U.S. NUCLEAR REGULATORY COMMISSION

Region I

Report No.:	50-333/90-07
Docket No.:	50-333
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:	September 23, 1990 through November 5, 1990
Inspectors:	W. Schmidt, Senior Resident Inspector R. Plasse, Jr., Resident Inspector
Approved by:	Glenn W. Meyer, Section Chief Reactor Projects Section No. 1B

11-21-90
Date

INSPECTION SUMMARY

This inspection report discusses routine and reactive inspections of plant activities during day and backshift hours including: plant operations, radiological protection, surveillance and maintenance, emergency preparedness, security, engineering and technical support, and quality assurance and safety verification. This period included deep backshift and weekend inspection.

INSPECTION RESULTS

The inspectors did not identify any violations. An Executive Summary and an Outline of Inspection follow.

RESIDENT INSPECTOR OFFICE
JAMES A. FITZPATRICK NUCLEAR POWER PLANT
INSPECTION REPORT NO. 50-333/90-07

EXECUTIVE SUMMARY

Operations: NYPA performed well when lake debris clogged cooling water intakes and the plant was manually scrammed. The inspector identified an unresolved item regarding the availability of the ultimate heat sink not being monitored by any safety related instrumentation. NYPA took appropriate actions regarding an SRO who did not comply with drug testing requirements. An error in an alarm response procedure and other minor discrepancies were corrected.

Radiological Controls: Walkdowns of radiologically controlled areas and review of RWPs identified no deficiencies. The addition of locked gates at entry points to potential high radiation areas (100 - 1000 mr/hr) represented a good initiative. Although potential personnel exposure was minimal, NYPA was not effective in informing workers of the unusual radiological conditions in the east electric bay.

Surveillance and Maintenance: The planned use of LCOs for preventive and corrective maintenance continued to be a well controlled and performed process. Continued technical concerns regarding the SLC discharge accumulator pressure were upgraded to an unresolved item. Evaluations of an out-of-specification MOV stroke time prompted a modification to the valve operator and further evaluation of stroke time methods. Corrective maintenance for a RHRSW strainer basket, two air-operated isolation valves, and a non-safety related pump motor failure were effective, particularly the pump actions.

Emergency Preparedness: The inspector found the Emergency Response Data System (ERDS) useful in evaluating plant conditions in Region I during the October 19 reactor scram.

Security: Adequate performance continued in the security area.

Engineering and Technical Support: The inspector identified an unresolved item regarding the QA classification, testing, and operational control of MOVs that isolate the RHR to radwaste line. This issue demonstrated poor problem solving as site engineering had previously identified the concern but it had not been resolved.

Safety Assessment/Quality Verification: NYPA's identification of the containment isolation valve leakage in a reactor coolant sample line showed a good safety perspective, and NYPA correctly determined the valves to be inoperable. However, the administration of operability determination was poorly controlled, and lacked an occurrence report and logging in the control room.

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OUTLINE OF INSPECTION

1. **Operations** (MC 71707, 93702)

   1.a Operator performance during degradation of plant cooling water supply event. Adequacy of the monitoring of the ultimate heat sink. Unresolved Item 90-07-01.
   1.b Licensed SRO failed to comply with 10 CFR 26, Fitness For Duty Rule.
   1.c Error in HPCI steam leak detection alarm response procedure corrected.
   1.d Minor deficiencies noted during plant tours.

2. **Radiological Controls** (MC 71707)

   2.a Plant surveillance and RWP review.
   2.b Installation of locked gates at high radiation area entry points not specifically required by TS 6.8.11.
   2.c Offgas leakage in the east electric bay.

3. **Surveillance and Maintenance** (MC 61726, 62703, 92702, 92703)

   3.a Safety system walkdowns.
   3.b Planning and maintenance performed during recent LCO's.
   3.c Minimum nitrogen pressure in SLC accumulators required to maintain SLC operable. Unresolved Item 90-07-02.
   3.d Valve motor operator design modified to meet TS valve stroke test. NYPA evaluating previous surveillance testing and Limitorque maintenance. Unresolved Item 90-07-03.
   3.e Corrective maintenance performed on RHR SW strainer.
   3.f Failure of drywell equipment and floor drain outboard PCIVs to meet IST stroke time requirements during ST-1C, PCIV Exercise Test.
   3.g NYPA actions to inspect safety related pump motor leads.
   3.h Planned review of weaknesses identified during Maintenance Team Inspection 90-80.

4. **Emergency Preparedness** (MC 71707)

   4.a Inspector verification of Emergency Response Data System (ERDS) effectiveness during October 19 reactor scram in Region I office.

5. **Security** (MC 71707)

   5.a Routine activities.
   5.b NYPA responded to weaknesses identified in Regulatory Effectiveness Review.

6. **Engineering and Technical Support** (MC 37700, 90712, 92700, 92702, 71710)

   6.a NYPA's QA II/III classification of 10 MOV 57 and associated piping and utilization of this piping for evolutions during plant operation. Unresolved Item 96-07-04.
   6.b LER review.

7. **Safety Assessment and Quality Verification** (MC 30703)

   7.a NYPA request for Region Temporary Waiver of Compliance to resolve inoperability of reactor coolant sample line containment penetration.

8. **Other Inspections and NRC Management Tours**

9. **Exit Interview**

Attachment A **Acronyms**

DETAILS

1. **Operations**

The unit operated at rated power until October 19 when NYPA commenced a reactor shutdown due to suction problems for cooling water pumps caused by debris buildup on the intake structure traveling screens. A manual reactor scram from 45 percent followed because of further degradation of the cooling water supply. NYPA returned the unit to full power operation on October 21 and operated throughout the remainder of the period.

a. The control room operators performed well during the degradation of plant cooling water supply on October 19. Initial indications that there was a problem with the cooling water supply were high condenser differential temperatures. The decision made by plant management to commence a reactor shutdown and thereafter to manually scram the reactor was proper. These actions were taken based on the continued high differential temperatures and lower than normal water level in the bays, as observed locally, downstream of the traveling screens. The traveling screens were not functioning to clean themselves, so debris buildup continued causing less and less water to pass through the screens. Further, because of the unusual loading of the screens, operators could not restore them to service locally. The water level downstream of the traveling screens was important because it represented the ultimate heat sink. The safety related emergency service water (ESW) and residual heat removal service water (RHRSW) pumps, the non-safety related circulating water and service water pumps, and the fire system pressurization, electric and diesel pumps all take suction from this supply.

NYPA's poor control of the non-safety related traveling screen differential water level instrument contributed to this event. This instrument normally takes an average of the differential water levels from all three bays. This signal then is used to control the operation of the traveling screens and to provide an annunciated control room alarm on an average six (6) inch differential. NYPA was completing normal preventive maintenance on the B bay, which required that draining of the bay. The differential level input from the drained bay was not disconnected from the averaging instrument and thus made the entire instrument inoperable. On October 19, high Southerly winds caused a rapid accumulation of Lake Ontario debris, the traveling water screens did not operate as designed, and the alarm was never received. Accordingly, operators responded to the condition later, and their actions were unable to resolve the debris problem before the plant had to be taken off line.

This particular event did not result in any loss in the ability of the emergency cooling water systems to perform their safety functions. The water level did not reach the minimum necessary for providing NPSH to the safety related cooling water pumps (235 feet), condenser vacuum was maintained at 28" Hg, and main circulating water pump (239.5 feet required for NPSH) amperage was normal and steady. However, the level at the far end of the bay did apparently reach the minimum required for operation of the electric fire pumps (239.5 feet), since it lost suction. NYPA estimates that the maximum differential across the screens was ten (10) feet. This caused significant damage to the C traveling water screen which allowed water to bypass the screen.

The inspector attended NYPA's Post Trip Review and determined that the analysis of the event and the corrective actions were adequate to prevent disabling of the traveling water screen differential level instrument in the future. However, the inspector questioned the way that the availability of the ultimate heat sink was monitored - indirectly by the non-safety related screen differential level instrument. Further, the operating procedures did not indicate the minimum required bay water levels for maintenance of cooling capacity to the emergency core cooling and fire systems. This item remained unresolved pending inspector review of NYPA's corrective actions to address monitoring of the ultimate heat sink. UNRESOLVED 90-07-01

b. NYPA took adequate action once it was determined that a senior licensed operator would not comply with the drug testing requirements of 10 CFR 26. In this instance the individual would not provide a second observed sample after the temperature of the first sample did not meet the acceptance criteria (90.5-98.5 F). NYPA informed the individual that not providing the second sample would be considered a positive test. Based on this the individual's site access was suspended and he was referred to the Employee Assistance Program (EAP).

This same individual had tested positive in 1988 before 10 CFR 26 was issued, by urinalysis, for cocaine use, at a level lower than that specified in 10 CFR 26 (.3 ppm vice .4 ppm).

The individual entered NYPA's EAP and was not expected to return to site for about one month. This issue will continue to receive NRC review prior to the individual's access being reinstated and prior to resumption of licensed duties.

c. The inspector identified a minor error in an alarm response procedure (ARP) for a HPCI steam leak detection logic power failure, and it was subsequently corrected. Specifically, based on a drawing review, the inspector found that the A side of HPCI steam leak detection logic power is powered from 71ESSA1 breaker #1, but that ARP 09-3-3-22 listed breaker #6 as the power source. NYPA reviewed this concern, agreed with the inspector's finding and corrected the ARP.

d. The inspector noted several minor deficiencies which were quickly corrected during the course of the inspection.

-- Several danger tags used to isolate the A crescent area unit cooler during modification were not properly disposed of when cleared. The three tags were found on top of the unit cooler.

-- The C RHR pump circuit breaker, which was racked out and removed from its enclosure was not restrained from rolling.

2. **Radiological Protection**

a. The inspector performed walkdowns of radiologically controlled areas and identified no adverse practices or conditions, other than those addressed below. Several RWPs were reviewed while in use and no deficiencies were noted.

b. During the past few months the inspectors have noted the installation of locked gates at entry points to high radiation areas (100 - 1000 mr/hr) not required by TS 6.11.A (>1000 mr/hr) to be locked and concluded that this represented a good initiative and an improvement in control of radiation areas. Nevertheless, during a routine inspection tour the inspector found the locking device for the gate to the torus area was not functioning properly. NYPA RES took corrective actions to repair the locking device. The RES superintendent stated that the existing survey of the area did not identify any areas greater than 100 mr/hr and that the improperly locked gate did not represent a problem.

c. The inspector questioned the radiological controls used when NYPA had indications of an offgas leak in the east electric bay. A portal monitor indicated that the inspector was contaminated after he momentarily passed through the east electric bay on route to the screenwell. The inspector notified a radiation protection (RP) technician who, after discussing where the inspector had been, stated that the contamination was due to offgas isotopes. Discussions with the RP supervisor confirmed that there was a known leak inside the offgas exosensor panel. I&C troubleshooting identified and repaired some leaks, but had been

unsuccessful in correcting the offgas leakage. The inspector asked the RP supervisor if there was any radiological hazard and if any posting of this area was required. The RES department then posted the area with an "Authorized Personnel Only" sign. Subsequently the inspector was again contaminated by offgas isotopes while reading the sign from outside the room. This posting did not appear effective to the inspector since any personnel with security access to the area were authorized.

On October 31, NYPA performed an additional survey and identified noble gas isotopes at 75% MPC inside the leaking panel. The general room area was at 0% MPC. As a precautionary action NYPA posted the room as an Airborne Radioactivity Area. Further I&C troubleshooting was successful in correcting the leakage and the postings were removed on November 1. In assessing this problem the inspector determined that while personnel exposures were minimal, NYPA RES was not effective in informing workers of the radiological condition in the room or ensuring timely resolution of leakage correction.

3. **Surveillance and Maintenance**

a. The inspector completed control room and in-plant walkdowns for the following systems to verify correct positioning of valves and power supplies to ensure proper function if called upon.

1. A and B RHR
2. A and B core spray
3. Emergency diesel generators
4. High pressure coolant injection
5. Steam leak detection system

b. NYPA adequately planned and carried out maintenance on both core spray sub-systems, on both SLC sub-systems and on the A RHR sub-system by entering the appropriate TS limiting conditions for operations (LCO). The planning for each LCO entry was well conducted including an indepth schedule for each job to be completed. Associated tagouts were released and work commenced in a timely but controlled manner. The inspector verified that one train of the effected systems was operable during the maintenance periods. The inspector reviewed several completed work requests, associated post-maintenance testing and the completed surveillance tests for each system. No discrepancies other than those noted in section c., d. and e. were identified.

c. The inspector observed maintenance and testing conducted on both trains of SLC. The personnel involved performed properly, in accordance with approved procedures. However, based on the continuation of existing technical concerns with the maintenance and testing of the pump discharge accumulators, the inspector upgraded the concerns to an unresolved item.

Previously NYPA determined that both SLC trains were inoperable, after their accumulators were found with less than 450 psig during a performance of ST-6A, the SLC monthly functional test. Because there is no installed pressure gauge or alarm, the pressure measurement was suspected to have affected the measured pressure. In Inspection Report 89-07 the inspector had two questions:

-- What was the design basis for the accumulators?

-- If a pressure of 450 psig was part of the design basis, why was there no pressure indication or low pressure alarm?

NYPA had stated that they would review the issue and had opened a PORC action item to track resolution.

ST-6A was revised to specify in a prerequisite step that the accumulator pressure be measured and if necessary recharged to above 450 psig before beginning the test. Through discussions with operators, the inspector determined that during recent tests the as found pressures for both trains were frequently in the range of 125 to 250 psig.

Based on the continuation of accumulator pressures below 450 psig and the lack of a basis for the acceptability of such pressures, the inspector concluded that NYPA had not taken effective action on the previous concerns. As the previous concerns had been classified as an F item, the concerns were upgraded to an unresolved item and the F item closed administratively. UNRESOLVED 90-07-02

d. The inspector identified an unresolved item regarding valve position limit switch settings and stroke time testing for the RHR to Radwaste MOV (10 MOV 57). While performing preventive maintenance on 10 MOV 57, NYPA found that the open and closed limit switches were outside the nominal acceptance criteria of 95% and 10%, at 85% and 20%, respectively. After resetting the switches within the acceptance criteria, the valve closure time exceeded the TS requirement of 24 seconds. The MOV engineer initiated an occurrence report, which documented this condition, and subsequently determined that the valve manufacturer designed the valve to close in 29 seconds. NYPA's original design documentation specified

a 21 second design stroke time. Inspector review of past surveillance testing showed that the acceptance criteria of 24 seconds on stroke time had been met. However, during the same stroking evolution valve maintenance data sheets showed a stroke time of 27 seconds. The surveillance test times the stroke from switch actuation to the closed indication, while the maintenance data for stroke time is based on observed stem travel.

To correct the problem NYPA performed a design equivalent modification (D1-90-234) to reduce the valve operator gear ratio and thus lessen the time needed for the valve to shut. Upon completion of this modification the valve closure time was satisfactorily tested at 18.8 seconds.

NYPA was evaluating the causes of the improper limit switch settings, the apparent discrepancy between the surveillance test and maintenance data, and the need to specify a tolerance range on the limit switch position. The inspector considered that these items represented an unresolved item pending review of NYPA's corrective actions and evaluation of this event. UNRESOLVED 90-07-03

e. NYPA was reviewing the cause of the failure of a basket in the A RHRSW duplex strainer and whether the B strainer was susceptible to the same type of failure. NYPA inspected this strainer because it exhibited a slightly higher than normal differential pressure. NYPA found that the upper portion of the strainer basket had collapsed. The inspector reviewed this situation and the temporary modification performed to remove the damaged portion (upper six inches) and to weld a retaining ring with handle to the remaining mesh for additional support. The modified strainer was retested and verified to pass technical specification required flow.

NYPA was performing a failure analysis on the damaged portion. The temporarily modified strainer basket will remain installed until a replacement can be obtained and the other strainer basket, which was verified to be satisfactory based on differential pressure readings, will remain selected unless it becomes fouled. Further, NYPA planned to inspect the B strainer when feasible. The inspector concluded that the corrective actions and plans were acceptable.

f. During the performance of ST-1C Primary Containment Isolation Valve Exercise Test (IST) both the drywell equipment and floor drain outboard isolation valves (20 AOV 83 and 20 AOV 95) exceeded their two second IST stroke time requirement. Technical Specification 3.7.D.2.b allows intermittent opening of an inoperable PCIV with proper administrative controls. The inspector reviewed NYPA's administrative controls established in surveillance test ST-1H, Primary Containment Isolation Valve Inoperable Test, and found the technical specification requirements satisfied.

g. The inspector observed that NYPA took proper actions to inspect safety related pump motors after the failure of a non-safety related service water (SW) pump motor lead. The inspector concluded that the maintenance engineering evaluation of the cause for the SW pump failure was of high quality and offered good recommendations and corrective actions. The investigation determined that the failure was related to the use of copper motor lugs with aluminum lead lugs. It appears that a crack in the copper motor lug resulted in increased resistance and high temperatures. These temperatures caused degradation of the insulation and further melting of the lug. The condition continued until the lug was exposed and contacted the motor casing causing a ground and the trip of the pump.

NYPA reviewed plant records to determine where such installations existed, so that inspections could be conducted. The inspector observed the inspection of the B ESW pump motor leads; the individuals involved were knowledgeable and performed the task well. The motor leads for the B ESW pump were found in good condition as were those for the A ESW pump.

h. The inspector discussed the weaknesses identified in Appendix 2 to the Maintenance Team Inspection Report (90-80) with NYPA. Based on this discussion and review of the report the inspector planned to review the following issues in subsequent inspections.

-- The effectiveness of NYPA's management observation program.

-- Use and definition of where QC hold points are required.

-- Development of a failure/root cause analysis program.

-- The system engineer's role in maintenance planning (i.e. pre-work and post-work).

-- The understanding by plant personnel of what constitutes a deficiency and a non-conforming condition.

4. **Emergency Preparedness**

a. The inspector used the Emergency Response Data System (ERDS) to monitor plant parameters from the regional office following the October 19 reactor scram. The inspector asked NYPA to initiate the tie into the NRC system, which was completed very promptly and with great ease. The inspector found the information provided by the different screens useful in evaluating plant conditions.

5. **Security**

a. The inspector monitored the searching of packages and personnel entering the protected area on several occasions. The inspector concluded that the searches were acceptable.

b. On October 29 NYPA responded to the weaknesses identified during the Regulatory Effectiveness Review conducted in August 1990.

6. **Engineering and Technical Support**

a. The inspector identified an apparent discrepancy between the QA category and primary containment isolation valve (PCIV) requirements for the A RHR to radwaste MOVs (10 MOV 57 and 10 MOV 67).

While reviewing the temporary modification, discussed in section 3.d above, the inspector noted that the QA classification for these valves was ASME category II/III (non-safety related), yet each is listed in TS table 3.7-1 for PCIVs and receive PCIS isolation signals (typical of safety-related applications). Further review determined that neither valve received local leak rate test (LLRT) nor was tested as part of the containment boundary during the integrated leak rate test (ILRT). The normally shut manual isolation valves upstream of the MOVs appeared to be the ILRT boundary valves.

The inspector was concerned that with the manual valve and the two MOVs open (as allowed by OP-13 during normal operation to pump the torus down or to flush the RHR system) there would be a breach of containment and diversion of A LPCI inventory if the MOVs did not go shut following an event, until the manual valve was closed. Further, the arrangement of the B RHR sub-system utilizes all manual valves to perform this operation. In neither case did OP-13 have a caution to indicate the significance of shutting the manual isolation valve. Normal draining evolutions are completed using the A side because the evolution can be controlled from the control room once the manual valve is open.

Site management requested that NYPA licensing determine if the MOVs should be PCIVs or be deleted from TS Table 3.7-1. NYPA made a night order entry to ensure that operators were aware of the need to close the manual valves in the event the containment needed to be isolated or LPCI was required. Further, NYPA was reviewing the need for a procedure change. This item remained unresolved pending further inspector review. UNRESOLVED 90-07-04

The inspector noted that system engineering had documented the above concern in a classification evaluation, which was never formally resolved by plant management. The inspector concluded that this represented poor problem solving by NYPA.

b. The inspector reviewed the following LERs and found them to be acceptable.

-- 89-08-01; HPCI and RCIC inoperable due to missed surveillance.

-- 90-03-01; Core over-power due to feed flow calibration error.

-- 90-17; HPCI level 8 trip instrument drift.

-- 90-18, 90-18-01; Safety relief valve setpoint drift.

-- 90-16-01 and 90-20-00; Shutdown cooling isolation.

7. **Safety Assessment/Quality Verification**

a. On November 2 NYPA was granted a Regional Temporary Waiver of Compliance (RTWC) to allow completion of a modification to a reactor coolant sample line containment penetration. The RTWC permitted NYPA to install a blank in the sample line after NYPA determined that the containment isolation valves (SOV 39 and 40) were leaking at a rate greater than that allowed by ASME section XI, IWV 3426. In this condition NYPA had four hours to install the blank (TS 3.7.D.2.c) or commence a shutdown. A RTWC was granted allowing continued operation until 4 p.m. on November 5, from which point NYPA would have had to have been in cold shutdown within 24 hours, if not in compliance with TS 3.7.D.2.c. The modification to install the pipe cap was completed as of November 3, which placed NYPA in compliance with TS 3.7.D.2.c.

The inspector concluded that NYPA's administration of the operability determination of these primary containment isolation valves was weak. Although NYPA correctly determined that the valves were inoperable and took actions to comply with the technical specifications, the inspector concluded that the administration of the process was poorly controlled in that the potential inoperability was not entered into the occurrence report system or any other such system, the potential inoperability and subsequent determinations and actions were not entered into the control room logs, and actions regarding tagouts and closing of manual valves were confusing.

Specifically, on November 1 at approximately 2 p.m. the SS informed the inspector that SOV 40 was inoperable because of lack of closed position indication during quarterly IST stroke time testing. He also stated that SOV 40 was leaking past its seat at approximately 1.0 liters per minute, and that when SOV 39 was shut and electrically isolated (as required by TS 3.7.D.2.c), the leakage had dropped to approximately .5 liters per minute. He further stated that NYPA was reviewing potential flow paths that could have contributed to this leakage. The inspector concluded that the SS showed a good safety perspective in identifying the PCIV leakage and beginning an evaluation. Although the SS had raised the apparent operability concerns regarding the leakage through the valves, the inspector later found that no occurrence report or other administrative method to track this operability determination was initiated at that time.

The inspector found NYPA's operability determination to be correct. NYPA determined that ASME Section XI, 3417, Corrective Actions, permits 24 hours to be used to determine operability of a valve which does not exhibit full valve stroke with an indirect observation that the valve might not be fully shut. Subsequently, NYPA performed leak checks of the SOVs at normal reactor coolant pressure (1005 psi) and used a method to extrapolate the leakage to that which would have occurred under Appendix J local leak rate test conditions of 45 psi air. This calculation indicated that the actual leak rate would have been approximately 40 to 80 times greater than the allowed leakage of 5.6 scfd for that penetration as determined by Section XI, IWV 3426. Thus NYPA concluded the valves would not have performed their design function and were inoperable. NYPA determined this within approximately 24 hours.

However, the inoperability determination was not entered into the control room logs to enable compliance with the action statement which then specified that a blank be installed within four hours (TS 3.7.2.c) or a shutdown commenced to be in cold shutdown within the next 24 hours (TS 3.7.3). Also, the lack of logging and an occurrence report precluded demonstrating that the 24 hour period for determining operability under the ASME Code was met. Further, the waiver of compliance, which extended the action statement until November 5, was not entered into the logs.

Regarding closing of the manual valves, at approximately 4 p.m. on November 1 the inspector was contacted by the operations superintendent who stated that NYPA was going to tag shut downstream sample system boundary manual valves to stop the leakage. The inspector questioned if the manual valves and the piping between the containment isolation valves and the manual valves was ASME category 1 and seismically qualified. The operations superintendent stated that he would review these issues.

When the inspector later reviewed the use of the downstream manual valves to isolate the containment penetration, he found these valves and tubing were not seismic, not ASME category 1, nor were they leak tested as part of the Appendix J process. However, NYPA had made a temporary change to ST-1H, the procedure for inoperable containment isolation valves, to enable these valves to meet the requirement of TS 3.7.D.2.c for closed manual valves. As this change was made prior to the actual determination of inoperability, this incorrect action did not affect compliance with the technical specifications. Nevertheless, the inspector concluded that the incorrect temporary change was confusing and represented an inappropriate course of action.

In addition, on November 2 the inspector reviewed the tagout used to accomplish this isolation. It stated that SOV 39 and SOV 40 were inoperable. The inspector questioned whether SOV 39 was in fact determined to be inoperable since an OR was not written to document this. At that point the work control center supervisor stated that SOV 39 was never declared inoperable and lined out and initialed SOV 39 from the tagout sheet. The inspector concluded that this confusion on the tagout was evidence of the weak control of the operability determination.

In summary, the inspector concluded that NYPA's determination that the valves were inoperable was correct and that NYPA had complied with the technical specifications. However, the inspector concluded that the administration of this process was poorly controlled and included absence of an occurrence report, lack of logging of appropriate steps in the control room logs, and confusion in tagouts and actions to isolate the leakage. Based on these weaknesses, the inspector judged that it appeared that the records demonstrating compliance with the technical specifications should be improved.

8. Other Inspections and Enforcement Conferences

a. Inspection Report 90-21 OL, Operator License Exams, October 29 through November 2.

b. On November 1, W. Hehl, Director DRP, Region I, toured the plant with the inspectors.

9. Exit Interview

At periodic intervals during the course of this inspection, meetings were held 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 of the inspection as they are described in this report.

APPENDIX A

FitzPatrick

Acronyms

ARP	-	Alarm Response Procedure
AOP	-	Abnormal Operating Procedure
ASME	-	American Society of Mechanical Engineers
EAP	-	Employee Assistance Program
ESW	-	Emergency Service Water
FSAR	-	Final Safety Analysis Report
HPCI	-	High Pressure Coolant Injection System
I&C	-	Instrumentation and Control
IST	-	In-Service Testing
LCO	-	Limiting Condition of Operation
LER	-	Licensee Event Report
LLRT	-	Local Leak Rate Test
LPCI	-	Low Pressure Coolant Injection
MOV	-	Motor Operated Valve
MPC	-	Maximum Permissible Concentration
NPSH	-	Net Positive Suction Head
NRC	-	Nuclear Regulatory Commission
NYPA	-	New York Power Authority
OP	-	Operating Procedure
OR	-	Occurrence Report
PCIV	-	Primary Containment Isolation Valve
PM	-	Preventive Maintenance
RCIC	-	Reactor Core Isolation Cooling
RES	-	Radiological and Environmental Services
RHR	-	Residual Heat Removal System
RWP	-	Radiation Work Permit
SLC	-	Standby Liquid Control
SOV	-	Solenoid Operated Valve
SS	-	Shift Supervisor
ST	-	Surveillance Test
SW	-	Service Water
TS	-	Technical Specification