Island Power Authority (L. M. Hill).
(2) LIPA letter LSNRC-2080, dated June 8, 1993, to Richard W. Cooper, II from L. M. Hill; subject: Root Cause Analysis for April 29, 1993 Jib Crane Incident.
(3) USNRC letter dated June 16, 1993 to L. M. Hill from Richard W. Cooper, II; subject: Notice of Violation.

Dear Mr. Cooper:

As required by NRC Confirmatory Action Letter (CAL) 1-93-006 (Reference 1), this letter is provided to notify you that Long Island Power Authority (LIPA) has completed the actions specified in the CAL. The CAL was written to document certain immediate and interim actions which had been or were to be taken by LIPA following the April 29, 1993 incident which involved the failure of a jib crane's lifting device and the subsequent toppling of the jib crane onto the Refuel Floor (Reactor Building el. 175'-9").

As indicated in item 2 of the CAL, LIPA immediately initiated an extensive root cause analysis of the incident. The analysis, along with the planned actions to prevent recurrence of similar incidents, was provided to you by LSNRC-2080 (Reference 2), in accordance with the CAL. The analysis and corrective actions were also discussed with members of your staff in an enforcement conference which took place on June 9, 1993 (see Reference 3). It is LIPA's understanding, based on subsequent discussions with your staff, that LIPA's root cause analysis and corrective actions are satisfactory to the NRC. It is LIPA's further understanding that our corrective actions, as implemented, are considered to be adequate to permit elimination of the interim actions (item 3.a and 3.b) specified in the CAL.

Accordingly, LIPA has completed the implementation of all corrective actions identified in our root cause analysis, except for one item related to the development of a plan for monitoring long-term compliance with station procedures and other administrative requirements. Completion of this plan is due by July 31, 1993; however, it is our understanding that implementation of this item is not considered by your staff to be a prerequisite to eliminating the interim actions specified in the CAL.

In addition to the completion of a root cause analysis, the CAL stipulated the following interim actions:

"1. Prior to lifting the jib crane that fell on April 29, 1993, and pending implementation of the final corrective actions that follow completion of your root cause analysis of the April 29, 1993, incident:

a. Revise procedure 35X001.01 for handling of heavy loads to require pre-job briefings of personnel involved in the heavy load lift and assure that the pre-job briefings are conducted.

b. For each lift of a heavy load, prior to and during the work execution, assure the presence and involvement of (1) a Nuclear Quality Assurance (NQA) representative to verify program and procedure compliance; (2) the responsible management Section Head and a qualified Nuclear Engineering Division (NED) representative to monitor work fundamentals and to monitor technical acceptability of the work; and (3) a Safety Engineer to monitor occupational safety matters."

Interim action 1.a above was implemented prior to lifting the jib crane that fell on April 29, 1993, and for all other refuel floor heavy load lifts since the incident. This requirement will be retained as a permanent corrective action. Interim action 1.b above has been implemented since the jib crane incident, however, this requirement will be subject to change in the future in view of other corrective actions taken by LIPA as noted in Reference 2.

"2. Complete a formal root cause analysis of the April 29, 1993, incident and provide the results, along with planned actions to prevent the occurrence of similar events, to me."

This action was completed as noted above.

"3. Pending completion of item 2 above:

a. Notify me [Richard W. Cooper] (215-337-5281) or Mr. Joyner (215-337-5370) in advance and receive authorization to lift any heavy loads anywhere on the refuel floor when such loads consist of any jib crane or of equipment that has the potential, because of its size or proximity to the spent fuel storage pool, to damage the fuel. Notification is specifically required for, but not limited to, equipment that will be directly involved in future handling, packaging, or shipping of irradiated fuel.

b. Prior to lifting a jib crane with a lifting device identical or similar to the device that failed on April 29, 1993, complete a redesign of that lifting device and assure that the redesigned device is consistent with the guidelines of NUREG-0612 ("Control of Heavy Loads at Nuclear Power Plants")."

Interim action 3.a has been implemented as required since the jib crane incident. Records of notifications by LIPA and NRC authorizations made via telephone are available. Upon receipt of NRC's verbal or written confirmation of the request being made by LIPA in this letter (see below), LIPA intends to discontinue implementation of interim action 3.a.

Interim action 3.b has been implemented for the planned lifting of the repaired jib crane and placement of the crane in its originally installed location, i.e., a NUREG-0612 qualified lifting device has been designed and installed on the crane. The requirement to assure that the lifting devices are designed to meet the guidelines of NUREG-0612 is being retained as a permanent prerequisite for any movement of a jib crane across the Refuel Floor.

In summary, LIPA has completed the actions addressed in CAL 1-93-006, and believes that it has adequately evaluated the root causes of the jib crane drop incident. LIPA also believes that the corrective actions as implemented to date are adequate to allow the elimination of the interim actions addressed in the CAL, and hereby requests that the NRC consider such elimination.

Should you have any questions or concerns in regard to this matter, please do not hesitate to contact me at (516) 929-8429.

Very truly yours,

L. M. Hill
Resident Manager

SS/kc

cc: L. Bell
C. L. Pittiglio
T. T. Martin
R. Nimitz