September 22, 2000

Mr. Michael J. Colomb
Site Executive Officer
New York Power Authority
James A. FitzPatrick Nuclear Power Plant
Post Office Box 41
Lycoming, New York 13093

SUBJECT: JAMES A. FITZPATRICK - NRC INSPECTION REPORT 05000333/2000-011

Dear Mr. Colomb:

On August 11, 2000, the NRC completed a team inspection at the James A. FitzPatrick Nuclear Power Plant. The enclosed report presents the results of that inspection. The results were discussed with you, and members of your staff, on August 11, 2000.

This inspection was a review of activities conducted under your license as related to the identification and resolution of problems, compliance with the Commission's rules and regulations, and with the conditions of your license. Within these areas, the inspection consisted of an examination of selected procedures and records, observation of activities, and interviews with personnel.

Overall, the findings from this inspection were consistent with previous observations by the NRC. The New York Power Authority (NYPA) continues to have significant weaknesses in various aspects of the corrective action program at FitzPatrick, due in part to the inadequate implementation of the corrective action administrative procedures. Your recent self-assessments and external reviews identified many of the same weaknesses that the inspection team found. We considered your internal "Common Cause Analysis" of the corrective action program to be extensive and critical, and the resultant improvement action plan appears acceptable. Continued NYPA management attention is warranted to ensure these proposed actions are effective in improving the implementation of the corrective action process.

Based on the results of this inspection, there was one green finding associated with post-maintenance testing, and three findings of no-color associated with the corrective action program. The findings were determined to be violations of NRC requirements. However, in accordance with Section VI.A of the Enforcement Policy, issued on May 1, 2000 (65FR25368), the violations were not cited due to their very low safety significance and because the findings were entered into your corrective action program. If you contest these non-cited violations, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; with copies to the Regional Administrator, Region I; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001; and the NRC Resident Inspector at the FitzPatrick facility.

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Sincerely,

/RA/

Wayne D. Lanning, Director
Division of Reactor Safety

Docket No. 05000333
License No. DPR-59

Enclosure: NRC Inspection Report 05000333/2000-011

cc w/encl:
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REGION I

Docket No:	05000333
License No:	DPR-59
Report No:	05000333/2000-011
Licensee:	New York Power Authority
Facility:	James A. FitzPatrick Nuclear Power Plant
Location:	Post Office Box 41 Lycoming, New York 13093
Dates:	July 24 - August 11, 2000
Inspectors:	Barry S. Norris, Senior Reactor Inspector Frank J. Arner, Reactor Inspector Carl E. Sisco, Operations Engineer Richard A. Skokowski, Resident Inspector
Approved By:	Lawrence T. Doerflein, Chief Systems Branch Division of Reactor Safety

SUMMARY OF FINDINGS

James A. FitzPatrick Nuclear Power Plant
NRC Inspection Report 05000333/2000-011

IR 05000333-00-11; on 07/24-08/11/2000; New York Power Authority; James A. FitzPatrick Nuclear Power Plant; Annual baseline inspection of the Identification and Resolution of Problems; Findings in identification and evaluation of problems, effectiveness of corrective actions, and post-maintenance testing.

The inspection was conducted by three regional inspectors and one resident inspector. This inspection identified 1 green finding and 3 findings of no color, all of which were categorized at Severity Level IV Non-Cited Violations. The significance of the issues is indicated by their color (green, white, yellow, red) and was determined by the Significance Determination Process (SDP). (Refer to Attachment 1)

Identification and Resolution of Problems:

The findings from this inspection were consistent with issues identified by inspection reports over the course of the last year. NYPA continues to be challenged with implementation of the corrective action program at FitzPatrick. Specific areas of concern include ineffective tracking of corrective actions to ensure completion, insufficient problem evaluation, and recurring equipment performance deficiencies due to inadequate corrective actions. Although the findings identified during this inspection were of very low safety significance, the concerns noted above have previously contributed to degraded conditions with the high pressure coolant injection system, the reactor core isolation cooling system, the emergency service water system, and the reactor protection system electrical protection assemblies. The FitzPatrick self-assessments and external reviews were consistent with the inspection findings. During the inspection, FitzPatrick management approved the report of an internal "Common Cause Analysis" of the corrective action program. The team found this report to be extensive and critical. As a result of the Common Cause Analysis, FitzPatrick developed an "Action Plan for Improvement of the Corrective Action Program." Continued NYPA management attention is warranted to ensure these proposed actions are effective in improving the station performance in the problem identification and resolution (PI&R) area.

Cornerstone: Barrier Integrity

- GREEN. A Non-Cited Violation of 10CFR50, Appendix B, Criterion XI, "Test Control," was identified due to a failure to perform post-maintenance testing after the adjustment of mechanical over-speed stops on the reactor recirculation pump motor generator sets. NYPA subsequently determined that the stops were set non-conservatively high and created the potential for the reactor to exceed the minimum critical power ratio operating limit under a postulated pump flow runout condition. The risk associated with this failure was determined to be of very low safety significance using the SDP. Inspection findings that only affect the fuel barrier, screen as very low risk significance (green) in Phase I of the SDP.

Cross-Cutting Issues

- NO COLOR. A Severity Level IV, Non-Cited Violation of 10CFR50, Appendix B, Criterion XVI, was identified associated with three examples of failure to promptly identify problems. Specifically, two opportunities were missed to identify a degraded condition with the safety related flow indication for the residual heat removal service water system (RHRSW); NYPA failed to identify conflicts between operating and surveillance test procedures for flow rate limitations; and NYPA failed to identify an adverse trend with the performance of core spray automatic start timers. These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding in accordance with NRC Manual Chapter 0610*, Appendix E.

- NO COLOR. A Severity Level IV, Non-Cited Violation of FitzPatrick Technical Specifications was identified due to three failures to perform adequate operability determinations during the evaluation of deficiency documents, as required by the administrative procedures. Specifically, the operability determination for the RHRSW degraded flow indication did not consider the inconsistency between the procedures regarding maximum pump flow; an operability determination was not conducted when it was determined that post-maintenance testing (PMT) was not performed after the reactor recirculation pump motor generator (RRP-MG) over-speed stops were adjusted; and the initial indications of a problem with the ground detection for the RHR control power monitoring relay were not evaluated with respect to operability, and the subsequent operability evaluation was inadequate; further evaluation resulted in NYPA declaring the relay inoperable. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

- NO COLOR. A Severity Level IV, Non-Cited Violation of 10 CFR50, Appendix B, Criterion XVI, was identified regarding four examples of ineffective corrective actions. The ineffective corrective actions were associated with the failure to perform a 50.59 review for operation in single element level reactor water level control versus three element, a repetitive runback of the reactor recirculation pumps, inappropriate resolution to a missed PMT associated with the reactor recirculation pump motor generator system, and a repetitive trip of a reactor protection system electrical protection assembly breaker. These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. This violation was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E.

- The FitzPatrick staff were familiar with the program for implementation of a safety conscious work environment. There was no indication of any hesitancy on the part of the station personnel to identify safety issues to management.

REPORT DETAILS

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

1R19 Post-Maintenance Testing

a. Scope

The inspectors reviewed the licensee's activities related to the failure to perform post-maintenance-testing (PMT) after the adjustment of the mechanical over-speed stops on the reactor recirculation pump (RRP) motor generator (MG) sets.

b. Issues and Findings

In April 2000, during a forced outage, maintenance technicians adjusted the mechanical over-speed stops on the RRP-MG sets; the stops were adjusted to allow FitzPatrick to achieve 100% power. It wasn't until after the reactor start-up on April 5, 2000, that licensee personnel realized that the required PMT had not been performed. Initially, the licensee assumed that the PMT needed to be performed with the plant shutdown. In July, the licensee re-assessed the required plant conditions, performed the PMT, and determined that the stops were adjusted too high. Technicians re-adjusted the stops and performed the necessary PMT.

The required stop settings are determined by the Core Operating Limits Report (COLR); specifically, the settings are predicated on limits for reactor recirculation flow based on core age. The licensee determined that the as-found condition of the over-speed stops was non-conservative for the period of time from the reactor start-up until April 11, 2000. After April 11, the recirculation flow limit in the COLR increased and the settings were adequate. The table below indicates the limits and test results.

PUMP	As found % Flow	COLR Limit Before 4/11/00	COLR Limit After 4/11/00
A	104.3%	102.5%	107%
B	105.7%	102.5%	107%

This condition could have resulted in the reactor exceeding the Minimum Critical Power Ratio (MCPR) operating limit under a recirculation pump runout condition; however, there was no indication that a pump runout occurred. This event was determined to Green (of very low safety significance) using the Significance Determination Process for fuel barrier issues. Nonetheless, the condition was a violation of 10CFR50, Appendix B, Criterion XI, "Test Control," which requires that testing demonstrate that systems will perform satisfactorily in accordance with the applicable design documents. This violation was treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy, issued on May 1, 2000 (65FR25368). The issues associated with this violation were in the FitzPatrick corrective action system as DER 00-3657. **(NCV 05000333/2000-011-01)**

4. OTHER ACTIVITIES (OA)

CORNERSTONES: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Occupational Radiation Safety, Public Radiation Safety, and Physical Protection

4OA2 Identification and Resolution of Problems

The objective of the inspection was to determine if problems affecting equipment, personnel, or processes at FitzPatrick were properly identified and resolved. This included verifying that problems were: (1) entered into the corrective action system, (2) reviewed and prioritized, (3) evaluated for operability and reportability, and (4) received the appropriate level of root cause analysis (RCA) to ensure the problems would not recur.

The inspectors reviewed Deviation/Event Reports (DERs - the formal corrective action program) and associated documents. Specifically, the inspectors' review included: 11 implementing procedures, 114 DERs, 25 work requests, 45 non-cited violations, 3 administratively closed cited violations, 5 items related to operating experience, 19 self-assessments, 4 quality assurance audits and surveillances, and meeting minutes for the 7 onsite and 7 offsite review committee meetings. The inspectors focused on safety-related and risk significant systems and components The specific documents reviewed were chosen to acquire a sufficient sample across all of the cornerstones, and are listed in Attachment 2 to this report.

.1 Effectiveness of Problem Identification

a. Scope

The inspectors evaluated the documents listed in Attachment 2 to determine the licensee's threshold for identification of problems and entering them into the corrective action program. The review included DERs, problem identifications (PIDs), operator workarounds, temporary modifications, maintenance and engineering backlogs, the security and radiological logs, self-assessments, and quality assurance audits and surveillances. The inspectors also interviewed plant staff and management, and the employee concerns program coordinator, and attended the daily Plan-of-the-Day meeting to observe the management review of DERs.

b. Issues and Findings

Earlier in the year, the licensee consciously lowered the threshold for the initiation of DERs, with the intent of ensuring that conditions of even minor significance were entered into the corrective action system. Based on the new threshold, NYPA will identify approximately 7000 DERs this year. Notwithstanding, this lower threshold, the inspector

found several instances where the licensee failed to promptly identify issues. Three of the more significant examples are:

- On July 24, 2000, DER 00-3351 identified that the safety related flow indication in the control room for the residual heat removal service water (RHRSW) system read 10-14% less than the actual flow, as measured during the quarterly surveillance test (ST). Although the licensee had performed the ST previously in February and in June of this year, they did not identify until July the difference between the measured flow and the indicated flow on the installed instrumentation in the control room.

- Also related to the RHRSW system, during the inspection, the NRC identified a conflict between the RHRSW operating procedure (OP) and the quarterly ST. The OP had a design-based upper limit on pump flow of 4000 gallons-per-minute (gpm); however, the ST required flows in excess of 4200 gpm. A review of past STs identified flowrates as high as 6200 gpm. The NRC-identified conflict between the OP and ST resulted in the need for an operability determination. Both engineering and operations personnel had a chance to identify this problem during review of the ST. (See IR Section 4OA2.2.)

- In August 1999, NYPA identified that the automatic start timers for both trains of core spray were outside the acceptance criteria specified in the FitzPatrick technical specification (TS). This rendered both divisions of core spray inoperable, and resulted in a non-cited violation (NCV 1999-08-06). During this inspection, the team noted that prior to the violation, these timers were found to be outside of the TS acceptance values three times in eighteen months. However, the August 1999 event was the first time both divisions failed at the same time. In each of the previous cases, a DER was initiated, but the DERs were coded as “isolated events.” As such, the licensee’s evaluations failed to identify the adverse trend and take effective corrective actions to prevent recurrence.

These examples of promptly failing to identify conditions adverse to quality were determined to be more than minor because they indicated an adverse performance trend. The failure to promptly identify deficiencies was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E. 10CFR50, Appendix B, Criterion XVI, “Corrective Action,” requires conditions adverse to quality to be promptly identified and corrected. These examples were considered a Severity Level IV violation and were treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy, issued on May 1, 2000 (65FR25368). This finding was entered into the FitzPatrick corrective action program as DER 00-3654
(**NCV 05000333/2000-011-02)**

.2 Prioritization and Evaluation of Issues

a. Scope

The inspectors reviewed the DERs listed in Attachment 2 to assess the licensee's extent of review into the reason for the problem (RCA, apparent cause evaluation, or most probable cause). The inspectors also assessed the licensee's review of the DERs for operability, reportability, and reliability and unavailability within the scope of the Maintenance Rule.

b. Issues and Findings

Root Cause Analysis

The inspectors identified no significant findings associated with root cause analysis. In general, the root cause evaluations were considered adequate. The inspectors did note some examples of comprehensive RCAs, primarily associated with high-profile issues related to the emergency service water system, the reactor core isolation cooling system, and the reactor protection system (RPS) electrical protection assemblies (EPA).

Operability Determinations

During the inspection, the team identified several instances where the DER was not forwarded to the control room for an operability determination, or where the operability determination was inadequate. AP-03.02, "Deviation and Event Reporting," requires the initiator of a DER to inform the Shift Manager of any potential operability concerns (by checking the appropriate block on the DER form); this alerts the Shift Manager to perform an operability determination per AP-03.11. Examples of the above were:

- The initial operability evaluation performed on July 25, 2000, for the RHRSW issue discussed previously, was weak in that it only addressed the affect on pump operability as related to inservice test pump performance and technical specification minimum flow requirements. However, the inspectors identified that system operating procedures had caution statements and limits established for allowable maximum pump flowrates (4000 gpm) in order to prevent pump damage. The affect of the degraded indication resulted in actual flowrates exceeding this maximum limit. Additionally, the team identified that during surveillance testing, pump flowrates had been as high as 6200 gpm, which was well beyond the pump performance curves. The licensee initiated DER-00-03351 to evaluate the long term operability of the system based on the higher flowrates observed and the affect on heat exchanger limitations. The evaluation concluded that RHRSW system had not been adversely affected by the higher flowrates. To prevent future challenges to the system, the licensee established upper limits on pump flowrates to ensure that pump operation remains on the pump curves.

- In April 2000, the mechanical over-speed stops for the RRP-MG sets were adjusted. Several days after the reactor start-up, the licensee initiated a DER identifying that the required PMT was not performed; however, no operability determination was performed. Following discussions with the resident inspectors, a second DER was initiated noting that an operability determination should have been performed for the first DER. Subsequently, the RRP-MG sets were determined to be operable based on an assumption that the work was performed satisfactorily. Testing later determined that the over-speed stops were set too high (i.e., in the non-conservative direction) and that design basis was exceeded.

- In February 2000, the licensee identified that an evaluation of NRC Information Notice (IN) 94-80, "Inadequate DC Ground Detection in Direct Current Distribution Systems," had not been completed at the time the IN was issued. FitzPatrick initiated DER 00-0680 to complete the review. The due date for the review was extended three times even though the responsible system engineer noted in the extension request that a relay in the RHR system may require a more sensitive ground detection setpoint. During the inspection, the inspectors identified that the extensions were approved without questioning the operability of the relay in question. The licensee determined that the relay provided an alarm in the control room in the event control power was lost to the RHR system. The licensee's initial conclusion to the team's concern was that the relay had no safety function, and therefore had no impact on operability. The inspectors later determined this conclusion was incorrect because due to this inadequate ground detection setpoint a loss of control power to the RHR system could go undetected. Furthermore, NYPA failed to recognize that the relay had a function controlled by their Administrative Procedure (AP) 01.04, "Tech Spec Related Requirements, Lists, and Tables," Revision 20. Consequently, NYPA declared the relay inoperable and took the actions specified in AP01.04. The licensee initiated DERs 00-3572 and 00-3632.

AP-03.02 and AP-03.11 require all potential operability concerns be evaluated. These examples of inadequate operability evaluations were determined to be more than minor in that they indicated an adverse performance trend. The failure to perform adequate operability evaluations was not subjected to a cornerstone significant determination process, and is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E. Nonetheless, the failure to perform adequate operability determinations, as identified by the above examples, was a violation of the FitzPatrick TS, Section 6.8, related to procedure use. The violation was categorized at Severity Level IV and was treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy, issued on May 1, 2000 (65FR25368). This finding was entered into the FitzPatrick corrective action program as DER 00-3655.
(NCV 05000333/2000-011-03)

.3 Effectiveness of Corrective Actions

a. Scope

The inspectors reviewed the licensee's corrective actions with respect to their determination of the cause of the problem (for example, the root cause analysis). The review also included an assessment of the backlog of corrective actions, including the maintenance and engineering backlogs, to determine if any actions, individually or collectively, represented an increased risk due to the delay of implementation.

b. Issues and Findings

The inspectors identified no significant findings. However, the inspectors found many examples where corrective actions were not implemented or were not adequate. 10CFR50, Appendix B, Criterion XVI, states, in part, that measures shall be established to assure that conditions adverse to quality are promptly identified and corrected. For significant conditions adverse to quality, the measures shall assure that the cause of the condition is determined and actions taken to prevent recurrence. Contrary to the above:

- In late 1999, the NRC noted that, since 1984, FitzPatrick had operated the reactor water level control system in the single element mode of operation vice the three element mode, as described in the FSAR. NCV 99-09-03 was issued, citing that the requisite 10CFR50.59 safety evaluation had not been performed. As of the beginning of this inspection, the 50.59 had not been performed.

- Inadequate corrective actions for a RRP runback in April 1998, allowed a second runback to occur in April 2000. Both runbacks were due to a short duration voltage transient that impacted the RRP system control circuit. Following the 1998 event, the licensee recognized that the control circuit was sensitive to short duration voltage transients and opened item 98-32606 in the action commitment tracking system (ACTS) to develop corrective actions. The ACTS item was extended seven times; corrective actions were not taken in a timely manner to prevent the second runback.

- In April 2000, the mechanical over-speed stops for RRP-MG sets were adjusted. It was identified several days later (after the reactor startup) that no PMT was performed for the adjustment. No immediate corrective action was taken to determine if the stops were adjusted properly or to ensure operability. Testing later determined that the over-speed stops were not adjusted properly, in the non-conservative direction.

- The corrective actions for a June 26, 2000, trip of the "A" RPS EPA failed to prevent a second trip on July 3. The corrective action for the June event was to replace a computer logic card. Although the EPA output voltage was logged daily, the licensee failed to recognize that the voltage was not constant at the nominal 122 VAC, but dropped to 119 VAC. The failure to recognize the repetitive degradation of the RPS motor generator set output voltage resulted in the second "A" RPS EPA breaker trip 1 week later.

These examples of ineffective corrective actions were determined to be more than minor because they indicated an adverse performance trend. However, since this was not subjected to a cornerstone significant determination process, it is, therefore, a no color finding, in accordance with NRC Manual Chapter 0610*, Appendix E. Nonetheless, the failure to take immediate corrective actions and/or actions to prevent recurrence for conditions adverse to quality, as identified by the above examples, was a violation of 10CFR50, Appendix B, Criterion XVI, "Corrective Action." This violation was categorized at Severity Level IV and was treated as a Non-Cited Violation (NCV), consistent with Section VI.A of the NRC Enforcement Policy, issued on May 1, 2000 (65FR25368). This finding was entered into the FitzPatrick corrective action program as DER 00-3656. **(NCV 05000333/2000-011-04)**

.4 Effectiveness of Licensee Audits and Assessments

a. Scope

The inspectors reviewed quality assurance (QA) audit and surveillance reports, departmental self-assessments, an internal analysis of the corrective action program, and third-party reviews of licensee performance. The review was to determine whether they were consistent with NRC findings, to determine if assessment findings were entered into the licensee's corrective action program, and to determine if corrective actions were completed to resolve identified program deficiencies.

b. Issues and Findings

The licensee's self assessments and audits were effective in identifying deficiencies in the corrective action program. Assessments noted deficiencies in implementation of the corrective action program in the following areas: ineffective tracking of corrective actions to ensure completion, inadequate DER responses and closures, and recurring equipment performance deficiencies due to inadequate corrective actions. The licensee findings were similar to the problems identified by the NRC during this inspection.

.5 Assessment of Safety Conscious Work Environment

a. Scope

The inspectors reviewed the licensee's employee concerns program with respect to a safety conscious work environment at FitzPatrick. As part of this inspection, the inspectors questioned plant staff to determine if conditions existed that would result in personnel being hesitant to raise safety concerns to their management and/or the NRC.

b. Issues and Findings

The inspectors reviewed the FitzPatrick employee concerns program (Speakout) for implementation of a safety conscious work environment. During interviews with plant staff, the team found that personnel were familiar with the Speakout program and that there was no indication of any hesitancy on the part of personnel to identify safety issues to management

4OA5 (Closed) LER 50-333/2000-006-00: RPS Motor Generator Voltage Regulator Failure Causes Loss of "A" RPS Bus and ESF Actuation

On June 26, 2000, and again on July 3, 2000, the "A" RPS bus was de-energized due to an unplanned loss of power. The EPA breakers that supply the RPS bus were found in a tripped condition. The loss of power de-energized one-half of the RPS logic and one-half of the primary containment isolation system logic. This resulted in isolation of the reactor water cleanup system, the primary containment drain system, the reactor water sample system, and the reactor building ventilation system; the loss of power also caused the initiation of the standby gas treatment system. The inspector performed an on-site review of the equipment failure evaluation form along with the completed and proposed corrective actions. See also Section 4OA2.3 of this inspection report for additional information. Based on this review, the LER was closed.

4OA6 Exit Meeting Summary

The inspectors presented the inspection results to Mr. M. Coulomb, Site Executive Officer, and other members of licensee management, at the conclusion of the inspection on August 11, 2000. The licensee acknowledged the findings presented.

The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENTS

1. NRC's Revised Reactor Oversight Process
2. Partial List of Personnel Contacted
   Items Opened, Closed, and Discussed
   List of Acronyms
   List of Documents Reviewed
3. Handouts NYPA Presentation Entrance Meeting July 24, 2000

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	Radiation Safety	Safeguards
● Initiating Events	● Occupational	● Physical Protection
● Mitigating Systems	● Public	
● Barrier Integrity		
● Emergency Preparedness		

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 margin and requires even more NRC oversight. And RED indicates performance that represents a significant reduction in safety margin 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.

ATTACHMENT 2

PARTIAL LIST OF PERSONNEL CONTACTED

FitzPatrick:

M. Colomb - Site Executive Officer
R. DenBleyker - Speakout Coordinator
J. Flaherty - Quality Assurance Manager
D. Kieper - General Manager, Maintenance
D. Lindsey - Plant Manager
W. O'Malley - General Manager, Operations
G. Tasick - Licensing Manager
A. Zaremba - General Manager, Support Services

NRC:

R. Rasmussen - Senior Resident Inspector
L. Doerflein - Chief, Systems Branch

ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

none

Opened & Closed

50-333/00-11-01	NCV	Failure to Perform Post-Maintenance Testing Resulted in the Reactor Recirculation Pump Mechanical Stops Being Set/Left in a Non-Conservative Condition	(IR Section 1R19)
50-333/00-11-02	NCV	Failure to Identify Conditions Adverse to Quality	(IR Section 4OA2.1)
50-333/00-11-03	NCV	Failure to Evaluate Conditions Adverse to Quality (DERs) for Operability	(IR Section 4OA2.2)
50-333/00-11-04	NCV	Failure to Take Immediate Corrective Actions and/or Actions to Prevent Recurrence	(IR Section 4OA2.3)

Closed

50-333/00-06-00	LER	RPS Motor Generator Voltage Regulator Failure Causes Loss of "A" RPS Bus and ESF Actuation	(IR Section 4OA5)

LIST OF ACRONYMS

CFR	Code of Federal Regulations
COLR	Core Operating Limits Report
DER	Deviation Event Response
EPA	Electrical Protection Assembly
ESF	Engineered Safety Function
gpm	gallons per minute
MG	Motor Generator

Attachment 2 (cont.)

LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
OP	Operating Procedure
PMT	Post Maintenance Test
QA	Quality Assurance
RCA	Root Cause Analysis
RPS	Reactor Protection System
RRP	Reactor Recirculation Pump
ST	Surveillance Test
TS	Technical Specification
VAC	Volts - Alternating Current
VIO	Violation
WOR	Work Order Request

LIST OF DOCUMENTS REVIEWED

PROCEDURES:

AP-01.04, Revision 20, Technical Specification Related Requirements, Lists, and Tables
AP-03.02, Revision 13, Deviation and Event Reporting
AP-03.03, Revision 15, Deviation and Event Analysis
AP-03.06, Revision 8, Performance Indicators
AP-03.08, Revision 13, Action and Commitment Tracking System
AP-03.11, Revision 5, Operability Determinations
AP-05.10, Revision 2, Control of Scaffolding
AP-10.01, Revision 21, Problem Identification and Work Control
ORG-SO-03.02, Revision 6, Deviation and Event Report Screening
RP-RESP-03.01, Revision 8, Drywell Constant Air Monitor
TP-05.07, Revision 8, Licensed Operator Requalification Examination Development and Administration

DEVIATION EVENT REPORTS:

1998-0762	RRP Pump 'A' Runback
1998-0816	'A' RRP Pump Runback to 44%
1998-0937	CRD Logic Power Supply Failure
1998-1557	Potential Adverse Trend - Failure of Fire Dampers
1998-1735	Potential Adverse Trend - Human Performance in Operations
1998-2118	Mis-Application of Calculation to Support Operability Determination
1998-3351	Binding of 52/STA 71-10502 Breaker
1998-3432	Adverse Trend for HL and STA Switches (4160 Breakers)
1998-3525	EDG Logic Test Deficiency
1999-0187	Core Spray Start Timer out of Tolerance Per ST-3J
1999-0302	LPRM Upscale Resulting in a Half-Scram
1999-0475	Dropped Nut & Washer Are Not Retrievable
1999-0551	Job Dropped on the Day to Be Worked
1999-0658	HPCI Operability with Leakage past 23MOV-14
1999-0838	Foreign Material Within Chlorine System

Attachment 2 (cont.)

1999-0946	Setpoint Change Request
1999-0969	EDG A Circulating Lube Oil Pump Trip
1999-1038	LER C/A ACTs Item Closed Without Completing Intended Actions
1999-1238	Timeliness of DER Initiation
1999-1270	Inaccurate RCIC Governor Parts List
1999-1272	PTR'd Valve Operated by Vendor Tech Rep
1999-1714	Potential Adverse Trend - PTR Tagout/Lockout
1999-2065	Main Turbine Trip/Reactor Scram
1999-2125	Potential Adverse Trend - Emergency Battery Lights
1999-2126	Potential Adverse Surveillance Trend (H2 Transmitters)
1999-2127	Potential Adverse Surveillance Trend (CAD H_2/O_2 Monitors)
1999-2128	Potential Adverse Surveillance Trend (27PS-110A/B)
1999-2154	Potential Adverse Trend - Containment Isolation Valves Failed Surveillances
1999-2484	Turbine Trip/Reactor Scram due to MSR 1B hi level trip
1999-2533	Ineffective Corrective Actions
1999-2700	Potential Adverse Trend Dynamic Response of Control Systems
1999-2728	DESO-13 and 14 vs 10 CFR 50.54f
1999-2730	Some No Validation Required During 50.54
1999-2797	Drywell Sampling Requirements Nearly Missed
1999-2877	Operating Procedure - FSAR Conflict
1999-3004	Potential Adverse Trend - Human Performance
2000-0003	67FN-12B Fan Failed to Start During ST-40K
2000-0017	Oil Leal on HPCI EGR
2000-0018	APRM Upscale Thermal Lights Coming in Without a ½ Scram
2000-0034	Access to Halon System and HVAC Cooler Blocked
2000-0041	14LS-20B Requires Frequent Adjustment and Expends Dose
2000-0048	ACT Transferred, Priority Changed & Extended with No Action
2000-0054	Corrective Actions of JOPS-93-236 Not Implemented
2000-0073	Reactor Head Spray limit switch failed
2000-0073	10LS-102 Failed ST-2AQ Acceptance Criteria
2000-0084	Surveillance Testing EDG Logic
2000-0084	EDG Logic Testing Deficiencies
2000-0085	Water Curtain #1 Blocked Nozzles
2000-0096	76FPS-315 Found Unlocked
2000-0174	AP-01.04 Does Not List All Smoke Detection Areas
2000-0179	73PS-116B Isolation Valve out of Position
2000-0185	ST-8V Failed Acceptance Criteria
2000-0231	Zone 32 Smoke Detection Inoperable
2000-0293	Rebuilt H2 PCV Installed Without PMT
2000-0447	76P-4 Start Time During ST-76AC
2000-0452	Potential Common Mode Failure of SR Unit Coolers
2000-0455	ESW TS Bases Not Consistent with Current Licensing Bases
2000-0461	Room Cooler Performance Monitoring
2000-0462	76P-1 Inoperable due to 76FPP Trouble Alarm
2000-0479	Air Compressor LP Piston Rod to head interference
2000-0524	Potential Adverse Trend #DERS Associated with ESW System Assessment
2000-0777	Potential Adverse Trend - ST Program
2000-0779	Tubes Plugged in West Cable Tunnel Ventilation Cooler Not Considered in Calculations

Attachment 2 (cont.)

2000-0780	4Q99 Potential Adverse Trend in Personnel Error Rates
2000-0811	76ELB-RB-300-1 Improperly Aimed
2000-0812	Wall Thickness less than Minimum for RHRSW Strainers A & C
2000-0949	Recirculation MG Set Runback Corrective Action
2000-0991	Portable HEPA Unit Secured to Safety Related Equipment
2000-1016	FFP 3.0 Signed of "SAT" While Incomplete and "UNSAT"
2000-1037	Wrong Sized Lug Installed on Jumper
2000-1133	No JAF Administrative Controls for Emergency Plan Volume 1 Documents
2000-1202	Potential Adverse Trend - Ops Procedures Scope, Content
2000-1208	Poor Work Coordination and Planning for Downpower Evolution
2000-1265	Potential Adverse Trend Control Room Deficiency Aging
2000-1276	Condenser Booster Pump Coupling Re-assembly (33P-9C)
2000-1301	'A' RRP Pump Run Back to 44% Limiter
2000-1390	Failure to Implement Corrective Actions for RWR Pump Runback
2000-1430	Potential Adverse Trend/implementation of Design Change Errors
2000-1471	Potential Adverse Trend in Procedure Adherence
2000-1536	Main Steam Leak Collection Input to A-SBGT
2000-1566	Potential Adverse Trend - Corrective Action Program Implementation
2000-1582	1Q00 Trend Report Identified Increase in Technical Services Personnel Error Rate
2000-1648	Trend DER - Control of Non-Station Personnel
2000-1675	Potential Adverse Trend
2000-1746	Emergency Light Pack Illumination Pathway Partially Blocked
2000-1828	ST-76AC Suspended Due to out of Spec Prestart Oil Level
2000-2112	Required Work Not Identified in Schedule
2000-2141	Solid Metal Scaffolding Grating/sprinkler Area
2000-2189	Air Compressor, 39AC-1A, HP I/B Valve Covers Loose
2000-2191	'A' Air Compressor Failed PWT
2000-2211	ESW Strainer Wall Thickness below Acceptance Criteria
2000-2227	Washer Found in LP Suction Valve for 39AC-1A
2000-2274	RCIC System Inoperable
2000-2311	39AC-1A Rework
2000-2398	10 Second Delay Reduced w/ Indicated Flow Rate -66DPT-109
2000-2426	Loose Protective Shroud on the RCIC turbine
2000-2430	34E-2A Union Has 10gpm Leak after Replacement
2000-2443	RCIC Operability Determination Seismic Concerns
2000-2524	Scaffolding Not Rigidly Supported
2000-2533	DER Response Did Not Meet Requirements of AP-3.03
2000-2534	10P-1A (M) IS-E-07 Enhancement
2000-2555	Correction to DER 2000-02534
2000-2566	10RHR-431A Seat Disc Found Disc Stuck in Closed Position
2000-2763	Untimely Corrective Actions for HPCI Foam Extinguishing Sys.
2000-2882	RWR MG Set PWT Delay Not Formally Evaluated for Operability
2000-2889	Hydrogen Farm System Safety Hazard
2000-2913	Degraded Performance of 76P-1
2000-2938	ISI Boundaries Improperly Indicated by ISI Engineer
2000-3283	Degraded Condition of RHRSW Flow Elements, 10FE-96A/B
2000-3323	20 Ton Hoist Over Sped Switch
2000-3329	Incorrect Size Strut Assembly Installed at PFSK-2402
2000-3355	Continued Use of RB Crane to Move New Fuel

Attachment 2 (cont.)

2000-3370 Problems Found with RCIC Flow Controller, 13FIC-91
2000-3510 23FS-78 Low Switch Contact High Resistance

NON-CITED VIOLATIONS AND VIOLATIONS:

Non-Cited Violations (NCVs):

1998-04-01 Inadequate Procedure Contributed to Low Reactor Water Level Scram
1998-05-01 Failure to Implement a Design Change for RCIC in 1994
1998-06-01 Failure to Perform Technical Specification Required Testing
1998-07-01 Failure to Perform Procedure as Written Resulted in Separated Hose During Torus Dewatering
1998-07-03 Missed Surveillance Test of Pressure Isolation Valves for RHR
1998-07-05 Surveillance Testing of the Pressure Suppression Chamber
1998-07-06 Unplanned Exposure Incident of September 17, 1998
1998-08-02 Inadequate Procedure to Control Reactor Vessel Level During Reassembly
1998-08-03 Failure to Adequately Test Primary Containment Isolation Valves
1998-08-04 Failure to Take Compensatory Actions for Inoperable CAM
1999-01-01 Failure to Take Appropriate Corrective Actions for an Operations Procedure Deficiency for CR PI
1999-01-02 Failure to Conduct an Adequate Post Work Test for Control Room Annunciators
1999-01-03 Failure to Adequately Control Scaffolding in the Vicinity of Safety Related Equipment
1999-02-01 Failure to Complete an EDG Surveillance Test Procedure Resulting in the Plant Being in an Unanalyzed Condition
1999-03-01 Failure to Have at Least 9 Safety Relief Valves Operable, as Required by Technical Specifications
1999-03-02 Failure to Meet Technical Specification Containment Leakage Requirements
1999-03-03 Failure to Perform Technical Specification Surveillances in Accordance with GL 96-01 (logic circuit testing)
1999-03-04 Use of a Trailer as a Third Source for the Hydrogen Addition System, Contrary to the UFSAR Design
1999-04-01 Failure to Properly Clear a Tagout During Refueling Outage, Resulted in RCIC Being Inoperable for ≈4 Months
1999-04-02 Failure to Properly Calibrate the Pressure Switches for the Suppression Chamber to Reactor Building Vacuum Breakers
1999-06-01 Failure to Initiate a Deficiency Report for Conditions Adverse to Quality
1999-06-02 Failure to Adequately Control the Configuration of the HPCI System
1999-06-03 Failure to Appropriately Revise a Procedure Following an NRC Identified Deficiency
1999-07-01 Failure to incorporate instrument uncertainties into the RHR Low Flow Switch Setpoint
1999-08-01 Failure to Install an Emergency Service Water Valve per the Installation Instructions
1999-08-02 Failure to Control the Fire Protection System Configuration per Plant Drawings
1999-08-03 Failure to Perform Independent Engineering Verification, as Required by the Procedure
1999-08-04 Failure to Properly Characterized a Pump as Surface Contaminated During a Shipment in March 1999
1999-08-05 Failure to Properly Verify Containment H_2 & O_2 Levels, as Required by TS
1999-08-06 Failure to Adequately Establish the Core Spray Timer Calibration Tolerances
1999-09-02 Failure to Identify Conditions Adverse to Quality Associated with the HPCI System

Attachment 2 (cont.)

1999-09-03 Failure to Complete a 50.59 Analysis for Long Term Operation with RX Water Level in Single Element Control
1999-09-04 Inadequate Test Control Associated with Post Maintenance Testing of the HPCI System
1999-10-01 Failure to Promptly Identify Conditions Adverse to Quality & to Take Timely Corrective Actions
1999-10-02 Failure to Meet the TS Requirements for the SBGT System "B" Charcoal Filter for ≈6 Months
2000-01-01 Inadequate Corrective Actions for a RHR SW Strainer with a High Δp Indication
2000-02-01 Failure to Adequately Verify the LPCI & CS Pump Discharge Piping Was Filled, as Required by TS
2000-03-01 Failure to Properly Implement the Maintenance Rule for the Offgas Recombiner Bypass Valve SOV
2000-03-02 Operators Failed to Follow Procedures by Not Scramming the Reactor on a Loss of Condenser Vacuum
2000-03-03 Failure to Implement the Corrective Action Program
2000-03-04 Failure to Adequately Control Contractors Performing Testing
2000-03-05 Failure to Implement the Corrective Action Program for Contractor Identified Deficiencies
2000-07-01 Failure to Implement Procedures as Written (3 examples)
2000-07-02 Ineffective Corrective Actions Associated with Failure to Promptly Identify Conditions Adverse to Quality (2 examples)
2000-08-01 Failure to Correct Problems with RCIC, Restore Operability Prior to Changing Modes in October 1999

Violations (VIOs):

NOTE: In accordance with the NRC Enforcement Policy, the three violations below were closed administratively, and entered into the licensee's corrective action program (similar to an NCV). As such, these violations were reviewed similarly to an NCV.

1998-02-05 LORT Program Procedures Regarding Duplication of Exam Materials
1998-04-02 Failure to Perform an Adequate Vehicle Search
1998-05-02 Failure to Analyze the Effects of a LOCA Plus LOOP on Containment Penetration Protection Degradation Due to Short Circuiting

OPERATING EXPERIENCE RELATED DERs:

1999-0230 OE9645 Data Error in Calc Results in Non-Conservative Maint.
1999-0272 Part 21 - Agastat E7000 Series Timing Relay
2000-0159 SEN 211 - Mispositioned Valve Causes Draindown of RCS
2000-0680 NRC IN 94-80 "DC Ground Detection System in DC Systems"
2000-1728 Part 21-Broken Yoke on 3" Pressure Seal Gate Valve

SELF-ASSESSMENT & FUNCTIONAL AREA ASSESSMENT REPORTS:

JOPS-2000-016, Effectiveness of Operations Department Management and Training (January 24, 2000)
JEP-2000-008, Self-Assessment of Emergency Planning Department (March 21 & 28, 2000)
JMC-2000-018, First Quarter Material Control Assessment of Human Performance (March 30, 2000)

Attachment 2 (cont.)

JORG-2000-018, Review of INPO Principles for Effective Self-Assessment and Corrective Actions Programs (March 29, 2000)
JMD-2000-044, 1st Quarter Maintenance Self-Assessment Roll-up Meeting Summary (April 11, 2000)
JMD-2000-042, Maintenance 1st Qtr Self-Assessment Summary for "Supervisory Effectiveness" (April 3, 2000)
JDED-1999-0221, Self-assessment of Fire Protection Program Organizational Effectiveness (June 23, 1999)
JAF Design Engineering Fire Protection Program Self-Assessment (July 24, 1998)
JIC-2000-012, Procedure Adherence, Self-Verification and Peer Checking (March 28, 2000)
JFPS-2000-033, Self-Assessment of Fire Brigade Annual Field Training (July 6 , 2000)
JDED-1998-0287, JAF Fire Protection Program's Self-Assessment (June 16, 1998)
Firewatch Rover Log Sheets (Jan 2000)
IAL Testing/Fence Perimeter (Jan 1999)
Weapons Inventory (Jan 2000)
1st Quarter 2000 Integrated Self-Assessment and Trend Report
2nd Quarter 2000 Support Services Self-Assessment (July 2000)
2nd Quarter 2000 Radiation Protection Program Roll-Up (July 2000)
2nd Quarter 2000 Assessment - Fire Protection and Safety Group
Common Cause Analysis of the FitzPatrick Corrective Action Program (April - August 2000)

QUALITY ASSURANCE AUDITS & SURVEILLANCES:

Audit 2000-07J, Results of Actions to Correct Deficiencies
JDED-2000-0108, First Quarter 2000 Self Assessment Rollup
JTS-2000-0107, Self assessment on TSSO-20, Performance Monitoring and Trending Program
Quality Assurance Standard Surveillance Report, SR No. 2172, Review of 1999 NRC Violations

OPEN WORK REQUESTS:

1997-3477-04	During Performance of ST-1r the Valve Indicated Dual Position When Closed. Set Screw Found Out. (Laying in the Housing)
1999-5945-04	Vibration Monitoring per PEP-3.1 Has Discovered That the Inboard Motor Bearing Has Worn Out. Motor Bearing Should Be Replaced and the Unit Aligned. Estimate Time to Failure 3-4 Months
1999-8845-02	While Attempting to Slow Close the MSIVs it Was Discovered That the Following Relays Were Open Prior to the Start of the Evolution: 5AK-3D (1.67-98) 5AK-3E (1.67-97)
1999-9509-00	Valve Found Open When Should Have Been Closed. This Same Problem Was Seen with this Valve Recently
2000-4887-00	SOV is Sticking Intermittently When Valve Stroked Causing Excessive Heat and Vibration. Investigate and Repair as Needed. No PID tag hung.

In addition, the below work requests related to Control Room Deficiencies and Operator Workarounds were reviewed:

1999-01215-00	1999-01214-00	1999-05183-00	1999-06641-00
1989-03397-00	1999-00095-00	1999-00014-01	1999-01629-04
1989-06872-01	1999-11266-00	1999-02582-00	1999-04883-00
1989-06873-07	1999-09370-01	1997-01354-00	1989-05997-04
1999-08396-00	1999-06708-02	1999-10928-09	1989-04044-09

Attachment 2 (cont.)

OVERSIGHT COMMITTEE MEETING MINUTES:

Plant Operations Review Committee (on-site):
PORC Meeting 99-08 Minutes (February 16, 1999)
PORC Meeting 99-29 Minutes (June 1, 1999)
PORC Meeting 99-41 Minutes (August 3, 1999)
PORC Meeting 99-71 Minutes (December 28, 1999)
PORC Meeting 00-01 Minutes (January 4, 2000)
PORC Meeting 00-08 Minutes (February 1, 2000)
PORC Meeting 00-39 Minutes (June 6, 2000)

Nuclear Safety Audit Review Committee (off-site):
SRC Meeting 06-99 Minutes (November 18-19, 1999)
SRC Meeting 01-00 Minutes (January 20-21, 2000)
SRC Meeting 02-00 Minutes (March 23-24, 2000)
SRC Special Meeting 99-06 Minutes (June 22, 1999)
SRC Special Meeting 99-07 Minutes (September 16, 1999)
SRC Special Meeting 99-08 Minutes (October 7, 1999)
SRC Special Meeting 99-09 Minutes (December 3, 1999)

ATTACHMENT 3

HANDOUTS

NYPA PRESENTATION

ENTRANCE MEETING

JULY 24, 2000