

July 31, 2000

Mr. Robert J. Barrett
Site Executive Officer
New York Power Authority
Indian Point 3 Nuclear Power Plant
Post Office Box 215
Buchanan, NY 10511

Subject: NRC's INDIAN POINT 3 INSPECTION REPORT NO. 05000286/2000-004

Dear Mr. Barrett:

On July 1, 2000, the NRC completed an inspection at the Indian Point 3 nuclear power plant. The enclosed report presents the results of that inspection. The results were discussed on July 20, 2000 with Mr. F. Dacimo and others of your staff.

The inspection was an examination of activities conducted under your license as they relate to safety and compliance with the Commission's rules and regulations, and with the conditions of your license. The inspection consisted of a selected examination of procedures and representative records, observations of activities, and interviews with personnel. Specifically, it involved six weeks of resident inspection and two region based inspections of the security program and radiation monitoring equipment.

The NRC identified one finding that was evaluated under the risk significance determination process and was determined to be of very low risk significance (Green). This finding was entered into your corrective action program and is discussed in the summary of findings and in the body of the attached inspection report.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of the NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/NRC/ADAMS/index.html> (the Public Electronic Reading Room).

Robert J. Barrett

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We appreciate your cooperation. Please contact me at 610 337-5234 if you have any questions regarding this letter.

Sincerely,

/RA/

Peter W. Eselgroth, Chief
Projects Branch 2
Division of Reactor Projects

Docket No.: 05000286

License No.: DPR-64

Enclosure: Inspection Report No. 05000286/2000-004

cc w/encl:

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REGION I

Docket No. 05000286
License No. DPR-64

Report No. 05000286/2000-004

Licensee: Power Authority of the State of New York,
doing business as The New York Power Authority (NYPA)

Facility: Indian Point 3 Nuclear Power Plant

Location: P.O. Box 215
Buchanan, New York 10511

Dates: May 21 - July 1, 2000

Inspectors: Peter Drysdale, Senior Resident Inspector
Jennifer England, Resident Inspector
John McFadden, Radiation Protection Specialist
Paul Frechette, Security and Safeguards Specialist
David Cullison, Project Engineer

Approved by: Peter Eselgroth, Chief
Projects Branch 2
Division of Reactor Projects

SUMMARY OF FINDINGS

IR 05000286/2000-004 on 5/21 - 7/1/2000; Power Authority of the State of New York; Indian Point 3 Generating Station. Personnel Performance in Nonroutine Operations.

The inspection covered a six week integrated report of resident inspection, and Region-based specialists in the areas of radiation monitoring instruments and plant physical security. The inspection identified one green issue. The significance of issues is indicated by their color (GREEN, WHITE, YELLOW, RED) and was determined by the Significance Determination Process in draft Inspection Manual Chapter 0609 (see Attachment 1).

Initiating Events

Green. Following secondary plant repairs on June 4, 2000, poor operator performance caused a reactor trip from approximately 22% during power ascension. Inadequate communications between members of the assigned watch crew, inadequate command and control of reactor operators by the control room supervisor, inadequate operator-trainee interaction during the startup, and inadequate oversight of control room activities by the shift manager all contributed directly to this event. This finding was evaluated using the SDP and determined to be Green (of very low significance), because all mitigating equipment functioned properly following the reactor trip.

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Report Details

SUMMARY OF PLANT STATUS

The Indian Point 3 plant remained at full power during most of the inspection period. Reactor power was reduced to 1% on June 2 through June 4 for leak repair of the common pre-separator drain line to the heater drain tank. Two reactor trips occurred during the inspection period. One occurred from approximately 22% power on June 4 following an operator error during power ascension following heater drain tank repairs; and a second occurred from 100% power on June 9 following an automatic load reject and turbine trip resulting from a faulted protection circuit in the station's main output lines.

1. REACTOR SAFETY (Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity)

1R04 Equipment Alignment

a. Inspection Scope (71111.04)

On May 24, 2000, the licensee performed planned maintenance of the 32 containment spray pump circuit breaker cubicle. During this activity, the inspector conducted a partial system walkdown of the containment fan cooler unit system using check-off lists COL-CB-1, "Containment Cooling and Filtration," and COL-RW-2, "Service Water System" to identify any discrepancies that could impact the function of the system and potentially increase risk since this system is an alternate containment cooling system.

On June 13, 2000, the licensee performed troubleshooting, repairs, and a setpoint check of the level control switch on the 32 emergency diesel generator (EDG) fuel oil day tank. During this activity, the inspector conducted a partial system walkdown of the fuel oil supply system for the 31 and 32 EDGs using COL-EL-1, "Diesel Generators," and drawing 9321-F-20303, "Flow Diagram - Fuel Oil to Diesel Generators." This inspection verified that redundant trains were operable and properly aligned.

b. Issues and Findings

There were no findings identified during this inspection.

1R05 Fire Protection

a. Inspection Scope (71111.05)

The inspectors conducted tours of the plant and examined the programmatic controls for combustible and flammable material, and the availability and material condition of fire protection and suppression equipment in the following areas:

- 31, 32, and 33 emergency diesel generator cells
- Station battery cubicles and the cable spreading room

- Primary auxiliary building general areas and containment access facility
- Primary auxiliary building hydrogen storage cubicle

b. Issues and Findings

There were no findings identified during this inspection.

1R12 Maintenance Rule Implementation

a. Inspection Scope (71111.12)

The inspectors reviewed problems involving selected in-scope structures, systems, and components (SSCs) to assess the effectiveness of the maintenance program. The reviews focused on proper maintenance rule scoping, characterization of failed SSCs, safety significance classifications, 10 CFR 50.65 (a)(1) and (a)(2) classifications, and performance criteria for SSCs classified as (a)(2), or goals and corrected actions for SSCs classified as (a)(1). The inspectors reviewed the NYPA's scoping documents. The following SSCs were reviewed:

- Repeated tripping of the central control room air conditioning compressors
- 32 boric acid transfer pump leak

b. Issues and Findings

There were no findings identified during this inspection.

1R13 Maintenance Risk Assessment and Emergent Work

a. Inspection Scope (71111.13)

The inspectors reviewed the maintenance risk assessments, corrective maintenance work packages, and observed activities associated with the following emergent work:

- 345KV line backup pilot wire relay replacement following failure of the relay
- 32 containment spray pump circuit breaker cubicle preventive maintenance
- Troubleshooting of 32 EDG fuel oil day tank level controller LC-1208S following corrective maintenance for internal binding
- Troubleshooting and repair of RCS loop 3 average temperature signal converter TM-432R following an erratic output signal that exceeded the over-temperature delta-temperature (OTdT) alarm setpoint

b. Issues and Findings

There were no findings identified during this inspection.

1R14 Personnel Performance during Non-routine Evolutions

a. Inspection Scope (71111.14, 71153)

The inspectors observed control room operator performance during the reactor down power on June 2, 2000, and reviewed the licensee's evaluation of operator performance that resulted in the subsequent reactor trip on June 4, 2000. The inspectors also reviewed the detailed root cause analysis performed by the licensee.

b. Issues and Findings

On June 2, 2000, control room operators completed an unplanned plant shutdown from 100% power in preparation for repairs of a through-wall fatigue failure that occurred in the common preseparator drain line penetration at the heater drain tank. The shutdown was uncomplicated and operators effectively maintained the reactor at a low steady-state power while the pipe repairs were completed.

However, during the subsequent power ascension, a high water level in the 33 steam generator (SG) resulted from an operator error that caused a main feedwater isolation and turbine trip from approximately 22% power during the transition from low flow bypass to normal feedwater flow. The reactor subsequently tripped automatically due to level shrink following closure of the main feedwater regulating valve (MFRV) for the 33 SG. At the time of the trip, an operator trainee was at the feedwater controls and under the supervision of a licensed reactor operator (RO) who did not adequately monitor the trainee's actions to control main feedwater flow and the positions of all four MFRVs during the transition from bypass feedwater flow. Upon observing a low feed pump discharge pressure, the RO increased feed pump speed and overfed the SGs, which caused the high SG level. All plant systems functioned normally and within design limits following the reactor trip, and operators exercised adequate controls to stabilize plant conditions and establish normal decay heat removal. The licensee's follow-up actions to analyze the plant response, and to understand and remediate the causal factors related to this event, were adequate prior to plant startup.

Poor human performance caused the reactor trip, and several contributing factors were identified which included inadequate communications between members of the assigned watch crew. Several operator trainees and watch crew members were new to their assignments, and had limited experience in the control room during plant startup activities. The assigned watch crew members were qualified for the evolutions in progress; however, the RO assigned to the primary plant and the control room supervisor (CRS) were both performing their first startup and power ascension in those designated watch positions. The operator trainee at the feedwater controls did not have any prior experience with a plant startup and did not have any prior training on the plant simulator. Inadequate command and control were demonstrated by the CRS when the RO assigned to the secondary plant misunderstood procedure directions to initiate the transition from bypass to normal feedwater flow. Consequently, the CRS was not aware that the transition activity was in progress at the time. The RO also demonstrated inadequate supervision over the operator trainee he had been assigned to direct at the

main control board. None of the above factors were detected or rectified by the shift manager in the control room at the time of the event.

The licensee did not previously consider that the plant startup warranted a level of management oversight given to an infrequently performed or special evolution. Senior plant management had been in the control room observing startup activities up to approximately 20 percent power, but were not present when the reactor tripped at approximately 22 percent power. Subsequent analyses performed by the PTRG and the root cause evaluation team concluded that the startup should have been performed as a special evolution with direct management oversight.

The inspector discussed the issue of inexperienced operator trainees manipulating plant controls during a complex evolution, even under the direct supervision of a licensed operator, with NYPA management. Management agreed that this practice should be re-evaluated and that the specific prior simulator experience should be considered prior to actual control board manipulations. The reactor trip is expected to be included in the licensee's second quarter 2000 performance indicator data for unplanned scrams.

This issue was considered to have very low risk significance (GREEN) using the SDP phase 1 evaluation, since all mitigating systems functioned properly following the reactor trip. Root cause analysis and corrective actions are being tracked by deficiency event report 00-1343.

1R15 Operability Evaluations

a. Inspection Scope (71111-15)

The inspector reviewed operability determinations (ODs) for the technical adequacy of the evaluations, whether continued operability was warranted, and whether other existing degraded systems adversely impacted the affected system or compensatory actions. The following operability evaluations were evaluated:

- OD 00-018, Degraded cell switch on 32 containment spray pump
- OD 00-021, Reactor coolant system overpressurization system bistable out of tolerance
- OD 00-022, Potentially nonconservative assumption for safety injection motor-operated valve SI-MOV-1810 design-basis differential pressure and thrust calculation

b. Issues and Findings

There were no findings identified during this inspection.

1R19 Post Maintenance Testing

a. Inspection Scope

The inspectors reviewed post maintenance test procedures and associated testing activities to assess whether the effect of testing on the plant had been adequately addressed by the control room, testing was adequate for maintenance performed, acceptance criteria was clear and adequately demonstrated operational readiness consistent with design and licensing documents, test instrumentation had current calibrations, range, and accuracy for the application, and test equipment was removed following testing. The following activities were evaluated:

- Post maintenance test of the 32 electric fire pump following repair of the pump suction valve
- Post maintenance test of the primary auxiliary building 31 exhaust fan following preventive maintenance on the fan motor circuit breaker
- Post maintenance test of the 34 service water pump following preventive maintenance on the pump discharge check valve

b. Issues and Findings

There were no findings identified during this inspection.

1R22 Surveillance Testing

a. Inspection Scope (71111.22)

The inspectors observed or reviewed the following technical specification surveillance tests:

- 3PT-Q83, "Refueling Water Storage Tank Lo-Lo Level Instrumentation System Check and Calibration"
- 3PT-Q21, "Steam Generator Blowdown Containment Isolation Valves" stroke times
- 3PT-Q92D, "34 Service Water Pump Operational Test," following corrective maintenance on the 34 service water vacuum breaker

b. Issues and Findings

There were no findings identified during this inspection.

1R23 Temporary Modifications

a. Inspection Scope (71111.23)

On June 9, 2000, the IP3 reactor automatically tripped following a main turbine trip that resulted from a direct signal in the protective circuitry for the main generator 345KV output line to the Buchanan substation. The inspectors reviewed temporary modification 00-3081-00, which replaced faulty wiring from the "TR1" trip relay between the Buchanan switchyard and the control room with spare wiring. The inspectors reviewed the temporary modification work package, and Administrative Procedure AP-13 "Temporary Modifications," and also performed a walkdown of the on-site portion of the temporary modification.

b. Issues and Findings

There were no findings identified during this inspection.

2. **RADIATION SAFETY** **(Cornerstone: Occupational Radiation Safety (OS))**

2OS3 Radiation Monitoring Instrumentation

a. Inspection Scope (71121.03)

The inspectors conducted the following activities to determine the effectiveness of plant radiation monitoring instrumentation.

Calibration, Operability, and Alarm Set-Point of Selected Instruments and Equipment

The inspection activities in this area selectively verified the calibration, operability, and alarm set-points (where applicable) of selected instruments and equipment, including the following:

- Health physics (HP) survey equipment, including an RO2 survey meter, a teletector, a neutron survey meter (remball), and an E-530 survey meter
- HP monitoring equipment, including area air samplers, hand-held friskers, a continuous air monitor (CAM), an area gamma radiation monitor (GA6), a small article monitor (SAM), a portal monitor, a whole-body contamination frisker, a remote radiation detector (AMP 100), and a personnel whole-body counting system
- HP counting room instrumentation, including gas flow proportional and sodium iodide detectors
- Installed radiation monitors, including vapor containment area monitors (R2 and R7), a waste holdup tank area monitor (R38A), a containment high range area monitor (R25), a main steam line radiation monitor (R62), and a primary auxiliary building area monitor (R64)

The inspection also included 1) a review of a scope-of-accreditation for ionizing radiation dosimetry (National Voluntary Laboratory Accreditation Program (NVLAP) Lab Code 100538-0, effective through June 30, 2000), and 2) a review of the whole-body thermoluminescent dosimeter (TLD) and extremity TLD blind spike results for the first quarter of the year 2000.

Problem Identification and Resolution

The inspection in this area included a selective review of the following licensee audits and self-assessments:

- Respiratory Protection Program Periodic Assessment, December 30, 1999
- Respiratory Protection Program Upgrade, February 1, 2000, Closure of RES Action Plan IRES-APL-99-003, 10 CFR 20, Subpart H
- Quality Assurance Audit Report A00-01-I, Indian Point 3 Training and Qualification of Plant Staff, April 19, 2000
- Report of Findings and Recommendations, Respiratory Protection Program, May 10, 2000

The inspection in this area also involved a review of the following Deviation/Event Reports (DERs) and discussion of corrective actions with cognizant personnel:

- DER 99-01933, Missed calibration due date for a HP small article monitor
- DER 99-02436, Condenser offgas radiation monitor alarm set points and performance trending of radiation monitors do not provide an early warning of primary-to-secondary steam generator leakage.
- DER 99-02643, Daily quality control check for whole body counting system not performed.
- DER 99-02888, labeling of HP air samplers used with 50 feet of tygon tubing not properly labeled as required
- DER 00-00413, R56C radiation monitor background setting unusually high with possible water intrusion
- DER 00-00512, Training waiver process for HP duty area 509 not performed as required.
- DER 00-00638, Low temperature alarm on the R27 plant vent monitor's heat trace circuit.
- DER 00-01025, Increased reading on the containment particulate radiation monitor R11
- DER 00-01136, Bar/lock not installed on HP source check device

Radiation Protection Technician Instrument Use

The inspection in this area included a review of the two radiation survey meter self-issue points inside the radiation controlled area (at the containment access facility (CAF) and at the HP control point on the 55 foot elevation of the PAB), the calibration status of the meters staged for use, the daily source check process, and the process for placing meters out of service.

Respiratory Protection - Self-Contained Breathing Apparatus (SCBA)

Inspection activities in this area included a tour to observe the location of all SCBAs and pressurized bottled air stations in the control room, on the turbine deck outside the control room, outside the operations support center, in the area protected by a carbon dioxide fire suppression system, and in the primary auxiliary building and included a selective review of the following documents:

- Procedure FP-13, "Inspection and Testing of Self-Contained Breathing Apparatus"
- Completed SCBA/Control Room Breathing Air Wheeled Manifold Units/Spare Air Cylinder Inspection/Test Checklist (tank pressure, visual inspection, operation, technician initials), May 2000
- Monthly Respiratory Protection Equipment Inventories, March, April, and May 2000
- PAB Emergency Breathing Air Stations Quarterly Inspections, February and May 2000
- Policies requiring respirator-qualified operations and security personnel to be clean-shaven in the respirator-sealing area
- Laboratory Lesson Plan, L.P. No. IP3-SCB-01, Self-Contained Breathing Apparatus, January 6, 1999
- Qualification Status Report for SCBA Use for Operations Personnel, June 8, 2000

b. Issues and Findings

There were no findings identified during this inspection.

**3. SAFEGUARDS
(Cornerstone: Physical Protection (PP))**

3PP1 Access Authorization Program

1. Inspection Scope (71130-01)

The inspectors conducted the following activities to determine the effectiveness of the licensee's behavior observation portion of the personnel screening and fitness-for-duty programs:

Five supervisors representing the Maintenance, Radiation Protection, Operations, System Engineering and Instrumentation & Control Departments were interviewed on May 24, 2000, regarding their understanding of behavior observation responsibilities and the ability to recognize aberrant behavior traits. The inspectors reviewed two Access Authorization/ Fitness-for-Duty self-assessments, a security audit, deviation/event reports, and loggable events for the four previous quarters written during May 22-24, 2000. On May 24, five individuals who performed escort duties were interviewed to establish their knowledge level of those duties. Behavior observation training procedures and records were reviewed on May 23, 2000.

2. Issues and Findings

There were no significant findings or observations identified in this area.

3PP2 Access Control

1. Inspection Scope (71130.02)

The following activities were conducted during May 22-26, 2000, to determine if the licensee had effective site access controls and equipment in place designed to detect and prevent the introduction of contraband (firearms, explosives, incendiary devices) into the protected area:

A random sample of twenty personnel who were granted unescorted access to the protected and vital areas was checked to assure that they were properly identified, screened, and authorized. The inspectors observed site access control activities, including personnel and package processing through the search equipment during peak ingress periods on May 23 and 24, 2000, and vehicle searches, on May 26, 2000. On May 24, 2000, the inspector observed testing of all access control equipment, including metal detectors, explosive material detectors, and X-ray examination equipment. The inspector also reviewed the Access Control Event Log, a security audit, and three maintenance work requests related to security systems.

2. Issues and Findings

There were no findings identified during this inspection.

4. **OTHER ACTIVITIES (OA)**

4OA1 Performance Indicator Verification

a. Inspection Scope

In accordance with procedure 71151, "Performance Indicator Verification," the inspector reviewed the corrective action program records for a prior occurrence involving a locked high radiation area key that was identified by the licensee on May 16, 2000. The licensee evaluated this as an occurrence meeting the criteria to be included under the performance indicator on occupational exposure control effectiveness. The inspector confirmed that the licensee appropriately identified the occurrence, and resolved it effectively and in a timely manner (DER 00-01178).

The inspectors reviewed the performance indicators for Fitness-for-Duty, Personnel Screening, and Protected Area Security Equipment. The review included the licensee's tracking and trending reports, personnel interviews, and security event reports for the Performance Indicator data submitted from the 2nd quarter of 1997 through the 1st quarter of 2000.

The inspectors also reviewed the performance indicator for unplanned scrams with a loss of the normal heat sink. Nuclear Energy Institute (NEI) guidance, NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," and Licensee Event Reports for the past year were used for this review.

b. Issues and Findings

There were no findings identified during this inspection.

40A3 Event Followup

a. Inspection Scope (71111.14, 71153)

On June 9, 2000, the main turbine-generator automatically tripped and was followed by a reactor trip from 100% power after a direct trip signal was received following a fault in the protection circuitry of the station's main output lines in a local substation. The inspectors observed operator actions in the control room to transition the plant to stable shutdown conditions, and to establish normal decay heat removal. The inspectors also observed the activities of the PTRG assembled to analyze the plant and operator response to the trip, and the formal bases for their subsequent recommendations to restart the plant following troubleshooting and repair of protective circuitry. This reactor trip is expected to be included in NYPA's second quarter performance indicator data for unplanned scrams.

b. Issues and Findings

There were no findings identified during this inspection.

40A4 Licensee Event Report Reviews

(Closed) Licensee Event Report (LER) 2000-004-00, Missed Control Room Oxygen Detector Surveillance Tests is a Condition Prohibited by Technical Specification, Caused by Personnel Error

On June 14, 2000, the licensee submitted LER 2000-004-00 to the NRC after discovering that channel checks on one of the control room oxygen detectors were not being performed as required by the technical specifications, and had not been documented between February 5, 1995 and May 18, 2000. The licensee determined that the channel check requirement had been deleted from the operator's logs, but the cause of that deletion was erroneous and could not be determined. This incident represented a violation of technical specification 4.5.A.5.e; however, since it was identified by the licensee and was immediately entered into the corrective action system (DER 00-01183), this will be treated as a Non-Cited Violation (NCV) in accordance with Appendix C of the NRC enforcement policy. The licensee's extent of condition review found no other channel checks required by technical specifications missing from operator log sheets. **NCV 05000286/2000-004-01**

(Closed) LER 2000-005-00, Pressurizer Safety Valves Discovered Outside Their As-found Lift Setpoint Test Acceptance Criteria After Removal; A Condition Prohibited by Technical Specifications

On June 19, 2000, the licensee submitted LER 2000-005-00 after being informed by an offsite testing laboratory that the lift setpoints for all three pressurizer code safety valves

were below their as-found lift setpoint acceptance criteria (2461 - 2509 psig). This condition represents a violation of technical specification 3.1.A.2.b, which requires that all pressurizer safety valves be operable when the plant is above cold shutdown. Since this condition was found in multiple valves during surveillance testing, it indicated that it may have existed during plant operation. The licensee entered this incident into the corrective action system (DER 00-01201) and initiated actions to overhaul and retest all three valves. Therefore this will be treated as a Non-Cited Violation in accordance with Appendix C of the NRC enforcement policy. **NCV 05000286/2000-004-002.**

(Closed) LER 2000-006-00, Plant Outside Design Basis because Cable Separation Criteria were Violated due to Human Error, Lack of Sufficient Engineering Details When Sparing a Channel III Cable, and a Lack of Configuration Control of Test Equipment

On June 26, 2000, the licensee submitted LER 2000-006-00 to the NRC after discovering two discrepancies where non-vital cables ran across separate cable trays containing independent channels of plant instrument bus cables. These conditions were caused by incomplete design changes from prior years that improperly spared installed cables, and resulted in a violation of the licensing basis criteria for cable channelization. No vital equipment cables were affected by these discrepancies and no faulted conditions were identified. The licensee performed an extent of condition review on spared plant cables and found no additional instances where the channelization criteria were violated. These discrepancies represent a minor violation of NRC requirements, and are not subject to enforcement.

4OA5 Other

a. Inspection Scope

In accordance with Temporary Instruction 2515/144, "Performance Indicator Data Collecting and Reporting Process Review," the inspectors reviewed LIC-SD-02 "Performance Indicator Reporting" and PFM-83, "WANO/NEI and Self Assessment Monthly Report." The inspectors used the licensee's performance indicator for Unplanned Power Changes per 7,000 Critical Hours as part of this review.

b. Issues and Findings

There were no findings identified during this inspection.

4OA6 Meetings

Exit Meeting Summary

On July 20, 2000, the inspectors presented the inspection results to Mr. F Dacimo and other NYPA staff members who acknowledged the findings presented. No proprietary information was identified during this inspection.

PARTIAL LIST OF PERSONS CONTACTED

R. Barrett	Site Executive Officer
R. Burroni	I&C Manager
F. Dacimo	Plant Manager
J. Comiotes	General Manager-Operations
J. DeRoy	Director, IP-3 Engineering
R. Deschamps	Health Physics Manager
D. Mayer	General Manager-Support Services
J. Perrotta	Quality Assurance Manager
K. Peters	Licensing Manager
P. Rubin	Assistant Operations Manager
J. Russell	General Manager-Maintenance
A. Vitali	Maintenance Manager
J. Wheeler	Training Manager
P. Asendorf	Security Manager
H. Bain	Security General Supervisor
L. Danko	Licensing Engineer

ITEMS OPENED, CLOSED, AND DISCUSSED

Closed

LER 2000-004-00	Missed Control Room Oxygen Detector Surveillance Tests is a Condition Prohibited by Technical Specification, Caused by Personnel Error
LER 2000-005-00	Pressurizer Safety Valves Discovered Outside Their As-found Lift Setpoint Test Acceptance Criteria After Removal; A Condition Prohibited by Technical Specifications
LER 2000-006-00	Plant Outside Design Basis because Cable Separation Criteria were Violated due to Human Error, Lack of Sufficient Engineering Details When Sparing a Channel III Cable, and a Lack of Configuration Control of Test Equipment

Open/Closed

NCV 05000286/2000-004-01	Missed Control Room Oxygen Detector Surveillance Tests
NCV 05000286/2000-004-02	Pressurizer Safety Valves Discovered Outside Their As-found Lift Setpoint Test Acceptance Criteria

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access and Management System
AP	administrative procedure
CAF	containment access facility
CAM	continuous air monitor
COL	check off list
CRS	control room supervisor
DER	deficiency/event report
EDG	emergency diesel generator
KV	kilo-volts
HP	health physics
LER	licensee event report
MFRV	main feedwater regulating valve
MR	maintenance rule
MSL	main steam line
NEI	Nuclear Energy Institute
NRC	Nuclear Regulatory Commission
NVLAP	National Voluntary Laboratory Accreditation Program
NYPA	New York Power Authority
ORS	occupational radiation safety
OSC	operations support center
PAB	primary auxiliary building
PARS	Publicly Available Records
PP	physical protection
PTRG	post-transient review group
RO	reactor operator
SAM	small article monitor
SCBA	self-contained breathing apparatus
TLD	thermoluminescent dosimeter
VC	vapor containment
WANO	World Association of Nuclear Operators

ATTACHMENT 1

NRC's REVISED REACTOR OVERSIGHT PROCESS

The federal Nuclear Regulatory Commission (NRC) recently revamped its inspection, assessment, and enforcement programs for commercial nuclear power plants. The new process takes into account improvements in the performance of the nuclear industry over the past 25 years and improved approaches of inspecting and assessing safety performance at NRC licensed plants.

The new process monitors licensee performance in three broad areas (called strategic performance areas): reactor safety (avoiding accidents and reducing the consequences of accidents if they occur), radiation safety (protecting plant employees and the public during routine operations), and safeguards (protecting the plant against sabotage or other security threats). The process focuses on licensee performance within each of seven cornerstones of safety in the three areas:

Reactor Safety

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness

Radiation Safety

- Occupational
- Public

Safeguards

- Physical Protection

To monitor these seven cornerstones of safety, the NRC uses two processes that generate information about the safety significance of plant operations: inspections and performance indicators. Inspection findings will be evaluated according to their potential significance for safety, using the Significance Determination Process, and assigned colors of GREEN, WHITE, YELLOW or RED. GREEN findings are indicative of issues that, while they may not be desirable, represent very low safety significance. WHITE findings indicate issues that are of low to moderate safety significance. YELLOW findings are issues that are of substantial safety significance. RED findings represent issues that are of high safety significance with a significant reduction in safety margin.

Performance indicator data will be compared to established criteria for measuring licensee performance in terms of potential safety. Based on prescribed thresholds, the indicators will be classified by color representing varying levels of performance and incremental degradation in safety: GREEN, WHITE, YELLOW, and RED. GREEN indicators represent performance at a level requiring no additional NRC oversight beyond the baseline inspections. WHITE corresponds to performance that may result in increased NRC oversight. YELLOW represents performance that minimally reduces safety margins and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margins but still provides adequate protection to public health and safety.

The assessment process integrates performance indicators and inspection so the agency can reach objective conclusions regarding overall plant performance. The agency will use an Action Matrix to determine in a systematic, predictable manner which regulatory actions should be taken based on a licensee's performance. The NRC's actions in response to the significance (as represented by the color) of issues will be the same for performance indicators as for inspection findings. As a licensee's safety performance degrades, the NRC will take more and increasingly significant action, which can include shutting down a plant, as described in the Action Matrix.

More information can be found at: <http://www.nrc.gov/NRR/OVERSIGHT/index.html>.