

U. S. NUCLEAR REGULATORY COMMISSION

Region I

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License No.: DPR-59  
Licensee: New York Power Authority  
Post Office Box 41  
Lycoming, New York 13093  
Facility: James A. FitzPatrick Nuclear Power Plant  
Location: Scriba, New York  
Dates: October 8, 1989 through December 2, 1989  
Inspectors: W. Schmidt, Senior Resident Inspector  
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Reactor Projects Section No. 1B  
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Inspection Summary:

This inspection report discusses routine and reactive inspections during day and backshift hours of plant activities including; plant operations, security, surveillance and maintenance, emergency preparedness, engineering and technical support and radiological protection. This period included deep backshift and weekend inspections conducted on October 14, 15, 22, 24, November 10, 12, 19, and 25, 1989.

Results:

The inspectors did not identify cited any violations and there were two licensee identified non-cited violations. A Table of Contents follows.

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## DETAILS

### 1. Operations

This inspection period began during power ascension following the October 5 completion of the fall maintenance outage. The plant returned to 100% power operation on October 12. Several reactor scrams and subsequent restarts occurred during the period. The inspector discussed the scrams below. On November 10, NYPA commenced startup following the November 5 scram. The plant restarted on November 13, following the November 12 scram and maintained reactor power within bypass valve capability (approximately 20%) to perform on-line monitoring of the EHC control system. On November 19, the unit was shutdown to correct electrical noise problems identified during the troubleshooting. NYPA with recommendations from GE performed additional repairs and testing of the electro-hydraulic control (EHC) system. The plant restarted on November 22, and achieved and continued to operate at 100% power from November 25, to the end of the inspection period.

- a. On November 5, a reactor scram occurred from 100% power. The high neutron flux APRM scram (120%) resulted from a pressure transient caused by improper closure of the turbine control valves (TCV). The reactor core isolation cooling system (RCIC) initiated and restored reactor water vessel level. The high pressure coolant injection system (HPCI) received an initiation signal, but was out of service due to the ongoing HPCI corrective maintenance.

The maximum indicated pressure during the event was 1082 psig. Based on review of safety relief valve (SRV) tailpipe temperatures, NYPA determined the F SRV (1140 psi setpoint) lifted. The E SRV (1105 psi setpoint) did not lift prior to F. To resolve this, NYPA replaced the pilot valve assemblies on the E and F SRVs and planned to test the SRVs on the subsequent startup. This approach appeared acceptable to the inspector.

The inspector reviewed the post trip review and attended the associated PORC meeting. During the event operators received the HPCI high suction pressure alarm. NYPA determined the cause of the alarm to be the starting of the HPCI condensate pump when HPCI received its start signal during the transient. Based on this, NYPA was developing a method to establish protective tagouts on inoperative equipment to prevent component operation if a system receives an initiation signal during the period the equipment is inoperable. The inspector planned to review this method in a subsequent inspection report, F-1.

Troubleshooting of EHC, which controls the TCVs, did not identify the cause of the closure. Based on recommendations from GE, NYPA replaced various circuit cards in the EHC control circuitry. The PORC recommended installation of a system to monitor EHC for abnormalities in the subsequent restart for a 48 hour period. On-line monitoring identified noise in the system, and NYPA chose to perform additional troubleshooting under GE guidance. GE recommended replacement of additional EHC system circuit cards. NYPA turned the original circuit cards over to GE who will perform additional testing to identify the cause of the EHC system abnormalities.

- b. On November 12, a reactor scram occurred with the plant in the start-up mode during SRV testing. The startup high neutron flux APRM scram resulted from power fluctuations during manual cycling of the E SRV. When the operator shut the SRV, the resulting pressure increase caused the power to reach the scram setpoint. The APRM readings prior to the SRV testing had been 10 to 11.3% with the scram settings 13.5 to 14.5%. NYPA determined that the margin to the ARPM setpoint was insufficient to prevent the scram from occurring during this transient.

PORC determined that SRV testing at reduced power levels and reactor pressures while in the startup mode may lead to reactor trips if insufficient operating margin exists. Testing of the Target Rock SRVs at lower reactor pressures (300 psig or less) can cause damage and wear. Target Rock recommendations typically specify testing at or above 500 psig. Based on this NYPA revised ST-22B, Manual SRV Operation and Valve Monitoring System Functional Test, to require SRV testing in the run mode with reactor pressure at approximately 940 psig. The revised testing method was used successfully during the subsequent reactor startup on November 13.

Based on review of the event, the inspector identified the following concerns:

1. The inspector reviewed technical specifications (TS) 3.5.D for the ADS SRVs and found that ADS shall be operable whenever reactor pressure is greater than 100 psig. Since NYPA determined that the ADS SRVs would be tested at approximately 940 psig with the mode switch in run, the inspector questioned if NYPA met this TS. The inspector noted that standard TS allow 12 hours to complete the SRV testing once reactor steam dome pressure is adequate to perform the test, or the plant must be placed in hot shutdown. The inspector reviewed the change to ST-22B and found it technically acceptable except that it did

not address the need to have the testing completed within 12 hours of achieving 940 psig. The inspector discussed this matter with Regional management and NYPA plant management. Upon further review NYPA agreed to add a procedure change to ensure testing of the SRVs within the 12 hour period. Further NYPA committed to reviewing this TS and submitting an amendment to clarify the testing requirements. The inspector considered this item unresolved pending submittal and review of this amendment. Unresolved Item 89-11-01.

2. The inspector concluded that weak procedural guidance and poor foresight by the operating crews had contributed to the scram. Specifically, the inspector found that the initial test procedure did not provide guidance regarding permissible reactor power levels, although it specified that two turbine bypass valves be open, an indirect indication of reactor power level. Following discussions with the shift supervisor (SS), the inspector concluded that the SS and his crew did not foresee the limited margin to the scram setting and had not closely monitored reactor power prior to testing the SRV. The revised test procedure properly addressed permissible reactor power levels.
3. Upon further review of past SS logs the inspector noted a successful performance of ST-22B on the L SRV on October 8 just after the maintenance outage. The inspector requested the APRM data for that test. For similar plant conditions, APRMs indicated between 5.5 and 7.5% power compared to 10-11% when the scram occurred. The inspector discussed this variation in APRM power levels for similar conditions with the Assistant Operations Superintendent. NYPA committed to evaluate APRM indication at low power and flow conditions and by calculating expected APRM readings when in these plant conditions. The inspector planned to follow this evaluation in a subsequent inspection report F-2.

#### 1.1 Safety Assessment

The inspector concluded that NYPA corrective actions and efforts taken to identify and correct the cause of the EHC abnormality were very aggressive. NYPA management showed a good safety perspective by limiting power output to support troubleshooting the EHC system.

The reactor scram during SRV testing indicated weak procedural guidance and poor foresight by the operating crew. Operators were not sensitive to the proximity of the plant power level to the trip set point. Power maneuvers made during a controlled plant startup require a careful review of plant parameters to ensure proper reactor response.



## 2. Radiological Protection

The inspector reviewed the radiological conditions in the plant. The inspector did not note any unacceptable conditions and concluded that NYPA continued to implement the radiological controls program effectively.

## 3. Surveillance and Maintenance

- a. LER 89-018: On October 8, NYPA declared HPCI inoperable. During HPCI Surveillance Test ST-4N, HPCI Flow Rate and In-Service Test (IST), the high steam flow annunciator illuminated and the outboard steam supply valve and steam line bypass valve closed. Inspection of the differential pressure transmitter that provides the high steam flow isolation noted a small amount of air in the sensing lines. NYPA concluded the air in the line combined with the HPCI start transient, resulted in a false high steam flow signal.

NYPA corrective action included reventing and calibrating the transmitter and plans to repeat these during the 1990 refueling outage. NYPA also committed to vent the transmitter prior to restart from the cold condition. The inspector verified this venting after the November 5 plant trip. The inspector found NYPA corrective actions to be adequate. NYPA reported this event via ENS.

- b. LER 89-019: On October 31, NYPA declared HPCI inoperable due to a ground in the B DC emergency bus. The ground isolation procedure located the ground on the HPCI turbine governor actuator circuit. NYPA entered a TS limiting condition for operation action statement (LCO) that allows the plant to continue to operate for seven days as long as the low pressure coolant injection (LPCI), core spray (CS), reactor core isolation cooling (RCIC), and automatic depressurization (ADS) systems were operable. Further, TS required operability testing of these systems.

RCIC failed its operability surveillance test due to failure of the inboard injection valve motor 13MOV21. This placed the plant in a 24 hour cold shutdown LCO because both HPCI and RCIC were inoperable simultaneously. At this point NYPA secured inoperability surveillance testing with only ADS testing completed satisfactorily. The LPCI and CS surveillance test had not commenced, and NYPA did not intend to complete them because they were in the 24 hour LCO that did not require testing.

The inspector discussed this with the Operations Superintendent, who intended to reenter the seven day HPCI LCO assuming that RCIC was repaired prior to HPCI. The inspector determined that this action would not meet the intent of the HPCI TS LCO that required the other ECCS systems to be demonstrated operable immediately. Upon further discussion with the Resident Manager, NYPA agreed that the low pressure ECCS operability demonstration should be completed if the seven day LCO would be reentered. NYPA completed the low pressure ECCS operability testing satisfactorily. RCIC testing after injection valve repair proved operability, ending the 24 hour LCO and placing the plant back into the seven day HPCI LCO.

The cause of the ground was the three pin connection internal to the actuator where the control wiring passes through the actuator body. It appeared that corrosion buildup around the connector pins caused an electrical short to the governor body. NYPA replaced the governor, manufactured by Woodward during the fall maintenance outage, following a similar ground in April 1989. In both cases, the ground cleared with removal of the corrosion. NYPA declared HPCI operable on October 31.

The connecting pin arrangement for the old and new governor actuators differed in design. The old actuator design (part number R8250-133) had an insulated three pin plug arrangement. The new design actuator (part number 9903-026) had each of the three pins separately insulated. The model number difference is due to Woodward changing their part numbering system. The new design appeared to be more affected by this form of corrosion due to the insulation of each pin separately from the housing. The actuator receives lube oil flow that should have prevented the corrosion.

NYPA reported the inoperability of HPCI via ENS. Further review of this event by PORC determined RCIC inoperability to be reportable under 50.72. NYPA made this report on November 8. This determination appeared conservative to the inspector.

On November 3, the ground reappeared again causing HPCI inoperability. The reactor tripped on November 5 (see Section 2.a) effectively ending the seven day LCO, since HPCI was no longer required to be operable. NYPA again removed the corrosion clearing the ground. To prevent recurrence they performed additional modifications discussed in Section 6.d.



- c. On November 7, NYPA declared various snubbers (shock suppressors) inoperable. NYPA could not verify the service life of these snubbers using existing plant records. It was not necessary for these snubbers to be operable since the plant was in the cold shutdown condition. TS 4.6.9 required NYPA to have a system that documents commencement of the designated service life, and all the associated installation and maintenance records.

The TS also requires a once per operating cycle review of the snubber program to ensure individual snubber service lives will not be exceeded prior to the next scheduled review. NYPA identified that these records were not up to date. This item will remain unresolved pending inspection of the available records and the previous operating cycle program reviews. Unresolved Item 89-11-02.

NYPA took corrective actions to replace the suspect snubbers and completed an evaluation for snubber service life extension. Corrective actions were taken for the HPCI snubber that failed its functional test. These actions appeared appropriate to the inspector.

- d. On November 29, NYPA performed ISP-22-1, RCIC Turbine Exhaust Diaphragm High Pressure Instrument Functional Test/Calibration. A portion of the test verified the RCIC turbine exhaust diaphragm high pressure trip logic to the inboard and outboard RCIC steam supply isolation valves, 13 MOV 15 and 13 MOV 16. The procedure required the racking out of the valve breaker for the logic system under test. This was to prevent an inadvertent steam line isolation when the logic system tripped.

The technician incorrectly requested that operations rack out the breaker for 13 MOV 15 and proceeded to test the isolation logic for 13 MOV 16. 13 MOV 16 went shut when the logic system tripped. The isolation caused the RCIC turbine to be inoperable. The Shift Supervisor secured testing and reopened 13 MOV 16 which restored RCIC to an operable condition. NYPA reported this event via ENS. NYPA conducted a critique of this event.

- e. On November 30, during HPCI surveillance testing, a spurious isolation signal caused an automatic isolation of the turbine and a turbine trip. The operators noted the high exhaust pressure alarm during the event. This alarm would give a turbine trip but no automatic isolation. NYPA entered a TS LCO that allows the plant to continue to operate for seven days as long as LPCI, CS, and ADS are operable. NYPA commenced HPCI system troubleshooting to determine the cause and subsequent corrective actions. NYPA reported this event via ENS. At the close of the inspection period HPCI remained inoperable. The inspector will follow NYPA's corrective actions in a subsequent report, F-3.

### 3.1 Safety Assessment

The Maintenance Department did not maintain adequate service life records for various shock suppressors. Management should provide increased attention to ensure control and maintenance of these records.

The improper surveillance testing of the RCIC steam supply isolation valves indicated that further management attention was necessary to ensure proper attention to detail during surveillance test procedures.

### 4. Emergency Preparedness

- a. During review of the November 5 scram, the inspector questioned the need for NYPA to declare an Unusual Event when an ECCS initiation occurs to restore reactor vessel water level. The FitzPatrick Emergency Plan Implementing Procedure IAP-2, Classification of Emergency Conditions, does not list initiation of ECCS as an initiating condition to an Unusual Event. The inspector determined that other licensee's declare an Unusual Event in such a case. The inspector reviewed NUREG-0654, Rev. 1, 1980, Appendix 1 that specifically gives this example as an initiating condition for an Unusual Event.

The inspector discussed this discrepancy with NRR and the FitzPatrick Emergency Director. According to NRR, the original approved FitzPatrick Emergency Plan dated January 1981, Figure 4-3, contained initiation of ECCS as an Unusual Event. The inspector requested that the Emergency Director determine how this discrepancy between the approved plan and the implemented plan came about. It appeared that this occurred during development of IAP-2, in March 1981. This item will remain unresolved pending inspector review of the justification to delete this initiating condition from the Emergency Plan. Unresolved Item 89-11-03.

- b. The reactor scram on November 5 occurred at 3:23 p.m. The SS planned to make a four-hour notification per 10 CFR 50.72. Upon further review, the SS determined that this was an error and completed one hour notification at 5:02 p.m. 10 CFR 50.72(b)(c)(IV) requires reporting of any event that results or should have resulted in Emergency Core Cooling System (ECCS) discharge into the reactor coolant system as a result of a valid signal within one hour. During the event RCIC restored reactor water level. HPCI received an initiation signal but did not inject due to system inoperability for maintenance.

Failure to make the required 10 CFR 50.72 one hour notification was a violation. NYPA did determine this error and made an ENS call within one hour and 40 minutes. In addition, the Operations Superintendent reviewed the importance of performing reportability reviews expeditiously after events with all shifts to prevent recurrence. These corrective actions appeared adequate. NYPA did not receive a Notice of Violation because they identified this issue and took corrective actions. NRC enforcement policy, 10 CFR Part 2, Appendix C, section V.G.1., allows licensee identified violations to not be cited. Assignment of an open item number identifies this non-cited violation solely for tracking purposes. LI NCV 89-11-04

- c. On November 17, NYPA made a late 10 CFR 50.72 four-hour notification for a major loss of emergency assessment. The event was a loss of six Prompt Notification System sirens on November 15. Five of the six sirens were out of service for one hour. By procedure the county reports siren status problems via the Radiological Emergency Control System (RECS) hotline. The RECS line was out of service at the time, so the county used normal phone communications to inform NYPA of this event. The SS did not fully understand the information when he received the report. Therefore, the SS did not make an ENS call. The emergency plan coordinator later determined the error and arranged the call on November 17.

Failure to make the required 10 CFR 50.72 notification within four hours was a violation. NRC had identified previous problems with the transfer of siren status information from the county to NYPA. In this case the county transferred the information via an alternative method and the NYPA reactor operator who received the report did not fully understand its significance. Niagara Mohawk made the required 50.72 report on November 15. The two utilities already have an agreement such that they inform each other of any changes in emergency assessment capability. NYPA committed to address this issue again with Niagara Mohawk during a planned December 19 meeting. This was necessary to ensure that both sites know of conditions that require 50.72 notification based on the emergency plan. These corrective actions appeared adequate.

NYPA did not receive a Notice of Violation because they identified this issue and took corrective actions. NRC enforcement policy, 10 CFR Part 2, Appendix C, section V.G.1. allows licensee identified violation to not be cited. Assignment of an open item number identifies this non-cited violation solely for tracking purposes. LI NCV 89-11-05.

On November 28, NYPA properly made a 50.72 notification due to a major loss of emergency assessment. NYPA received the information received via the RECS line from the county and made the required 50.72 notification satisfactorily.



#### 4.1 Safety Assessment

The shift supervisor was not sensitive to the requirements of 10 CFR 50.72. Corrective action based on enforcement action taken on a past reportability issue should have prevented this error. Management attention is necessary to ensure that corrective actions are fully effective.

NYPA and Niagara Mohawk must communicate changes of any safety significance that can impact both nuclear sites (i.e., loss of sirens, 115 kV, etc.). NYPA's intention to discuss this issue with Niagara Mohawk on December 19 was positive.

#### 5. Security

The inspector walked the protected area fence and observed personnel and vehicle searches. He noted no deficiencies and concluded that NYPA continued to effectively implement the security plan.

#### 6. Engineering and Technical Support

- a. Inspection Report 88-29, Section 6.b.2, raised a question about the safety evaluation for a modification to the nitrogen supply to the automatic depressurization system (ADS) relief valves. This modification installed a redundant nitrogen supply to the drywell instrument ring header, and upgraded the piping to be safety related. This modification provided these valves with a reliable source of nitrogen to comply with TMI Action Plan Item II.F.3.28. The evaluation stated that the two redundant supply lines into the drywell would be used to supply the ring header from one of the two pressure regulator stations. This was to be done through a cross connect line and valve 27CAD905. At that time the inspector found the valve shut. NYPA changed their operating procedures to specify that this valve be open. This resolved item F-5 from Inspection Report 88-29.

With 27CAD905 open the installed pressure sensor monitors the pressure on the header regardless of the operating regulator. This resolves the issue of the location of the pressure detector. NYPA committed to install a modification F1-87-164 that will meet the requirements of Bulletin 80-25 during the 1990 refueling outage. The inspector planned to review the design of this modification in a subsequent report. F-4

- b. (Closed) Unresolved Item 88-29-05: Testing of ADS piping was not as described in the NRC Safety Evaluation Report (SER), dated July 24, 1985. This SER Addressed TMI action plan item II.F.3.28, for upgrading the ADS system. NYPA reviewed the NRC SER and their submittals and determined that the statement that the leak testing of the supply piping to the ADS valves would be done at the pilot valve actually meant at the solenoid operated valve (SOV). The NRC SER took this to mean at the SRV itself. The inspector determined that NYPA was testing neither to the SRVs or the SOVs. NYPA had been disconnecting the nitrogen joint at the SRV and installing a pressure gage to monitor pressure drop and calculate a leak rate. The inspector felt that this was not taking into account any possible seat leakage from the SOV as well as the accumulators and check valves.

NYPA committed to implementing a modification during the 1990 Refueling outage to correct this testing problem. NYPA planned to install a tee with an isolation valve and a normally capped connection into each ADS SRV nitrogen supply line between the accumulator and the SOV. This modification would allow leak rate testing of the SOVs, check valves and accumulators. The inspector found the planned implementation of this modification and current quarterly testing of the leakrate of the entire drywell nitrogen header to be acceptable and sufficient to close this item. The inspector planned to review the final design of the modification in a subsequent report. F-5

- c. (Closed) Unresolved Item 88-00-07: NYPA did not perform an evaluation to demonstrate that the standby gas treatment system (SBGT) was capable to withstand the pressure and temperature from venting the primary containment following a loss of coolant accident. The emergency operating procedure inspection documented in Inspection Report 88-200 identified this issue. In response NYPA stated that it was preferable to vent the containment to SBGT, even if SBGT failed, than to let the containment fail. This is a true statement.

NRC issued Generic Letter (GL) 89-16, dated September 1, 1989, to deal with the issue of SBGT failure. This GL discussed the installation of a bypass around the SBGT trains to allow venting of the containment without over-pressurizing and potentially damaging the trains. NYPA responded to the generic letter. The inspector administratively closed this item because it will be addressed by the resolution of GL 89-16.

d. The inspector reviewed the following minor modifications to the HPCI system.

1. HPCI EGR Actuation Receptacle Insulation Coating, minor modification M1-89-149. This modification installs an insulating coating on the inside surface of the HPCI governor actuator 3-pin amphenol receptacle as corrective action to the November 3 ground (see Section 3.b). NYPA believed that this will prevent the accumulation of corrosion products from establishing a ground path to the actuator housing.
2. Rerouting of HPCI Turbine Shaft Seal Leak-off Piping, minor modification M1-89-153. NYPA rerouted the existing turbine shaft seal piping to reduce the height of the loop seal to an elevation below the shaft seals. They believed that this modification would improve the drain path of water trapped in shaft seal area, and improve the gland seal exhaust ability to remove shaft stem leakage.

The inspector concluded that safety evaluations JAF-SE-89-133 and 134, respectively, appeared proper and met 10 CFR 50.59 requirements, for determining that no unresolved safety questions existed.

e. (Closed) Unresolved Item (89-02-01): This item identified a HPCI operability concern due to the additional stress placed on piping because of the presence of water in the HPCI exhaust line. The inspector reviewed the engineering evaluation, JTS-89-0153. NYPA properly addressed this concern and determined that the HPCI system would have been able to perform its safety function with the water in the exhaust line. The inspector found this to be acceptable to close this item.

#### 7. Exit Interview (30703)

At periodic intervals during the course of this inspection, inspector held meetings with senior facility management to discuss inspection scope and findings. In addition, at the end of the period, the inspectors met with licensee representatives and summarized the scope and findings as described in this report.

Based on the NRC Region I review of this report and discussions held with NYPA representatives during the exit meeting, this report does not contain information subject to 10 CFR 2.790 restrictions.