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New York Power Authority

Harry P. Salmon, Jr.
Resident Manager

May 18, 1995
JAFP-95-0238

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

SUBJECT: **James A. FitzPatrick Nuclear Power Plant**
Docket No. 50-333
Reply to a Notice of Violation
NRC Inspection Report 50-333/95-06

Gentlemen:

In accordance with the provisions of 10 CFR 2.201, Notice of Violation, we are submitting our responses to the notice transmitted by your letter dated April 18, 1995. This refers to the routine Resident safety inspection conducted by Mr. W. Cook and Mr. R. Fernandes on February 12, 1995 to March 25, 1995, at the James A. FitzPatrick Nuclear Power Plant.

Included are descriptions of the violations, reasons for the violations, the corrective actions that have been taken and results achieved, corrective actions to be taken to avoid further violations, and the date of full compliance.

Attachment 1 summarizes the commitments contained in this submittal.

If you have any questions, please contact Mr. Michael Colomb at (315) 349-6005.

Very truly yours,

Harry P. Salmon, Jr.

STATE OF NEW YORK
COUNTY OF OSWEGO
Subscribed and sworn to before me
this 18th day of May, 1995

TAMMY L. DANN 4985563
Notary Public, State of New York
Qualified in Oswego County
Commission Expires 8/19/

Notary Public

cc: see next page

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RESPONSE TO NOTICE OF VIOLATION

VIOLATION A.

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.

Contrary to the above, three instances were identified where procedures were not followed. The following examples were cited.

1) Surveillance Test (ST)-76J21, Smoke and Heat Detector Functional Test - Relay Room, Section 8.1, Step 8.1.1.D, requires entry into AOP-63, Relay Room CO2 Discharge, if a system fault results in extended CO2 discharge into the relay room. However, during performance of Section 8.1 on March 19, 1995, an unanticipated discharge of CO2 in the relay room occurred and neither the test personnel or control room staff entered AOP-63.

2) Administrative Procedure (AP)-07.20, Radiation Work Permit Program, Section 8.4, requires radiation workers to log in and out of radiation work permits (RWP) using the computer (or RWP entry log if computer is inoperable) prior to entering and after exiting a radiologically controlled area (RCA). However, on January 24, 1995, a licensed operator entered the reactor building (RCA) to hang protective tags and did not log in and out of RWP 95-0008, task 32, to conduct his work.

3) Administrative Procedure (AP)-07.10, Radiological Requirements for Site Access and Egress, Section 8.2.5 requires a visitor to report to the dosimetry office for dosimetry issuance if they are required to be monitored inside the plant restricted area per Section 8.6 of AP-07.10. However, on March 7 and 8, 1995, an escorted visitor did not obtain dosimetry upon entering the restricted area.

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

Admission or Denial of the Alleged Violation:

The Power Authority agrees with the violation.

The Reasons for the Violation:

- The cause for the failure to enter Abnormal Operating Procedure AOP-63, "Relay Room CO2 Discharge" as directed by Surveillance Test Procedure ST-76J21 following an unanticipated CO2 discharge was attributed to: (1) a lack of supervisory oversite; and (2) poor assessment by the individuals involved with conducting the test of the risk and consequences involved.

- The cause for the failure of a licensed operator to meet the requirements of Administrative Procedure AP-07.20, "Radiation Work Permit Program" was due to poor worker practices. The operator failed to verify that his RWP computer entry had been properly executed. Additionally, the operator, upon exiting the RCA, and recognizing that his RWP entry had not been properly completed, did not take corrective actions to resolve the problem.

- The cause for the failure to implement the requirements of Administrative Procedure AP-07.10, "Radiological Requirements For Site Access And Egress" was poor communication. The visitor and escort, upon entering the Restricted Area on March 7, 1995, reported directly to the dosimetry office in accordance with the procedure. However, the exchange of information and direction given to the visitor at the dosimetry office allowed the visitor to exit the office without being issued the required dosimetry. This inadequate communication also lead to the same visitor failing to return to the dosimetry office on March 8, 1995.

Corrective Actions that have been taken:

- Operations Department personnel on duty during the unanticipated CO2 discharge were counseled by Operations Department management on missing steps within Surveillance Test Procedure ST-76J21 that required entry into AOP-63.

- A review was performed of all CO2 Heat Detection System Surveillance Test Procedures to identify additional procedures which may have contained precautionary statements involving AOP entry requirements in the event of an extended CO2 discharge. No other procedures were found to contain this requirement.

Corrective Actions that have been taken: (cont.)

- Procedure ST-76J21 was revised to relocate the requirement for entry into AOP-63 from the beginning of the test procedure to a text area immediately prior to operators opening the CO2 isolation valve to the relay room. This enhancement will provide a more desirable location and improve operator awareness for AOP-63 entry requirements in the event of an unanticipated CO2 discharge during the testing evolution. Additionally, a step was added to the Prerequisites section of the procedure to require the Shift Supervisor to conduct a pre-test briefing prior to the performance of the ST. This will reinforce the hazards associated with conducting CO2 tests and re-emphasize the actions to be performed in the event of an extended CO2 discharge. To prevent any future inadvertent CO2 discharges, the surveillance test will be revised and/or logic changes will be made prior to performance of the next scheduled test (due date: September 10, 1995).

- The licensed operator involved in the incident of entering and exiting the Radiological Controlled Area without logging in and out of the Radiation Work Permit (RWP) has been counseled by Operations Department management.

- An entry was made in the Operations Department Night Orders to re-enforce the RWP log in/out requirements for each RCA entry/exit to all department personnel. In addition, plant staff were briefed on requirements for RWP log in/out.

- Individuals (visitor, visitor's escort, and general clerk assigned to dosimetry office) involved with the circumstances which allowed an escorted visitor to enter the site's Restricted Area on two successive days without obtaining required dosimetry, have been counseled by their respective department supervisors. Additionally, a meeting was held by senior management with these individuals to understand circumstances of the event and assure the cause for this event was identified and addressed.

- Radiological and Environmental Services (RES) Department has instituted a program requiring the placement of a distinct identification tag on all visitor security badges, instructing the worker to report directly to the dosimetry office upon entering the Restricted Area. RES Department procedures and Security Department written guidance have been revised to provide instructions on tag usage.

Results Achieved:

The Power Authority believes that corrective actions taken will be effective in preventing recurrence. The Authority continues to reinforce the importance of proper execution of, and compliance with, procedures. Site programs such as Deviation/Event Reports (DER) and Performance Enhancement Review Committee (PERC), are intended to monitor the effectiveness of actions taken to improve human performance.

Corrective Actions to be taken:

- Procedure Change Requests (PCRs) have been issued to revise all remaining CO2 Surveillance Test Procedures to require the Shift Supervisor to conduct pre-test briefings to reinforce: (1) the hazards associated with conducting CO2 tests; and (2) the actions to be performed in the event of an extended CO2 discharge. These procedure changes are scheduled for completion by June 28, 1995.

- RES Department is presently re-evaluating JAF's radiation monitoring requirements for personnel in the plant's Restricted Area. This review is scheduled for completion by July 31, 1995.

Date When Full Compliance was Achieved:

Full compliance with procedure use was achieved on May 16, 1995, following management review of the failure to issue dosimetry to a visitor as required by plant procedures with the involved individuals. In addition, Operations Department managements counseling of the CO2 test personnel on AOP entry requirements (April 7, 1995) and the counseling of the operator on the RWP administrative requirements (January 25, 1995) established full compliance with those procedures.

VIOLATION B.

Technical Specification 6.8(A) states, in part, procedures shall be established, implemented, and maintained for the Fire Protection Program 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 5.4 states, in part, that each procedure shall be reviewed prior to initial use, periodically, and following any modification to the affected system to reflect the condition of the system at the time and to provide the best possible instructions to the operators.

Contrary to the above, on March 19, 1995, Surveillance Test (ST)-76J21, Smoke and Heat Detector Functional Test-Relay Room, Revision 14, Section 8.1, was performed resulting in an unanticipated CO2 discharge because a modification (No. F1-92-377) made to the CO2 discharge initiation logic circuit during the 1994-95 refueling outage was not reflected in this surveillance test.

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

Admission or Denial of the Alleged Violation:

The Power Authority agrees with the violation. However, the violation is more accurately described by recognizing that the surveillance test was revised to incorporate changes from the modification but failed to include a portion of a logic change.

Reasons for the violation:

- The causes for this condition were identified as: (1) the engineering design organization did not clearly identify one logic change and did not communicate the impact of this CO2 System modification actuation logic change; and (2) the review of the surveillance test procedure for implementation of the modification change did not identify this change in the systems actuation response.

Corrective Actions that have been taken:

- Operations personnel were briefed and department night order entries were made to provide operators instructions on the CO2 system logic changes and the sequence of events which caused the Relay Room extended CO2 discharge.

- A review of the modification logic has been completed to ensure no other deficiencies exist.

- A review for all 1995 refuel outage modifications was completed to ensure similar deficiencies were corrected.

Results Achieved:

- Additional actions were taken to correct deficiencies identified as a result of the review of modifications installed during the 1995 refuel outage. Also, plant personnel have been familiarized with the details of this event, the potential hazards associated when testing with CO2, the importance of a thorough understanding of the impact of a design change on associated system(s), and assuring all potential impact on system operation and testing is accurately reflected in operating, test and maintenance procedures.

Corrective Actions to be taken:

- A Procedure Change Request has been submitted to revise Surveillance Test Procedure ST-76J21 to incorporate the effects of the CO2 logic changes. Also, a review of the modification design will be completed to determine the need for logic changes. The procedure change and/or logic change will be complete prior to the performance of the next scheduled test. (Scheduled September 10, 1995).

- The Engineering Department is developing a system for review of major modifications including procedure changes and impact on Operations and Maintenance. The system will require an integrated team approach to the review process, and will give particular emphasis on the effect(s) of the modification on the operation and testing of plant systems and components. (Scheduled September 30, 1995).

- Operation Department personnel will receive additional training on modification to the Relay Room CO2 Fire Suppression System during the next operator training cycle period. (Scheduled July 7, 1995).

- Engineering Department will ensure that, as part of the modification process, all changes are reflected on modification documents and affected procedures by developing an adequacy review process. (Scheduled September 30, 1995).

Date When Full Compliance was Achieved:

Full compliance was achieved upon completion of the review of 1995 refuel outage modifications on April 4, 1995. Future compliance will be insured upon completion of the corrective actions to be taken.

Attachment 1

RESPONSE TO NOTICE OF VIOLATION
Commitment Status
JAFP-95-0238

Number	Commitment	Due Date
JAFP-95-0238-01	PCRs have been issued to revise all remaining CO2 Surveillance Test Procedures to require the Shift Supervisor to conduct pre-test briefings to reinforce: (1) the hazards associated with conducting CO2 tests; and (2) the actions to be performed in the event of an extended CO2 discharge.	6/28/95
JAFP-95-0238-02	RES Department is presently re-evaluating JAF's radiation monitoring requirements for personnel in the plant's Restricted Area.	7/31/95
JAFP-95-0238-03	A Procedure Change Request has been submitted to revise Surveillance Test Procedure ST-76J21 to incorporate the effects of the CO2 logic changes. Also, a review of the modification design will be completed to determine the need for logic changes. The procedure change and/or logic change will be complete prior to the performance of the next scheduled test.	9/10/95
JAFP-95-0238-04	The Engineering Department is developing a system for review of major modifications including procedure changes and impact on Operations and Maintenance. The system will require an integrated team approach to the review process, and will give particular emphasis on the effect(s) of the modification on the operation and testing of plant systems and components.	9/30/95
JAFP-95-0238-05	Operation Department personnel will receive additional training on modification to the Relay Room CO2 Fire Suppression System during the next operator training cycle period.	7/7/95
JAFP-95-0238-06	Engineering Department will ensure that, as part of the modification process, all changes are reflected on modification documents and affected procedures by developing an adequacy review process.	9/30/95