

U.S. NUCLEAR REGULATORY COMMISSION

Region I

Report No.: 96-01
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: January 7, 1996 through February 17, 1996
Inspectors: G. Hunegs, Senior Resident Inspector
R. Fernandes, Resident Inspector

Approved by:

Richard J. Barkley 3/11/96
for Curtis J. Cowgill, Chief Date
Projects Branch No. 2
Division of Reactor Projects

INSPECTION SUMMARY: Routine NRC resident 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. 50-333/96-01

Plant Operations: On January 8, a series of abnormal alarms associated with the offgas systems were received in the control room. These alarms resulted in an extensive troubleshooting effort on the licensee's part to identify an unusual amount of water collecting in the standby gas treatment system (SBGTS) and the offgas system piping. The licensee's investigation and corrective actions are continuing and appear to be appropriate.

Due to a recent intake structure icing event at a facility in the Midwest, the inspectors reviewed the corrective actions for a low screen well intake level event which occurred at the FitzPatrick plant in February, 1993. The inspectors verified these corrective actions were implemented and discussed the issue with plant operators. Operators were knowledgeable of required operator actions and the past event. On February 2, 1996, as an added precaution due to environmental conditions, the licensee implemented a procedure to determine the potential for ice formation. Implementation of this additional requirement was considered a prudent action by the NRC.

Maintenance: Two Residual Heat Removal (RHR) Service Water (SW) Pumps failed to start due to a contact switch failure in the closing spring motor circuit. Both breakers were repaired and retested satisfactorily that day. Additionally, the licensee replaced the switches in the remaining two RHRSW pump breakers and the four RHR pump breakers. The post maintenance retesting requirements were enhanced by verifying proper electrical function of the switches.

A pre-evolution brief was held prior to the performance of the containment spray/cooling system logic system functional test. The test is a semi-annual test which is to demonstrate the logic circuits for the containment cooling mode of residual heat removal system. Conducting a pre-evolution brief demonstrated conservative decision making.

Engineering: Based on the discussions and action items developed from a system engineer presentation, the inspector considered the system engineer presentation program to be a positive initiative. The program helps to establish the system engineer as the focal point for system performance and issues.

Plant Support: For security equipment problems, repairs were timely and appropriate compensatory measures were taken.

Several modifications to upgrade the security systems are nearing completion and are being implemented appropriately. Security force members were observed to be alert and closely monitoring equipment status and indications.

The licensee took positive steps to address a problem related to drug and alcohol testing program laboratory deficiencies.

Safety Assessment/Quality Verification: Performance enhancement review committee (PERC) meetings were observed and it was noted that events were thoroughly reviewed by station management and sound corrective actions were developed.

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DETAILS

1.0 SUMMARY OF FACILITY ACTIVITIES

1.1 NYPA Activities

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

1.2 NRC Activities

The NRC Systematic Assessment of Licensee Performance (SALP) management meeting was held on January 24, 1996 at the James A. FitzPatrick Nuclear Power Plant training center auditorium. Enclosures 2, 3 and 4 provide summaries of the discussions and meeting attendees. The meeting was open to the public.

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 expected. 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 operating logs, turnover sheets, system safety tags and temporary modifications. 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 Followup of Events Occurring During Inspection Period

2.2.1 Standby Gas Treatment System and Offgas Systems Water Collection

On January 8, a series of abnormal alarms associated with the offgas systems were received in the control room. These alarms resulted in an extensive troubleshooting effort on the licensee's part to identify an unusual amount of water collecting in the standby gas treatment system (SBGTS) and the offgas system piping. The inspectors monitored the troubleshooting activities to determine the safety significance of the problems and evaluate the licensee's corrective actions for problems identified with these systems. In particular the inspectors were concerned about: the operator distractions from the alarms, the potential for radiological releases to the environs, challenge to the SBGTS, and challenge to the plant should systems degrade which affect the ability of the plant to maintain condenser vacuum.

Background

In November of 1995, excavating work had been performed around the main stack to correct some deficiencies with lightning arresting equipment. Coincident with that work, the licensee postulated that heavy rainfall resulted in the main stack sump processing a large amount of high conductivity water. This water is returned to the reactor building equipment drain sump via the 24" SBGTS discharge pipe which is sloped towards the reactor building. At that time, to prevent excessive volume input to the radioactive waste processing systems, a temporary modification to the drain line was installed to divert the high conductivity water to the floor drain systems which is better suited for handling these types of liquids. A nuclear safety evaluation determined the temporary modification was an acceptable means to reroute the SBGT drain line.

On January 8, the steam packing exhauster piping exhibited large flow oscillations coincidentally with the offgas drip pot high level alarm. The steam packing exhauster is a steam and air removal system for the main turbine steam seals and assists in maintaining proper vacuum. The drain pot collects condensate from various sections of piping in the offgas system and returns it to the condenser via an air operated valve. The operators determined that upon starting a second steam packing exhauster fan, the oscillations diminished. It was later determined by the licensee that the cause of the

oscillations was a buildup of condensate in the exhaust piping, which was the result of the drip pot drain valve failing to cycle properly.

Concurrent with these activities, the licensee installed additional electric heating in the main stack to melt ice which had formed on the high efficiency filter units. The licensee postulated that this additional heating melted the ice which had built up on the inside of the exhaust plenum in the lower portions of the main stack and caused a minor water leak from a blank flange connected to the exhaust plenum.

The licensee's investigation and corrective actions are continuing and appear to be appropriate.

2.2.2 1993 Intake Structure Icing Event

Due to a recent event at a facility in the Midwest, the inspectors reviewed the corrective actions for a low screen well intake level event which occurred at the FitzPatrick plant in February, 1993. At that time, the accumulation, or formation, of ice at the intake structure resulted in the inability of the circulating water system (CWS) to maintain pump flow requirements. The intake structure also provides water to the emergency service water, residual heat removal service water, and fire protection systems. The event was significant because, had the operators not taken corrective action, the water level would have dropped below the minimum required for the safety related pumps which take suction from the intake structure. Licensee Event Report (LER) 93-004, Low Intake Level Scram, was submitted to document the event. In general, two types of ice accumulations may occur at the intake which are of concern. These types of ice accumulation are loose accumulations of ice and slush ice in front of the intake and/or ice buildup on the intake bar racks. Ice buildup can be caused by frazil ice. Frazil ice is small particles of ice that are formed when the water becomes super-cooled. Environmental conditions most conducive to frazil ice formation are considered to be cold, clear nights that are preceded by windy periods.

Following the February 1993 event, the licensee initiated the following corrective actions:

- Two computer alarm points were installed to identify a five degree circulating water temperature change over a one hour time interval. This would provide the operators with an early indication that ice blockage may be occurring at the intake structure.
- An abnormal operating procedure was developed to provide guidance to operators when a low screen well water level is observed or upon receiving the circulating water temperature change alarm.
- Daily and shift surveillance requirements were written to establish requirements for monitoring intake level, temperature, and to assess environmental conditions.
- A modification was installed to provide a screen well water level low level alarm in the control room and water level indicators were

installed in the screen well to provide operators with a reference as to actual water level.

The inspectors verified these corrective actions were implemented and discussed the issue with plant operators. The inspectors concluded that operators were knowledgeable of required operator actions and the past event.

On February 2, as an added precaution due to environmental conditions, operations implemented a procedure to determine the potential for ice formation. Implementation of this additional requirement was considered a prudent action by the licensee.

3.0 MAINTENANCE (62703,61726,92902)

3.1 Maintenance Observation

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:

- WR No: 96-00320, Remove 27S0V-114B from Containment Atmosphere Dilution (CAD) system and test per MP-59.07
- WR No: 94-06181, Perform operational surveillance testing of all intake structure deicing heaters in accordance with maintenance procedure MST-071.06, Intake De-icing Heaters Insulation Resistance Surveillance Test
- WR No: 95-02612, Perform operational surveillance testing of all intake structure deicing heaters in accordance with maintenance procedure MST-071.17, Intake De-icing Heaters Rated Current Surveillance Test
- WR No: 96-01137, Repair Magne-Blast Breaker utilizing MP-54.1, 4.16 kV Magne-Blast Breaker
- WR No: 96-00214, 10042 Breaker maintenance
- WR No: 95-07864, Control Rod Drive Hydraulic Control Water Accumulator Replacement

No concerns were identified during inspector review of the above activities.

3.1.1 4160 Volt Circuit Breaker Failures

On February 12, during the performance of surveillance test (ST)-2R, Residual Heat Removal (RHR) Service Water Pump and Motor Operated Valve (MOV) Operability Test, the C residual heat removal service water (RHRSW) pump failed to start. Trouble shooting by plant personnel revealed that a push-button contact switch in the breaker spring motor circuit had failed. The normally closed contacts should have allowed the closing coil to energize when the control room operator positioned the pump switch to run. However, because

of high resistance across the contacts the circuit was not complete and the 4160KV breaker failed to close. During the maintenance activities, control room operators attempted to start the A RHRSW pump and it also failed to start. The licensee determined this pump start failure was also the result of the contact switch in the spring motor circuit. Both breakers were repaired and retested satisfactorily that day.

The circuit breakers are GE Magne-Blast type AMH-4.76-250-1D breakers. There are 50 breakers of this style in the plant, of which 22 are safety related. The breaker manufacturer, General Electric (GE), informed the licensee that the contact switch (GE model CR2940V310) was qualified for 10,000 cycles. FitzPatrick breakers have an approximate usage range of 1000 to 3200 cycles. In addition to the two RHRSW pump breakers, the licensee replaced the switches in the remaining two RHRSW pump breakers and the four RHR pump breakers. Following the replacement of the switches, the licensee determined there was a definite correlation between number of breaker cycles and the degradation seen on the contacts of the switch.

The maintenance process for the initial breaker trouble shooting was made more difficult by the fact that the licensee's one-line electrical diagram for the breaker did not reflect the fact that the contacts were in the circuit. Vendor wiring diagrams did reflect the contact switch installation. However, notes in the diagrams appear ambiguous on the correct switch configuration. The licensee is continuing to investigate the drawing discrepancies and in the interim determined that the switch is properly installed.

The inspector learned that licensee maintenance practices do not normally look at these contact switches from an electrical function perspective, but do take clearance measurements on contact positioning. The licensee is currently evaluating maintenance procedure changes to address this issue.

The inspector observed maintenance activities associated with the replacement of the contact switches including quality assurance oversight and post maintenance testing. The inspector reviewed post maintenance testing with licensee engineering staff with particular emphasis on verification of proper electrical functionality of the switches following replacement. The inspector learned that although it had not been past practice to specifically call out point-to-point circuitry verification, it was added into the work packages for these switches. The inspector concluded that this additional post maintenance test was a positive input to the work package.

The inspectors concluded that the replacement of the eight sets of contact switches on the safety related breakers following the back-to-back failures of the two RHRSW pumps was appropriately conservative. The post maintenance retesting requirements were enhanced by the maintenance staff.

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:

- ST-9B, Emergency Diesel Generator (EDG) Full Load Test and Emergency Service Water (ESW) Pump Operability Test
- ST-8G, Intake Deicing Heaters Feeder Test
- ST-24P, Reactor Core Isolation Cooling (RCIC) Class 2 and 3 Piping 10 Year Pressure Test (ISI)
- ISP-71, Intermediate Range Monitor Calibration
- ST-35A, Containment Spray/Cooling System Logic system Functional Test

No concerns were identified during inspector review of the above activities. The inspectors noted that the licensee conducted a pre-evolution brief was held prior to the performance of the containment spray/cooling system logic system functional test. The test is a semi annual test which is to demonstrate the logic circuits for the containment cooling mode of residual heat removal system. The inspector concluded that conducting a pre-evolution brief demonstrated conservative decision making.

The inspector reviewed AP-19.08, Infrequently performed Tests or Evolutions and Plant Special Order (PSO)-11, Pre-job Preparation and Briefings. The procedures provide guidance on when and how a pre-job briefing should be conducted to ensure that complex tasks are performed correctly.

4.0 ENGINEERING (37551,92903,71707)

4.1 System Engineering Presentation

On February 2, 1996, the inspector observed the system engineering presentation for the direct current (DC) electrical distribution system. The DC electrical system is a 125 volt system consisting of two separate and independent systems of batteries, chargers, distribution equipment and interconnecting cabling. System engineering presentations are described in TSS0-24, System Presentations. The purpose of system engineering presentations is to inform management of key system issues. The presentation covered a detailed overview of system current status including system issues, status, modifications, maintenance rule, and the overall system health. The overall conclusion was that the system reliability and availability requirements were met.

Based on the discussions and action items developed from the meeting, the inspector considered the system engineer presentation program to be a positive initiative. The program helps to establish the system engineer as the focal point for system performance and issues.

5.0 PLANT SUPPORT (71707,40500,92904)

5.1 Radiological Controls

5.1.1 Previously Identified Items

Corrective actions for two previous violations, 94-30-01, Failure To Follow Procedures/Poor Radiological Worker Practices, and 95-03-01, Failure To Follow Procedures By Health Physics Technicians were updated in NRC inspection report 50-333/95-23. In response to the Notices of Violation and to a request for information contained in NRC Inspection Report No. 50-333/95-10, the licensee has outlined a corrective action program to address both the specific issues identified in the Violations and the programmatic weaknesses identified. These corrective actions have begun to be implemented, and have initially been successful. The inspectors will continue to monitor this area closely. These items are closed.

5.2 Security

5.2.1 Security System Status

The inspector reviewed the 4th quarter 1995 security loggable events report to determine if appropriate compensatory measures were taken for safeguards related issues and to assess the program effectiveness. The inspector noted that there were relatively few loggable events and that issues documented in the report were judged to be relatively minor. The inspector also noted that, for equipment problems, repairs were timely and appropriate compensatory measures were taken.

The inspector reviewed the status of several modifications to upgrade the security systems and inspected ongoing work on security modifications. The security department records show that the security camera upgrade is 99% complete, the vehicle barrier modification is 100% complete and security lighting and related modifications are 75% complete. Based on observations of the central alarm station (CAS), and secondary alarm station (SAS) the security modifications are being implemented to minimize distraction to security members. Security force members located in CAS and SAS were observed to be alert and closely monitoring equipment status and indications.

In conclusion, security equipment repairs were timely and appropriate compensatory measures taken. Modifications to upgrade security systems were well implemented.

5.2.2 Drug and Alcohol Testing Programs

In a letter to the NRC dated January 15, 1996 the licensee reported that a blind test specimen result had been incorrectly reported by their testing laboratory. Due to the presence of an interfering substance, a blind test specimen could not be reported as positive. A recent similar incorrect report involved the reporting of a false negative. For corrective actions, the licensee initiated new contracts with an alternate blind test specimen

supplier and testing laboratory and conducted additional reviews and audits of the program.

The inspector concluded that the licensee took appropriate steps to address the problem.

6.0 SAFETY ASSESSMENT/QUALITY VERIFICATION (40500,37551,92700,90712)

6.1 Onsite Review Committee

The inspectors observed several Plant Operations Review Committee (PORC) meetings. Areas warranting further review or additional detail were appropriately tabled for follow-up discussion during future committee meetings. An appropriate focus on the safety aspect of issues was observed.

Based upon these observations, the inspectors found the PORC to have been effective in their review and oversight function.

6.2 Performance Enhancement Review Committee

The inspectors observed performance enhancement review committee (PERC) meetings Nos. 96-0002 and 96-0004. The purposes of the PERC meetings are to provide for a timely review of events by management and an assessment of the accuracy and adequacy of root cause evaluations and critiques or responses for significant personnel errors, including corrective actions. The issues presented at the meetings the inspectors observed included procedure revision control, an electrician receiving an electrical shock during a low pressure coolant injection (LPCI) battery surveillance test, damage to auxiliary boiler doors, a service air compressor sight glass breaking and a jumper lead slipping off of a hydraulic control unit terminal during maintenance. The electrical shock and the terminal lead slipping events are described below:

On January 4, 1996, while performing the weekly low pressure coolant injection (LPCI) surveillance test (ST), an electrician received an electrical shock when he inadvertently touched the battery cell bus plate and another cell terminal on a tier of batteries he was reaching over. He was not injured in the event and this industrial safety occurrence was treated as a near miss.

On January 25, 1996 temporary modification No. 96-014 was implemented to support the hydraulic control unit (HCU)-42-07 accumulator tank replacement. The purpose of the temporary modification was to prevent masking valid accumulator trouble alarms. Operators hanging the jumper found it difficult to install lugged leads because of tight clearances and instead used an alligator clip. During restoration of the temporary modification, one jumper lead was removed and the other jumper lead at the terminal fell off apparently causing an arc and blowing the fuse which deenergized the alarm circuit. This resulted in false accumulator trouble lights on the full core display.

AP-5.02, Control of Temporary Modifications, has cautions in the procedure concerning the use of alligator clips because of previous problems during jumper installation. Operators were aware of the problems associated with

using alligator clips but it was determined that using the clips was the best course of action.

Both events were thoroughly reviewed by station management and sound corrective actions were developed.

7.0 MANAGEMENT MEETINGS (71707)

7.1 Review of UFSAR Commitments

A recent discovery of a licensee operating their facility in a manner contrary to the Updated Final Safety Analysis Report (UFSAR) description highlighted the need for a special focused review that compares plant practices, procedures and/or parameters to the UFSAR descriptions. While performing the inspections discussed in this report, the inspectors reviewed the applicable portions of the UFSAR that related to the areas inspected. The inspectors verified that the UFSAR wording was consistent with the observed plant practices, procedures and/or parameters.

7.2 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.

NYPA/NRC

***S*ystematic**

***A*ssessment**

***L*icensee**

***P*erformance**

Public Meeting

January 24, 1996

OPERATIONS

- **SAFE OPERATION/CONSERVATIVE DECISION-MAKING**
- **IMPROVED OPERATOR PERFORMANCE**
 - **Shift Manager Responsibilities**
 - **Performance Enhancement Review Committee (PERC) Oversight**
 - **Additional Work Practice Training**
 - **Use of Observation/Briefing Checklist**

OPERATIONS (continued)

- **PROTECTIVE TAGGING PROGRAM ENHANCEMENTS**
- **EFFECTIVE CONTROL OF COMPLEX EVOLUTIONS**
 - **Control Rod Sequence Exchange**
 - **345KV Breaker Maintenance**

MAINTENANCE

- **WORK PLANNING AND CONTROL PROCESSES**
 - **Work Week Managers Assigned**
 - **On-Line LCO Maintenance Successes**
 - **Corrective Maintenance Backlog Reduction**
 - **Work Package Quality Improvements**
 - **Established Refueling Outage Milestones**
 - **Use of "Fix-it-Now" (FIN) Teams**

- **ENGINEERING INTERFACE**
 - **Modification Teams Assigned**
 - **Pre-Op Tests Developed**

ENGINEERING

- **DESIGN ENGINEERING REORGANIZATION**
- **WORK MANAGEMENT PROCESSES / ENGINEERING SKILLS**
- **REFUEL OUTAGE SCOPE / MILESTONES**
- **CONFIGURATION MANAGEMENT / PLANT DRAWING UPDATE**
- **SELF-ASSESSMENTS**

PLANT SUPPORT

- **RADIOLOGICAL PROGRAM**
 - **Successful ALARA / Environmental Programs**
 - **Improved Radiation Worker Practices**
 - ▶ **Assessments**
 - ▶ **Communications**
 - ▶ **Problem Recognition / Self-Identification**
 - **Plant Staff Ownership**
 - ▶ **Performance Standards**
 - ▶ **Enhanced Radiation Worker Training**
 - ▶ **Teams Developed to Review / Simplify Processes**

PLANT SUPPORT (continued)

- **EMERGENCY PLAN SUCCESSES**
 - Challenging Drills
 - Effective Training
 - Dedicated Organization

- **STRONG SECURITY PLAN**

- **IMPROVED FIRE PROTECTION PROGRAM**

NYPA/NRC

***S*ystematic
*A*ssessment
*L*icensee
*P*erformance**

Public Meeting

January 24, 1996

UNITED STATES
NUCLEAR REGULATORY COMMISSION



**SYSTEMATIC ASSESSMENT OF
LICENSEE PERFORMANCE (SALP)**

FITZPATRICK NUCLEAR PLANT

ASSESSMENT PERIOD: APRIL 10, 1994 - NOVEMBER 18, 1995

BOARD MEETING: NOVEMBER 30, 1995

MANAGEMENT MEETING: JANUARY 24, 1995

AGENDA

NRC INTRODUCTORY REMARKS: William F. Kane
Deputy Regional Administrator

NYPA INTRODUCTORY REMARKS: William J. Cahill
Chief Nuclear Officer

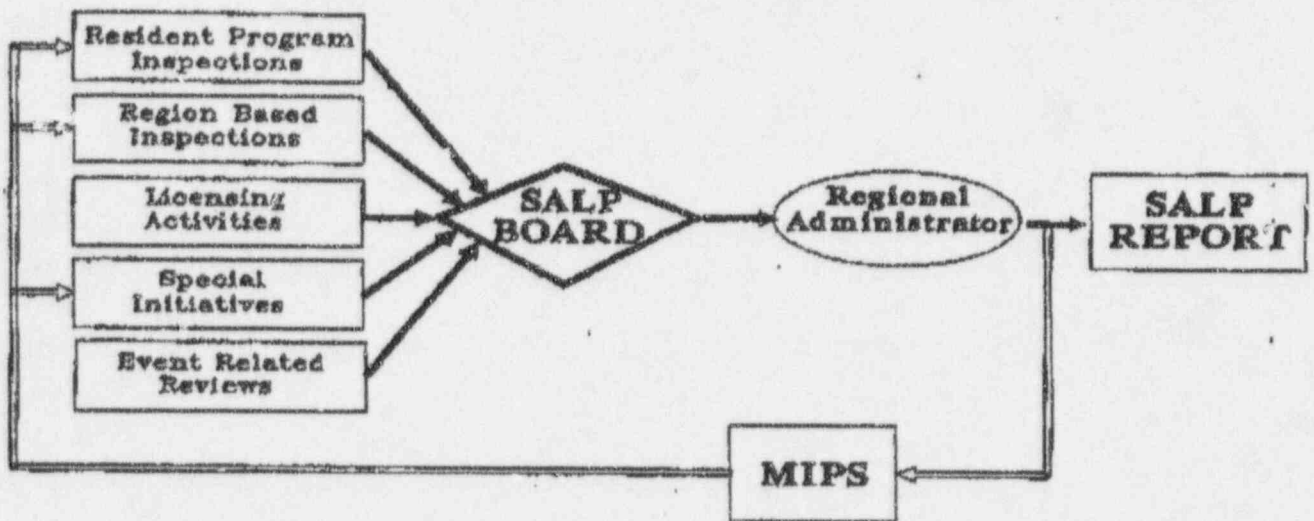
NRC SALP PROCESS AND RESULTS: Curtis J. Cowgill
Chief, Division of Reactor Projects Branch 2

NYPA CLOSING REMARKS: William J. Cahill

NRC CLOSING REMARKS: William F. Kane

PUBLIC QUESTIONS AND ANSWERS: NRC

NEW SALP PROCESS



PERFORMANCE ANALYSIS AREAS

- **Plant Operations**
- **Engineering**
- **Maintenance**
- **Plant Support**
 - **Radiological Controls**
 - **Emergency Preparedness**
 - **Security**
 - **Fire Protection**
 - **Housekeeping**

PERFORMANCE CATEGORY RATINGS

CATEGORY 1: SUPERIOR PERFORMANCE

- PROGRAMS AND PROCEDURES PROVIDE EFFECTIVE CONTROLS
- SELF-ASSESSMENT EFFORTS ARE EFFECTIVE
- CORRECTIVE ACTIONS ARE COMPREHENSIVE
- MINIMUM INSPECTIONS TO VERIFY SAFETY

CATEGORY 2: GOOD PERFORMANCE

- PROGRAMS AND PROCEDURES NORMALLY PROVIDE CONTROLS
- SELF-ASSESSMENT EFFORTS ARE GOOD - EMERGING ISSUES
- RECURRING ISSUES
- ADDITIONAL INSPECTION TO ASSESS PERFORMANCE

CATEGORY 3: ACCEPTABLE PERFORMANCE

- PROGRAMS AND PROCEDURES ARE WEAK
- SELF-ASSESSMENT EFFORTS ARE REACTIVE
- CORRECTIVE ACTIONS LESS THAN ADEQUATE
- SIGNIFICANT NRC AND LICENSEE ATTENTION REQUIRED

PERFORMANCE ANALYSIS

<u>FUNCTIONAL AREA</u>	<u>RATING</u> <u>LAST</u> <u>SALP</u>	<u>RATING</u> <u>THIS</u> <u>SALP</u>
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Plant Operations	2	2
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Maintenance	2	2
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Engineering	2	2
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Plant Support	2	2
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PLANT OPERATIONS

Category 2

- **GOOD STATION AND SHIFT MANAGEMENT OVERSIGHT**

- **CONSERVATIVE DECISION MAKING**

- **OVERALL CONTROL OF ACTIVITIES GOOD**

- **SOME PERSONNEL ERRORS DUE TO:**
 - **INATTENTION TO DETAIL**
 - **POOR COMMUNICATIONS**

- **SOME WEAK PROCEDURE ADHERENCE**

MAINTENANCE

Category 2

- IMPROVED PERFORMANCE OBSERVED
- GOOD MANAGEMENT INVOLVEMENT
- RELIABLE AND SAFE PLANT OPERATION
- EQUIPMENT PERFORMANCE MONITORING EFFECTIVE
- WORK PLANNING AND CONTROL PROCESS PROBLEMS PERSIST

ENGINEERING

Category 2

- MANAGEMENT INVOLVEMENT GOOD
- CRITICAL AUDITS OF WORK PROCESSES
- ACTIVE SELF-ASSESSMENT INITIATIVES
- GOOD TECHNICAL SUPPORT TO SITE ORGANIZATIONS
- SOME TECHNICAL LAPSES OCCURRED
- SOME CONFIGURATION MANAGEMENT WEAKNESSES EVIDENT

PLANT SUPPORT

Category 2

- EP, SECURITY AND EFFLUENT CONTROLS PROGRAMS ACHIEVED EXCELLENT SAFETY PERFORMANCE
- RADIOLOGICAL ENVIRONMENTAL MONITORING PROGRAM VERY GOOD
- FIRE PROTECTION MEASURES GENERALLY GOOD AND IMPROVING
- STRONG ALARA PROGRAM
- CONTINUING ROUTINE IN-PLANT RADIOLOGICAL CONTROL PROBLEMS
 - CORRECTIVE ACTION INITIATED

UNITED STATES
NUCLEAR REGULATORY COMMISSION



**SYSTEMATIC ASSESSMENT OF
LICENSEE PERFORMANCE (SALP)**

FITZPATRICK NUCLEAR PLANT

ASSESSMENT PERIOD: APRIL 10, 1994 - NOVEMBER 18, 1995

BOARD MEETING: NOVEMBER 30, 1995

MANAGEMENT MEETING: JANUARY 24, 1995

AGENDA

NRC INTRODUCTORY REMARKS: William F. Kane
Deputy Regional Administrator

NYPA INTRODUCTORY REMARKS: William J. Cahill
Chief Nuclear Officer

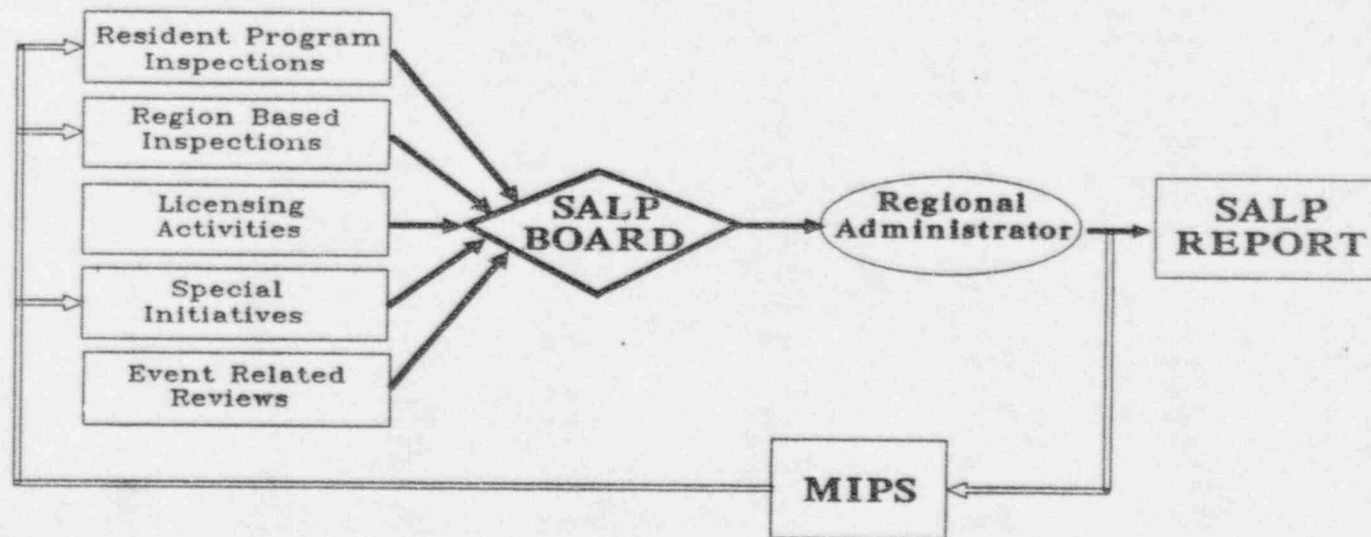
NRC SALP PROCESS AND RESULTS: Curtis J. Cowgill
Chief, Division of Reactor Projects Branch 2

NYPA CLOSING REMARKS: William J. Cahill

NRC CLOSING REMARKS: William F. Kane

PUBLIC QUESTIONS AND ANSWERS: NRC

NEW SALP PROCESS



PERFORMANCE ANALYSIS AREAS

- **Plant Operations**
- **Engineering**
- **Maintenance**
- **Plant Support**
 - **Radiological Controls**
 - **Emergency Preparedness**
 - **Security**
 - **Fire Protection**
 - **Housekeeping**

PERFORMANCE CATEGORY RATINGS

CATEGORY 1: SUPERIOR PERFORMANCE

- PROGRAMS AND PROCEDURES PROVIDE EFFECTIVE CONTROLS
- SELF-ASSESSMENT EFFORTS ARE EFFECTIVE
- CORRECTIVE ACTIONS ARE COMPREHENSIVE
- MINIMUM INSPECTIONS TO VERIFY SAFETY

CATEGORY 2: GOOD PERFORMANCE

- PROGRAMS AND PROCEDURES NORMALLY PROVIDE CONTROLS
- SELF-ASSESSMENT EFFORTS ARE GOOD - EMERGING ISSUES
- RECURRING ISSUES
- ADDITIONAL INSPECTION TO ASSESS PERFORMANCE

CATEGORY 3: ACCEPTABLE PERFORMANCE

- PROGRAMS AND PROCEDURES ARE WEAK
- SELF-ASSESSMENT EFFORTS ARE REACTIVE
- CORRECTIVE ACTIONS LESS THAN ADEQUATE
- SIGNIFICANT NRC AND LICENSEE ATTENTION REQUIRED

PERFORMANCE ANALYSIS

<u>FUNCTIONAL AREA</u>	<u>RATING LAST SALP</u>	<u>RATING THIS SALP</u>
Plant Operations	2	2
Maintenance	2	2
Engineering	2	2
Plant Support	2	2

PLANT OPERATIONS

Category 2

- STATION AND SHIFT MANAGEMENT DEMONSTRATED A QUESTIONING ATTITUDE
- CONSERVATIVE DECISION MAKING
- OPERATOR CONTROL OF ROUTINE OPERATIONS AND UNPLANNED TRANSIENTS WAS GOOD
- PERSONNEL ERRORS CAUSED BY INATTENTION TO DETAIL AND POOR COMMUNICATIONS CAUSED PROBLEMS
- SOME WEAK PROCEDURE ADHERENCE

MAINTENANCE

Category 2

- EVIDENCE OF PERFORMANCE IMPROVEMENT
- MANAGEMENT EFFECTIVELY INVOLVED IN THE MAINTENANCE PROCESS
- MAINTENANCE EFFECTIVE IN ACHIEVING RELIABLE AND SAFE PLANT OPERATION
- EQUIPMENT PERFORMANCE MONITORING EFFECTIVE
- WORK PLANNING AND CONTROL PROCESS PROBLEMS PERSIST

ENGINEERING

Category 2

- MANAGEMENT INVOLVEMENT GOOD
- CRITICAL AUDITS OF WORK PROCESSES
- ACTIVE SELF-ASSESSMENT INITIATIVES
- GOOD TECHNICAL SUPPORT TO SITE ORGANIZATIONS
- SOME TECHNICAL LAPSES OCCURRED
- SOME CONFIGURATION MANAGEMENT WEAKNESSES EVIDENT

PLANT SUPPORT

Category 2

- EP, SECURITY AND EFFLUENT CONTROLS PROGRAMS ACHIEVED EXCELLENT SAFETY PERFORMANCE
- RADIOLOGICAL ENVIRONMENTAL MONITORING PROGRAM VERY GOOD
- FIRE PROTECTION MEASURES GENERALLY GOOD AND IMPROVING
- IN-PLANT RADIOLOGICAL PROTECTION PROGRAM HAD SOME ATTRIBUTES OF STRONG PERFORMANCE, PARTICULARLY RELATED TO ALARA MEASURES
- WEAK AND INCONSISTENT PERFORMANCE OF BASIC IN-PLANT RADIOLOGICAL CONTROLS

Enclosure 4

SALP Management Meeting Attendees

NRC attendees:

E. Carpenter, Project Manager
C. Cowgill, Chief Projects Branch No. 2
R. Fernandes, Resident Inspector
G. Hunegs, Senior Resident Inspector
W. Kane, Deputy Regional Administrator

FitzPatrick attendees:

W. Cahill, Jr., Chief Nuclear Officer
M. Colomb, General Manager, Operations
D. Lindsey, General Manager, Maintenance
D. Ruddy, Director, Design Engineering
H. Salmon, Site Executive Officer
D. Topley, Acting General Manager, Support Services