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JAFP-14-0001
January 06, 2014

United States Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

SUBJECT: LER: 2013-005-00, Failure to Isolate the Reactor Building Results in a
Condition Prohibited By Technical Specifications
James A. FitzPatrick Nuclear Power Plant
Docket No. 50-333
License No. DPR-59

Dear Sir or Madam:

This report is submitted in accordance with 10 CFR 50.73(a)(2)(i)(B), "Any operation or condition which was prohibited by the plant's Technical Specifications...".

There is no commitment contained in this report.

Questions concerning this report may be addressed to Mr. Chris M. Adner, Manager, Regulatory Assurance, at (315) 349-6766.

Sincerely,

A handwritten signature in black ink that reads "Lawrence M. Coyle".

Lawrence M. Coyle
Site Vice President

LMC/CMA

Enclosure: LER: 2013-005-00, Failure to Isolate the Reactor Building Results in a Condition Prohibited By Technical Specifications

cc:

USNRC, Region 1

USNRC, Project Directorate

USNRC, Resident Inspector

INPO

Document Components:

001 Transmittal Letter with Enclosure

NRC FORM 366 (10-2010)			U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB: NO. 3150-0104 EXPIRES: 10/31/2013 Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.					
LICENSEE EVENT REPORT (LER)											
1. FACILITY NAME James A. FitzPatrick			2. DOCKET NUMBER 05000333		3. PAGE 1 OF 6						
4. TITLE Failure to Isolate the Reactor Building Results in a Condition Prohibited by Technical Specifications											
5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER	
11	07	2013	2013 – 005– 00			01	06	2014	N/A	N/A	
9. OPERATING MODE 01			11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) <input type="checkbox"/> 20.2201(b) <input type="checkbox"/> 20.2203(a)(3)(i) <input type="checkbox"/> 50.73(a)(2)(i)(C) <input type="checkbox"/> 50.73(a)(2)(vii) <input type="checkbox"/> 20.2201(d) <input type="checkbox"/> 20.2203(a)(3)(ii) <input type="checkbox"/> 50.73(a)(2)(ii)(A) <input type="checkbox"/> 50.73(a)(2)(viii)(A) <input type="checkbox"/> 20.2203(a)(1) <input type="checkbox"/> 20.2203(a)(4) <input type="checkbox"/> 50.73(a)(2)(ii)(B) <input type="checkbox"/> 50.73(a)(2)(viii)(B) <input type="checkbox"/> 20.2203(a)(2)(i) <input type="checkbox"/> 50.36(c)(1)(i)(A) <input type="checkbox"/> 50.73(a)(2)(iii) <input type="checkbox"/> 50.73(a)(2)(ix)(A) <input type="checkbox"/> 20.2203(a)(2)(ii) <input type="checkbox"/> 50.36(c)(1)(ii)(A) <input type="checkbox"/> 50.73(a)(2)(iv)(A) <input type="checkbox"/> 50.73(a)(2)(x) <input type="checkbox"/> 20.2203(a)(2)(iii) <input type="checkbox"/> 50.36(c)(2) <input type="checkbox"/> 50.73(a)(2)(v)(A) <input type="checkbox"/> 73.71(a)(4) <input type="checkbox"/> 20.2203(a)(2)(iv) <input type="checkbox"/> 50.46(a)(3)(ii) <input type="checkbox"/> 50.73(a)(2)(v)(B) <input type="checkbox"/> 73.71(a)(5) <input type="checkbox"/> 20.2203(a)(2)(v) <input type="checkbox"/> 50.73(a)(2)(i)(A) <input type="checkbox"/> 50.73(a)(2)(v)(C) <input type="checkbox"/> OTHER <input type="checkbox"/> 20.2203(a)(2)(vi) <input checked="" type="checkbox"/> 50.73(a)(2)(i)(B) <input type="checkbox"/> 50.73(a)(2)(v)(D)								
10. POWER LEVEL 100			Specify in Abstract below or in NRC Form 366A								
12. LICENSEE CONTACT FOR THIS LER											
FACILITY NAME Mr. Chris Adner, Manager, Regulatory Assurance								TELEPHONE NUMBER (Include Area Code) 315-349-6766			
13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT											
CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX		
14. SUPPLEMENTAL REPORT EXPECTED						15. EXPECTED SUBMISSION DATE			MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO						<input type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO					
ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) <p>On November 07, 2013, with the "A" Reactor Building Ventilation Radiation Monitor inoperable, the required action for Technical Specification (TS) 3.3.6.2 Condition A was not met within the required completion time of 24 hours. In addition, the required actions for TS 3.3.6.2 Condition C were also not met within the completion time of 1 hour after the action for Condition A was not completed. The failure to perform the TS required actions within the required completion times resulted in a condition prohibited by the TS which is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B).</p> <p>The apparent cause of this event was operating procedures instructions were not adequately followed and understood. Additionally control room personnel failed to verify that the actual plant configuration matched the configuration needed to remain compliant with the TS. Immediate corrective actions included isolating the reactor building ventilation system to restore compliance with the TS. All involved control room personnel were removed from watch standing duties. Following remediation, some personnel were reinstated. Operations Management briefed on-coming watch crews on this event and the need to resolve discrepant items identified during turnover. Additionally, Shift Managers were briefed on the need to be more intrusive on TS related work preparation activities and execution.</p>											

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NARRATIVE

EVENT DESCRIPTION

At 0740, November 7, 2013, with the “A” Reactor Building Ventilation Radiation Monitor (17RM-452A) [EIS System Identifier: IL] inoperable, the required action for Technical Specification (TS) 3.3.6.2 Condition A was not met within the required completion time of 24 hours. In addition, the required actions for TS 3.3.6.2 Condition C were also not met within the completion time of 1 hour after Condition A was not met. The failure to perform the TS required actions within the required completion time resulted in a condition prohibited by the TS which is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B).

SEQUENCE OF EVENTS

On November 6, 2013, the plant was in mode 1 at 100% power. Planned daily activities included removing 17RM-452A and its associated sample pump, “A” Reactor Building Exhaust Monitor Rack Sample (17P-36A) from service for planned replacement of the sample pump. At 0735, the Operations Field Support Supervisor (FSS) authorized protective tagging (tagout) to be hung in support of the maintenance activities to replace the pump. Subsequent to this the FSS referred to the appropriate operating procedure for removing a reactor building radiation monitor from service. At 0740 the FSS directed Chemistry to perform verification of Operable monitor “B” Reactor Building Ventilation Radiation Monitor (17RM-452B) [IL]. Once this was complete, the FSS directed Instrument & Control technicians to remove 17RM-452A from service. The FSS did not consult the Offsite Dose Calculation Manual (ODCM) or TS as required by procedure but rather relied on recent experience with removing a non-Reactor Building Radiation Monitor from service the day before. The non-Reactor Building Radiation monitors only have ODCM requirements to have one of two monitor channels in service.

The Reactor Building Radiation monitors require both channels to be Operable for Secondary Containment Isolation Safety Function. Removing a single Reactor Building Radiation Monitor from service requires entry into Tech Spec 3.3.6.2 Condition A. Condition A requires placing the channel in trip within 24 hours whenever one channel of the Reactor Building Ventilation Radiation Monitor is inoperable. If Condition A is not met, Condition C requires one of the following within one hour: (1) Isolate the associated secondary containment penetration flow path, i.e. isolate the Reactor Building Ventilation System (RBVS) [NG], or (2) declare the associated secondary containment isolation valves inoperable. Either option requires placing the associated Standby Gas Treatment (SGT) [BH] Subsystem in operation or declaring the associated SGT subsystem inoperable.

During the time period that the tagout was being hung the Work Control Supervisor (WCS) performed a tagout and work order (WO) challenge with the maintenance personnel performing the pump replacement. The WCS reviewed the Operation Impact in the work order and noted that an action statement for a TS Limiting Condition for Operation (LCO) was applicable. He contacted the Control Room Supervisor (CRS) and was informed that the action was being tracked.

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SEQUENCE OF EVENTS (CONTINUED)

Maintenance completed the pump replacement and on November 6, 2013 at 1314 the tagout for the pump replacement was authorized for removal. To support additional planned maintenance on the radiation monitor, a line inspection, a second tagout was approved to be hung at 1320 on the same day. This tagout had similar guidance to remove the radiation monitor from service per applicable sections of the same operating procedure referenced by the first tagout. It also had guidance to refer to a caution tagout for applicability of reactor building isolation. The same FSS briefed this tagout at 1325. He did not refer to the referenced operating procedure since he considered that section was completed earlier in the shift.

At 1800 on November 6, shift turnover was conducted between dayshift and nightshift. The FSS turnover notes stated 17RM-452A was removed from service. During the control room panel walk down the oncoming SM noticed an annunciator in alarm for the RB radiation monitor being out of service. He made a mental note to follow up on why there was no corresponding LCO action statement entry in the logs. Prior to resolution of this apparent discrepancy, the operating crew commenced a down power to address an emergent condenser tube leak.

On November 7 at 0600 turnover was conducted between the night shift and the day shift. The oncoming dayshift was the same crew that was on during the previous day. At 0740 on November 7, TS 3.3.6.2 Condition A expired for 17RM-452A, and entry into TS 3.3.6.2 Condition C was required. As noted earlier in this narrative, this Condition has a 1 hour completion time.

At 0754 the Work Control Supervisor (WCS) performed a tagout and work order challenge with the maintenance personnel performing the line inspection. Again the Operation Impact in the work order was reviewed and it referenced Technical Specifications: LCO 3.3.6.2 Table 3.3.6.2-1, Function 3, and ODCM LCO 3.1.1. It additionally stated the affected radiation monitor 17RM-452 A was rendered inoperable.

The WCS recognized the requirement to isolate the reactor building had expired. He went to the control room to brief the CRS. The CRS told the WCS that the ODCM only required a single channel. The WCS returned to the WCC to review the TS requirements and re-perform the WO Operational Impact if necessary. At approximately 1220 the WCS completed his TS and WO Operational Impact review. He was still convinced the RB ventilation was required to be isolated and informed the WWM. The WWM notified the SM of the WCS concern about the reactor building not being isolated as required by TS.

By 1245 the shift Senior Reactor Operators had completed their review of the TS and ODCM requirements and concluded that a TS action statement had been missed.

At 1247 the control room staff isolated the reactor building ventilation and placed 'A' SGBT in service to satisfy TS 3.3.6.2.C Action requirements.

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EXTENT OF CONDITION

The LCO module was reviewed to ensure compliance for all current active LCOs. No other deficiencies were identified. Additionally, a review of the work schedule and narrative log was performed for the previous 24 hours to identify all work tasks requiring TS/TRM/ODCM evaluation to ensure the appropriate actions were taken to maintain compliance with the associated specifications.

CAUSE OF EVENT

The apparent cause of this event was the FSS did not adequately follow and understand operating procedure instructions when authorizing work on a RBVS radiation monitor. The involved individual failed to review the associated TS LCO requirements as required in the procedure instructions. The FSS allowed himself to get distracted / involved in other activities and he never entered the required Technical Specifications and Technical Requirements Manual actions. He did not follow procedures correctly or request a peer check for his actions. This can be categorized as a program breakdown by a single human error.

There were several opportunities that could have prevented this event from occurring. When briefing the removal of the Reactor Building Radiation Monitor per OP-31, section F.5, the reactor operator (RO) asked if the review of TS and the TRM was completed. Because the FSS was familiar with the specifications and requirements, the RO was told that he could proceed with the procedure even though the specifications and requirements were not yet formally reviewed. The FSS intended to perform a formal review subsequent to the briefing but he became involved with other activities. This resulted in not performing a formal review and not entering the required Technical Specifications and Technical Requirements Manual actions. Because the FSS never entered and logged entry into an LCO, a peer check by a second SRO did not occur.

Contributing to this event was failure of the Operation Work Control Supervisor to ensure the LCO actions were met and being tracked in the LCO log following the Work Authorization Challenge. The Work Order (WO) Operational Impact Statement correctly referenced the appropriate Technical Specifications and Technical Requirements Manual sections. The Work Control Supervisor performed a Work Authorization Challenge and reviewed the Plant Impact with the maintenance group. Although the WCS briefed the CRS that the maintenance crews were going to work he did not ensure the actual LCO was met or AP-12.08, LCO TRACKING AND SAFETY FUNCTION DETERMINATION PROGRAM, requirements to track the LCO were met.

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CAUSE OF EVENT (CONTINUED)

A second contributing cause was failure to track resolutions for deviations identified during the turnover process. As part of the pre-shift brief and turnover, each licensed operator reviews the LCO log and performs a control room panel walk down. It was identified that the reactor building ventilation radiation monitor downscale annunciator window was in alarm with no corresponding LCO entry by the oncoming night shift, but follow-up and resolution of this discrepancy was not tracked because a condenser waterbox leak and subsequent down power shortly after turnover became the primary focus of the crew.

SAFETY CONSEQUENCES

Actual

There were no actual industrial, radiological, or nuclear safety consequences during or as a result of this event.

Potential

There are no potential industrial or radiological safety concerns as a result of this condition. This issue deals with a missed Technical Specification required action that does not have any industrial or radiological safety implications. The potential nuclear safety consequences are minimal and are explained in the following paragraphs.

The purpose of the “A” Reactor Building Ventilation Radiation Monitor is to generate a trip signal upon detecting high exhaust radiation levels in the reactor building ventilation system. High secondary containment exhaust radiation is an indication of possible gross failure of the fuel cladding and may originate from the primary containment due to a break in the reactor coolant pressure boundary. The trip signal would isolate the RBVS and start the SGT System thus limiting any fission product releases during a design basis accident (DBA).

The failure to take the required actions for one channel being inoperable per TS 3.3.6.2 increases the potential nuclear safety risk because the ability to isolate the secondary containment and start the SGT System cannot be ensured. However this risk was minimal because the “B” Reactor Building Ventilation Radiation Monitor channel (17RM-452B) was operable during this event and would have provided the isolation function if required. In addition, if 17RM-452B were to lose power or fail downscale, a reactor building ventilation isolation would have occurred and the SGT system would have started. Also, the reactor building operator takes rounds on the Reactor Building Ventilation Radiation Monitor every shift to ensure that it is reading properly – an equipment failure would be quickly detected.

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PREVIOUS SIMILAR EVENTS

A review of LER's and condition reports for the previous four years found four similar events: CR-JAF-2010-6556, CR-JAF-2011-00189 (LER-2011-002-00), CR-JAF-2012-2591, and CR-JAF-2012-8359 (LER-2012-009-00). Each of these events had aspects related to human performance. The corrective actions included process changes, training on controlling procedures for TS associated activities and individual accountability. Additionally, the station performed a root cause evaluation (RCE) (CR-JAF-2012-08767) for Operations Department Human Performance Error Rate. This RCE was completed in February of 2013 and the effectiveness review is scheduled for January of 2014. The causes identified in this RCE were: Inadequate Program Monitoring or Management, inadequate communication within the organization and personnel exhibited insufficient awareness of the impact of actions on safety/reliability. Corrective actions have been implemented to change these embedded behaviors. Improvements in this area are apparent based on trending of the Operations Department Human Performance Error Indicator.

CORRECTIVE ACTIONS

Completed Actions

- The RBVS was isolated and the SGT system started; restoring compliance with TS LCO 3.3.6.2.
- All involved control room personnel were removed from watch standing duties. Following remediation, some personnel were reinstated.
- On-coming control room operators briefed by Operations management on the need to resolve discrepant items identified during turnover.
- Expectation established for shift managers to approve each LCO action entry as a third check.
- Operations management briefed shift managers to be more intrusive in work planning and work execution activities involving TS related equipment.

Open Actions

- All operating crews, Work Control Supervisors and Work Week Managers are to review the apparent cause evaluation associated with this event for lessons learned.

REFERENCES

- JAF Condition Report, CR-JAF-2013-05676
- Technical Specification (and Bases) 3.3.6.2, Secondary Containment Isolation Instrumentation