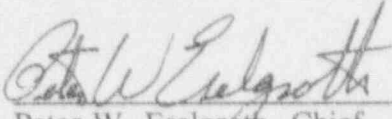


U.S. NUCLEAR REGULATORY COMMISSION

Region I

Report No.: 92-12
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: June 28, 1992 through August 1, 1992
Inspectors: W. Cook, Senior Resident Inspector
R. Plasse, Jr., Resident Inspector
N. Perry, Senior Resident Inspector, Yankee Rowe
Approved by:  8/12/92
Peter W. Eselgroth, Chief Date
Reactor Projects Section 1B, DRP

Inspection Summary: Routine NRC resident inspection of plant operations, radiological controls, maintenance, security and safeguards, engineering and technical support, and quality assurance/safety verification.

Results: See Executive Summary

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NOTE: The NRC inspection manual procedure or temporary instruction that was used as inspection guidance is listed for each applicable report section.

Executive Summary

James A. FitzPatrick Nuclear Power Plant

NRC Region I Inspection Report No. 50-333/92-12

June 28, 1992 - August 1, 1992

Plant Operations

The unit was in a refueling outage with the core off loaded throughout the inspection period. The performance of the operations department was generally acceptable. An inadvertent initiation of the A standby gas system was handled properly once the shift supervisor was made aware of the condition. Pending completion of NYPA's review of the standby gas system event, and subsequent NRC review, this item is unresolved. (URI 92-12-01)

Radiological Controls

Good adherence to proper radiological work practices was observed during inspector monitoring of routine maintenance activities.

Maintenance

The inspector reviewed and closed a Diagnostic Evaluation Observation (DEO) dealing with air operated valve preventive maintenance program improvements. The inspector reviewed and closed an unresolved item dealing with work control weaknesses in the post maintenance testing area.

Engineering and Technical Support

The inspector reviewed a core spray pump control circuit design deficiency identified by NYPA. The inspector concluded the corrective action taken by the operators and engineers to resolve this issue was appropriate. The inspector reviewed and closed two unresolved items which were properly reviewed and resolved by the NYPA staff. The inspector reviewed and closed a violation dealing with the torus temperature monitoring system and opened an item regarding a concern about the torus high temperature deviation setpoint. (URI 92-12-02)

Safety Assessment/Quality Verification

The inspector concluded that NYPA management continues to place emphasis on minimizing shutdown risk during the outage. The contingencies established during the emergency diesel generator maintenance were conservative and commendable with respect to plant safety.

DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

1.1 NYPA Activities

During this inspection period, the plant remained in cold shutdown with the core off loaded and the reactor flooded to the refuel level with the fuel pool gates removed, to support various outage work activities. Major work tasks completed or in progress during the inspection period included emergency diesel generator jacket cooler discharge piping replacement, various B residual heat removal system maintenance, recirculation system pipe support modifications and various electrical system maintenance.

1.2 NRC Activities

The inspection activities during this report period included inspection during normal, backshift and weekend hours by the resident staff. There were 29 hours of backshift (evening shift) and 6 hours of deep backshift (weekend, holiday and midnight shift) inspections during this period.

A region-based inspector conducted a review of the site welding program and inservice inspection activities during the week of July 20, 1992.

On July 29, 1992, Harry Salmon, Resident Manager, met with the NRC staff in the Region I office to discuss the status of the current refueling outage.

2.0 PLANT OPERATIONS (71707, 71710, 93702)

2.1 Routine Plant Operations Review

During the inspection period the inspectors observed control room activities including operator shift turnovers, shift crew briefings, panel manipulations and alarm response, and routine safety system and auxiliary system operations conducted in accordance with approved operating procedures and administrative guidelines. The inspectors made independent verification of safety system operability by review of operator logs, system markups, control panel walkdowns and component status verifications in the field. Discussions were held with operators and technicians in the field to assess their familiarity with current system status and personnel response to events during the inspection period. In addition, during plant tours, inspectors reviewed routine radiological control practices. The activities inspected were acceptable.

2.1.1 Operational Safety Verification

The inspector conducted partial control room and in-plant walkdowns of the following systems:

- A and D temporary cooling water to the emergency diesel generators.

2.2 Automatic Start of the Standby Gas Treatment System

On July 21, 1992, during shift turnover at 6:09 a.m., operators noticed that the B standby gas treatment system was running unexpectedly. After determining that the system should not be running, operators restored the system to a standby condition. Investigation revealed that the system had automatically started at 1:40 p.m. on July 20, 1992. No annunciator alarms were received when the system actuated, so operators were unaware of the actuation. Two shift turnovers had apparently occurred since the system automatically started, without anyone noticing anything abnormal. The event was determined to be reportable to the NRC as an engineered safety feature actuation, within four hours, and notification was made on July 21, 1992 at 5:13 p.m..

Investigation by plant personnel determined that the actuation occurred due to instrumentation and control technicians inadvertently contacting a terminal point, while removing a jumper. The technicians were installing and removing jumpers as part of post work testing for a modification. It is believed that the inadvertent contact of the jumper energized a relay which started the system without giving any alarms, which would normally be received during an automatic actuation. Operators did not discover the standby gas treatment system running until 6:09 a.m. on July 21, 1992. Two operator shift turnovers failed to identify the automatic actuation due to lack of attention to detail. Operations management is investigating the failure of the operators to identify the running system for that long a period of time, and will take corrective actions as necessary. As a minimum, the operators will be counselled. Notification of the actuation to the NRC was delayed due to the period of time necessary for personnel to determine when the actuation actually occurred and how it may have occurred.

The inspectors reviewed the actions taken in response to the automatic actuation of the standby gas treatment system and concluded that the actions taken were appropriate to the circumstances and that the investigation and critique of the event were comprehensive. Pending completion of the NYPA review of this event, and subsequent NRC review, this is an Unresolved Item (92-12-01).

2.3 Previously Identified Items

2.2.1 (Closed) Unresolved Item (89-12-04) and DEO.OPS.037: Daily Shift Checks Procedural Deficiencies

This inspection item identified a few areas in operations surveillance test procedure ST-40D,

Daily Surveillance and Instrument Check, where enhancements could be made to the test procedure. These enhancements included better surveillance test format, improved test guidance, EOP entry point identification and data point acceptance criteria. None of these enhancements were regulatory in nature; however, to improve the overall quality of their surveillance procedure many of these suggestions have been or are planned to be incorporated by NYPA in revisions to ST-40D. The inspector reviewed a revision to ST-40D (revision 52) and verified format changes have been proposed and that a task has been undertaken to include setpoint tolerances or data point acceptance criteria in a future revision to the procedure. This item is resolved. Likewise, a duplicative Diagnostic Evaluation Observation, DEO.OPS.037, is closed.

2.2.2 (Closed) Violation 91-80-01: Rad. active Waste Discharged in Concentrations that Exceeded Those of 10 CFR 20, Appendix B, Table II, Column 2

As documented in Augmented Inspection Team report 50-333/91-80, on March 18, 1991, there was an unmonitored release of radioactive waste. NYPA concurred with the resulting violation in a letter dated August 16, 1991. In addition to taking prompt action to minimize the spread of contamination, NYPA completed a number of corrective actions prior to unit restart, including: verifying all known material deficiencies were documented on work requests, verifying outstanding radioactive waste system modifications were assigned an appropriate priority, and reviewing all radwaste operating procedures. These actions were previously reviewed and documented in inspection report 50-333/91-02. NYPA also retired the affected boiler and waste concentrator. One of the deficiencies that was highlighted by this event was a need for an overall assessment to determine work priority and NYPA committed to develop a new method for prioritizing corrective actions. Historically, priority was based on a rigid system classification scheme, (i.e. safety related, power conversion, etc.), without regard to safety significance. NYPA is implementing a root cause prioritization program through Work Activity Control Program 10.1.30, Integrated Causal and Corrective Action Evaluation Program, and modifications are now being prioritized with a cost/benefit analysis that takes into account a wide variety of factors including system classification, safety significance and reliability, among others. The effectiveness of this new program will continue to be assessed. This violation is closed.

2.2.3 (Closed) Violation 91-80-02: Waste Concentrator Operating Procedure was not Implemented as Written and no Temporary Changes were Processed

In their response dated August 16, 1991, NYPA agreed with the violation. In response to identified procedural inadequacies, NYPA reviewed and upgraded all radwaste procedures. Procedural adherence deficiencies led to the issuance of a memorandum clearly expressing management expectations, placing licensed operators in charge of radwaste operations, and implementing a new Operations Department Standing Order that provided a formal mechanism to allow performance of tasks not covered by procedures. Subsequently, Administrative Procedure (AP) 1.14, Procedure Use and Adherence, was issued which describes different levels of use for procedures. The level of use indicates whether a procedure is to be used continuously, referred to, or is available for informational use. AP 1.14 also describes actions to be taken if

an activity cannot be performed as described. The inspector concluded these actions were comprehensive and appropriate. This violation is closed.

2.2.4 (Closed) DEO.OPS.010

This Diagnostic Evaluation Observation identified that the operations shift turnover was narrow in scope. The shift meeting conducted by the shift supervisor was brief and failed to mention shift objectives, out of service equipment or planned surveillance testing to be conducted. The inspector observed several recent shift turnovers and determined significant improvement and active participation by all members of the oncoming shift. The inspector reviewed ODSO-4, shift turnovers and log keeping. Specific instructions were provided for shift turnovers, control room log keeping practices, and daily shift briefings. The inspector reviewed the instructions and determined the changes provided the appropriate guidance to the operators to ensure a thorough and meaningful shift turnover and briefing. This DEO.OPS.010 is closed.

3.0 **RADIOLOGICAL CONTROLS (IP 71707)**

The inspector observed routine radiological work practices during observation of various maintenance activities and in routine tours of the plant. In general, radiological workers seemed to be well-trained and were observed to be using appropriate radiological work practices (i.e., bagged tools and other items, as required, maintained work areas clean, removed protective clothing properly, dosimetry worn properly, and all radiological postings obeyed). The health physics technicians were observed to give good pre-job briefings and maintained close surveillance over the work activities in their assigned areas. The radiological work areas, in general, were well-maintained (i.e., clean with appropriate radiological postings). The inspector concluded that the workers and health physics technicians were working well together to ensure safe and appropriate radiological work practices.

4.0 **MAINTENANCE (IP 62703)**

4.1 Observation of Maintenance Activities

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

Work Request 71/86823, Uninterruptible power supply (UPS) motor generator set request was initiated to perform a tune-up of the motor generator (MG) electrical controls. Operations and maintenance personnel performed a transfer test of the UPS MG set with a loss of AC power to ensure the DC motor maintained proper speed and the generator maintained proper frequency. The equipment was operated per OP-46B instructions. The inspector noted proper work practices and procedure compliance for this activity.

The inspectors observed portions of the modification (F1-92-008) to the emergency service water return piping from the emergency diesel generator jacket coolers. In particular, work in progress was observed, the controlling procedure was reviewed, and compensatory measures taken were reviewed. At least one emergency diesel generator was available for manual operation at all times. The inspectors concluded that the activities were conducted in a controlled manner with good planning evident.

4.2 Previously Identified Items

4.2.1 (Open) DEO.OPS.002

The Diagnostic Evaluation Team (DET) observation identified a potential safety concern due to a rapid hydrogen recombination (explosion) in the offgas system in early 1991. The office of Analysis and Evaluation of Operational Data (AEOD) conducted a review to determine if further NRC or utility action was warranted for this type of event. AEOD concluded on March 4, 1992, that offgas systems are designed to reduce hydrogen concentrations to below the combustible limits and to be capable of withstanding the effects of hydrogen detonation without a breach of the pressure boundary. Since offgas systems are designed to withstand a detonation, fires are unlikely to spread to associated safety systems. Consequently, the office of AEOD concluded no further generic review of these types of events was warranted at this time.

Another concern raised by the DET involving the offgas system was a large number of outstanding equipment deficiencies which impacted the proper operation and performance monitoring of the system. This item remains open until the inspectors complete review of NYPA's offgas system corrective action plan.

4.2.2 (Closed) DEO.MT.032

This Diagnostic Evaluation Observation identified that NYPA had a less than fully effective preventive maintenance program for safety related air-operated valves (AOVs), resulting in routine corrective maintenance to maintain valve operability. The inspector reviewed PME-0115, Preventive Maintenance for Air-Operated Valves, and concluded that NYPA had completed a satisfactory review of this issue. The evaluation reviewed the corrective maintenance history of various safety and non-safety related AOVs in twenty-two plant systems. The review resulted in preventive maintenance (PM) recommendations to approximately five hundred AOVs. The effectiveness of the PM recommendations will be determined by future AOV reliability and required corrective maintenance. The inspectors will continue to monitor the PM program during routine maintenance inspection activity. This DEO.MT.032 is closed.

4.2.3 (Closed) Unresolved Item 89-10-03, Review Post Modification Testing

This item dealt with weaknesses in the work control system in that required post modification testing was not properly identified prior to equipment operation. The work control center developed a method to track system maintenance and required post-maintenance and post-

modification testing. The inspector reviewed this process as documented in memorandum JPLN-92-144, dated May 15, 1992. The inspector also reviewed the restoration of the B and D emergency diesel generators and determined the process was adequate to ensure proper system restoration and testing. This item is closed.

5.9 SECURITY AND SAFEGUARDS (71707)

The inspector monitored the searching of packages and personnel entering the protected area on several occasions. The inspector conducted a walkdown inspection of the protected area barrier including the protected area fence around the construction site for the ongoing construction of the new administration building. The inspector concluded all areas reviewed were acceptable with the required security force support for the monitored activities.

6.0 ENGINEERING AND TECHNICAL SUPPORT (93702)

6.1 Core Spray Pump Control Circuit Design Deficiency

On July 11, 1992, during testing of the core spray system, plant personnel identified a malfunction in the main control board annunciator operation. Proper annunciator operation did not occur consistently, depending how quickly the pump's control switch was returned from the start position to the normal-after-start (NAS) position. After testing the pump, and reviewing the appropriate DC elementary diagram, plant personnel identified a design deficiency. When the control switch for the pump is taken from the start position to the NAS position, contacts open as the switch leaves the start position. Other contacts, which close when the switch is in the NAS position, must close before a relay's contacts drop out, or the circuit which feeds the pump trip annunciator will not operate. Therefore, if the pump's control switch is taken from the start position to the NAS position quickly, the relay's contacts will not drop out and the annunciator will operate. However, if the switch is returned from the start to the NAS position slowly, the annunciator will not operate properly and the operators will not know that the annunciator is lost. During testing, it was observed that different operators returned the switch to the NAS position at different rates; with some operators the annunciator will work properly, and with others it will not.

This circuitry was originally designed this way and also exists for the RHR system. This circuitry only feeds the annunciator for a pump trip. Therefore, the concern is that if a pump trips in this situation, the operators would not get the annunciator and might not be aware that the pump had tripped. Plant personnel determined that although the annunciator might not be operable, the pump and the breaker would still be operable. Therefore, the system was operable at all times. Engineering personnel are evaluating the circuitry, the safety significance of the issue, and will evaluate correcting the deficiency prior to unit restart.

The inspectors reviewed the work request, the elementary diagram and discussed the situation with operators and engineers, and determined that system operability was not affected by the inoperable annunciator. Additionally, the inspectors noted that the operators have several other redundant indications of a pump trip available on the main control board. Overall, the inspectors concluded that actions taken to assure that the systems are operable and that all components will operate as designed were commendable.

6.2 Previously Identified Items

6.2.1 (Closed) Violation 90-09-02, Inadequate Test of a Design Change on the Torus Bulk Temperature Monitoring System

This violation resulted from inadequate post-modification testing of the torus bulk temperature monitoring system in that it failed to identify a design deficiency. The torus bulk temperature monitoring system design did not provide accurate information to the control room operators, due to inadequate corrective actions taken to delete a missing RTD from the averaging circuitry. This resulted in the indicated torus water average temperature being non-conservatively low, and rendering this instrumentation inoperable since the modification was installed in October 1989.

Initial corrective action consisted of replacing the missing RTD input with another signal from an adjacent, functioning RTD, in December 1990, such that two signals were averaged in from that RTD. A positive temperature bias was added to the average calculation program in April 1991 to account for potential inaccuracies. Procedure ST-40D, Daily Surveillance and Instrument check, includes a once per shift reading and recording of individual torus bay temperatures to detect potential RTD failures. Setpoint changes are now required to be implemented through a formal modification process rather than through the normal work request process. Additionally, the sixteenth RTD was installed and testing was being performed at the close of the inspection period.

The inspectors reviewed the procedure changes, the evaluations and the test procedures and discussed the changes with plant personnel, and identified no deficiencies. This violation (90-09-02) is closed.

During testing of the torus temperature monitoring system, plant personnel had a concern regarding the high temperature deviation setpoint. The concern was forwarded to engineering to determine if the system was operating as expected or if a change in the software was warranted. This item is unresolved pending resolution by NYPA and review by the NRC. (UNRESOLVED ITEM 92-12-02)

6.2.2 (Closed) Unresolved Item 91-02-01, Inaccuracies in Torus Temperature Readings

This unresolved item concerned the adequacy of using 15 versus 16 RTDs for torus bulk temperature monitoring. As noted in section 6.2.1, the sixteenth RTD is now installed and the system is being tested. However, NYPA evaluated the adequacy of and safety significance of using 15 versus 16 RTDs; the signal from an adjacent RTD was averaged in twice to make up for the missing RTD. The evaluation examined possible torus temperature errors indicated during nonuniform heatup, such as from a single safety relief valve discharge. The results indicated a potential for no more than a one degree error below the actual torus bulk temperature, with the residual heat removal system providing torus cooling. Based on this potential error and other errors associated with the instruments, NYPA added a conservative four degree bias in the software program, so that the displayed temperature would be four degrees higher than the actual temperature sensed by the RTDs. NYPA also found that the highest torus temperature recorded during the time period in question was 86 degrees; the technical specification limit is 95 degrees. NYPA therefore concluded that the torus temperature was within acceptable limits at all times and was never an actual or potential adverse effect on plant safety.

The inspectors reviewed the documentation associated with this issue, and also noted that the final resolution of replacing the missing RTD has been completed, and identified no deficiencies. This unresolved item is closed.

6.2.3 (Closed) Unresolved Item 92-01-02, Primary Containment Isolation Valve (PCIV) Stem Packing Not Subjected to Local Leak Rate Testing (LLRT)

During the process of eliminating the industry operating experience backlog, NYPA reviewed NRC Information Notice (IN) 86-16, Failures to Identify Containment Leakage Due to Inadequate Local Testing of BWR Vacuum Relief System Valves. NYPA's review determined that the stem packing to two butterfly valves in the primary containment vent and purge system were not subjected to local leak rate testing following valve maintenance. Design and physical orientation of the valves prevented application of pressure on the valve stem packing during LLRT. This LLRT deficiency remained unresolved pending completion of NYPA's evaluation and determination of the safety significance of having two untested primary containment leak paths since August 1990. The inspector reviewed NYPA's corrective actions documented in LER 92-008-01, dated June 24, 1992. NYPA completed a special LLRT on the stem packing of the valves to demonstrate their leak tight integrity. The measured leak rate results were

included in the as left LLRT results for demonstration of primary containment integrity. In addition, NYPA committed to modify all similar butterfly valves with a LLRT testable packing arrangement during the 1994 refueling outage. This item is closed.

6.2.4 (Closed) DEO.ENG.058 and DEO.ENG.061

These Diagnostic Evaluation Observations identified several broad fire protection program and Appendix R safe shutdown program weaknesses. To address these concerns the NRC conducted a special safety team inspection of the fire protection program documented in Inspection Report 50-333/92-80. These two DEO items have been superseded by IR 92-80 items and will be tracked accordingly. DEO.ENG.058 and DEO.ENG.061 are closed.

6.2.5 (Closed) DEO.ENG.051

This Diagnostic Evaluation Observation identified what appeared to be inadequate tracking and performance of Instrumentation and Controls (I&C) department surveillance tests, which resulted in surveillance tests being performed consistently past the scheduled due date. This assessment was based upon a cumbersome manual auditing capability and apparently a lack of clear communication between the inspector and the responsible NYPA representative.

The inspector reviewed the I&C surveillance scheduling and tracking program with the I&C supervisor and testing coordinator. The automated surveillance test schedule was clearly explained and demonstrated for the inspector. In addition, the inspector reviewed a sampling of completed surveillance tests and verified tests were being performed within their specified periodicity. The inspector found no evidence of excessive use of the grace period to complete the tests reviewed. DEO.ENG.051 is closed.

7.0 SAFETY ASSESSMENT/QUALITY VERIFICATION (71707, 93702)

7.1 Review of Licensee Event Reports (LERs)

The following LERs were reviewed and found satisfactory:

- 92-021-00, Unauthorized Temporary Modification of Relay Room Cooling, dated June 15, 1992. On April 7, 1992, a walkdown of the emergency service water system revealed the presence of an unauthorized modification of a temperature control valve (TCV) on one train of redundant relay room air handling cooling units. The TCV stem was restrained in the fail-safe maximum cooling position using wire without a documented engineering evaluation.

The inspector reviewed NYPA's corrective actions outlined in LER 92-021-00 and determined they were acceptable to address the inadequate control of a temporary modification. In addition, NYPA committed to complete a review of safety related system work requests and selected system walkdowns for the presence of unauthorized temporary modifications. The inspector considered NYPA's review to be thorough and complete.

- 92-032-00, Incomplete Surveillance Due to Procedure Deficiency, dated July 6, 1992. On June 5, NYPA identified that the functional testing of the isolation logic for the shutdown cooling mode of residual heat removal system (RHR) was inadequate. During post work test determination for 10 MOV-17 (the shutdown cooling outboard suction valve) NYPA identified that the existing surveillance test failed to verify the shutdown cooling primary containment isolation valves isolate in response to low reactor vessel level. NYPA determined this deficiency existed since initial plant operation. NYPA corrected the test deficiency and committed to perform a systematic review of surveillance test procedures to ensure test requirements are adequately implemented. The inspector considered NYPA's review to be thorough and complete.
- 92-033-00, Local Leak Rate Test Program Deficiencies, dated July 17, 1992. On June 17 and June 25, 1992, NYPA identified two local leak rate (LLRT) program deficiencies during a detailed review of the LLRT program in response to Information Notice 92-20, dated March 3, 1992. The inspector discussed the program review with the LLRT coordinator and reviewed the LER and determined that NYPA completed a thorough and timely review of this concern and these results are an example of the improvements NYPA has recently made in the review of existing industry operating events.

7.1.2 Shutdown Risk Contingency

Plant management continues to show a strong commitment to shutdown risk management. The inspector continued to observe that shutdown risk management was an integral factor in the scheduling of maintenance activities. During the inspection period the plant was in cold shutdown with the core off loaded and reactor vessel water level at the refuel level with the fuel pool gates removed. With these plant conditions no safety systems were required to be operable by Technical Specifications; however, NYPA has maintained a complement of emergency cooling, injection, and electrical power systems available. A noteworthy example of NYPA's commitment in this area was the contingencies NYPA put in place to support the availability of A and D emergency diesel generators (EDGs) during modification F1-92-008.

Modification F1-92-008 required rerouting the emergency service water (ESW) discharge piping from all four EDG jacket coolers. This modification required isolation of ESW to all four EDGs rendering all backup emergency diesel power unavailable with the plant at risk to a station blackout (SBO). To minimize the potential risk to a SBO event, NYPA provided temporary

cooling water to the A and D EDGs during the modification and provided TOP-141, Operation of the EDGs and Plant Electrical System During the EDG ESW Discharge Piping Modification, to the operators for operation of the electric plant during the modification. The inspector monitored a portion of the testing of the EDGs with TOP-141 and reviewed the procedure in its entirety. The inspector concluded TOP-141 was well thought out, and of a technical quality indicative of a significant resource commitment in this area. The inspector concluded that plant management, control and oversight of this modification, and the associated contingency plans developed in the event of a problem, were effective and commendable.

7.2 Previously Identified Items

7.2.1 (Closed) DEO.ENG.009

This Diagnostic Evaluation Observation identified that the analysis of several events was superficial and failed to identify the root cause. Also, that management support in producing quality licensee event reports appeared to be weak, (e.g., accepting less than rigorous explanations as root causes). The inspector has observed significant improvement and good programmatic initiatives in this area. NYPA has established a formal Root Cause Analysis Program (WACP 10.1.27) and an Integrated Causal and Corrective Action Program (WACP 10.1.30). Management support in this area has been evident by providing necessary resources to develop an Operations Review Group to manage these programs and by providing training in root cause analysis to plant personnel. These initiatives coupled with increased resources to review the operating event review backlog and engineering work backlog has resulted in an increase in identification and correction of longstanding plant deficiencies, and a higher quality LER process. This DEO.ENG.009 is closed.

7.2.2 (Closed) Violation (90-09-03): Inadequate Corrective Actions to Address Identified Deficiencies

This violation identified two examples where conditions adverse to quality were not promptly identified and corrected. In both instances, the specific concerns were, or are being appropriately corrected. Other corrective actions include: the adverse quality condition report (AQCR) has an operability review guideline section for determining significant conditions; an operability review form is required for work requests for equipment deficiencies; and a work activity control procedure was implemented which establishes an integrated causal and corrective action evaluation program which is overseen by an operational review group. Additionally, NYPA is evaluating implementation of a deviation event reporting system, which is intended to tie together all of the other corrective action systems. These corrective actions were developed to ensure that deficiencies are promptly identified and corrected.

The inspectors reviewed the procedure and programmatic changes, discussed the changes with plant personnel, and reviewed examples of recent operability reviews of work requests. The inspector concluded that the corrective actions taken were comprehensive in addressing the concerns. This violation is closed.

8.0 MANAGEMENT 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.