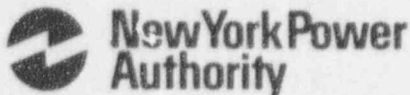


James A. FitzPatrick
Nuclear Power Plant
P.O. Box 41
Lycoming, New York 13093
315-342-3840



Michael J. Colomb
Plant Manager

September 25, 1996
JAFF-96-0377

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
Reply to Notice of Violation
NRC Inspection Report 50-333/96-05

Gentlemen:

In accordance with the provisions of 10 CFR 2.201, Notice of Violation, the Authority submits a response to the notice transmitted by your letter dated August 21, 1996. Your letter refers to the results of the integrated inspection conducted from June 2, 1996 to July 27, 1996 at the James A. FitzPatrick Nuclear Power Plant.

Attachment I provides the description of the violations, reason for the violations, the corrective actions that have been taken and the results achieved, corrective actions to be taken to avoid further violations, and the date of full compliance.

Attachment II provides a summary of the commitments contained in this submittal.

If you have any question, please contact Mr. Arthur Zaremba at (315) 349-6365.

Very truly yours,

A handwritten signature in cursive script, appearing to read 'Michael J. Colomb'.

MICHAEL J. COLOMB

STATE OF NEW YORK
COUNTY OF OSWEGO
Subscribed and sworn to before me
this 25 day of September, 1996

A handwritten signature in cursive script, appearing to read 'Nancy B. Burke'.
NOTARY PUBLIC

cc: next page

9610020025 960925
PDR ADOCK 05000333
Q PDR

A circular notary seal for Nancy B. Burke, Notary Public, State of New York. The seal includes the text 'Notary Public, State of New York' and 'My Commission Expires 12-26-97'. There is a handwritten '1701' to the right of the seal.

cc: Regional Administrator
U.S. Nuclear Regulatory Commission
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

Ms. K. Cotton, Acting Project Manager
Project Directorate I-1
Division of Reactor Projects-I/II
U.S. Nuclear Regulatory Commission
Mail Stop 14 B2
Washington, DC 20555

Attachments:

- I. Reply to Notice of Violation
- II. Summary of Commitments

Attachment i
Reply to Notice of Violation 96-05

VIOLATION A

Technical Specification 6.2.2.6 requires that administrative procedures shall be developed and implemented to limit the working hours of unit staff who perform safety-related functions; e.g., senior reactor operators, health physicists, auxiliary operators, and maintenance personnel who are working on safety-related systems. Requirements, in part, include that an individual should not be permitted to work more than 72 hours in any seven day period, all excluding shift turnover time. In addition, any deviation from the above guidelines shall be authorized by the Site Executive Officer or the General Manager - Operations or higher levels of management, in accordance with established procedures and with documentation of the basis for granting the deviation.

Contrary to the above, in February and March 1996, the requirements to limit the working hours of unit staff who perform safety-related functions were not met in that a radiological protection worker and a maintenance planner exceeded the 72-hour work limitation during a seven day period without appropriate authorization for the deviation from overtime guidelines.

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

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The Authority agrees with this violation.

REASONS FOR THE VIOLATION

The cause for the violation was a misinterpretation of the overtime requirements provided in JAF's Administrative Procedure.

Administrative Procedure AP-11.03, "Control of Overtime", which provides the policy and standards with respect to restrictions of hours worked, was written consistent with Technical Specification requirements. However, the procedure guidance on restrictions to overtime usage allowed plant staff the opportunity for misinterpretation of the "seventy-two (72) hours in any seven (7) day period", overtime work limit. The error involved establishing overtime limits based on a seven (7) day period rather than viewing total overtime hours worked over any one-hundred sixty-eight (168) hour period. This resulted in an incorrect application of the overtime policy by plant personnel and the subsequent violation of Technical Specification requirements.

Attachment I
Reply to Notice of Violation 96-05

VIOLATION A (cont.)

CORRECTIVE ACTIONS THAT HAVE BEEN TAKEN

- Following discovery of the misapplication of the overtime policy, the Plant Manager conducted a special meeting with Department Managers to brief them on the conditions identified and instructed Managers on the correct applications for establishing overtime limits consistent with Technical Specifications requirements.
- Department managers conducted training sessions with department supervisors to review and reinforce Technical Specification and Administrative Procedure policies governing the use of, and the restrictions placed on, overtime applications.
- Tailgate meetings were conducted with department personnel to review and reinforce JAF's policies and rules governing the use and restrictions placed on overtime. The meetings communicated management's expectations that the requirements of Administrative Procedure AP-11.03 are to be conservatively managed by supervision and the worker. The meeting reviewed the procedural steps to be followed in the event special work evolutions require individuals to deviate from the prescribed overtime limits.
- Administrative Procedure AP-11.03, "Control of Overtime", was revised to provide clarification regarding restrictions to overtime usage, specifically, stating overtime hourly limits as any seven (7) day, 168 hour period.

RESULTS ACHIEVED

The above actions increased awareness, sensitivity and understanding of the overtime policies by personnel at the James A. FitzPatrick Nuclear Power Plant.

CORRECTIVE ACTIONS TO BE TAKEN

- A case study of the details associated with this violation will be included in the Training Department's Technical Supervisor Selection and Development (T.S.S.D.) course. The course is designed to promote various potential supervisory position candidates. The inclusion of this case study into the program will provide future supervisors an understanding of the plant's administrative policies and rules governing the use of overtime at JAF. Scheduled completion is 1/31/97.
- A Quality Assurance Department audit is being conducted to review overtime practices used during a recent short duration plant outage which involved overtime usage. Audit results will provide a measure of assurance that overtime policies are being correctly implemented. The audit is scheduled for completion by 10/15/96.

Attachment I
Reply to Notice of Violation 96-05

VIOLATION A (cont.)

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on July 16, 1996 following the Plant Manager's meeting with the Department Managers to instruct Managers on the correct application for establishing overtime limits consistent with Technical Specification requirements.

VIOLATION B

Technical specification 6.8.(A)1 requires that written procedures and administrative policies shall be established, implemented and maintained that meet or exceed the requirements and recommendations of Sections 5 of American National Standards Institute (ANSI) 18.7-1972 "Facility Administrative Policies and Procedures." Section 5 of ANSI 18.7-1972 requires, in part, that instructions shall be established for returning equipment to its normal operating status. Administrative Procedure 12.01, "Equipment and Personnel Protective Tagging", provides instructions to maintain equipment status control.

Contrary to the above, on July 9, 1996, the NRC identified that requirements for maintaining equipment status control were not met in that the "D" emergency diesel generator jacket water cooler outlet valve was found to be full open vice the required throttled four (4) turns closed, and on July 11, 1996, the Control Room refrigeration water chilled water pump 9B was in pull to lock vice a normal standby condition. Therefore the equipment was not returned to normal operating status following maintenance previously performed on this equipment.

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

ADMISSION OR DENIAL OF THE ALLEGED VIOLATION

The Authority agrees with this violation.

REASONS FOR THE VIOLATION

The cause for the violation involving the out of position Emergency Diesel Generator jacket water cooler outlet valve 46ESW-5D was personnel error. The operator assigned the position of Controller, who was responsible for specifying the equipment restoration sequence following the system outage, did not ensure the released valve position matched the position specified in the system valve lineup.

Attachment I
Reply to Notice of Violation 96-05

VIOLATION B (cont.)

REASONS FOR THE VIOLATION (cont.)

The cause for the incorrect equipment line up of the Control Room Ventilation System was an inadequate procedure. The FSAR states that "if the normal operating chiller fails and the room ambient temperature reaches 98 degrees F, the spare air handling unit supply fan will start. This will start its associated chilled water pump and the chiller unit. Thus, the complete spare air handling unit will start." Operating Procedure OP-55A, "Control and Relay Room Refrigeration Water Chiller" addressed the startup and shutdown of chiller units, but did not address the standby condition as mentioned in the FSAR. For the shutdown sequence of the chiller unit, the procedure directed the operator to place the Control Room chiller switch in the off position and to place the chilled water pump switch in pull-to-lock position. The reserve chiller unit standby condition had never been addressed in the operating procedure and had never been questioned.

CORRECTIVE ACTIONS THAT HAVE BEEN TAKEN

- An audit of Protective Tagging Record (PTR) release positions was performed to obtain assurance that the specified release positions for PTRs since the last Refuel Outage are in accordance with the operating procedure valve lineups. Audit results identified a normally open RHR pump seal cavity drain valve 10RHR-23C to have been left closed during a PTR restoration. The drain valve was restored to its normal open position. The audit found no other components out of the correct position.
- The Controllers responsible for entering the incorrect release position for valves 46ESW-5D and 10RHR-23C on the PTR clearance forms have been counseled.
- A review of the safety significance of (1) valve 46ESW-5D being in the full open position vice the correct position of throttled 4 turns; (2) Control Room refrigeration water chilled pump 9B control switch being in pull-to-lock position versus standby position; and (3) valve 10RHR-23C being closed vice open was completed. The results of this review concluded that the mispositioning of these components had negligible system performance impact.
- Administrative Procedure AP-12.01, "Equipment and Personnel Protective Tagging" has been revised to add the requirement that all PTR release positions be independently verified by another qualified individual prior to protective tagging restoration.
- Operating Procedure OP-55A was revised to reflect FSAR requirements that the redundant Control Room Ventilation train not in service be in a standby line up.

Attachment I
Reply to Notice of Violation 96-05

VIOLATION B (cont.)

CORRECTIVE ACTIONS THAT HAVE BEEN TAKEN (cont.)

- An FSAR versus Operating Procedure review was completed to verify that when the "standby" operating condition for redundant equipment is described in the plant's Final Safety Analysis Report, plant procedures reflect this requirement. The remaining operating procedures contained correct standby requirements.
- The events associated with this violation were placed into an Operations Department briefing package for review with all department personnel. The Operations Department Manager reinforced expectations regarding recent human performance issues, including those related to this event, with all Shift Managers. The need for attention-to-detail, a questioning attitude, and prompt follow-up of concerns brought to the attention of Operations Department personnel was reinforced by Shift Managers with Operations Department shift personnel. Additionally, these events have been submitted for inclusion into the biennial operator PTR training module.

RESULTS ACHIEVED

A general improvement in operator awareness and the maintaining of a questioning attitude has been observed. The FSAR versus Operating Procedure reviews have provided assurance that similar procedure deficiencies do not exist.

CORRECTIVE ACTIONS TO BE TAKEN

- A summary of recent equipment status control issues will be developed and presented to plant personnel to reinforce expectations in this area. This action will be completed prior to the plant's Fall 1996 refuel outage.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance was achieved on August 3, 1996 following the proper positioning of valves 46ESW-5D and 10RHR-23C, the procedure change to OP-55A, and the corrected equipment line up for the Control Room Ventilation System.

Attachment II
Reply to Notice of Violation 96-05

Summary of Commitments

Number	Commitment	Due Date
JAFP-96-0377-01	A case study of the details associated with this violation will be included in the Training Department's Technical Supervisor Selection and Development (T.S.S.D) course. The course is designed to promote various potential supervisory position candidates. The inclusion of this case study into the program will provide future supervisors an understanding of the plant's administrative policies and rules governing the use of overtime at JAF.	01/31/97
JAFP-96-0377-02	A Quality Assurance Department audit is being conducted to review overtime practices used during a recent short duration plant outage involving overtime usage. Audit results will provide a measure of assurance that overtime policies are being correctly implemented.	10/15/96
JAFP-96-0377-03	A summary of recent equipment status control issues will be developed and presented to plant personnel to reinforce expectations in this area. This action will be completed prior to the plant's Fall 1996 refuel outage.	10/26/96