

May 22, 1998

Mr. Michael J. Colomb
Site Executive Officer
New York Power Authority
James A. FitzPatrick Nuclear Power Plant
Post Office Box 41
Lycoming, NY 13093

SUBJECT: PLANT PERFORMANCE REVIEW (PPR) - FITZPATRICK

Dear Mr. Colomb:

On April 28, 1998, the NRC staff completed the semiannual Plant Performance Review (PPR) of FitzPatrick. The staff conducts these reviews for all operating nuclear power plants to develop an integrated understanding of safety performance. The results are used by NRC management to facilitate planning and allocation of inspection resources. The PPR for FitzPatrick involved the participation of all technical divisions in evaluating inspection results and safety performance information for the period from October 1997 through April 1998. PPRs provide NRC management with a current summary of licensee performance and serve as inputs to the NRC Systematic Assessment of Licensee Performance (SALP) and senior management meeting (SMM) reviews.

Enclosure 1 contains a historical listing of plant issues, referred to as the Plant Issues Matrix (PIM), that were considered during this PPR process to arrive at an integrated view of licensee performance trends. The PIM includes only items from inspection reports or other docketed correspondence between the NRC and the New York Power Authority. The PPR may also have considered some predecisional and draft material that does not appear in the attached PIM, including observations from events and inspections that had occurred since the last NRC inspection report was issued, but had not yet received full review and consideration. This material will be placed in the PDR as part of the normal issuance of NRC inspection reports and other correspondence.

This letter advises you of our planned inspection effort resulting from the FitzPatrick PPR review. It is provided to minimize the resource impact on your staff and to allow for scheduling conflicts and personnel availability to be resolved in advance of inspector arrival onsite. Enclosure 2 details our inspection plan for the next 6 months. Resident inspections are not listed due to their ongoing and continuous nature.

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We will inform you of any changes to the inspection plan. If you have any questions, please contact me at 1-610-337-5255.

Sincerely,

Original Signed by:

David C. Lew, Chief
Projects Branch 2A
Division of Reactor Projects

Docket Nos. 50-333
License Nos. DPR-26

Enclosures:

1. Plant Issues Matrix
2. Inspection Plan

cc w/encls:

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E. Zeltmann, President and Chief Operating Officer
R. Hiney, Executive Vice President for Project Operations
J. Knubel, Chief Nuclear Officer and Senior Vice President
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FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	S/A	Code	Item Description
2/22/98	Negative	IR 97-10	N	OPS	5B 5C	Errors associated with implementing the corrective action program and administration of the action commitment tracking system (ACTS) were identified. These errors were administrative in nature and the licensee implemented corrective actions to resolve the discrepancies.
2/22/98	Positive	IR 97-10	S	OPS	1B 3A	On January 16, a partial loss of control room annunciators was caused by an unexpected electrical short during maintenance activities. Operators demonstrated good use of procedures, including the emergency plan, to respond to the event. The approach to return the annunciators to service was well developed and appropriate management involvement was noted.
2/22/98	VIO	IR 97-10 VIO 97-10-01	N	OPS	3A 1C	During maintenance activities, the licensee disabled one channel of the radiation monitor system and impacted the operable train of the standby gas treatment system (SBGTS) with the other SBGTS out of service. Poor review of TS requirements resulted in making inoperable the automatic start function on high radiation in the reactor building below the refuel floor for the SBGTS. The licensee did not complete the required TS actions to isolate containment and start the SBGTS until the condition was identified by the NRC.
12/21/97	VIO	IR 97-08 VIO 97-08-01	S	OPS	3A 1C	Operator error while performing an electrical ground isolation abnormal operating procedure. Breakers were operated out of sequence which caused inadvertent automatic operation of high pressure coolant injection valves. This is a violation of TS 6.8.(A)1. Additionally, the pre-evolution brief was weak in that the assignment of personnel to conduct breaker manipulations was not made.
12/21/97	Positive	IR 97-08	N	OPS	1A	The shutdown for the December 7, 1997, forced outage was well controlled. Good command and control, communication and procedure adherence were noted.
11/7/97	Negative	IR 97-09	N	OPS	3B	The quality of the initial submittal of the licensed operator exam was not at the level that met NRC expectations. The submitted exam was not capable of discriminating between acceptable and unacceptable licensee candidates. Poor written question distractors, correlation, and lack of balance. The final exam was acceptable.
11/7/97	Positive	IR 97-09	N	OPS	3B	All 8 applicants for licensed operators passed the exam. All applicants were well prepared for the exam. On the operating test, examiners noted very good performance regarding team work, use of prints, communication, procedure use, and peer checking. Weak performance was noted related to an alternate path task related to the refueling interlock test.

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/26/97	Negative	IR 97-07	N	OPS	5C	An improperly substituted component (tachometer generator brushes) for the recirculation system by a vendor ultimately resulted in plant single loop operation due to recirculation motor generator set oscillations. The licensee generated an action commitment tracking system item to plan replacement of the brushes for the other recirculation loop with a due date of about 1 year past the potential failure date of the brushes based on the due date, this planned corrective action was not prudent and could result in an unplanned plant transient.

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
2/22/98	Negative	IR 97-10	N	MAINT	2A	A full face gasket on an inspection port degraded because of flow turbulence and resulted in the "B" standby gas treatment system fan being inoperable. There was no guidance for the type of gasket to be installed. The licensee's review of and corrective actions for the problem were of sufficient scope and depth.
2/22/98	Negative	IR 97-10	N	MAINT	3A	An electrical short unexpectedly occurred during a power supply replacement intended to eliminate control room operator nuisance alarms, resulting in a partial loss of annunciators. Technical manual information concerning operation of the annunciator power supply was not fully utilized in the work planning process for annunciator power supply replacement. This resulted in a delay in restoring control room annunciators in order to conduct additional research into how to restore the annunciator function.
1/13/98	Negative LER	LER 97-12	L	MAINT	3A	Drywell personnel airlock outer door seals local leak rate test (LLRT) not properly performed. Loss of configuration control caused failure to perform LLRT for personnel airlock.
12/21/97	Negative	IR 97-08	N	MAINT	2B	The licensee's use of junction boxes for temporary storage of parts was considered to be a poor work practice.
12/21/97	VIO	IR 97-08 VIO 97-08-02 LER 97-011	S	MAINT	3A 1C 3C	Work control activities associated with troubleshooting to locate a DC ground were unsatisfactory and resulted in an invalid engineered safeguards feature actuation signal for the high pressure coolant injection system. The fact that the primary containment isolation system was inoperable was not recognized and therefore TS limiting condition for operation was not entered. This is a violation of TS 3.7.D.2
12/21/97	Positive	IR 97-08	N	MAINT	3A 5C	Extensive supervisor involvement was noted during emergency diesel generator activities. Emergent issues were effectively addressed through good coordination between licensee departments.
10/26/97	VIO	IR 97-07 VIO 97-07-01	N	MAINT	2B 3A	Incorrect oil was used in several pumps. The procedure change program was not sufficiently controlled to ensure that work instructions to perform pump lubrication would be accurate. Additionally, review efforts were not thorough enough to identify the error. The licensee's operability review and corrective actions associated with the pumps were timely and satisfactory. This is violation of TS 6.8.A.1
10/26/97	Negative	IR 97-07	N	MAINT	2A	Generally, plant material condition was considered to be acceptable. However, there were several specific issues that detracted from the overall appearance and condition of the plant. The licensee adequately addressed the specific items which were noted.

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/26/97	Positive	IR 97-07	N	MAINT	5C	Licensee actions to address the potential for residual heat removal service water system degradation due to strainer gasket deterioration, including the operability; review were appropriate. The previous modification to address strainer gasket cover leakage was ineffective in that the potential for the flow turbulence to destroy the gasket was not recognized.
10/26/97	Negative	IR 97-07	S	MAINT	3A 3C	A personnel error that occurred during the installation of a limit switch operating arm in the Emergency Diesel Generator (EDG) breaker indicate that continued licensee focus on attention to detail is warranted.
10/26/97	Positive	IR 97-07	N	MAINT	3A 1C	The work activities associated with the "B" EDG were generally well conducted and had good management as well as supervisory oversight. Emergent maintenance issues, including the degraded voltage regulator transformer and contaminated fuel oil were adequately addressed. EDG maintenance activities were well conducted.

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
10/26/97	Negative URI	IR 97-07 URI 97-07-02	N	ENG	4B 3C	Questions concerning evaluations and procedures for moving spent fuel to the perimeter regions of the fuel pool using the reactor building crane were raised. Subsequent evaluations were in progress.
2/22/98	Negative URI	IR 97-10 URI 97-10-02	N	ENG	2B	The current method of testing secondary containment did not take into account the single train isolation design of the reactor building isolation system. A failure of a building radiation monitor could result in isolation of one set of building isolation valves, leaving the other valves unisolated in the event of a high radiation signal. However, the reactor building leak rate test is conducted with both sets of the building isolation valves closed. This testing configuration may not reveal a degraded reactor building isolation valve and its adverse effect on secondary containment. This issue will remain open pending review of the potential design and/or testing inadequacies associated with secondary containment.
12/21/97	Positive	IR 97-08	N	ENG	2A 2B	The licensee's program to monitor safety relief valve (SRV) leakage was effective. Licensee management exercised good judgement in electing to shut down the plant to effect repairs to leaking SRVs.
2/22/98	Positive	IR 97-10	N	ENG	3A	A previously damaged fuel pin resulted in two loose fuel pellets on the spent fuel pool floor. Actions to recover the fuel pellets were well conducted and procedures were effectively used.
2/22/98	Positive	IR 97-10	N	ENG	5A 5C	The identification of the loose connections, incorrect hardware and joint configuration were good observations and corrective actions were prompt and thorough. The licensee replaced portions of the reactor protection system electrical protection assemblies and identified several component discrepancies including loose connections, improper assembly and incorrect bolting configuration.
12/19/97	Negative	IR 97-11	N	ENG	4A 4B 5C	The disposition of a deviation/event report for replacement of a nonsafety-related 24 vdc power supply in the TIP system was weak. No actions were taken to ensure that personnel performing installation must read and understand instructions before starting installation.
12/21/97	VIO Negative	IR 97-08 VIO 97-08-03	N	ENG	4C 4A	Environmental qualification (EQ) components for the high pressure coolant injection system were erroneously removed from the EQ program. Component safety function was not recognized during a program completed in 1993 which led to the erroneous removal of several components from the EQ program. When this issue was identified, engineering was slow to address system operability and a justification for continued operation. This is a violation of 10 CFR 50.49(f) and 10 CFR 50.49(j).

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
11/20/97	LER	LER 97-010	L	ENG		Surveillance testing of the pressure suppression chamber-drywell vacuum breakers could have resulted in a partial loss of the primary containment pressure suppression safety function. Technical reviews of procedures which utilize this configuration were inadequate. Accident analysis assumptions did not include a configuration where steam could bypass the suppression pool, via the 20 inch and 24 inch lines, and enter the torus space.
10/26/97	Negative	IR 97-07	N	ENG	4A	The previous modification to address strainer gasket cover leakage was ineffective in that the potential for the flow turbulence to destroy the gasket was not recognized. Previous ineffective corrective action.

FITZPATRICK PLANT ISSUES MATRIX

Date	Type	Source	ID	SFA	Code	Item Description
12/21/97	Positive	IR 97-08	N	PS	3C	Radiological housekeeping was good; aisle ways were clear and clean; storage areas were clean and orderly; contaminated areas were minimized; radioactive material was clearly and properly labeled and stored in an orderly fashion.
1/22/98	Positive	RE 97201	N	PS	1C	Security force demonstrated an effective contingency response capability.
12/21/97	Positive	IR 97-08	N	PS	1A	On December 11, 1997, an emergency plan drill with Nine Mile Point demonstrated solid performance of the Emergency Preparedness staff and licensee organization.
12/21/97	Positive	IR 97-08	N	PS	1C	Solid radioactive waste and transportation program were well managed and effective. Quality assurance audits were thorough, programmatic and well documented. Training was appropriate. However, training program was not well administered.
10/26/97	Positive	IR 97-07	N	PS	1A	Procedures were in place to direct the appropriate response to fires in the control room and control room evacuation in the event of a relay room CO2 system discharge. Operators were knowledgeable of equipment operation and familiar with the associated procedures.
10/26/97	Negative	IR 97-07	N	PS	3B 5B	Initial operator actions to investigate and respond to a fire protection system alarm were appropriate, although it was questionable whether it is necessary to remove an automatic function of a fire water suppression system from service due to the false alarm. Apparently poor coordination and communication between different licensee departments resulted in the fire protection system being isolated for a longer period of time than was necessary.
10/26/97	Positive	IR 97-07	N	PS	1C 2B 3C	The radioactive liquid and gaseous effluent control programs were well implemented. Good management control and oversight of the radioactive liquid and gaseous effluent control programs was noted. The radiation monitoring system calibration program was well implemented. Reactor Monitor System (RMS) reliability has been generally good. The air cleaning system program area was well-implemented. Monitoring and trending of air cleaning system performance parameters was a noted Positive. The technical depth of quality assurance audits was good and chemistry laboratory quality assurance/quality control was very good.
10/6/97	LER	LER 97-009	L	MAINT		Exceeded quarterly calibration frequency for radwaste building exhaust radiation monitor. Missed surveillance was the result of personnel error. Cause of the error was poor work practices.
10/3/97	Positive	IR 97-80	N	MAINT	3B 4B	System engineers were very knowledgeable and had performed effective root cause evaluations and corrective action determinations, despite high turnover within the system engineers.

ABBREVIATIONS USED IN PIM TABLE

ACTS	Action Commitment Tracking System
CO2	Carbon Dioxide
DC	Direct Current
EDG	Emergency Diesel Generator
EQ	Equipment Qualification
ESF	Engineered Safety Feature
LLRT	Local Leak Rate Test
OSRE	Operational Safeguards Readiness Exam
RMS	Radiation Monitoring System
SBGTS	Standby Gas Treatment System
SRV	Safety Relief Valve
TIP	Traverse Incore Probe
TS	Technical Specifications

GENERAL DESCRIPTION OF PIM TABLE COLUMNS

Date	The actual date of an event or significant issue for those items that have a clear date of occurrence (mainly LERs), the date the source of the information was issued (such as for EALs), or the last date of the inspection period (for IRs).
Type	The categorization of the item or finding - see the Type / Findings Type Code table, below.
Source	The document that describes the findings: LER for Licensee Event Reports, EAL for Enforcement Action Letters, or IR for NRC Inspection Reports.
ID	Identification of who discovered issue: N for NRC; L for Licensee; or S for Self Identifying (events).
SFA	SALP Functional Area Codes: OPS for Operations; MAINT for Maintenance; ENG for Engineering; and PS for Plant Support.
Code	Template Code - see table below.
Item Description	Details of NRC findings on LERs that have safety significance (as stated in IRs), findings described in IR Executive Summaries, and amplifying information contained in EALs.

TYPE / FINDINGS CODES

ED	Enforcement Discretion - No Civil Penalty
Strength	Overall Strong Licensee Performance ³
Weakness	Overall Weak Licensee Performance
EEI *	Escalated Enforcement Item - Waiting Final NRC Action
VIO	Violation Level I, II, III, or IV
NCV	Non-Cited Violation
DEV	Deviation from Licensee Commitment to NRC
Positive	Individual Good Inspection Finding
Negative	Individual Poor Inspection Finding
LER	Licensee Event Report to the NRC
URI **	Unresolved Item from Inspection Report
Licensing	Licensing Issue from NRR
MISC	Miscellaneous - Emergency Preparedness Finding (EP), Declared Emergency, Nonconformance Issue, etc. The type of all MISC findings are to be put in the Item Description column.

TEMPLATE CODES

1	Operational Performance: A - Normal Operations; B - Operations During Transients; and C - Programs and Processes
2	Material Condition: A - Equipment Condition or B - Programs and Processes
3	Human Performance: A - Work Performance; B - Knowledge, Skills, and Abilities / Training; C - Work Environment
4	Engineering/Design: A - Design; B - Engineering Support; C - Programs and Processes
5	Problem Identification and Resolution: A - Identification; B - Analysis; and C - Resolution

NOTES:

* EEIs are apparent violations of NRC requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the EEIs and the PIM entries may be modified when the final decisions are made. Before the NRC makes its enforcement decision, the licensee will be provided with an opportunity to either (1) respond to the apparent violation or (2) request a predecisional enforcement conference.

** URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.

Enclosure 2

FitzPatrick Inspection Plan

INSPECTION	TITLE/PROGRAM AREA	PLANNED DATES	INSP. TYPE COMMENTS
64704	Fire Protection Program	7/13-17	Core
81700	Physical Security Program for Power Reactors	7/20-24	Core
82701	Operational Status of the Emergency Preparedness Program	7/27-31	Core
40500	Effectiveness of Licensee Controls in Identifying, Resolving & Preventing Problems	7/27-3 8/10-14	Core
93809	Safety System Engineering Inspection		
37001	10 CFR 50.59 Safety Evaluation Program		
83726	Control of Radioactive Materials and Contamination, Surveys, and Monitoring	8/31-9/4	Regional Initiative
73753	Inservice Inspection	10/26-30	Core
83750	Occupational Radiation Exposure-Outage	10/26-30	Core