U.S. NUCLEAR REGULATORY COMMISSION

Region I

Report No.:	95-23
Docket No.:	50-333
License No.:	DPR-59
Licensee:	New York Power Authority P.O. Box 41 Lycoming, New York 13093
Facility:	James A. FitzPatrick Nuclear Power Plant
Location:	Scriba, New York
Dates:	November 19, 1995 through January 6, 1996
Inspectors:	G. Hunegs, Senior Resident Inspector R. Fernandes, Resident Inspector J. Furia, Senior Radiation Specialist

Approved by: _____ 1/30/96

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INSPECTION SUMMARY: Routine NRC inspection of plant operations, maintenance, engineering, plant support, and quality assurance/safety verification.

RESULTS: See Executive Summary

EXECUTIVE SUMMARY

James A. FitzPatrick Nuclear Power Plant

Inspection Report No. 50-333/95-23

Plant Operations: The material condition of the A and B residual heat removal heat exchanger rooms was considered to be average. No operability concerns were identified and the licensee performed thorough reviews of the above and other observations made and initiated timely corrective actions.

Maintenance: An evaluation and completion of a repair to residual heat removal service water piping was well performed. The licensee's decision to apply Generic Letter 90-05 guidelines to a repair not subject to the American Society of Mechanical Engineers (ASME) code was considered to be conservative.

The control rod scram time evaluation surveillance test program was reviewed. Technical specification requirements were met, however, the testing and evaluation process was not well defined.

Engineering: The FitzPatrick engineering organization's responsibilities, interfaces and work control are clearly defined in station procedures. The licensee periodically reviews equipment history and maintenance records for safety significant plant equipment to identify repetitive failures and adverse trends. This effort is aided by the Quality Assurance Department. A considerable number of reports are generated in which plant performance information is readily available and accessible. Although there appears to be a large number of outstanding engineering work items, they are appropriately prioritized based on importance to safety.

Plant Support: The licensee's program for maintaining occupational exposures as low as reasonably achievable (ALARA) has shown continued improvement, especially in the area of work control and outage planning. Additionally, effective corrective actions have been initiated to address previously identified weaknesses involving Radiological and Environmental Services (RES) health physics technician and general radiological worker performance.

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DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

1.1 NYPA Activities

FitzPatrick operated at 100% power with the exception of several short duration power reductions for scheduled activities.

1.2 NRC Activities

The NRC Systematic Assessment of Licensee Performance (SALP) board was held on November 29, 1995 at the NRC Region I office.

A health physics inspection was conducted December 11-15, 1995 and the results are included in this inspection report.

An inspection of residual heat removal system operation was conducted from December 11-15, 1995 and the results are included in NRC inspection report 50-333/95-25.

The inspection activities during this report period included inspection during normal, backshift and weekend hours by the resident staff.

2.0 PLANT OPERATIONS (71707,93702,92901,62703)

2.1 Operational Safety Verification

The inspectors observed plant operation and verified that the facility was operated safely and in accordance with procedures and regulatory requirements. Regular tours were conducted of the plant with focus on safety related structures and systems, operations, radiological controls and security. Additionally, the operability of engineered safety features, other safety related systems and on-site and off-site power sources was verified. No safety concerns were identified as a result of these tours.

The inspectors observed plant operation and verified that the facility was operated safely and in accordance with licensee procedures and regulatory requirements. Regular tours were conducted of the following plant areas:

Control room
Secondary containment building
Radiological control point
Electrical switchgear rooms
Emergency core cooling system pump rooms
Security access point
Protected area fence
Intake structure
Diesel generator rooms

Control room instruments and plant computer indications were observed for correlation between channels and for conformance with technical specification (TS) requirements. Operability of engineered safety features, other safety related systems and onsite and offsite power sources was verified. The

inspectors observed various alarm conditions and confirmed that operator response was in accordance with plant operating procedures. Compliance with TS and implementation of appropriate action statements for equipment out of service was inspected. Plant radiation monitoring system indications and coolant stack traces were reviewed for unexpected changes. Logs and records were reviewed to determine if entries were accurate and identified equipment status or deficiencies. These records included operation logs, turnover sheets, system safety tags and temporary modifications log. The inspectors also examined the condition of meteorological and seismic monitoring systems. control room and shift manning were compared to regulatory requirements and portions of shift turnovers were observed. The inspectors found that control room access was properly controlled and that a professional atmosphere was maintained. Partial control room and in-plant walkdowns of several safety related systems including high pressure coolant injection, residual heat removal, and emergency diesel generator systems were conducted.

2.2 Engineered Safety Feature (ESF) System Walkdown

A detailed walkdown of the A and B Residual Heat Removal (RHR) Heat Exchanger rooms to verify operability of the safety related equipment in the rooms was performed. The walkdown was performed to identify equipment conditions and items that might degrade plant performance. Inspection activities included verification of hanger and support hardware alignment and fluid levels; housekeeping and cleanliness; condition of support equipment such as insulation and ventilation components; and condition of valves, valve packing and hardware. In addition, as both rooms have extensive scaffolding, an inspection was performed to determine if system performance could be degraded by the scaffolding.

The inspectors had the following observations:

- A structural support was welded to a section of the RHR service water discharge piping and not found on the system drawings. The licensee concluded that the structure was not supposed to be there and documented the item on a deficiency event report(DER). An engineering evaluation determined that the piping was operable. The licensee processed a work request that removed the hanger and is processing a drawing change request to document the abandoned section of steel attached to the pipe.

- The inspectors noted that the bonnet insulation had come off one motor operated valve and debris had spilled onto another valve. The licensee determined the condition not to be detrimental to the valve operation and generated a plant identified deficiency (PID) to restore the insulation.

- The inspectors noted that a room temperature element had been deformed by a section of the scaffolding staged in the A RHR heat exchanger room. The element provides for room temperature indication and does not perform a safety function. The inspector verified that control room indication was still available and consistent with ambient conditions. The licensee generated a PID to repair the temperature element.

The NRC concluded that the material condition of the A and B RHR heat exchanger rooms were average. No operability concerns were identified and the licensee performed thorough reviews of the above and other observations made and initiated timely corrective actions.

3.0 MAINTENANCE (62703,61726,92902)

3.1 Maintenance Observation

The inspector observed and reviewed selected portions or preventive and corrective maintenance to verify compliance with codes, standards and Technical Specifications, proper use of administrative and maintenance procedures, proper Quality Assurance/Quality Control (QA/QC) involvement, and appropriate equipment alignment and retest. The following activities were observed:

- WR 95-8854 46(70) SWS-102 Control Room/Relay Room Ventilation Service Water to System B Service Water Supply Check Valve Seat Leakage Repair.
- WR 95-03932-01, Repair Pin Hole Leak per Modification D1-95-083 and JAF Weld Map and Data Sheet.
- WR 96-000214-02, FitzPatrick-Scriba line breaker maintenance.
- WR 94-07224, Service Water Ventilation Room Relay.

No concerns were identified during inspector review of the above activities. The activities observed and reviewed were properly conducted.

3.1.1 Residual Heal Removal Service Water System Piping Leak

On November 27, a roving fire watch reported a small stream of water coming from piping in the vicinity of the B residual heat removal (RHR) heat exchanger room. Upon further investigation, it was determined that the leak was from the RHR service water piping on the downstream side of the B RHR heat exchanger outlet valve. The licensee performed an operability review and determined there was no operability concern, as the leak did not pose a threat to the ability of safety related components to perform their function. The inspector observed ultrasonic testing (UT) of the piping in the vicinity of the leak and adjacent welds. The licensee concluded that the defect was localized and most likely the result of microbiologically induced corrosion (MIC) based on UT results. This conclusion was based, in part, on the analysis of two other defects found in the same pipe during unit startup following the refueling outage completed in early 1995. The inspector reviewed the work package, non-destructive examination and weld records associated with the repair, which consisted of the installation of a one inch sockolet on the existing pipe. The work was completed properly. The inspector noted that the repair was evaluated using Generic Letter 90-05, Guidance for Performing Temporary Non-Code Repair of ASME Code Class 1, 2, and 3 Piping, guidelines even though the piping was non-ASME Code Class.

As previously noted, there have been multiple defects identified in the RHR service water system piping. Following the UT inspections last fall and engineering review, the licensee determined that the corrosion rate in the area of piping in question had decreased and, based on non-destructive examination (NDE) results and end-of-life calculations, elected to defer the replacement until the next outage. Following the identification and repair of the two leaks further downstream during unit start-up, the licensee performed additional inspections, however, the area where the most recent defect was located was not included in these additional inspections. The characteristics for the degradation mechanism (MIC) are usually different than those which the licensee was previously inspecting for, which was erosion/corrosion. The previous inspection sample size appeared to have been adequate and reasonable.

In conclusion, the licensee's evaluation and completion of a repair to RHR service water piping was well performed. The licensee's decision to apply Generic Letter 90-05 guidelines to a repair not subject to the ASME code was considered to be conservative.

3.2 Surveillance Observation

The inspector observed and reviewed portions of ongoing and completed surveillance tests to assess performance in accordance with approved procedures and Limiting Conditions for Operation, removal and restoration of equipment, and deficiency review and resolution. The following tests were reviewed:

- RAP-7.4.1, Control Rod Scram Time Evaluation.
- ST-24J, Reactor Core Isolation Cooling (RCIC) Flow Rate and Inservice Test.
- RAP-7.4.6, Core Performance Daily Surveillance.
- RAP-7.4.5, Average Power Range Monitor (APRM) Calibration.

The activities observed and reviewed were properly conducted. Observations related to the control rod scram time evaluation are noted below.

3.2.1 Control Rod Scram Time Testing

During the inspection period the inspector reviewed the completed surveillance test, reactor analyst procedure (RAP)-7.4.1, revision 5, Control Rod Scram Time Evaluation, to verify compliance with technical specifications and completeness of test data. The purpose of the surveillance test is to describe the method by which control rods will be scram tested, evaluate results, and satisfy inservice test (IST) valve testing requirements. The inspector concluded that the requirements were met, but determined that the testing and evaluation process was not well defined as described below:

- Test acceptance criteria includes the determination that the average scram insertion times for the three fastest operable control rods of all groups of four control rods in a two-by-two array is not greater than

several required criteria. The inspector noted that the computer generated report which includes this data is not attached to the procedure and is voluminous making it difficult for an adequate review by the on-watch shift manager and nuclear control operator. The licensee concurred with the observation and issued an Action Commitment Tracking System (ACTS) item to review the possibility of revising the procedure.

- The technical specifications require ten percent of the control rods to be scram time tested every 16 weeks. The inspector noted that although the licensee was meeting this requirement, the selection of rods every 16 weeks did not include a different ten percent of the total population of rods. The licensee's practice for the selection process for rods to be scrammed was to utilize good engineering judgement. Considerations included the length of time since the rod was last tested, the position of the rod with respect to the current rod pattern, and past performance attributes. The inspector noted that this issue was also raised by the licensee's quality assurance staff during an audit. Prior to this observation the licensee had submitted a Technical Specification Change Request to add the requirement for a different ten percent sample size each 16 weeks. The inspector noted that control rod number 26-19 had a beginning of cycle (BOC) scram time to position 46 that was three times as long as the average, yet it had not been retested during any of the three testing cycles since BOC testing. The licensee stated that a plant identified deficiency had been written on the rod at that time, but the request to retest it had not been identified during the subsequent scram testing evaluations. The licensee stated that rod 26-19 will be tested during the next surveillance and an ACTS item was assigned to revise the procedure to include guidance on writing PIDs.

- The technical specification basis discusses the occurrence of scram times within limits, but significantly longer than the average, should be viewed as an indication of a systematic problem with control rod drives, especially if the number of drives exhibiting such scram times exceeds eight, the allowable number inoperable. The inspector noted that there was no guidance in the procedure as to the definition of "significantly longer than the average" and questioned how a "a systematic problem" would be identified. The licensee stated that should a control rod or a number of control rods exhibit excessive scram times the procedure would require that the operating minimum critical power ratio be revised. Under normal plant conditions the MCPR limit provided in the core operating limits report (COLR) should not require adjustment. The licensee further provided and reviewed statistically generated data to evaluate recent scram times and compared those to times which would be indicative of changes to the MCPR. Review of the scram times for the last cycle and the most current revealed that one rod (26-19) met the screening criteria. The licensee concluded that it would have taken three more rods with similar times before a revised MCPR would have been required.

- The inspector noted that the technical specification basis states that scram time evaluations shall be performed following reactor trips. This

statement was included in the licensee's initial licensing basis. The plant is not configured to record the scram times when the plant trips. The licensee intends to revise the basis as part of their effort to adopt standard technical specifications.

- The technical specifications require that whenever scram time measurements are made an evaluation shall be made to provide reasonable assurance that proper control rod performance is being maintained. The inspector noted that the procedure provided an evaluation on overall core performance, but lacked direction on individual control rod performance and trending. The licensee currently utilizes an informal process of recording individual control rod scram times and monitoring past performance. The licensee concurred with this observation and intends to review the procedure to determine if the process could be made more thorough.

The inspector concluded that the licensee was meeting the technical specifications scram time testing requirements, however, the testing and evaluation process was not well defined. The licensee intends to review their procedures to enhance and clarify requirements.

4.0 ENGINEERING (37551,92903,71707)

4.1 Safety Related Equipment Deficiency Trending and Backlogs

A review of licensee management of safety related engineering backlog and trending of equipment deficiencies was performed. To perform this review, the inspector held interviews with engineering managers and the Quality Assurance Manager, reviewed applicable department performance indicators, procedures and reports, and attended several station meetings. The inspector concluded that the licensee periodically reviews the equipment history for safety significant plant equipment. Senior plant management places considerable effort and focus on the management of outstanding work. Information is readily available in the form of computer generated reports on indices, work requests and open items and that, although the backlog is considered to be large quantitatively, important issues are prioritized and addressed.

Engineering Organization

Engineering functions are provided by a number of plant operations and engineering groups at FitzPatrick as well as at the corporate office. The system engineering functions are provided by the Technical Services Department and include the evaluation of system performance, review of plant identified deficiencies and work requests, and monitoring system operation. The Technical Services Department implements the system engineering programs and provides coordination between the systems engineering program and other engineering programs. The stated purpose of the system engineering program is to provide daily support of operations, maintenance, and outage activities and long-term system improvements and equipment performance monitoring. The backbone of the program is to establish the system engineer position as the focal point for system information and as the initial responsible individual for emergent system issues. Technical Services Department Standing Order

(TSSO)-19, Systems Engineering Program, describes the duties and responsibilities for the system engineer. Duties include monitoring system performance, interface with maintenance and operations personnel and evaluation of system performance.

In May 1995, the licensee reorganized so that the Design Engineering organization relocated to the site. The design engineering organization responsibilities include mechanical, civil/structural, electrical and instrumentation and control design activities. These activities include design basis requirements, resolution of design deficiencies, engineering analysis and calculations and modifications. A formal time analysis of work that Design Engineering performs determined that the majority of time is spent on modifications, followed by analysis which includes design basis documentation review and calculations, emergent work, plant support and training. Nuclear Administrative Policy NuAP 3.7, Delineation of Engineering Responsibilities, describes the engineering organization, interfaces and functions.

The FitzPatrick engineering organization's responsibilities, interfaces and work control are clearly defined in station procedures.

Engineering Work Control Processes

Several other procedures describe the organization responsibilities and engineering processes. Various reports are developed to track, trend and evaluate outstanding work and activities. Several periodic meetings are routinely held to aid in communication and prioritization of work. The primary procedures which describe engineering activities include:

TSSO 23, Technical Services Work Management, The procedure describes the process used to identify, prioritize, and track technical services work activities. A work load management system is used to determine the amount and type of work and to track closed, open and overdue work items.

TSSO 24, System Presentations, describes one process used to provide management with specific system information as presented by the system engineer and to inform management of system issues challenging reliable system operation. The presentation is structured to give a detailed overview of a system's current status including maintenance requirements, system performance outstanding action items/commitments, and planned or proposed modifications. Issues discussed include open work requests, jumpers, deviation event reports, operating experience, limiting conditions for operation, and drawing change requests. The system engineer provides an interpretation of the data by comparing system performance indicators to expectations and discusses system performance trends. Corrective actions, as necessary are identified and discussed.

TSSO 20, Performance Monitoring and Trending Program, describes the requirements and methods of monitoring plant systems and components to determine the effectiveness of maintenance. The program is designed to enhance the ability of system engineers to ensure that the reliability and availability of important plant equipment is maintained.

As previously stated, several reports are generated to assist in engineering work management. These include:

A daily status report for technical services is prepared. This report is discussed at the technical services morning meeting and covers priority PIDs which were initiated since the last meeting, station priorities, action items, goals and milestones.

The Technical Services Department maintains various engineering performance indicators. Design Engineering prepares monthly indices which includes, in part, plant modifications, engineering work requests, and document change requests. Design Engineering uses resource loading to prepare schedules. In June 1995, the licensee developed a plan designed to improve design engineering work management. The system is designed to ensure that engineering requests are prioritized, ranked, and scheduled. Work is loaded by priority and due date.

Based on the inspector's review of engineering programs, the inspector determined that the licensee management of engineering programs is well defined. The licensee periodically reviews equipment history and maintenance records for safety significant plant equipment to identify repetitive failures and adverse trends. This effort is aided by the Quality Assurance Department. A considerable number of reports are generated in which plant performance information is readily available.

Engineering Performance

An effort was made to evaluate engineering performance based on the review of engineering and station performance indicators. The following performance indicators were evaluated:

A list of operator workarounds is maintained and tracked. The total number of operator workarounds has remained relatively steady for the last quarter at around ten. These items are shared equally between technical services and maintenance. Based on the inspectors review of the current items, the inspector judged that station management provides a strong focus on addressing operator workarounds.

The inspector reviewed the Technical Services Department ACTS outstanding items report. The total number of items has remained relatively steady with only a small number of overdue items. The total number of outstanding items does not appear to have an adverse impact on station safety performance.

The daily status report for Technical Services lists priority A and B PIDs, work requests and site priorities. The licensee primarily uses a 4 tier priority and rank system. The majority of new PIDs and work requests fall into the Priority C category. These are considered to be an item that may become a challenge to the availability or reliability of plant systems. Higher priorities are assigned for addressing challenges to the operability of a technical specification related system. In their most simple form, priorities are described from highest to lowest as crucial, urgent, important and deferable. The inspector reviewed several recent Technical Services daily

status reports which highlight important work and determined that the report was an effective method to aid in managing engineering work.

Control room deficiencies and temporary modifications are tracked and periodically reviewed. The current number of control room deficiencies is approximately 30 with over half of those requiring an outage to address. Based on the inspectors review, it appears that appropriate management attention is applied to address control room deficiencies.

Priority B work requests on hold for engineering have been trending down and are currently around 10. The majority of work requests on engineering hold are priority C. The total number of engineering work requests has been trending up over the last quarter and is currently in the mid 200s. Since October, 1995, the engineering department has been focusing on the reduction of temporary modifications, resolving overdue Quality Assurance action items and completing modifications closeouts. This effort has resulted in the total number of items increasing. Although there appears to be a large number of outstanding engineering work items, they are appropriately prioritized based on importance to safety.

The FitzPatrick engineering organization's responsibilities, interfaces and work control are clearly defined in station procedures. The licensee periodically reviews equipment history and maintenance records for safety significant plant equipment to identify repetitive failures and adverse trends. This effort is aided by the Quality Assurance Department. A considerable number of reports are generated in which plant performance information is readily available and accessible. Although there appears to be a large number of outstanding engineering work items, they are appropriately prioritized based on importance to safety.

5.0 PLANT SUPPORT (71707, 92904)

5.1 Radiation Protection Program

In response to a request for information contained in the transmittal letter for NRC Inspection Report 50-333/95-10, the licensee outlined actions to be taken to address NRC-identified programmatic weaknesses in correspondence, dated July 20, 1995. These weaknesses included: (1) radiation worker practices; (2) support provided by radiation protection technicians; (3) use and recognition of the usefulness of quality assurance; (4) need for improvements in radiological procedures; and (5) radiation protection technician procedural compliance.

Much of this inspection was spent examining the corrective actions proposed by the licensee and determining their adequacy and evaluating, to the extent practical, the effectiveness of those corrective actions that have already been implemented. Corrective actions for two previous identified violations, violation (50-333/94-30-01): Failure to follow procedures/poor radiological worker practices, and violation (50-333/95-03-01): Failure to follow procedures by health physics technicians, were also reviewed. These violations will remain open pending additional review. The licensee proposed

a corrective action plan that appears to address all concerns and has successfully begun to implement these actions.

During a previous inspection in this area (NRC Inspection No. 50-333/95-17), the inspector reviewed some of the corrective actions that had been initiated, including: (1) enhanced radiation worker training for all plant staff; (2) specialized training for health physics technicians; (3) implementation of a health physics self-assessment program, and (4) procedural upgrade program. As part of this inspection, a review of the status of these corrective actions was conducted.

An enhanced radiological worker training program, which consisted of two days of training - both classroom and mock-up - was developed and implemented during the summer of 1995. Initial reaction of both the students and plant management was very positive for this training program. However, at that time, the licensee scheduled all employees to take this training only once prior to the commencement of the next refueling outage; and there were no provisions for the training to be offered on a continuing basis.

During the exit meeting for NRC Inspection 50-333/95-17, the licensee indicated their intent to complete this program in a more timely manner and continue it as a part of the training program for all plant workers. During this inspection, it was determined that the training schedule had been accelerated, and that all plant workers are scheduled to complete this training by March 1996. In addition, plant training procedure TP-3, Rev 0, "General Employee Training," has been written to include the advanced radiation worker training as part of the continuing training program and to have all plant workers attend it on a biennial basis.

During this inspection period, no issues were identified involving improper radiological worker practices. Reviews of the training documentation, including classroom instructions and mock-up training, indicated that this program was well presented and addressed the radiation worker issues previously found deficient. As observed by the NRC inspector and by the plant quality assurance auditors, this training program has made a significant positive contribution towards addressing the radiological worker problems.

Effective communications between the health physics technicians and the general plant staff had been identified by the licensee as a significant root cause for the previously-identified violations. All radiological and environmental services (RES) department health physics technicians and RES department supervisors attended a Communications and Conflict Resolution training course during October 1995. This training was presented at a local university by contracted university professors. This training was generally well received by the participants, as documented in course critiques reviewed by the inspector. Additional training in this area is currently scheduled for January 1996. The inspector noted improved technician performance in this area during the inspection. This was especially apparent during high traffic times at the Radiologically Controlled Area (RCA) access point, when a number of whole body frisker alarms occurred. Health physics technicians were quick to identify the sources of the contamination, to assist workers in exiting the RCA, and in advising other workers and plant management of the cause of the

problems (small steam leaks in the turbine building, and a build-up of natural radon due to outside weather conditions).

A previously-identified significant weakness in the health physics program has been the lack of acceptance of quality assurance and other assessment findings. Starting in the spring of 1995, the Radiological & Environmental Services (RES) department initiated a self-assessment program utilizing supervisors, radiological engineers, and health physics technicians to review various program areas and to offer recommendations on program improvements. Since the last inspection in this area, nine additional self-assessments have been performed by a variety of RES staff members. In general, a noted improvement in the quality of these reports was observed.

The licensee has undertaken numerous procedural upgrades in the health physics area over the past several years, all ending with less than satisfactory results. In the newest version of the procedures upgrade program, a dedicated staff has been assigned to write the procedures in a clear, concise manner; to have these reviewed by field technicians and supervisors; and to incorporate their comments prior to issuance. Six of these new procedures were reviewed by the NRC inspector and, in general, were found to be well written and meeting the licensee's goals.

5.1.1 Maintaining Occupational Exposures As Low As Reasonably Achievable (ALARA)

The licensee's program for maintaining occupational exposures ALARA has shown continued improvement, especially in the area of work control and outage planning. Since the conclusion of the last refueling outage, the work control and radiological planning process has progressed to such an extent that work packages, including ALARA reviews and radiation work permits (RWPs), are prestaged for potential forced outages. During a recent forced outage in September 1995, the effectiveness of this advanced planning process was clearly seen. The outage work scope was clearly defined based on the length of the outage established by the Resident Manager. Senior management showed a significant interest in controlling outage work scope expansion. In general, only that work that would improve plant performance and not extend the outage was allowed to be added to the outage scope. The outage was then completed on time and three person-rem under budget.

Due to this type of success, as of December 12, 1995, the site annual exposure was 324.3 person-rem, approximately 5.7 person-rem less than the year-to-date goal. Additionally, a number of licensee staff members indicated to the inspector a significant increase in management involvement in the ALARA process and ALARA performance.

5.1.2 Assurance of Quality

As part of its program to meet the requirements set forth in Title 10, Code of Federal Regulations, Part 20.1101(c), for an annual audit of its radiation protection program, the licensee conducted an audit, Report No. 95-20J, dated November 22, 1995, of the RES department radiation protection program. This audit focused extensively on radiation worker practices and radiation worker

interactions with the health physics staff and concluded that their were notable improvements in these areas. The audit also extensively reviewed the instrumentation calibration and respiratory protection program.

The audit team included two outside consultants, drawn from the Niagara Mohawk Power Corporation. The audit identified three deficiencies, which were noted in DERs, and made several recommendations. The inspector noted that the RES department staff was more receptive to these audit findings than had previously been observed and was actively working to review and address both the DERs and the other audit recommendations. This is a significant improvement.

On September 1, 1995, the licensee commenced themoluminescent dosimetry (TLD) processing through the use of a vendor. In support of this significant change, the licensee's corporate audit department undertook an audit at the vendors facility in mid-September, when a small batch of used TLDs was sent for processing. This effort was documented in a New York Power Authority Surveillance Report, dated September 18, 1995. This report was extremely short in length, with little detail. The inspector was unable to determine either the scope or depth of this audit. The inspector discussed this with members of the quality assurance staff at FitzPatrick, who indicated that additional audits of the contractor had been conducted previously by the Nuclear Utilities Procurement Issues Council (NUPIC) and that these audit results were the basis for accepting the work of the contractor. The inspector had no further questions.

5.2 Security

The inspectors performed a tour of the protected area (PA) during this inspection period to assess the integrity of the PA barriers. No openings or degraded conditions were found in the PA barrier and no concerns were identified by the inspector in this area.

6.0 MANAGEMENT MEETINGS (71707)

6.1 Exit Meetings

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. The licensee did not take issue with any of the findings reviewed at this meeting.